Robert F. Kennedy Jr. **3/2/25**
Chairman of US Health and Human Services

Dear Mr. Kennedy,

I'm Dr. Miohael Goodkin, retired cardiologist, friend and colleague of Dan O'Connor. I'm on the medical advisory committee of Trialsite News along with Peter McCullough where I've published about 40 opinion pieces, mostly about government fraud involving the use of generic and over the counter drugs for all aspects of COVID.

FRAUD AND COLLUSION IN THE 4 LARGE RANDOMIZED IVERMECTIN TRIALS

In regard to acute COVID, funding for the study of 29 branded drug company products was provided by the NIH ACTIV committee for various aspects of COVID before any generic or over the counter drug had been tested for outpatients with COVID. The first generic drugs to be tested were ivermectin, fluvoxamine and fluticasone in ACTIV-6 run by the Duke Clinical Research Institute, Vanderbilt and others. They made sure to sabotage ivermectin and collude with TOGETHER, COVID-OUT and PRINCIPLE to prevent ivermectin from competing with drug company vaccines and antivirals. NIH received about $1.2 billion from Pfizer and Moderna for their dirty work.

The issue with ivermectin isn't just in the treatment of acute COVID. According to the CDC there are 17 million Americans with Long COVID. Preventing it would be crucial. In the PRINCIPLE trial from Oxford, ivermectin, severely

underdosed and given late, lowered the risk of Long COVID 36% but was falsely reported as showing no benefit.

The NIH sponsored ACTIV-6 400 and ACTIV-6 600 trials were supposed to report whether ivermectin lowered the risk of Long COVID but have never reported any results.The only other drug to lower the risk of Long COVID in a large trial is metformin which is rarely used. Paxlovid does not lower the risk of Long COVID or successfully treat Long COVID.

Dr. Pierre Kory, who takes care of my vaccine injury, has madę you well aware of the fraud involving repurposed drugs for COVID and is the world expert on ivermectin. I have documents far superior to those of anyone else regarding the fraud in the NIH sponsored ACTIV-6 ivermectin trial, later called ACTIV-6 400. It is by far the most corrupt medical trial in history.

I also excellent evidence of collusion between ACTIV-6, TOGETHER, COVID-OUT and PRINCIPLE to falsely make ivermectin appear ineffective to prevent it from competing with drug company vaccines and antivirals. That evidence has been published in Trialsite News, including two videos, one of which I made with Dan.

I emailed Drs. Francis Collins and Cliff Lane 10/18/21 that ACTIV-6 was giving those patients randomized to ivermectin 40% of the FLCCC recommended cumulative dosage on an empty stomach when the blood level would have been 157% higher if given with a fatty meal.The TOGETHER trial, using a 10% higher dose had already failed to show benefit. It is not conceivable that Collins and Lane did not tell Fauci that I had exposed major problems with their ivermectin trial.

Dr. Lane emailed me that someone was looking into it. We know that the ACTIV committee met to discuss it because Robert Malone is a nonvoting member of the ACTIV committee and he told Pierre Kory that they considered adding a higher dose arm but didn't. Dr. Fauci was on the NIH ACTIV executive committee along with, among others, acting FDA chairman, Dr. Janet Woodcock and Pfizer executive Dr. Michael Dolsten. ACTIV-6 was published 10/21/22. Fauci retired the end of December 2022.

If my allegations about the ACTIV-6 400 trial are corroborated by incoming NIH chairman, Dr. Jay Bhattacharya's review of the trial documents at NIH, it should be sufficient to warrant congressional hearings by the house select subcommittee on the coronavirus pandemic including questioning of Dr. Fauci, lawsuits against those involved in ACTIV-6 and COVID-OUT on behalf of those damaged by the fraud and actions by the DOJ against those involved who caused the deaths of hundreds of thousands of Americans and millions around the world.

MAST CELL ACTIVATION IN COVID

What you are probably not aware of is the fraud preventing the appropriate treatment of acute and Long COVID with therapies for mast cell activation syndrome(MCAS). It was known early in the pandemic that Sars-CoV-2 stimulated mast cells, a type of white blood cell, to release chemical mediators which were responsible for much or most of the damage in acute COVID, including cytokine storm.

Mast cells are most commonly involved in releasing histamine and causing seasonal allergies. Most people with seasonal allergies take histamine-1(H1) receptor blockers like claritin and zyrtec.

Mast cell expert, Dr. Lawrence Afrin, said in a November 2020 paper that 15-20% of the general population has underlying MCAS and he suspected that those were the patients who were getting really sick from COVID. His mast cell patients, all of whom were on H1 and H2 blockers, when they got COVID, were never hospitalized.

I asked Dr. Cliff Lane, NIAID deputy chairman about famotidine, the generic of pepcid, the heartburn drug, an H2 blocker, in Dec 2020. There had been some studies suggesting benefit. He said the ACTIV committee turned it down for a large randomized trial. He said he was open to reviewing new data. I sent him and a mast cell expert at NIH, Dr. Dean Metcalfe, the Afrin article with no response.

1/25/21 I sent an email and Dr. Afrin's paper to the president elect and head of research of the American Academy of Asthma Allergy and Immunology(AAAAI). They thanked me for the email. They had been unaware of the association of COVID with mast cells. They said they were excited and were sending my email to the Biden coronavirus taskforce.

3 weeks later I received an email from AAAAI that Dr. Afrin's article was all theory. I knew they had been "captured" by our federal government whose goal was to see that no generic or over the counter drug was used to treat any aspect of COVID.

In Feb 2022, a paper was published from Cold Springs Harbor Lab of high dose famotidine, 80 mg 3 times a day for acute COVID in 55 very low risk patients predominantly with delta, averaging 35 years old. Nothing else has ever shown benefit in patients that young. In patients averaging 42 years old, paxlovid failed in EPIC SR. At two weeks, those who took famotidine were half as likely to be symptomatic. It is unclear how much famotidine would help those with omicron and its descendants where there is much less mast cell activation.

It is widely known by mast cell experts that most patients with Long COVID have MCAS which often responds to some of the many mast cell therapies. Unfortunately, a number of Long COVID experts are unaware of it. Dr. Kory treated my vaccine injury with various mast cell therapies. My daughter has MCAS unrelated to COVID and is on various therapies, oddly enough including a branded product, xolair, used off label. Xolair is a monoclonal antibody which blocks IgE receptors on mast cells and basophils. I have approached Novartis and Roche to study it in Long COVID without success. Getting drug companies to get a "piece of the action" might be a way to promote the idea that MCAS is a major issue in Long COVID. POTS and MCAS patients should be very excited about it.

Since I received the final email from AAAAI in Feb 2021, there has been nothing on the AAAAI website suggesting any association of any aspect of COVID with MCAS including at their national meeting 2/27-3/3/25. Under Long COVID there is a long list of articles, none of which mentions MCAS in Long COVID.

You need to get some honest mast cell experts involved. I recommend Dr. Lawrence Afrin and Dr. Leonard Weinstock.

You need to confront AAAAI leadership with their failure to give their 7000 allergists and the public the appropriate knowledge that MCAS therapies can be very effective for MCAS.

There were 500,000 to 3 million patients in the US with postural orthostatic tachycardia(POTS) prior to COVID, about 40% pediatric, 90% women. Mayo Clinic said 1% of teenagers had POTS.

About one third of the 17 million Long COVID patients which the CDC estimates are in the US have POTS. Dysautonomia International estimates there are 6 million patients now. On a questionnaire they did, 67% of Long COVID patients had evidence of moderate to severe autonomic dysfunction. Tilt testing of Long COVID patients has had positive results in 18-80% of patients.

Almost all POTS patients see a cardiologist. Cardiologists for the most part hate treating POTS because the treatments often fail and the patients get frustrated. I saw 400 POTS patients while working in a 100 man cardiology group. My partners stopped me from seeing patients twice.

I worked with American College of Cardiology education 2018-19. They did nothing and blew me off. I asked the then president of the American Autonomic Society, a cardiac electrophysiologist, to help me with training cardiologists to recognize, care about and treat POTS. He said he was too busy.

I'm 75 and retired. I asked my group to rehire me part time to train their cardiologists in POTS and give them places to refer patients for treatment of the other aspects of Long COVID and vaccine injury. They turned me down. They have no concern that their cardiologists will give the same lousy care as every other cardiology group.

A former partner of mine told me that the last thing our group wanted was for it to become known that our group delivered good care for POTS and be bombarded with POTS patients seeking treatment. Very sad.

Dr. Kory treats Long COVID with a wide variety of mast cell therapies and antiinflamatory therapies. The POTS often goes away, something Long COVID related POTS patients and cardiologists would find miraculous.

About 15% of Long COVID patients have microclotting which can be proven by a test done by Dr. Jordan Vaughn in Alabama. It often responds to eliquis plus aspirin and plavix.

Treatment of Long COVID and vaccine injury is difficult complex but not impossible. The federal government so far has wasted a lot of money and come up with nothing. Looking at what they studied, I believe their failure was intentional as they did not want patients treated with generic and over the counter drugs, hoping a new drug company product would save the day.

I would like to see you:

1. **Set up a commission on the treatment of long COVID and vaccine injury with Drs. Pierre Kory, Jordan Vaughan,**

Leonard Weinstock, Lawrence Afrin, Akiko Iwasaki a Yale, researcher, Bruce Patterson scientist with vast experience with cytokines and Cathy Pederson, president of Standing Up To POTS. Jill Brook, research liaison from Standing Up to POTS and Lauren Stiles, president of Dysautonomia International should be involved. So should Steve Kirsch who has done a lot to study vaccine injury. Drs. Bhattacharya and Makary should be involved.

2. **Tell the AAAAI leadership that you know they were captured and you will not tolerate it any more. Drs. Afrin and Weinstock need to become part of their leadership. In my opinion, since most Long COVID patients have MCAS, the physician group who should be mostly responsible for their care should be allergists, the only ones who understand MCAS. AAAAI has 7000 members. Since these patients are very difficult and time consuming, allergists must get financial incentives to be responsible for their care. Allergists are well aware of POTS but are afraid to treat it.**
3. **Talk to Roche and Novartis as to whether xolair is appropriate for MCAS associated with Long COVID. They may know it doesn't work. I doubt that. A branded product for MCAS and POTS would raise awareness of these conditions exponentially. Novartis and Roche would make a fortune.**
4. **Meet with American College of Cardiology president, Cathy Biga RN, accompanied by POTS leadership. She needs to be told of the POTS issue which cardiologists are dealing with poorly. She needs to train cardiologists to care about and treat POTS effectively and refer the patients to other physicians who can effectively manage the other aspects of POTS, namely. Allergy/immunology.**
5. **Get my ivermectin trial fraud work to Jay Bhattacharya and have him corroborate my findings. I have spoken with**

Brian Hooker twice who has my data and has become friends with Dr. Bhattacharya. Meryl Nass has seen my data.

6. You and Dr. Bhattacharya approach JAMA that their article of 10/21/22 on ACTIV-6(ACTIV-6 400) was fraudulent. I sent editor in chief, Dr. Kirsten Bobbins Domingo and executive editor Dr. Gregory Corman evidence of the fraud two years ago and better data on 3/1/25.

You want them to retract the ACTIV-6 trial, Dr. Bibbins-Domingo's deceptive editorial of 2/20/23 and publish an accurate account of what happened in ACTIV-6 ivermectin and the other large randomized ivermectin trials. I sent them a completed article which needs editing. Brian Hooker has it.

To get them to do that, you could portray them as heroes who came forward with the information. I suggested that in an email to them 3/1/25. Hopefully you won't have to play rough.

7. I would love to be part of your HHS team to work on all of this. I have a lot of skills and knowledge which would be useful.

Sincerely,

Michael B. Goodkin MD, FACC
doctrumpet@aol.com
484-433-8283