

From Fleming's Petri Dish to a Global Cancer Registry: Turning Signals into Evidence

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In 1928, Alexander Fleming returned from holiday to his cluttered laboratory at St. Mary's Hospital in London and noticed something that most would have discarded. A mold had contaminated one of his petri dishes. Around the mold, the staphylococcal bacteria were dead. He isolated the substance, named it penicillin, and showed its effect. Years passed before it became a practical, usable medicine. Fleming never became a rich man from the discovery. He shared the 1945 Nobel Prize with Howard Florey and Ernst Chain, yet always stressed that such a finding should serve humanity openly. Some occurrences arrive with a sense that they are larger than any one person or profit motive. They carry an unspoken call to be shared openly, as if given for the benefit of all.

This principle remains as powerful today as it was then

The lesson is clear. Observation alone is not enough. A discovery becomes real medicine only when a system exists to turn scattered signals into reliable, reproducible treatment. Today, many clinicians and volunteers find themselves in a position similar to Fleming in 1928. They are seeing genuine signals with repurposed drugs in advanced cancers but without a proper system to capture and study them, these experiences risk remaining mere curiosities

instead of catalysts for change.

Cancer care has seen major advances in surgery, chemotherapy, targeted therapy, and immunotherapy. Yet for a substantial number of patients with advanced or recurrent disease, standard options eventually fail or become intolerable. Oftentimes, when these happen, patients and families search for something more. Repurposed drugs, medicines originally developed for parasitic infections, hypertension, diabetes, or psychiatric disorders, fill in this gap. Ivermectin, honored with a Nobel Prize for its impact on human health, forms the basis of combinations (often called IVM+) that have produced striking real-world results.

These past four years, our simple protocols have evolved through the unselfish sharing of doctors and researchers across countries. Some outcomes appear remarkable. Ben, in the USA, at age 92 with metastatic prostate cancer and a PSA around 97, saw his PSA drop to 0.28 by age 95 after following a structured approach. He regained weight and started driving his own car again. Andrew in the Philippines with inoperable pancreatic cancer gained over 20% in weight, returned to cycling more than 12 hours a week, and, last we checked, lives a normal life on roughly \$ 8.00 a day.

Then there is Jose, a 45-year-old in Spain with multifocal glioblastoma grade 4. After three brain surgeries, a full Stupp protocol, radiosurgery, bevacizumab and an experimental trial where all of which have failed has come asking for help. We reckon a structured repurposed protocol could help him, yet because of where he is, getting reliable access to the necessary medicines remains extremely difficult. Cases like Jose's highlight that supply barriers must be solved.

At present, however, most of these experiences remain privately documented. They live in physicians' notes, some chat messages, or personal files. These outcomes, both successes and failures, are largely invisible to regulators, guideline committees, other clinicians, and patients in other countries.

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Just as Fleming's discovery risked being forgotten without wider development, today's repurposed protocols risk remaining in the shadows.

This invisibility is not only a scientific loss but also an ethical one! Why deny future patients the chance to benefit from real-world patterns that could guide better, cheaper care?

The process from patient data to adjusted care

When a patient reaches out, they submit whatever medical information is available to them. Not everyone can afford extensive testing, but whatever records exist, imaging, pathology, labs, treatment history, and current medications ought to be gathered and shared in as clear and chronological a way as possible. An experienced team then reviews the case and prepares a tailored low-toxicity protocol, often combined with dietary guidance. The patient proceeds under informed consent and personal responsibility. Periodic blood tests and clinical observations follow, tracking symptoms, energy, side effects, and overall condition. These updates allow the protocol to be adjusted. Doses modified, elements added or removed, or diet refined. Both progress and setbacks are recorded honestly. This feedback loop turns isolated attempts into a living process of learning and refinement.

Why a registry matters and what it needs to do

The ethical and scientific question is not whether individual improvements are real. Many clearly are. The real question is whether they reflect reproducible patterns that can be generalized and under what conditions. To answer that, a structured global registry is the missing link.

Most experiences still live in private notes or small circles. A registry would collect cases consistently, turning individual journeys into broader evidence. Patterns would emerge. Which combinations work better? In what cancers or cases? Is there optimal timing with other treatments? What are the common side effects, and what patient factors may predict response?

To be effective, the registry would need to accomplish several essential functions:

1. Allow anyone, anywhere, to come into our registry asking for help. Where the patient is informed to first gather whatever diagnostic and treatment data for submission.
2. Standardize the sourcing, quality, and supply of medications and supplements through reliable

channels, compounding pharmacies, legal importation, and partnerships for quality generics. There's a need to directly solve barriers like those Jose faces in Spain or other patients encounter across the rest of Europe or South America, where access is often prohibitive or impossible.

3. Support the design and documentation of individualized protocols based on each patient's available history.
4. Enable secure, ongoing monitoring with available blood tests, clinical observations, symptom tracking, and protocol adjustments, while systematically recording both improvements and setbacks.
5. Build a protected digital platform for intake, data collection, real-time analysis, and cross-border learning that maintains strong privacy standards and ethical compliance.
6. Operate under the principles of the Declaration of Helsinki Article 37, with informed consent and proper documentation, while aligning with Right to Try principles that support access to safe, affordable medicines when standard options have been exhausted.

All these would promote fairness by giving low-cost options a transparent chance to prove their value, recording failures as openly as successes, and allowing continuous real-world learning beyond what traditional randomized trials can achieve alone.

Under the auspices of the US Department of Health and Human Services, this kind of effort would gain a strong worldwide boost through better coordination, data standards, ethical guidance and international collaboration.

This registry would not replace randomized trials, but it would fill critical gaps by generating real-world evidence in real time. It would also fulfill the deeper duty that comes with compassionate use. When standard treatments fail, the choice to try something else should not be a one-off shot in the dark. It should contribute to collective knowledge that benefits future patients.

Patients and families can play a vital role by organizing whatever records they have. Volunteers and physicians, often limited in time and resources, would gain the structure needed for careful, scalable support. This is a worldwide movement that is bigger than any of us. We need to do this as the brothers we all are.

We have the obligation to do this. We are called to be today's Flemings. It is not about money or fame. It is about helping others so we can all help our-

selves and in doing so, leave this world better than we found it. Why shouldn't the sick and the helpless and every one of us step forward as today's Flemings?

The signals are before us. The choice is clear. We can let these hard won experiences fade into scattered conversations or we can build a system that honors the pioneers in Medicine. We will promote structure, honesty and open sharing. Let us unite, create the registry and turn individual hope into collective progress for everyone, sick or not.

Conflict of interest declaration

I am a co-founder and an administrator of **IVM+ Heals Cancers**. We're an international vol-

unteer organization supporting cancer patients with repurposed drug protocols and our community is on the Viber App.

I have no financial conflicts of interest related to the content of this essay. Neither my immediate family members nor I receive personal profit from the sale of any specific medications, supplements, or treatments mentioned, including ivermectin or mebendazole.

This essay was written independently and reflects my personal views based on observed patient outcomes and the limitations of current fragmented efforts. No external funding or pharmaceutical company influenced the writing or conclusions presented.

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