CANCER TREATMENT PROTOCOLS

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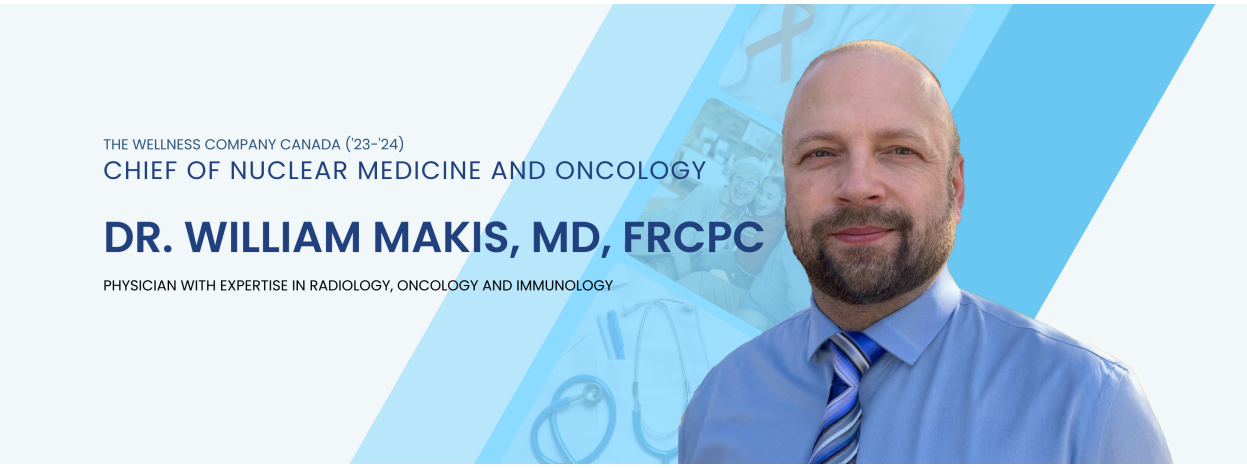
This is a Grok AI generated informational package drawing from Dr. William Makis' publicly discussed experimental approaches. This is not a product of Dr. Makis.



Dr. William Makis, MD, FRCPC, is a Canadian physician specializing in nuclear medicine, radiology, and oncology. He graduated from McGill University Faculty of Medicine (Class of 2005) and completed specialty training in nuclear medicine. He previously served as a nuclear medicine oncologist at the Cross Cancer Institute in Edmonton, Alberta, where he was involved in PET/CT imaging, targeted radionuclide therapy (theranostics), and neuroendocrine tumor management. He held positions including PET/CT Lead, Theranostics Expert, and Assistant Clinical Professor in the Department of Radiology and Diagnostic Imaging at the University of Alberta. Makis has authored over 100 peer-reviewed publications, with research cited more than 1,200 times, focusing on nuclear medicine, PET/CT, and targeted cancer therapies.

Dr. Makis's license with the College of Physicians & Surgeons of Alberta is inactive, and he argues his 2019 license cancellation and 2025 CPSA injunction were retaliatory, triggered by his whistleblowing on alleged corruption and patient harm at the Cross Cancer Institute. He sees these actions as attempts to silence his criticism of mainstream medicine, vaccine policies, and his promotion of repurposed drugs.

Dr. Makis has gained prominence through his Substack newsletter (a top medical author platform), where he discusses cancer research, repurposed drug protocols (e.g., ivermectin for "turbo cancers"), and related topics. He offers worldwide personalized cancer consultations via wmcareconsult.online and can be contacted at info@makisw.com.

Important Disclaimer

This is not medical advice or a prescription, but an educational overview of components commonly referenced in Dr. William Makis' discussions. The approaches involve experimental and off-label uses of repurposed drugs (such as ivermectin, fenbendazole, and mebendazole) and nutritional supplements, supported primarily by preclinical studies, small case series (including fenbendazole self-administration reports), and anecdotal patient outcomes, with claimed response rates exceeding 75% in his clientele. No large-scale randomized controlled trials (RCTs) currently validate the safety or efficacy of these regimens for cancer treatment. Always consult a licensed oncologist first for evidence-based care, proper integration with standard treatments such as chemotherapy or immunotherapy, and to avoid potential drug interactions or risks.

CORE REPURPOSED DRUGS FOR CANCER

These target microtubule disruption, apoptosis, autophagy, immunogenic cell death, and metastasis inhibition while supporting immune activation.

Ivermectin — Often the foundation (dose-dependent for cancer cell killing).
- Low/mild: 0.2–0.5 mg/kg, 3×/week or daily.
- Moderate: 0.5–1 mg/kg daily.
- Severe/aggressive ("turbo"): 1–2 mg/kg daily (up to 2.5 mg/kg in extreme cases; watch for side effects like vision changes).
- Cycles: Often 3 weeks on/1 week off; with fatty meal.

Fenbendazole (preferred for advanced/metastatic cases; high-dose tolerant).
- Typical: 444–1776 mg/day (or pulsed: 888–1000 mg 3–6 days/week).
- With fatty meal for absorption; often cycled.

Mebendazole (human-approved; preferred for brain cancers, absorption issues, or synergy).
- Typical: 1000–1500 mg/day.
- Often combined with fenbendazole in refractory/hybrid protocols for broader coverage.

Combination Strategy: Many cases use ivermectin + fenbendazole (or + mebendazole) for synergy, especially stage 4 or chemo-resistant. Adjust based on response (e.g., tumor marker drops, scans).

5 PRIORITY SUPPLEMENTS

- **Vitamin D3 + K2 + Magnesium**: High-dose repletion (5,000–10,000+ IU D3/day; aim serum 25(OH)D ≥80 ng/mL) — immune boost, anti-cancer protection (mitochondrial/stem cell effects). Test baseline + every 2–4 weeks initially.

- **Curcumin** (with piperine/black pepper for bioavailability): 600 mg+ daily — anti-inflammatory, anti-metastatic, NF-κB/TNF-α suppression.

- **Berberine**: 500–600 mg twice daily — metabolic targeting (glucose/insulin control, AMPK activation).

- **Milk Thistle** (silymarin): 250–350 mg/day — hepato (liver) protection (key during high benzimidazole (' bendazole') doses)

- **Zinc**: Replete to 80–120 µg/dL serum — immune/mitochondrial function.

Optional Add-Ons (tailor per case; e.g., for extra immunity/detox):

- Black seed oil (Nigella sativa)
- Lactoferrin (with ivermectin/zinc).
- Turkey tail mushroom.
- Melatonin (10–40 mg nightly).
- High-dose vitamin C, tocotrienols (vitamin E form), bromelain, garlic/ginger/olive leaf.

Take supplements with fatty meals; low-carb diet + intermittent fasting recommended.

MONITORING AND SAFETY ESSENTIALS

Regular labs ensure tolerability, dose tweaks, and objective tracking (e.g., marker reductions like 80–99% CA19-9 drops in anecdotes).

Baseline + every 1–3 months:
- Liver function (ALT/AST, bilirubin, ALP).
- Kidney (creatinine, BUN via CMP).
- CBC (anemia/neutropenia check).
- CMP (electrolytes, glucose).
- Tumor markers (cancer-specific: CA19-9, CEA, PSA, etc.).
- Vitamin D (25(OH)D), zinc.
- Optional: CRP (inflammation), coagulation.

Imaging: PET/CT or scans to track progression/response.

LIFESTYLE AND GENERAL GUIDANCE

- Diet: Ketogenic/low-carb; avoid sugars (cancer metabolic targeting).
- Intermittent Fasting(e.g., 16 fasting window/8 eating window) for autophagy synergy.
- Start slow: Begin core drugs + top supplements after baseline labs.
- Response tracking: Monitor symptoms, markers, scans (e.g., 1–4 months for changes in testimonials).
- If no response: Escalate doses, rotate/add combos, or consult for adjustments.
- Support: 24/7 monitoring in some protocols; detox kits for chemo recovery.

Intermittent fasting involves cycling between eating and fasting periods (e.g., 16 hours fasting, 8 hours eating). It lowers insulin/glucose to starve cancer cells, stresses tumors metabolically, and enhances synergy with repurposed drugs like ivermectin and fenbendazole.

MECHANISMS OF ACTION & TREATMENT INSIGHTS

Three repurposed medicines can help fight cancer in several ways.

Ivermectin slows down cancer cell growth and spread by blocking certain signals inside the cells, triggers different forms of cell death (including ones that alert your immune system), and may help your immune cells better recognize and attack the cancer. It can also target stubborn cancer stem cells and sometimes make other treatments work better.

Fenbendazole works by damaging the tiny tubes (microtubules) that cancer cells need to divide and move, causing them to stop growing or die. It also interferes with how cancer cells use sugar for energy and harms their mitochondria (powerhouses), which weakens the tumor overall.

Mebendazole does something similar—it disrupts those same microtubules, stops cancer cells from dividing, promotes cell death, and reduces new blood vessel growth that tumors need to survive. It's especially noted for reaching brain tumors more effectively.

Together or in combination, these drugs aim to directly harm cancer while helping strengthen your immune system so it can better overwhelm and control the disease. This is still an experimental approach—always talk with your doctor about what's safe and right for you.

For physicians: Preclinical anticancer activity through multiple mechanisms.

Ivermectin inhibits proliferation, migration, and angiogenesis in diverse cancer cell lines by modulating PAK1 kinase and other signaling cascades. It induces apoptosis, autophagy, and pyroptosis, while promoting immunogenic cell death via HMGB1 release and calreticulin exposure on the cell surface. This enhances antigen presentation and T-cell activation, shifting the tumor microenvironment from immunosuppressive to immunostimulatory. Ivermectin also targets cancer stem-like cells and may reverse multidrug resistance by inhibiting P-glycoprotein-mediated efflux.

Fenbendazole and mebendazole, benzimidazole microtubule-destabilizing agents, disrupt tubulin polymerization, leading to mitotic arrest at the G2/M phase, subsequent apoptosis, and inhibition of cell division. They impair glucose uptake and glycolytic metabolism, induce mitochondrial dysfunction, and suppress angiogenesis. Fenbendazole shows activity in resistant models, often enhanced when combined with vitamins or other agents. Mebendazole demonstrates superior blood-brain barrier penetration, making it particularly relevant for CNS malignancies.

In combination regimens, these agents may exert synergistic direct cytotoxicity while augmenting adaptive immune responses, potentially enabling immune-mediated tumor clearance. Observed effects remain largely preclinical and anecdotal in human use; large-scale prospective clinical trials are absent. Off-label application requires careful risk-benefit assessment, monitoring of hepatic/renal function, and integration with established oncology standards.

Dr. Makis discusses and shares testimonials/case reports for specific protocols (often involving ivermectin + fenbendazole/mebendazole, plus supplements) in numerous major/systemic cancers, particularly aggressive or "turbo" types post-vaccination. These are experimental/off-label, based on his anecdotes, preclinical data, and patient outcomes (no large RCTs).

He often uses similar core elements (high-dose ivermectin/fenbendazole hybrids, vitamin D repletion, curcumin, berberine, etc.) tailored by severity, with claimed rapid marker drops and remissions in many. For personalized details on your cancer type, email info@makisw.com or visit wmcareconsult.online—always consult licensed oncologists first for evidence-based integration. (198 words)

In testimonials and protocols, **he uses fenbendazole** (often 222–444 mg daily or 1000 mg 3x/week) alongside mebendazole **for difficult cancers like sarcomas, neuroendocrine tumors, lung cancers**, or when patients respond well to fenbendazole-inclusive regimens (e.g., Joe Tippens-inspired cases). Combinations appear in hybrid orthomolecular approaches for broader coverage, enhanced response rates (claimed ~75% in his clientele), or when fenbendazole's accessibility aids high-dose or pulsed use.

Makis prefers mebendazole (typically 1000–1500 mg/day) less commonly, such as when fenbendazole access is limited, absorption concerns arise, or in chemo-refractory cases (e.g., after multiple failed lines like FOLFIRINOX/Gem-Abraxane). One case used mebendazole alone with ivermectin for tumor control and shrinkage.

He **prefers mebendazole** over fenbendazole in cases where preclinical research indicates superior efficacy for specific cancer types. Mebendazole (FDA-approved for human use) shows stronger microtubule disruption, better potency in certain cell lines (e.g., **gastric, brain tumors like glioblastoma**), and advantages in scenarios requiring higher systemic absorption or targeting cancer stem cells and metastases. Makis cites studies where mebendazole outperforms fenbendazole or other chemotherapies in vitro/in vivo for select cancers, making it *his choice for low- to intermediate-grade* or specific histologies.

Makis recommends both (or allows substitution/combination) in many aggressive or stage IV cases, especially when aiming for synergy. Overall, mebendazole edges out for evidence-based potency in targeted cancers, while both together maximize impact in advanced, resistant, or multi-modal settings. These are experimental/off-label uses lacking large-scale clinical validation.

SPECIFIC CANCERS

For brain cancers (e.g., glioblastoma, glioma, astrocytoma, DIPG), Makis prefers mebendazole over fenbendazole Mebendazole crosses the blood-brain barrier effectively, shows superior preclinical potency and survival benefits in GBM models, and has human clinical trial data/patents (e.g., Johns Hopkins). Fenbendazole is used in some brain cases but is secondary due to poorer BBB penetration.

For uterine/endometrial cancers, Makis prefers fenbendazole (often with ivermectin) in most testimonials, using high doses (e.g., 1000–1500 mg/day) for stage 3–4 cases with dramatic responses like tumor shrinkage, no spread pre-surgery, or CA125 drops. Mebendazole (1000–1500 mg/day) is added for synergy in refractory or hybrid protocols when initial fenbendazole response is partial, enhancing outcomes in peritoneal mets. Fenbendazole dominates successes due to accessibility and tolerability.

For breast cancer, Makis prefers fenbendazole (often with ivermectin) in most testimonials and protocols, featuring prominently in stage 4 successes (e.g., metastatic to bones, CA15-3 drops 93–99%, tumor shrinkage/remission after months). Examples include 42-year-old Canadian (fenbendazole 1776 mg/day), 53-year-old Utah woman (remission in 11 months), and 51-year-old Canadian (fenbendazole 888 mg/day + ivermectin). Mebendazole is discussed less frequently for breast (e.g., TNBC preclinical synergy), used as add-on or hybrid in refractory cases, but fenbendazole dominates anecdotes due to accessibility and high-dose results.

For prostate cancer, Makis prefers fenbendazole over mebendazole based on numerous testimonials and protocols (e.g., stage 4 Gleason 9, PSA drops from thousands to low/single digits). Fenbendazole (often 888–1500+ mg/day with ivermectin) features prominently in successes like PSA 195→0.9, 385→1.2, or 2798→33, due to accessibility, high-dose use, and anecdotal responses. Mebendazole is used less commonly or as an add-on/hybrid for stubborn cases, but fenbendazole dominates prostate testimonials.

For stage 3 & 4 pancreatic cancer, Dr. William Makis strongly prefers fenbendazole (often 888–1776 mg/day, sometimes pulsed higher) combined with ivermectin as the core regimen in most cases. His numerous testimonials show rapid, dramatic responses: CA19-9 drops of 79–99%, tumor volume reductions of 40–99% (e.g., primary masses shrinking 80–84%, liver mets resolving or shrinking 70–99%), and even cancer-free outcomes after chemo failures or progression. Fenbendazole is favored for its accessibility, high-dose tolerability, anti-metastatic effects, and synergy in aggressive, metastatic, or poorly differentiated/neuroendocrine subtypes.

For lung cancer, Makis prefers fenbendazole (often combined with ivermectin) in most testimonials and protocols, including stage 3/4 NSCLC and small cell lung cancer, with notable successes such as bulky tumors shrinking dramatically or nearing remission in months. Fenbendazole is highlighted more frequently due to its accessibility and high-dose effectiveness in aggressive cases. Mebendazole appears as an occasional add-on or in hybrid regimens for added synergy, but fenbendazole dominates the shared patient outcomes.

For colorectal/bowel cancer, Makis features both fenbendazole and mebendazole in testimonials, but mebendazole is preferred in several recent stage 4 successes (e.g., Utah patient cancer-free in 3 months with ivermectin + mebendazole 1000 mg/day plus chemo; California man with tumor shrinkage). Fenbendazole appears frequently in other cases (e.g., Slovenia patient with near-complete liver met response), but mebendazole dominates his latest "cancer-free" stories due to synergy with chemo. Hybrids are common for advanced disease.

For ovarian cancer, Makis strongly prefers mebendazole (often 1000–1500 mg/day with ivermectin) in most testimonials and protocols, including multiple stage 4 successes like dramatic CA125 drops (e.g., 2138→357, 7200→30, 7000+→27), tumor shrinkage (up to 93–99%), metastasis resolution on PET/CT, and near-remission or cancer-free outcomes after months. Fenbendazole is used in some cases but less effectively; he notes South Korean research shows ovarian cancer responds poorly to fenbendazole without special delivery, and switched patients from it to mebendazole for better results. Hybrids or ivermectin + mebendazole dominate his shared ovarian cancer stories.

For lymphoma, Makis features both fenbendazole and mebendazole in testimonials (e.g., DLBCL, follicular, marginal zone), but he highlights fenbendazole prominently in

many recent successes, such as stage 4 DLBCL achieving near-complete remission in 3 months with ivermectin + fenbendazole (no chemo) or complete remission in under 2 months with ivermectin + fenbendazole + IP6. Fenbendazole dominates anecdotes for rapid, dramatic responses in aggressive cases.

Mebendazole appears in some combinations (e.g., ivermectin + mebendazole + RCHOP for remission), with literature leaning toward it in certain contexts, but he notes both work well in hybrids and doesn't show a strict preference—fenbendazole features more in his shared lymphoma stories due to high-dose accessibility and tolerability. These are anecdotal/experimental.

For sarcoma and melanoma, Makis features fenbendazole prominently in testimonials, often combined with ivermectin for advanced/metastatic cases. For melanoma, a key case series (co-authored by Makis) describes a stage 4 patient achieving complete remission (NED for 11+ months) with fenbendazole (222–444 mg/day) plus supplements and brief nivolumab—fenbendazole is highlighted for rapid ctDNA drops to zero. Sarcoma successes appear in broader anecdotes with fenbendazole high doses.

Mebendazole is used less specifically or as an add-on/hybrid in refractory scenarios, but fenbendazole dominates his shared stories for both due to accessibility, tolerability, and dramatic anecdotal responses in aggressive sarcomas/melanomas. These are experimental; contact info@makisw.com for details.

For hepatocellular/liver cancer, Makis features both fenbendazole and mebendazole in and cholangiocarcinoma testimonials, but often uses hybrids or switches based on response. In successes like a 40s UK athlete with 11cm inoperable intrahepatic cholangiocarcinoma (shrunk to 8cm necrotic after ivermectin + fenbendazole then mebendazole 1500mg/day + chemo) or a 75-year-old Florida man with cholangiocarcinoma (14cm tumor necrotic inside after ivermectin + mebendazole 1000mg/day), mebendazole features prominently for necrosis and synergy.

Fenbendazole appears in other cases (e.g., stage 4 colon with liver mets shrinking on ivermazole + fenbendazole 888mg/day). No strict preference; he combines or rotates them for advanced liver involvement, emphasizing tolerability even in liver failure cases (e.g., stage 4 melanoma with liver mets resolving on ivermectin + both). These are anecdotal/experimental.

For neuroendocrine tumors, Makis features both fenbendazole and mebendazole in neuroendocrine tumor testimonials (e.g., small cell neuroendocrine lung, small bowel, urethral, colorectal with neuroendocrine features), but he prominently highlights fenbendazole (often with ivermectin) in many successes: e.g., 55-year-old Texas man with multifocal neuroendocrine lung cancer achieving 95% tumor shrinkage after 1 year on fenbendazole 1332–1776 mg/day; 55-year-old Texas man with stage 4 small bowel neuroendocrine normalizing markers after 3 months; stage 4 small cell neuroendocrine urethral reaching full remission in 5 months. Fenbendazole dominates shared stories for

rapid, dramatic responses in aggressive neuroendocrine cases due to high-dose use and accessibility. Mebendazole appears occasionally in hybrids or switches, but fenbendazole is more frequently showcased. These are anecdotal/experimental.

For head and neck cancer, Makis features both fenbendazole and mebendazole in testimonials (e.g., squamous cell carcinoma of tonsil, epiglottis), often combined with ivermectin for aggressive or metastatic cases. He highlights mebendazole prominently in successes like a 62-year-old with HPV+ tonsil cancer (progressing to lung mets post-chemo/radiation) achieving cancer-free status (negative NavDx, near-complete pulmonary resolution) after 2.5 months on ivermectin 1mg/kg/day + mebendazole 1000mg/day plus chemo/immunotherapy.

Fenbendazole appears in other cases (e.g., advanced epiglottis cancer patient with "no options" reaching survival/gratitude after ivermectin + fenbendazole). No strict preference; he uses both or hybrids for synergy in refractory or post-treatment progression, with dramatic anecdotal responses in head/neck squamous cell types due to accessibility and tolerability. These are experimental.

For bladder cancer, Makis features fenbendazole prominently in testimonials (e.g., papillary urothelial carcinoma, high-grade invasive, stage 4 small cell urothelial), often combined with ivermectin for successes like recurrent cases becoming cancer-free (e.g., 65-year-old Sweden patient NED after relapses; 61-year-old Virginia man with two clear cystoscopies after 6 months on ivermectin 1mg/kg + fenbendazole 1000mg + CBD; 69-year-old Canadian high-grade invasive clear on cystoscopy; stage 4 small cell Chicago man cancer-free in 2 months). Fenbendazole dominates his shared stories due to high-dose accessibility, preventing recurrence, and dramatic responses in aggressive/ recurrent bladder cases.

Mebendazole appears less frequently or as part of hybrids, with no strict preference shown—fenbendazole is highlighted more in bladder-specific anecdotes. These are experimental/off-label.

For stomach cancer, Makis features both fenbendazole and mebendazole in testimonials, but he highlights mebendazole prominently in several stage 4 successes (e.g., 72-year-old Dallas, Texas woman outliving her oncologist's life expectancy prediction with ivermectin + mebendazole 1000 mg/day). Preclinical data in his protocols notes mebendazole's superior potency against gastric cancer cell lines compared to standard chemotherapies.

Fenbendazole appears in cases like stage 4 colon/gastric with dramatic responses (e.g., cancer-free after ivermectin + fenbendazole + methylene blue). He often uses hybrids or ivermectin combinations for advanced gastric involvement, with no strict preference but mebendazole featured more in key "outliving prognosis" stories due to synergy. These are anecdotal/experimental.

For genitourinary malignancies, Makis features both fenbendazole and mebendazole in (e.g., bladder/urothelial, prostate, kidney/renal cell), but he prominently highlights fenbendazole (often with ivermectin) in many successes: e.g., stage 4 urothelial bladder cancer with dramatic PET/CT improvements (complete resolution of lung/liver mets, primary tumor inactivity after 2 months on high-dose fenbendazole 1500 mg/day); recurrent papillary urothelial "cancer-free" since 2014 on ivermectin + fenbendazole 444 mg; high-grade invasive bladder clear on cystoscopy. Fenbendazole dominates anecdotes due to high-dose accessibility and rapid responses in advanced/recurrent cases.

Mebendazole appears in hybrids or less prominently, with no strict preference shown—fenbendazole is showcased more in his genitourinary testimonials (e.g., prostate remissions, kidney reductions in case series). These are anecdotal/experimental. (50 words)

BLOOD WORK AND LAB TESTS

Dr. Makis recommends regular bloodwork and lab tests primarily to monitor safety and organ function when using high-dose repurposed drugs like ivermectin, fenbendazole, or mebendazole in his experimental cancer protocols. These drugs (especially benzimidazoles) can potentially affect the liver, kidneys, or cause other side effects, so monitoring is emphasized for tolerability, dose adjustments, and detecting issues early.

Key recommended tests (from protocol summaries, JASE Medical overviews, case reports, and patient anecdotes 2025–2026):

- Liver function tests (LFTs): ALT, AST, bilirubin, alkaline phosphatase—to check for hepatotoxicity (e.g., elevated enzymes noted in some fenbendazole cases; often paired with milk thistle for protection).
- Kidney function tests: Creatinine, BUN (part of CMP)—to ensure no renal impairment from high doses or long-term use.
- Complete blood count (CBC): To monitor for anemia, neutropenia, or other hematologic changes (rare but possible with antiparasitics).
- Comprehensive metabolic panel (CMP): Broad overview including electrolytes, glucose, and organ markers.
- Tumor markers: Cancer-specific (e.g., CA19-9 for pancreatic, CEA for colorectal, PSA for prostate, CA27.29 for breast)—to track response (e.g., dramatic drops in testimonials).
- Other occasional: Vitamin D levels (he advocates high-dose supplementation for immune/cancer benefits), possibly inflammatory markers or coagulation if relevant.

Why? These ensure safe, high-dose regimens (e.g., fenbendazole 888–1776 mg/day, ivermectin 1–2 mg/kg) without serious adverse effects, allow personalization (e.g., cycle adjustments if LFTs rise), and provide objective evidence of efficacy via marker reductions or stabilization. In his hybrid orthomolecular approaches, monitoring supports synergy claims with chemo/immunotherapy while minimizing risks.

These are experimental/off-label; no large RCTs validate them. Protocols are personalized via consultations—contact info@makisw.com for specifics. Always prioritize licensed oncologist-guided, evidence-based care and standard monitoring.

NUTRITIONAL SUPPLEMENTS

Makis recommends various nutritional supplements and vitamins as adjuncts in his experimental "hybrid orthomolecular" cancer protocols (often combined with repurposed drugs like ivermectin, fenbendazole/mebendazole). These target inflammation reduction, immune support, mitochondrial function, cancer stem cell inhibition, liver protection, and synergy against tumor growth/metastasis, based on preclinical studies, case reports, and his anecdotal successes (no large RCTs).

Common recommendations include:

- Vitamin D3 (often 5,000–10,000+ IU/day, sometimes higher with monitoring) + K2 and magnesium — for immune boosting, cancer protection, and bone health; he stresses repletion (aim ≥80–100 ng/mL) as protective against progression.
- Curcumin (e.g., 600 mg+ with black pepper/piperine) — anti-inflammatory, anti-metastatic, and synergistic with protocols.
- Berberine (500–600 mg twice daily) — targets metabolism, glucose control, and cancer cells.
- Black seed oil (Nigella sativa) — anti-cancer, detox, and stem cell targeting.
- Milk thistle (250–350 mg) — hepatoprotection during high-dose benzimidazoles.
- Zinc (to therapeutic levels, e.g., 80–120 µg/dL) — mitochondrial/immune support.
- Lactoferrin — often with ivermectin/zinc for tumor shutdown and immunity.
- Turkey Tail mushroom — immune enhancement.
- Tocotrienols (vitamin E form) — with fenbendazole for metabolic blockade.
- Others (frequently cited): Garlic, ginger, olive leaf extract, citrus pectin, melatonin (10–40 mg), high-dose vitamin C, omega-3s, green tea extract.

Dosing is personalized (via consultations), often with fatty meals for absorption and blood monitoring. These are off-label/experimental adjuncts to enhance drug efficacy and mitigate risks—always consult licensed oncologists for evidence-based care first. For specifics, email info@makisw.com.

RESOURCES

Online Physicians

For prescriptions: bloodwork, medications, and testing.

- Telemedicine Opportunity https://myfreedoctor.com/
- Telemedicine Opportunity GlobaltekMD
- Telemedicine Opportunity https://jasemedical.com/
- Telemedicine Opportunity http://www.wtphealthcare.com/
- Telemedicine Opportunity https://konect.to/thewellnesscompany

Pharmacy

PharmacyonAir contact information (India)

Website: https://pharmacyonair.com

This is only one of many options, used repeatedly without concern. Their billing and shipping procedure is odd but has not been a problem. Shipping time is approximately two weeks. Overseas prices are a tiny fraction of US prices.

- Phone: +1 409 290 7834
- Email: pharmacyonair350@gmail.com
- Other numbers (from Trustpilot listings): +1 310-491-0704 or contact@pharmacyonair.com (may vary by region or time).
- WhatsApp:
  - Primary: wa.me/919558065368 (+91 95580 65368)
  - Secondary: wa.me/14092907834

Useful Links

https://substack.com/@makisw

https://jasemedical.com/useful-info/dr-makis

IVERMECTIN, FENBENDAZOLE, & MEBENDAZOLE ONLINE

These can be found at Pharmacyonair without a prescription

Calculate your daily dose in milligrams. It is better to buy the largest tablets (E.g., Fenbendazole 40 mg and add the remaining daily dose by buying 12mg or 24mg tablets as needed).

Ivermectin is the generic name and is available under various trade/brand names worldwide, including the original Stromectol (Merck, common in the US and many countries for human use), Mectizan (for river blindness programs in some regions), topical forms like Soolantra (cream for rosacea) and Sklice (lotion for head lice), and veterinary brands such as Ivomec, Heartgard, and Ivexterm. Overseas brands from India, a major generic producer, include Ivermectol (Sun Pharma), Ivecop (Menarini), Scavista (Zuventus), Ascapil (Abbott), Iverheal, Iverjohn, Covimectin, Scabover (Brinton), Vermact, Ivrea (Ajanta), Ivertreat (Zydus), Lupimectin (Lupin), and many others like Biover, Ectin, Agimect, and combinations with albendazole (e.g., Warmact, Benrod-I).

Fenbendazole and Mebendazole are also generic names and will have many different trade names.

Vitamin D is critical for immune support. Two tablets a day (8-10,000 units) *should* result in a blood level of 80-100 micrograms/milliliter. Vitamin D3K2 can be found at Amazon.com.

This package aims for manageability while covering the most frequently highlighted elements. For your specific cancer type/stage (e.g., stage 4 pancreatic), seek personalized input directly—proceed with extreme caution and professional oversight. Evidence remains anecdotal/preliminary; prioritize conventional oncology.

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This entire package was screened by Grok AI for accuracy:

Grok responds “The package accurately reflects Dr. Makis' publicly shared protocols, preferences, mechanisms, supplements, monitoring, and disclaimers from his Substack and testimonials, with strong anecdotal alignment.”