STATE OF NEW YORK : COUNTY OF NASSAU
SUPREME COURT

SCOTT MANTEL,

Plaintiff,

v.

MOUNT SINAI SOUTH NASSAU HOSPITAL, MOUNT SINAI HEALTH SYSTEM, INC.,

Defendants.

AFFIRMATION OF PIERRE KORY, M.D.

Index No.: 604589/2021

I, Pierre Kory, M.D., affirms pursuant to CPLR Rule 2106, under the penalties of perjury as follows:

1. I am a pulmonary and critical care medicine doctor and am board certified by the American Board of Internal Medicine in Internal Medicine, Pulmonary Diseases, and Critical Care Medicine. I am licensed to practice medicine in Wisconsin. From 2008 to 2015, I was an attending physician providing critical care medicine, inpatient pulmonary consultation, and outpatient pulmonary consultation services at Mount Sinai Beth Israel Medical Center in New York City. From 2015 to 2020, I was an Associate Professor at the University of Wisconsin where I served as the Medical Director of the main medical-surgical Intensive Care Unit called the Trauma and Life Support Center and was also the Critical Care Service Chief. I am considered a world-expert and pioneer in the field of critical care ultrasonography as I am the senior author of a best-selling textbook on the topic which has been translated into 6 languages.

2. Since the onset of COVID-19, I have worked in numerous "hot spots" around the country, including Mount Sinai Beth Israel in New York City, Greenville Memorial in South

Carolina, St. Luke's Aurora in Milwaukee, and the University of Wisconsin. I am considered an expert in the pathophysiology and management of COVID-19, having published ten increasingly cited papers on the disease and its clinical management. Further, I am a member of an expert panel of highly published thought leaders in critical care medicine, that formed in March of 2020 with the sole intent of developing the most effective treatment protocols for COVID-19. Our review paper on ivermectin, of which I am the first author, concludes that ivermectin should be immediately and systematically deployed in the prevention and treatment of COVID-19 (Exhibit "A"). The paper is published, having passed peer-review at the American Journal of Therapeutics. The peer reviewers included two career FDA scientists, a senior scientist at the Defense Threat Reduction Agency, and an expert ICU clinician – all the reviewers' identities, and their reviews are publicly available. It should be noted that this paper is the third review paper to pass peer-review and be published in a major medical journal, with all reviews supporting this same conclusion. A true and correct copy of my curriculum vitae, which contains a more detailed and accurate summary of my education, training and experience, is attached hereto Exhibit "B".

3. The opinions and conclusions that I am expressing in this declaration are for the purpose of addressing the issues raised in Scott Mantel vs. Mount Sinai South Nassau Hospital and the Mount Sinai Health System.

4. Based upon my knowledge, education, training and experience in COVID-19, as well as on my extensive research in the compiling of the existing, up-to-date evidence base supporting the use of ivermectin, I am generally considered the foremost expert on ivermectin in the treatment of COVID-19 in the world. The current evidence base now includes 52 studies with 27 randomized controlled trials, with all except one reporting benefits in at least one important clinical outcome, with the vast majority finding statistically significant benefits. A detailed

summary of each of the trial results is attached hereto as Exhibit "C". Most importantly, the mortality benefits are beyond striking, even in late phase disease such as that of Ms. Bucko. Our review paper's conclusions that the existing data indicates a significant mortality benefit is also supported by multiple other, very recent, expert research groups, including a group from Kitsato University in Tokyo, Japan, senior authored by Professor Satoshi Omura, Nobel Prize Winner in Medicine in 2015. (Exhibit "D"). Other posted and published review papers calling for adoption of ivermectin come from the United Kingdom, Spain, and Italy (Exhibits "E", "F", and "G" respectively).

5. In regard to Dr. Aaron Glatt's Affidavit, I find numerous errors, inaccuracies, and misrepresentations of the above evidence base which severely depart from the findings of the above expert panels. I will respond to his assertions below. First, the records that I have reviewed and am relying upon in this matter include but are not limited to the following:

(a) An extensively detailed, day-by-day account of the medical events, treatments rendered, and responses observed compiled by Ms. Bucko's husband, Mr. Scott Mantel, entitled "Debbie Corona Notes";

(b) Affidavit of Dr. Aaron Glatt sworn to on April 27, 2021;

(c) All lab test results of Ms. Bucko's entire admission through 4/28/21;

(d) All medical notes and radiography reports through 4/21/21; and

(e) Mr. Scott Mantel's "counterpoints to the hospital's Affidavit" document.

6. My review of the documents identified in the preceding paragraph of this Affirmation contained the following facts upon which I am relying to rebut the Affidavit of Dr. Aaron Glatt.

7. In response to Dr. Glatt's Affidavit at paragraph 4 – the description of the clinical state and prognosis based on "requiring two pressors and intermittently requiring a third" is not supported by the medical record given that on April 28, Ms. Bucko's vasopressors requirements consisted of a very low dose of a single vasopressor, norepinephrine, and likely only served to counteract the vasodilatory effects of sedative medications, thus do not represent a failure of the cardiovascular system, thus portending a much improved prognosis from what Dr. Glatt asserts.

8. Secondly, the multiple society and agency guidelines referenced which Dr. Glatt claims to "uniformly" support the non-use of ivermectin is both incorrect and out of date. In terms of such a statement being incorrect, the U.S NIH guidelines instead find that "there is insufficient data to recommend for or against use". This is important to note because 1) such a recommendation is identical to that in support of the use of convalescent plasma and monoclonal antibodies, both widely used medicines throughout the entire US health system throughout the pandemic, thus instead, would similarly suggest a physicians decision to use the medicine depending on clinical context and a risk/benefit analysis; and 2) in the NIH recommendation they identify and review multiple trials supporting use, as do the recommendations by the WHO and the IDSA. In fact, the IDSA review includes the following statement "the available evidence consisted mostly of positive trials of smaller size." Further, increasing amounts of national health ministries around the world have incorporated ivermectin into their country's treatment guidelines, recently including India, Mexico, Czech Republic, Slovakia, Bulgaria, S. Africa, and Zimbabwe to name a minority. Thus, this contradicts Dr. Glatt's statement "that the scientific community found that there is no clinically acceptable research supporting the use of ivermectin."

9. Further, Dr. Glatt overlooks the fact that Public health agencies and medical societies have historically issued recommendations only after they have devoted the resources and

time to allow for sufficient evidence to be compiled reviewed, and assessed, with these efforts largely relying on the peer-reviewed literature to do so. As an expert in the most current body of peer-reviewed literature, as of today, April 29, 2021, it must be noted that the most current expert reviews from UK, Japan, Italy, Spain and the US (Exhibits "E", "D", "G", "F" and "H" respectively) all find evidence for and recommend widespread use of ivermectin in COVID-19.

10. Note that from the Dr. Glatt Affidavit Exhibits, the NIH recommendation was last updated almost 3 months ago on February 12, 2021; the IDSA recommendation was last updated on February 13, 2021; and the WHO Guideline on March 31, 2021, with this latter recommendation including only 16 of the 23 randomized controlled trials results available as of that date of publication.

11. The fact that Ms. Bucko's husband is aware of and advocating for the most up to date evidence based on my non-profit organizations efforts to disseminate this information in the midst of a pandemic for humanitarian purposes should be commended and not disparaged. Thus, it is also inaccurate to say that the "professional scientific community has "uniformly" found that there is no clinically acceptable research data supporting the use of ivermectin to treat COVID-19".

12. Again, not only numerous expert groups around the world have found evidence directly contradicting such a statement, in the United States alone, a large hospital system in Broward country, Florida published a large propensity matched trial in the major American Journal Chest, which reported a decrease in mortality from 80% to 30% in the most severely ill patients. (Exhibit "H"). Thus, Dr. Glatt's sweeping statements that "no clinically acceptable research data", "supporting the use of COVId-19 for a seriously ill patient" is thus clearly contradicted by the peer-reviewed and published evidence in a prominent American medical journal.

13. In response to paragraph 5 of Dr. Glatt's Affidavit, his statement that the infectious disease consulting physician ordered the ivermectin "solely due to the family's desperate and increasingly vocal demands" is contradicted by her husband, Scott Mantel's written statement to me that "*There were never any demands or threats made for Ivermectin. A discussion between Dr. Gozenpud, Dr Clark, and I took place upon receiving the results of a CT Scan in which it appeared after several weeks the pneumonia had gotten worse. I presented the FLCCC protocols and studies and mentioned Ivermectin and Plasma Therapy. I was told that the hospital does not have Plasma Therapy and that would not be an option. We thoroughly discussed Ivermectin and its possible benefits and overall safety. They said they would review it. Later Dr G came and said Dr Clark ordered the prescription for the Ivermectin. Dr Clark came down in about an hour and told me that he had ordered the Ivermectin but the hospital was blocking it.*" (Exhibit "I").

14. In response to Dr. Glatt's statement in paragraph 6 of his Affidavit, we refer to the evidence provided herein, which directly contradicts the accuracy of the Hospital Steward Ship Committee's assessment that "administration of ivermectin to this patient was not supported by any of the medical literature, experts in the field, and or official guidance." This particular hospital's steward ship committee's opinion is simply not based on the available evidence, given that my expert panel, consisting of well-known thought leaders in the field of critical care medicine, with almost 2,000 peer-reviewed publications to our credit, who have spent months studying, compiling and assessing the evidence base on ivermectin in COVID-19, instead conclude in our peer-reviewed and published manuscript "ivermectin should be deployed in the prevention and treatment of COVID-19." (Exhibit "A"). In addition, three other expert groups reaching similar conclusions have been recently published in the medical literature (Exhibits "C", "E", and "F").

15. In response to paragraph 8 of Dr. Glatt's Affidavit, it refers to the fact that ivermectin was given to Ms. Bucko on April 20th and that on April 26th, no improvement was shown. This willfully overlooks and erroneously represents important data which again, directly contradict statements of Dr. Glatt in that meaningful clinical improvements were repeatedly documented in this time period, such as significantly reduced oxygen requirements and ventilator support requirements.

16. Further, for the first time since admission, on April 28th, the chest radiograph demonstrated a reduction in the severity of abnormalities. On April 29th, further improvements were noted on the chest radiograph. As of today, April 29th, Ms. Bucko no longer requires any vasopressor support, given that her vasopressor needs have been steadily decreasing since administration of ivermectin. Thus, in direct contradiction to Dr. Glatt's statement that no improvements were shown, the medical record clearly documents significantly improved respiratory and cardiovascular function since ivermectin treatment was initiated.

17. In response to paragraph 9 of Dr. Glatt's Affidavit, the hospital and Dr. Glatt's request to withdraw the order for ivermectin, would, based on the most up-to-date interpretations of the emerging evidence base by numerous expert panels from around the world, result in grievous harm to the patient by the withholding of a clearly beneficial intervention. I recommend that daily doses of ivermectin at higher doses (0.6mg/kg) be immediately initiated and not to be discontinued until the patient achieves a full recovery.

18. Lastly, the concerns regarding the safety of ivermectin departs from the most recent expert review by one of the most prominent toxicologist's in the world, who, after reviewing 350 studies over several decades and almost 4 billion doses administered worldwide, that "the incidence of severe adverse events are unequivocally and exceedingly rare." (Exhibit "J")

19. Further, based on our groups analysis of the reported adverse event profiles in pharmaceutical databases including the United States VAERS and the WHO's Vigiaccess, instead find that ivermectin is actually one of the safest medicines in history, and has been distributed widely by the WHO across many continents in children, pregnant women and adults, and is thus on the WHO's List of Essential Medicines. Its safety is unparalleled, and in the setting of a patient in severe critical illness, any risk/benefit analysis would strongly indicate that the provision of this medicine should be undertaken immediately.

I declare under penalty of perjury of the laws of the State of Wisconsin that the foregoing is true and correct.

Executed on April 29, 2021 Madison, Wisconsin.

Pierre Kory, M.D.