

COVID-19 PROPOSAL

NUTRITIONAL RECOMMENDATIONS FOR IMMUNOLOGICAL PREVENTION DEVELOPED FROM EVIDENCE-BASED CLINICAL STUDIES

Presentation Disclaimer

- The Information Presented In This Presentation Is A Matter Of Public Record Presented During Invited Expert Forums & Public Workshops.
- The Information Presented Is An Effort To Collaborate With Public Health Officials At City, County, State & Federal Levels To Issue Evidence-Based Nutritional Guidance For The Safe Reopening Of Schools, Small Businesses & Places Of Worship.
- The Information Presented Is For Educational Purposes Only And Should Be Discussed With A Licensed Primary Care Doctor With An Educational Background In Clinical Nutrition & Biochemistry Before Implementing.
- The Information Presented Is Not Intended To Conflict With Guidance Provided By The US FDA, CDC or State Health Departments.
- The Information Presented Is Intended To Create Collaboration & Discussion That Can Help Develop Additional Options To Protect Americans.

ARE THE INOCULATIONS
EXPERIMENTAL?

PFIZER/BIONTECH – MAY 2, 2023

The screenshot shows a web browser window with the following elements:

- Browser Tabs:** Contacts, My Energetic Health Institute - E..., CT Study to Describe the Safety, Tol...
- Address Bar:** clinicaltrials.gov/ct2/show/NCT04368728
- Navigation:** Back, Forward, Refresh icons.
- Bookmarks:** Apps, Counties, Intermittent Fasting, Outreach, Informed Consent, COVID-19 Stats, States COVID, States 2 COVID, CHD Articles, Clackamas County..., Hawaiian Dictionary..., Reading list.
- Page Header:** Study Design Go to ▼
- Study Details:**
 - Study Type ⓘ: Interventional (Clinical Trial)
 - Estimated Enrollment ⓘ: 43998 participants
 - Allocation: Randomized
 - Intervention Model: Parallel Assignment
 - Masking: Triple (Participant, Care Provider, Investigator)
 - Primary Purpose: Prevention
 - Official Title: A PHASE 1/2/3, PLACEBO-CONTROLLED, RANDOMIZED, OBSERVER-BLIND, DOSE-FINDING STUDY TO EVALUATE THE SAFETY, TOLERABILITY, IMMUNOGENICITY, AND EFFICACY OF SARS-COV-2 RNA VACCINE CANDIDATES AGAINST COVID-19 IN HEALTHY INDIVIDUALS
 - Actual Study Start Date ⓘ: April 29, 2020
 - Estimated Primary Completion Date ⓘ: May 2, 2023
 - Estimated Study Completion Date ⓘ: May 2, 2023
- Section Header:** Arms and Interventions Go to ▼
- Table:**

Arm ⓘ	Intervention/treatment ⓘ
Experimental: 10 µg dose, 18-55 years of age (2 doses)	Biological: BNT162b1 Intramuscular injection Biological: BNT162b2 Intramuscular injection
Experimental: 20 µg dose, 18-55 years of age (2 doses)	Biological: BNT162b1 Intramuscular injection Biological: BNT162b2 Intramuscular injection
- Taskbar:** Windows taskbar with icons for Start, File Explorer, Edge, Chrome, Firefox, Word, Excel, PowerPoint, Outlook, Teams, OneDrive, and system tray showing 52°F and date 10/24/2021.

MODERNA/NIAID – OCT 27, 2022

Contacts x My Energetic Health Institute - E x CT A Study to Evaluate Efficacy, Safe x +

clinicaltrials.gov/ct2/show/NCT04470427

Apps Counties Intermittent Fasting Outreach Informed Consent COVID-19 Stats States COVID States 2 COVID CHD Articles Clackamas County... Hawaiian Dictionary... Reading list

Study Design Go to ▾

Study Type ⓘ : Interventional (Clinical Trial)
Actual Enrollment ⓘ : 30420 participants
Allocation: Randomized
Intervention Model: Parallel Assignment
Masking: Quadruple (Participant, Care Provider, Investigator, Outcomes Assessor)
Masking Description: Part A is observer-blind. During Part B participants may request to be unblinded by scheduling a Participant Decision clinic visit.
Primary Purpose: Prevention
Official Title: A Phase 3, Randomized, Stratified, Observer-Blind, Placebo-Controlled Study to Evaluate the Efficacy, Safety, and Immunogenicity of mRNA-1273 SARS-CoV-2 Vaccine in Adults Aged 18 Years and Older
Actual Study Start Date ⓘ : July 27, 2020
Estimated Primary Completion Date ⓘ : October 27, 2022
Estimated Study Completion Date ⓘ : October 27, 2022

Arms and Interventions Go to ▾

Arm ⓘ	Intervention/treatment ⓘ
Experimental: mRNA-1273 Part A: Participants will receive 1 intramuscular (IM) injection of 100 microgram (ug) mRNA-1273 on Day 1 and on Day 29. Part B: Participants who choose to be unblinded and received mRNA-1273-matching placebo during Part A, will receive 1 IM injection of 100 ug mRNA-1273 on Day 1 and Day 29, if the participant chooses. Participants who choose to be unblinded and was only able to receive 1 dose of mRNA-1273 due to administrative reasons, will receive 1 IM injection of 100 ug mRNA-1273 on Day 1, if the participant chooses.	Biological: mRNA-1273 Sterile liquid for injection Biological: Placebo 0.9% sodium chloride (normal saline) injection
Placebo Comparator: Placebo Part A only: Participants will receive 1 IM injection of mRNA-1273-matching placebo on Day 1 and on Day	Biological: Placebo 0.9% sodium chloride (normal saline) injection

Windows taskbar: 7:28 PM 10/24/2021

J&J – JAN 2, 2023

Contacts x My Energetic Health Institute - E x CT A Study of Ad26.COV2.S for the P x +

clinicaltrials.gov/ct2/show/NCT04505722

Apps Counties Intermittent Fasting Outreach Informed Consent COVID-19 Stats States COVID States 2 COVID CHD Articles Clackamas County... Hawaiian Dictionary... » Reading list

Study Design

Go to ▼

Study Type ⓘ : Interventional (Clinical Trial)
Actual Enrollment ⓘ : 44325 participants
Allocation: Randomized
Intervention Model: Parallel Assignment
Masking: Quadruple (Participant, Care Provider, Investigator, Outcomes Assessor)
Primary Purpose: Prevention
Official Title: A Randomized, Double-blind, Placebo-controlled Phase 3 Study to Assess the Efficacy and Safety of Ad26.COV2.S for the Prevention of SARS-CoV-2-mediated COVID-19 in Adults Aged 18 Years and Older
Actual Study Start Date ⓘ : September 7, 2020
Actual Primary Completion Date ⓘ : January 22, 2021
Estimated Study Completion Date ⓘ : January 2, 2023

Arms and Interventions

Go to ▼

Arm ⓘ	Intervention/treatment ⓘ
Experimental: Ad26.COV2.S Participants will receive intramuscular (IM) injection of Ad26.COV2.S at a dose level of 5×10^{10} virus particles (vp) as single dose vaccine on Day 1. At Year 1 (booster visit), participants who previously received any coronavirus disease-2019 (COVID-19) vaccination (as primary regimen or additional dose) will be offered a single booster dose of Ad26.COV2.S at the 5×10^{10} vp dose level.	Biological: Ad26.COV2.S Ad26.COV2.S will be administered at a single dose of 5×10^{10} virus particles (vp) on Day 1 (or Month 6 for placebo recipients) and as a single booster dose at Year 1. Other Names: <ul style="list-style-type: none">JNJ-78436735Ad26COVS1
Experimental: Placebo Participants will receive IM injection of placebo on Day 1. At Month 6/unblinding visit, post Emergency Use Authorization (EUA), conditional licensure, or approval for the single dose regimen, participants initially receiving placebo will be offered to receive a single dose of Ad26.COV2.S vaccine IM at a dose	Biological: Ad26.COV2.S Ad26.COV2.S will be administered at a single dose of 5×10^{10} virus particles (vp) on Day 1 (or Month 6 for placebo recipients) and as a single booster dose at Year 1. Other Names:

Windows taskbar: 7:30 PM 10/24/2021, 52°F

IS COMIRNATY FULLY APPROVED
BY THE FDA?


APPROVED CONDITIONALLY...BUT

Contacts x My Energetic Health Institute - E x Mandates - What You Can Do x FDA August 23, 2021 Approval Letter x +

fda.gov/media/151710/download

Apps Counties Intermittent Fasting Outreach Informed Consent COVID-19 Stats States COVID States 2 COVID CHD Articles Clackamas County... Hawaiian Dictionary... Reading list

August 23, 2021 Approval Letter - Comirnaty 1 / 11 125%

 **FDA U.S. FOOD & DRUG ADMINISTRATION**

Our STN: BL 125742/0 **BLA APPROVAL**

BioNTech Manufacturing GmbH
Attention: Amit Patel
Pfizer Inc.
235 East 42nd Street
New York, NY 10017

August 23, 2021

Dear Mr. Patel:

Please refer to your Biologics License Application (BLA) submitted and received on May 18, 2021, under section 351(a) of the Public Health Service Act (PHS Act) for COVID-19 Vaccine, mRNA.

LICENSING

We are issuing Department of Health and Human Services U.S. License No. 2229 to BioNTech Manufacturing GmbH, Mainz, Germany, under the provisions of section 351(a) of the PHS Act controlling the manufacture and sale of biological products. The license authorizes you to introduce or deliver for introduction into interstate commerce, those products for which your company has demonstrated compliance with

7:32 PM 10/24/2021

TRIALS DON'T END UNTIL MAY 31, 2027

Contacts x My Energetic Health Institute - E x Mandates - What You Can Do x FDA August 23, 2021 Approval Letter x +

← → ↻ fda.gov/media/151710/download 🔍 ☆ 📄 🌐 ⚙️ 👤 ⋮

Apps Counties Intermittent Fasting Outreach Informed Consent COVID-19 Stats States COVID States 2 COVID CHD Articles Clackamas County... Hawaiian Dictionary... » Reading list

☰ August 23, 2021 Approval Letter - Comirnaty 7 / 11 | - 125% + | 📄 ↺

Study Completion: March 31, 2021

Final Report Submission: September 30, 2024

7. Study C4591036, a prospective cohort study with at least 5 years of follow-up for potential long-term sequelae of myocarditis after vaccination (in collaboration with Pediatric Heart Network).

We acknowledge the timetable you submitted on August 21, 2021, which states that you will conduct this study according to the following schedule:

Final Protocol Submission: November 30, 2021

Study Completion: December 31, 2026

Page 8 – STN BL 125742/0 – Elisa Harkins

Final Report Submission: May 31, 2027

8. Study C4591007 substudy to prospectively assess the incidence of subclinical myocarditis following administration of the second dose of COMIRNATY in

Windows taskbar: 7:35 PM 10/24/2021

ARE MEDICAL PROFESSIONALS
LEGALLY OBLIGATED TO REPORT
ALL ADVERSE EVENTS TO VAERS?

APPROVED CONDITIONALLY...BUT

The screenshot shows a web browser window with the URL vaers.hhs.gov/faq.html. The page title is "VAERS Home" and the main heading is "Frequently Asked Questions (FAQs)". A left-hand navigation menu includes links for "VAERS Home", "About VAERS", "Report an Adverse Event", "VAERS Data", "Resources", "Submit Follow-Up Information", "Frequently Asked Questions", "Contact Us", and "Privacy". The main content area lists five FAQ items, each with a right-pointing arrow or a down-pointing arrow indicating expandability. The last item, "What adverse events should healthcare providers report to VAERS after COVID-19 vaccination?", is expanded to show a list of required events.

VAERS Vaccine Adverse Event Reporting System
www.vaers.hhs.gov

VAERS Home

Home / Frequently Asked Questions (FAQs) / en Español

Frequently Asked Questions (FAQs)

- What is VAERS? >
- Which government agencies manage VAERS? >
- Who can report to VAERS? >
- What are healthcare providers required to report to VAERS? >
- What adverse events should healthcare providers report to VAERS after COVID-19 vaccination? ▾

Healthcare providers are **required to report to VAERS** the following adverse events after COVID-19 vaccination [under Emergency Use Authorization (EUA)], and other adverse events if later revised by CDC:

- Vaccine administration errors, whether or not associated with an adverse event (AE)
- Serious AEs regardless of causality. Serious AEs per FDA are defined as:
 1. Death;
 2. A life-threatening AE;
 3. Inpatient hospitalization or prolongation of existing hospitalization;
 4. A persistent or significant incapacity or substantial disruption of the ability to conduct normal life

7:39 PM 10/24/2021

IS THE SPIKE PROTEIN (S PROTEIN)
INJURIOUS TO THE HUMAN BODY
IN AND OF ITSELF?

YES THE SPIKE PROTEIN IS INJURIOUS

ahajournals.org/doi/10.1161/CIRCRESAHA.121.318902

caused increased basal acidification rate, glucose-induced glycolysis, maximal glycolytic capacity, and glycolytic reserve (Figure [D], ii). Also, ECs incubated with S1 protein had attenuated mitochondrial function but increased glycolysis, when compared with control cells treated with IgG (Figure [D], iii and iv). We also compared the expressions of mitochondria- and glycolysis-related genes in lung ECs isolated from ACE2-D or ACE2-L knock-in mice.⁴ Shown in Figure [E], the mRNA levels of *NRF1*, *HO1*, and *TFAM* (mitochondria biogenesis-related genes) were increased, whereas those of *HK2*, *PFKFB3*, and *ENO2* (glycolysis-related genes) were decreased in lung ECs in ACE2-D mice, as compared to those in ACE2-L mice.

SARS-CoV-2 infection induces EC inflammation, leading to endotheliitis.^{1,5} Because S protein decreased ACE2 level and impaired NO bioavailability, we examined whether S protein entry is indispensable for dysfunctional endothelium. As shown in Figure [F], i, the endothelium-dependent vasodilation induced by acetylcholine was impaired in pulmonary arteries isolated from Pseu-Spike-administered hamsters, whereas the endothelium-independent vasodilation induced by sodium nitroprusside was not affected. We also compared the acetylcholine- and sodium nitroprusside-induced vasodilation of pulmonary vessels from ACE2-D or ACE2-L mice. As anticipated, acetylcholine-induced vasodilation was hindered in pulmonary arteries isolated from ACE2-L mice in comparison to ACE2-D mice (Figure [F], ii). There was, however, little difference in sodium nitroprusside-induced vasodilation between ACE2-D and ACE-L animals.

Although the use of a noninfectious pseudovirus is a limitation to this study, our data reveals that S protein alone can damage endothelium, manifested by impaired mitochondrial function and eNOS activity but increased glycolysis. It appears that S protein in ECs increases redox stress which may lead to AMPK deactivation and ultimately ACE2 destabilization.⁴ Although these findings need to be confirmed with the study, it seems paradoxical that ACE2 reduction by S protein would decrease the virus infectivity, thereby protecting endothelium. However, a dysregulated renin-angiotensin system due to ACE2 reduction may exacerbate endothelial dysfunction, leading to endotheliitis. Collectively, our results suggest that the S protein-exerted EC damage overrides the decreased virus infectivity. This conclusion suggests that vaccination-generated antibody and/or exogenous antibody against S protein not only protects the host from SARS-CoV-2 infectivity but also inhibits S protein-imposed endothelial injury.

Nonstandard Abbreviation and Acronyms

ACE	angiotensin-converting enzyme
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April 30, 2021
Vol 128, Issue 9

Article Information

Metrics

- Picked up by 73 news outlets
- Blogged by 11
- Tweeted by 18592
- On 6 Facebook pages
- Referenced in 2 Wikipedia pages
- Reddited by 14
- On 10 videos

8:31 PM
10/24/2021

WHAT IS THE CURRENT POST-
INOCULATION SAFETY DATA?

OVERVIEW – THRU OCT 15, 2021

The screenshot shows the CDC WONDER VAERS data interface. The browser address bar shows the URL: wonder.cdc.gov/controller/datarequest/D8.jsessionid=591BC2D509269389DE38800795A0. The page title is "The Vaccine Adverse Event Reporting System (VAERS)".

Navigation tabs include: Request Form, Results, Map, Chart, Report, About. Utility buttons include: Save, Export, Reset, Top, Notes, Citation, Query Criteria.

Messages:

- ▶ VAERS data in CDC WONDER are updated every Friday. Hence, results for the same query can change from week to week.
- ▶ These results are for 818,044 total events.

Event Category ↓	Events Reported ↑↓	Percent (of 818,044) ↑↓
Death	17,128	2.09%
Life Threatening	18,924	2.31%
Permanent Disability	26,199	3.20%
Congenital Anomaly / Birth Defect *	575	0.07%
Hospitalized	83,412	10.20%
Existing Hospitalization Prolonged	1,064	0.13%
Emergency Room / Office Visit **	57	0.01%
Emergency Room *	91,961	11.24%
Office Visit *	127,640	15.60%
None of the above	538,327	65.81%
Total	905,287	110.66%

System tray information: 7:41 PM, 10/24/2021, 52°F.

BY AGE – THRU OCT 15, 2021

Contacts | My Energetic Health Institute - E | Mandates - What You Can Do | CDC The Vaccine Adverse Event Rep

wonder.cdc.gov/controller/datarequest/D8jsessionid=591BC2D509269389DE38800795A0

Apps | Counties | Intermittent Fasting | Outreach | Informed Consent | COVID-19 Stats | States COVID | States 2 COVID | CH

CDC WONDER | FAQs | Help | Contact Us | WONDER Search

The Vaccine Adverse Event Reporting System (VAERS)

Request Form | Results | Map | Chart | Report | About

[Dataset Documentation](#) | [Other Data Access](#) | [Help for Results](#) | [Printing Tips](#) | [Help with Exports](#)

Quick Options | More Options

Messages:

- ▶ **VAERS data in CDC WONDER are updated every Friday. Hence, results for the same query can change from week to week.**
- ▶ **These results are for 818,044 total events.**

Age ↓	Events Reported ↑↓	Percent (of 818,044) ↑↓
< 6 months	102	0.01%
6-11 months	50	0.01%
1-2 years	79	0.01%
3-5 years	53	0.01%
6-17 years	24,124	2.95%
18-29 years	83,708	10.23%
30-39 years	111,319	13.61%
40-49 years	109,116	13.34%
50-59 years	109,922	13.44%
60-64 years	51,166	6.25%
65-79 years	118,307	14.46%
80+ years	34,301	4.19%
Unknown	175,797	21.49%
Total	818,044	100.00%

Note: Submitting a report to VAERS does not mean that healthcare personnel or the vaccine caused or contributed to the adverse event (possible side effect).

Help: See The Vaccine Adverse Event Reporting System (VAERS) Documentation for more information.
Query Date: Oct 24, 2021 10:40:44 PM

7:42 PM 10/24/2021

DEATH – THRU OCT 15, 2021

Messages:

- ▶ VAERS data in CDC WONDER are updated every Friday. Hence, results for the same query can change from week to week.
- ▶ These results are for 17,128 total events.
- ▶ Rows with zero Events Reported are hidden. Use Quick Options above to show zero rows.

Age ↓	Events Reported ↑↓	Percent (of 17,128) ↑↓
< 6 months	2	0.01%
1-2 years	2	0.01%
6-17 years	37	0.22%
18-29 years	173	1.01%
30-39 years	292	1.70%
40-49 years	434	2.53%
50-59 years	915	5.34%
60-64 years	771	4.50%
65-79 years	3,713	21.68%
80+ years	4,406	25.72%
Unknown	6,383	37.27%
Total	17,128	100.00%

Note: Submitting a report to VAERS does not mean that healthcare personnel or the vaccine caused or contributed to the adverse event (possible side effect).

DEATH W/IN 48 HOURS – THRU OCT 15, 2021

Contacts | My Energetic Health Institute - E | Mandates - What You Can Do | CDC The Vaccine Adverse Event Reporting System

wonder.cdc.gov/controller/datarequest/D8?jsessionid=591BC2D509269389DE38800795A0

Apps | Counties | Intermittent Fasting | Outreach | Informed Consent | COVID-19 Stats | States COVID | States 2 COVID | CH

CDC WONDER | FAQs | Help | Contact Us | WONDER Search

The Vaccine Adverse Event Reporting System (VAERS)

Request Form | Results | Map | Chart | Report | About

[Dataset Documentation](#) | [Other Data Access](#) | [Help for Results](#) | [Printing Tips](#) | [Help with Exports](#)

Quick Options | More Options

Messages:

- ▶ **VAERS data in CDC WONDER are updated every Friday. Hence, results for the same query can change from week to week.**
- ▶ **These results are for 5,489 total events.**
- ▶ **Rows with zero Events Reported are hidden. Use Quick Options above to show zero rows.**

Age ↓	Events Reported ↑↓	Percent (of 5,489) ↑↓
< 6 months	1	0.02%
1-2 years	2	0.04%
6-17 years	6	0.11%
18-29 years	76	1.38%
30-39 years	96	1.75%
40-49 years	174	3.17%
50-59 years	343	6.25%
60-64 years	277	5.05%
65-79 years	1,254	22.85%
80+ years	1,626	29.62%
Unknown	1,634	29.77%
Total	5,489	100.00%

Note: Submitting a report to VAERS does not mean that healthcare personnel or the vaccine caused or contributed to the adverse event (possible side effect).

Help: See The Vaccine Adverse Event Reporting System (VAERS) Documentation for more information.
Query Date: Oct 24, 2021 10:40:44 PM

7:45 PM 10/24/2021

CAN VACCINE MANUFACTURERS
BE SUED IF THEIR PRODUCTS
INJURE OR KILL INNOCENT
PEOPLE ?

PREP ACT

The screenshot shows a web browser window with the URL <https://www.phe.gov/Preparedness/legal/prepact/Pages/prepqa.aspx>. The browser's address bar and tabs are visible at the top. The page content includes a blue header for 'Public Health Emergency' with the tagline 'Public Health and Medical Emergency Support for a Nation Prepared'. Below the header is a breadcrumb trail: 'PHE Home > Preparedness > Legal Authorities > Public Readiness and Emergency Preparedness (PREP) Act > PREP Act Q&As'. A search bar is located on the right side of the header. The main content area features a section titled 'PREP Act Q&As' with an introductory paragraph and a list of bullet points detailing the act's provisions. A sidebar on the right contains two sections: 'PREP Act' with links to 'Public Readiness and Emergency Preparedness (PREP) Act Overview', 'PREP Act Glossary of Terms', and 'PREP Act Question and Answers'; and 'Legal Authorities' with links to 'Legal Authorities Overview', 'Legal Authority of the Secretary', 'Public Health Emergency (PHE) Declaration', 'PHE Frequently Asked Questions', '1135 Waivers', 'Emergency Use Authorization', 'Pandemic and All-Hazards Preparedness Act of 2006', 'Pandemic and All-Hazards Preparedness and Advancing Innovation Act (PAHPAIA) of 2019', and 'Pandemic and All-Hazards Preparedness Reauthorization Act of 2013'. A Windows taskbar is visible at the bottom of the screen.

Public Health Emergency
Public Health and Medical Emergency Support for a Nation Prepared

PHE Home > Preparedness > Legal Authorities > Public Readiness and Emergency Preparedness (PREP) Act > PREP Act Q&As

PREP Act Q&As

The following is intended to address an overview of the PREP Act and frequently asked questions from the manufacturing industry, the healthcare community, and state and local government officials. It is not an exhaustive review of the PREP Act's provisions in all contexts or a protocol for the HHS's implementation of the PREP Act. In addition, other legal protections may be available at the federal, state, and local government level.

The Public Readiness and Emergency Preparedness Act (PREP Act):

- ▶ adds new legal authorities to the Public Health Service (PHS) Act
- ▶ provides liability immunity related to the manufacture, testing, development, distribution, administration and use of medical countermeasures against chemical, biological, radiological and nuclear agents of terrorism, epidemics, and pandemics
- ▶ adds authority to establish a program to compensate eligible individuals who suffer injuries from administration or use of products covered by the PREP Act's immunity provisions

The PREP Act authorizes the Secretary of the Department of Health and Human Services (Secretary) (HHS) to issue a PREP Act Declaration ("Declaration") that provides immunity from liability for any loss caused, arising out of, relating to, or resulting from administration or use of countermeasures to diseases, threats and conditions determined in the Declaration to constitute a present or credible risk of a future public health emergency.

Liability Immunity and Compensation

In general, the liability immunity applies to entities and individuals involved in the development, manufacture, testing, distribution, administration, and use of medical countermeasures described in a Declaration. The only statutory exception to this immunity is for actions or failures to act that constitute willful misconduct.

The PREP Act also authorizes a United States Treasury fund that compensates eligible individuals for serious physical injuries or deaths directly caused by administration or use of a countermeasure covered by the Declaration.

PREP Act

- ▶ [Public Readiness and Emergency Preparedness \(PREP\) Act Overview](#)
- ▶ [PREP Act Glossary of Terms](#)
- ▶ [PREP Act Question and Answers](#)

Legal Authorities

- ▶ [Legal Authorities Overview](#)
- ▶ [Legal Authority of the Secretary](#)
- ▶ [Public Health Emergency \(PHE\) Declaration](#)
- ▶ [PHE Frequently Asked Questions](#)
- ▶ [1135 Waivers](#)
- ▶ [Emergency Use Authorization](#)
- ▶ [Pandemic and All-Hazards Preparedness Act of 2006](#)
- ▶ [Pandemic and All-Hazards Preparedness and Advancing Innovation Act \(PAHPAIA\) of 2019](#)
- ▶ [Pandemic and All-Hazards Preparedness Reauthorization Act of 2013](#)

1986 NATIONAL CHILDHOOD VACCINE INJURY ACT

42 USC 300aa-22: Standards of re x +

uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title42-section300aa-22&num=0&edition=prelim

Apps Counties Intermittent Fasting Outreach Informed Consent COVID-19 Stats States COVID States 2 COVID CHD Articles Clackamas County... Hawaiian Dictionary... Reading list

Current

<< Previous TITLE 42 / CHAPTER 6A / SUBCHAPTER XIX / Part 2 / subpart b / § 300aa-22 Next >>

[Print] [Print selection] [OLRC Home] Help

42 USC 300aa-22: Standards of responsibility
Text contains those laws in effect on October 25, 2021

From Title 42-THE PUBLIC HEALTH AND WELFARE
CHAPTER 6A-PUBLIC HEALTH SERVICE
SUBCHAPTER XIX-VACCINES
Part 2-National Vaccine Injury Compensation Program
subpart b-additional remedies

Jump To:
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[References In Text](#)
[Codification](#)
[Amendments](#)

§300aa-22. Standards of responsibility

(a) General rule
Except as provided in subsections (b), (c), and (e) State law shall apply to a civil action brought for damages for a vaccine-related injury or death.

(b) Unavoidable adverse side effects; warnings

(1) No vaccine manufacturer shall be liable in a civil action for damages arising from a vaccine-related injury or death associated with the administration of a vaccine after October 1, 1988, if the injury or death resulted from side effects that were unavoidable even though the vaccine was properly prepared and was accompanied by proper directions and warnings.

(2) For purposes of paragraph (1), a vaccine shall be presumed to be accompanied by proper directions and warnings if the vaccine manufacturer shows that it complied in all material respects with all requirements under the Federal Food, Drug, and Cosmetic Act [21 U.S.C. 301 et seq.] and section 262 of this title (including regulations issued under such provisions) applicable to the vaccine and related to vaccine-related injury or death for which the civil action was brought unless the plaintiff shows-

(A) that the manufacturer engaged in the conduct set forth in subparagraph (A) or (B) of section 300aa-23(d)(2) of this title, or

(B) by clear and convincing evidence that the manufacturer failed to exercise due care notwithstanding its compliance with such Act and section (and regulations issued under such provisions).

(c) Direct warnings
No vaccine manufacturer shall be liable in a civil action for damages arising from a vaccine-related injury or death associated with the administration of a vaccine after October 1, 1988, solely due to the manufacturer's failure to provide direct warnings to the injured party (or the injured party's legal representative) of the potential dangers resulting from the administration of the vaccine manufactured by the manufacturer.

(d) Construction

11:54 PM 10/25/2021

HOW PROTECTIVE ARE THE
EXPERIMENTAL INOCULATIONS?

BARNSTABLE STUDY

The screenshot shows a web browser window with multiple tabs. The active tab is titled "Outbreak of SARS-CoV-2 Infections, Including COVID-19 Vaccine Breakthrough Infections, Associated with Large Public Gatherings — Barnstable County, Massachusetts, July 2021". The address bar shows the URL "cdc.gov/mmwr/volumes/70/wr/mm7031e2.htm". The page header includes the CDC logo and the text "Centers for Disease Control and Prevention, CDC 24/7: Saving Lives, Protecting People™". A search bar is visible in the top right corner. The main content area features a dark blue banner with the text "Morbidity and Mortality Weekly Report (MMWR)". Below this, the article title is displayed in a large, bold font. The authors' names and affiliations are listed below the title. A "View suggested citation" link is present. At the bottom of the page, there are two buttons: "Summary" and "Article Metrics". The Windows taskbar is visible at the bottom of the screen, showing various application icons and the system tray with the date and time (8:32 PM, 10/24/2021).

Contacts | My Energetic Health Institut | Prevention - What You Can | Assessment of protection a | Rate and severity of suspect | CDC Outbreak of SARS-CoV-2 Infections, Including COVID-19 Vaccine Breakthrough Infections, Associated with Large Public Gatherings — Barnstable County, Massachusetts, July 2021

cdc.gov/mmwr/volumes/70/wr/mm7031e2.htm

Apps | Counties | Intermittent Fasting | Outreach | Informed Consent | COVID-19 Stats | States COVID | States 2 COVID | CHD Articles | Clackamas County... | Hawaiian Dictionary... | Reading list

CDC Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™

[A-Z Index](#)

Search

[Advanced Search](#)

Morbidity and Mortality Weekly Report (MMWR)

CDC

Outbreak of SARS-CoV-2 Infections, Including COVID-19 Vaccine Breakthrough Infections, Associated with Large Public Gatherings — Barnstable County, Massachusetts, July 2021

Weekly / August 6, 2021 / 70(31);1059-1062

On July 30, 2021, this report was posted online as an MMWR Early Release.

Catherine M. Brown, DVM¹; Johanna Vostok, MPH¹; Hillary Johnson, MHS¹; Meagan Burns, MPH¹; Radhika Gharpure, DVM²; Samira Sami, DrPH²; Rebecca T. Sabo, MPH²; Noemi Hall, PhD²; Anne Foreman, PhD²; Petra L. Schubert, MPH¹; Glen R. Gallagher, PhD¹; Timelia Fink¹; Lawrence C. Madoff, MD¹; Stacey B. Gabriel, PhD³; Bronwyn MacInnis, PhD³; Daniel J. Park, PhD³; Katherine J. Siddle, PhD³; Vaira Harik, MS⁴; Deirdre Arvidson, MSN⁴; Taylor Brock-Fisher, MSC⁵; Molly Dunn, DVM⁵; Amanda Kearns⁵; A. Scott Laney, PhD² ([View author affiliations](#))

[View suggested citation](#)

Summary [Article Metrics](#)

What is already known about this topic?

Windows taskbar: 52°F, 8:32 PM, 10/24/2021

BARNSTABLE STUDY

Contacts | My Energetic Health Institut | Prevention - What You Can | Assessment of protection a | Rate and severity of suspect | Outbreak of SARS-CoV-2 In | +

cdc.gov/mmwr/volumes/70/wr/mm7031e2.htm

Apps | Counties | Intermittent Fasting | Outreach | Informed Consent | COVID-19 Stats | States COVID | States 2 COVID | CHD Articles | Clackamas County... | Hawaiian Dictionary... | Reading list

Jurisdictions might consider expanded prevention strategies, including universal masking in indoor public settings, particularly for large public gatherings that include travelers from many areas with differing levels of SARS-CoV-2 transmission.

During July 2021, 469 cases of COVID-19 associated with multiple summer events and large public gatherings in a town in Barnstable County, Massachusetts, were identified among Massachusetts residents; vaccination coverage among eligible Massachusetts residents was 69%. Approximately three quarters (346; 74%) of cases occurred in fully vaccinated persons (those who had completed a 2-dose course of mRNA vaccine [Pfizer-BioNTech or Moderna] or had received a single dose of Janssen [Johnson & Johnson] vaccine ≥ 14 days before exposure). Genomic sequencing of specimens from 133 patients identified the B.1.617.2 (Delta) variant of SARS-CoV-2, the virus that causes COVID-19, in 119 (89%) and the Delta AY.3 sublineage in one (1%). Overall, 274 (79%) vaccinated patients with breakthrough infection were symptomatic. Among five COVID-19 patients who were hospitalized, four were fully vaccinated; no deaths were reported. Real-time reverse transcription-polymerase chain reaction (RT-PCR) cycle threshold (Ct) values in specimens from 127 vaccinated persons with breakthrough cases were similar to those from 84 persons who were unvaccinated, not fully vaccinated, or whose vaccination status was unknown (median = 22.77 and 21.54, respectively). The Delta variant of SARS-CoV-2 is highly transmissible (1); vaccination is the most important strategy to prevent severe illness and death. On July 27, CDC recommended that all persons, including those who are fully vaccinated, should wear masks in indoor public settings in areas where COVID-19 transmission is high or substantial.* Findings from this investigation suggest that even jurisdictions without substantial or high COVID-19 transmission might consider expanding prevention strategies, including masking in indoor public settings regardless of vaccination status, given the potential risk of infection during attendance at large public gatherings that include travelers from many areas with differing levels of transmission.

During July 3–17, 2021, multiple summer events and large public gatherings were held in a town in Barnstable County, Massachusetts, that attracted thousands of tourists from across the United States. Beginning July 10, the Massachusetts Department of Public Health (MA DPH) received reports of an increase in COVID-19 cases among persons who reside in or recently visited Barnstable County, including in fully vaccinated persons. Persons with COVID-19 reported attending densely packed indoor and outdoor events at venues that included bars, restaurants, guest houses, and rental homes. On July 3, MA DPH had reported a 14-day average COVID-19 incidence of zero cases per 100,000 persons per day in residents of the town in Barnstable County; by July 17, the 14-day average incidence increased to 177 cases per 100,000 persons per day in residents of the town (2).

During July 10–26, using travel history data from the state COVID-19 surveillance system, MA DPH identified a cluster of cases among Massachusetts residents. Additional

Views: 982,674
Views equals page views plus PDF downloads
Metric Details

Figures
Figure 1
Figure 2

References

Related Materials
PDF [180K]

8:33 PM 10/24/2021

DOD - PROJECT SALUS

Effectiveness of mRNA COVID-19 Vaccines Against the Delta Variant Among 5.6M Medicare Beneficiaries 65 Years and Older

Weekly update of September 28, 2021



Project Salus



DOD - PROJECT SALUS



Executive Summary

Project Salus provides answers to these questions

Basic questions which require data-driven answers

Is vaccine effectiveness (VE) **waning** over time?

Is VE **reduced** for the **Delta variant**?

Does the need vary by **sub-population**?

- VE of both mRNA vaccines appears to wane over time in this large 5.6M US-based 65 & over vaccinated cohort
- Risk of breakthrough hospitalization increases with time elapsed since mRNA vaccination with odds ratio increasing to 2.5 at 6 months post vaccination
- VE against Delta breakthrough hospitalization (62%) exceeds VE against Delta infection (41%)
- Prior COVID-19 infection has a major protective effect against breakthrough hospitalization
- Older age groups (75-84 & 85 and older) experienced further reduction in vaccine protection against hospitalization
- Hospitalization rate (21% vs 32%) and death rate (4% vs 12%) of breakthrough infections lower than rates observed in Covid-19 cases in pre-vaccination pandemic phase in 2020

Graphic adapted from CDC Presentation ACIP Meeting August 30, 2021
Oliver, S. Framework for Booster Doses of COVID-19 Vaccines

DOD - PROJECT SALUS



Project Salus

Salus Platform for COVID-19 Analyses

VE Study Attributes

Cohort

20M Medicare beneficiaries nationwide with 16M individuals 65 years and older

Exposure

5.6M fully vaccinated with 2.7M Pfizer and 2.9M Moderna

Period of study

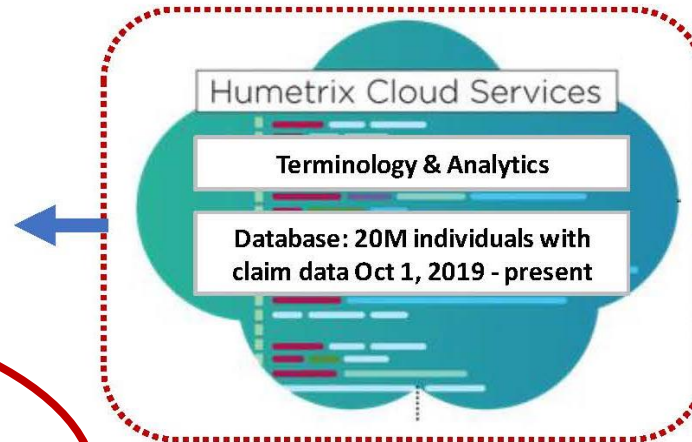
January - August 21 2021

Breakthrough Key Metrics

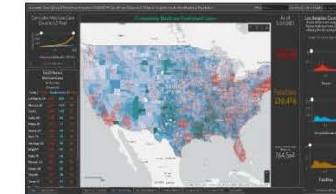
161K Breakthrough cases

33K Breakthrough hospitalizations

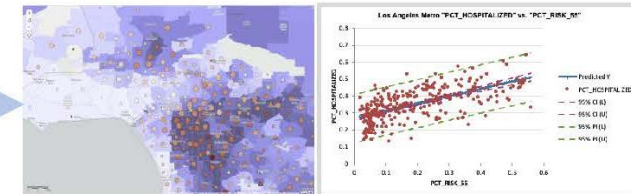
10.4K requiring ICU admissions



Other Platform Applications



Nationwide Mapping of COVID-19 Outcomes
Hospitalizations, ICU, Ventilator Rx, Deaths



Disease Risk Models with Population Risk Profiling: Severe COVID-19 risk with Validation with Hospitalization Rates



Vaccination Mapping overlaid on severe COVID-19 risk

hUMETRIX

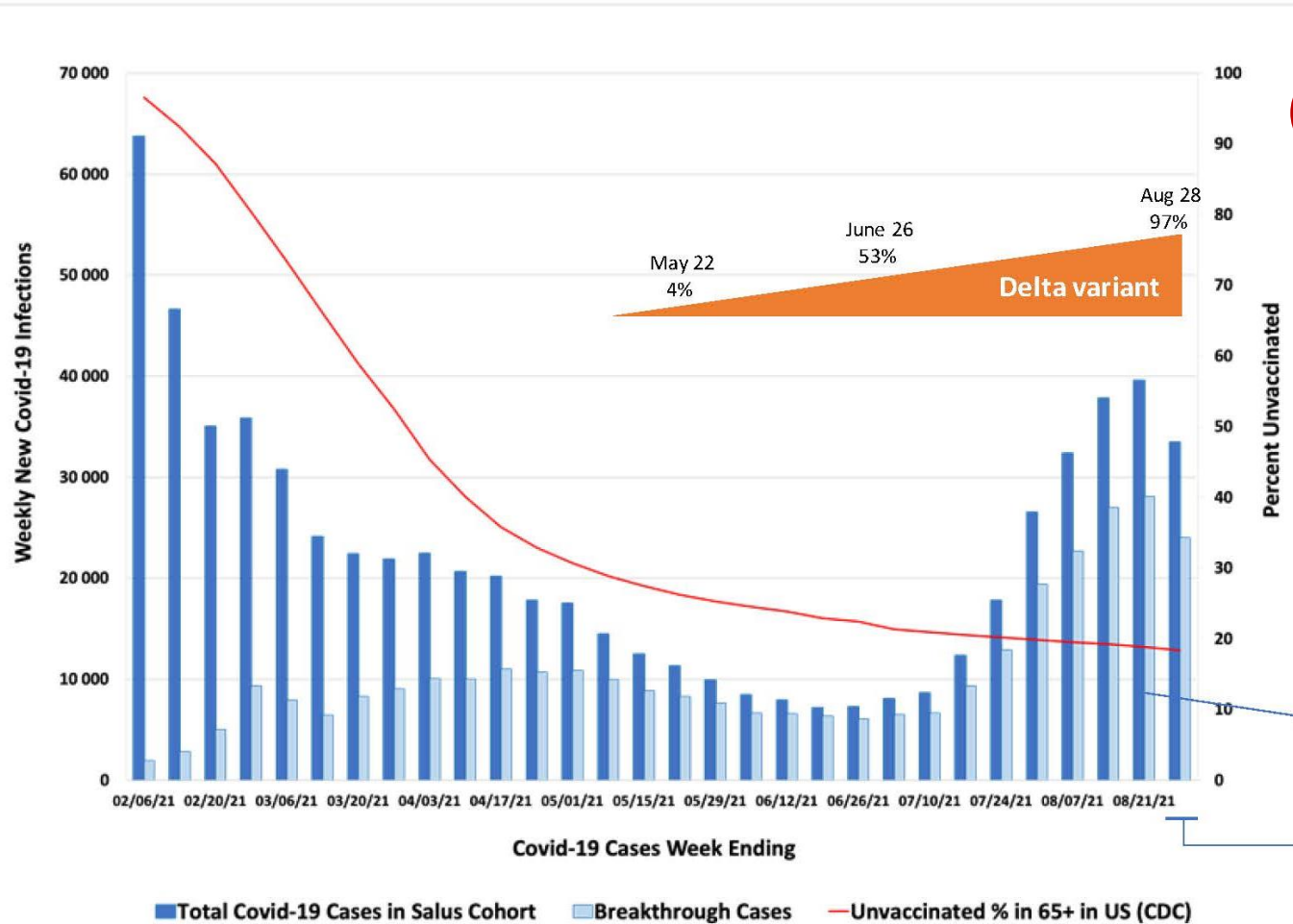
* Medicare data and Humetrix software are hosted in a secure government enclave of the Department of Defense

DOD - PROJECT SALUS



Project Salus

Total & Breakthrough Cases in the 65 Years and Older Salus Cohort



As Delta variant became predominant, COVID-19 cases increased five-fold in the ≥ 65 population

- As Delta variant became predominant, COVID-19 cases increased five-fold in the ≥ 65 population
- In this 80% vaccinated ≥ 65 population, an estimated 71% of COVID-19 cases occurred in fully vaccinated individuals

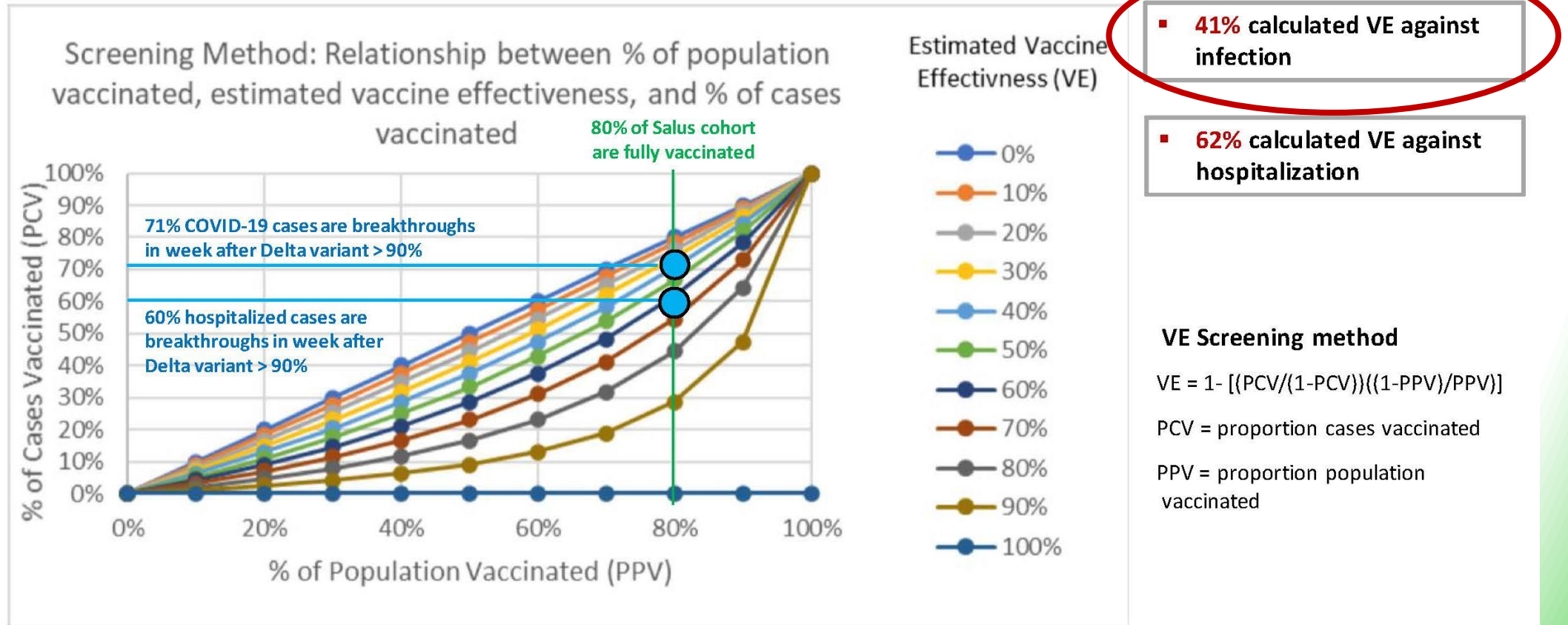
Breakthrough cases = 71% of total Covid-19 cases in cohort

Week ending 08/28/21, data incomplete due to lag in claims processing

DOD - PROJECT SALUS



What is the Vaccine Effectiveness Against the Delta Variant in the Salus Cohort? – Using the CDC Screening Approach



Graphic adapted from CDC Presentation July 30, 2021
Improving communication around vaccine breakthrough and vaccine effectiveness

ARE THERE SPECIAL RULES FOR
WHAT CONSTITUTES A
BREAKTHROUGH CASE?

YES, THERE ARE SPECIAL RULES

The screenshot shows a web browser window with the address bar displaying [cdc.gov/vaccines/covid-19/health-departments/breakthrough-cases.html](https://www.cdc.gov/vaccines/covid-19/health-departments/breakthrough-cases.html). The page content includes a list of bullet points, expandable sections for local and state health departments, and a section titled "How to send CDC sequence data or respiratory specimens from suspected vaccine breakthrough cases:" which contains a detailed list of instructions for specimen submission.

- Even if you are truly vaccinated, if you live in an area with [substantial or high transmission](#) of COVID-19, you will be better protected if you wear a mask when you are in indoor public places.
- Currently, CDC is recommending that moderately to severely immunocompromised people [receive an additional dose](#) of mRNA COVID-19 vaccine at least 28 days after a second dose of [Pfizer-BioNTech COVID-19 vaccine](#) or [Moderna COVID-19 vaccine](#).

For local health departments, healthcare providers, and clinical laboratories +

For state health departments +

How to send CDC sequence data or respiratory specimens from suspected vaccine breakthrough cases: -

- CDC would like to receive sequence data and respiratory specimens from COVID-19 vaccine breakthrough cases to assess the SARS-CoV-2 lineage, including variants. When a vaccine breakthrough case is identified, the health department will contact the laboratory to request that any residual respiratory specimen from the positive test be held for sequencing at CDC.
- The health department also will request the specimen ID numbers and the Ct value for positive RT-PCR results.
- If SARS-CoV-2 sequencing will not be performed locally and a specimen is available, the state public health laboratory should request the residual clinical respiratory specimen for subsequent shipping to CDC.
 - [For cases with a known RT-PCR cycle threshold \(Ct\) value, submit only specimens with Ct value \$\leq 28\$ to CDC for sequencing.](#)
 - If the Ct value is not known (e.g., positive by antigen test only or by a molecular test that does not provide a Ct value), the positive specimen may still be submitted to CDC for RT-PCR and potential sequencing.
- If your laboratory identifies a COVID-19 vaccine breakthrough case, please report it to your state health department so it can initiate the investigation with CDC.
- These instructions can also be found here: NS3 Submission Guidance [Documents](#) .

The Windows taskbar at the bottom shows the time as 8:41 PM on 10/24/2021, with a temperature of 52°F and various system icons.

IS NATURAL IMMUNITY
DEVELOPED POST-INFECTION
SUPERIOR
TO IMMUNITY POST-
EXPERIMENTAL INOCULATION?

91 STUDIES – THRU OCT 15, 2021

Contacts x My Energetic Health Institute - E x Grand Jury Petition x 91 Research Studies Affirm Natur x +

brownstone.org/articles/79-research-studies-affirm-naturally-acquired-immunity-to-covid-19-documented-linked-and-quoted/

Apps Counties Intermittent Fasting Outreach Informed Consent COVID-19 Stats States COVID States 2 COVID CHD Articles Clackamas County... Hawaiian Dictionary... Reading list

The Brownstone Institute previously documented 50 studies on natural immunity as it relates to Covid-19.

BROWNSTONE I N S T I T U T E

This follow-up chart is the most updated and comprehensive library list of 91 of the highest-quality, complete, most robust scientific studies and evidence reports/position statements on natural immunity as compared to the COVID-19 vaccine-induced immunity and allow you to draw your own conclusion.

I've benefited from the input of many to put this together, especially my co-authors:

- Dr. Harvey Risch, MD, PhD (Yale School of Public Health)
- Dr. Howard Tenenbaum, PhD (Faculty of Medicine, University of Toronto)
- Dr. Ramin Oskoui, MD (Foxhall Cardiology, Washington)
- Dr. Peter McCullough, MD (Truth for Health Foundation (TFH)), Texas
- Dr. Parvez Dara, MD (consultant, Medical Hematologist and Oncologist)

Evidence on natural immunity versus COVID-19 vaccine induced immunity as of October 15th 2021:

Study / report title, author, and year published	Predominant finding on natural immunity
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8:23 PM 10/24/2021

[HTTPS://BROWNSTONE.ORG/ARTICLES/79-RESEARCH-STUDIES-AFFIRM-NATURALLY-ACQUIRED-IMMUNITY-TO-COVID-19-DOCUMENTED-LINKED-AND-QUOTED/](https://brownstone.org/articles/79-research-studies-affirm-naturally-acquired-immunity-to-covid-19-documented-linked-and-quoted/)

HAVE WE ATTEMPTED TO
COLLABORATE WITH PUBLIC
HEALTH OFFICIALS?

INITIAL ATTEMPTS

- On June 30, 2020 Dr. Dean Sidelinger was kind enough to give a colleague and I, 20 minutes of his time via zoom.
- The focus of the meeting was to discuss data errors we were finding and to offer our services on a volunteer basis to develop nutritional guidelines to augment the existing guidelines for masking and social distancing.
- The meeting went very well. Dr. Sidelinger and Ms. Heiberg we're very open to hearing our presentation. Dr. Sidelinger admitted that there hadn't been nearly enough done to educate the public on nutrition during this crisis.
- Dr. Sidelinger also stated that he was open to reviewing any studies on nutrition we could provide him.
- Our follow-up requests to work in collaboration with the OHA to develop nutritional guidelines on a volunteer basis were never responded to.
- **It is our goal to work with the OHA on behalf of all Oregonians**



JUN 30TH COMMUNICATION



Henry Ealy <heneleeale@gmail.com>

meeting at 1:30 today

2 messages

Tue, Jun 30, 2020 at 5:00 AM

To: DAWN.L.QUITUGUA@dhsosha.state.or.us, DEAN.E.SIDELINGER@dhsosha.state.or.us, HOLLY.HEIBERG@dhsosha.state.or.us

Cc: Dr Henele <heneleeale@gmail.com>, Kautz Kristine M <KRISTINE.M.KAUTZ@dhsosha.state.or.us>, "Sugarman, Maxine" <Maxine.Sugarman@mail.house.gov>

Thank you for agreeing to meet us at 1:00 by zoom.

We are very interested in best supporting the OHA to help usher in a positive conclusion to this pandemic crisis. Below is a list of our agenda items. J

1. We have a very comprehensive data set filled with nationwide as well as individual state data from all 56 US State & Territory Health Departments we would like to share with the OHA. There's a lot of very revealing information within it with respect to demographics for Cases, Hospitalizations, & Fatalities for Age as well as Comorbidity. We believe this can be of some great assistance to OHA and would like Dr. Sidelinger's insights on it.
2. We have found some interesting peer-reviewed data from the Linus Pauling Institute at Oregon State University that we think can be instrumental in helping to protect our most vulnerable citizens as well as aiding in recovery efforts for all Oregonians and would like Dr. Sidelinger's insights.
3. We also are curious to know if Dr. Sidelinger is aware of the Probability of Recovery in the Age 0 to 19, Age 20 to 49, Age 50+ Demographics?
4. If time allows, we're curious as to Dr. Sidelinger's opinion on the increases in testing and what role that may be having in recent case increases, hot spots, etc.

Thank you in advance, we are very excited to do our part for the citizens of Oregon.

JUL 13TH FOLLOW-UP



Henry Ealy <heneleeale@gmail.com>

Request For A Follow Up Meeting To Discuss Nutrition

7 messages

Dr Henele <heneleeale@gmail.com>

Mon, Jul 13, 2020 at 1:00 PM

To: DEAN.E.SIDELINGER@dhsosha.state.or.us, HOLLY.HEIBERG@dhsosha.state.or.us

Aloha Fellow Oregonians,

Can you please instruct me as to what do I need to do to schedule another meeting with you both, so we can objectively discuss the importance of offering some additional guidance to the people of Oregon on the safe use of nutrition to aid their immune system?

I am deeply concerned with the following statistics, how the Oregonian is portraying them, and the immense adverse ramifications for the people of our great state.

July 5th to July 12th

Positive Confirmed Cases - 2,004 New Cases

Confirmed Negatives - 30,031 Negatives

Confirmed Hospitalizations - +23 Hospitalizations

Fatalities - 19 New Fatalities

Recoveries - 250 New Recoveries

Part of our work as medical professionals is in bringing hope and reassurance to people who have been beleaguered by all of the fear and negativity this crisis has created. If we're not bringing hope to people in great need of it, then the potential for unintended collateral damage skyrockets in my personal and professional opinion.

The Oregonian is reporting is that there were 2 new fatalities in the 20 to 49 Age Demographic, but isn't talking about the Recoveries. The Oregonian is warning that this is going to get worse over the next 6 weeks? But does it really have to?

I know in my heart that we can do so much better than this...doesn't nutrition deserve even a chance to be considered?

All I'm seeing online and in society are people afraid of each other in spite of the very high Recovery numbers nationwide and in our state.

I am BEGGING you both to at least hear me out, let's talk about what nutrition can do to make an incredibly positive impact on our society and bring us back together again. We were told to stay home to flatten the curve and we did. Oregonians were told to wear masks and we have. Oregonians can answer this call too but they need the resources for their immune system to be able to do so.

HAS ASYMPTOMATIC TRANSMISSION
EVER BEEN PROVEN?

ASYMPTOMATIC TRANSMISSION

Never Proven - <https://www.cdc.gov/coronavirus/2019-ncov/hcp/duration-isolation.html>

Wuhan 10 Million Study Using PCR - <https://www.nature.com/articles/s41467-020-19802-w>

What Would Be Required To Prove It?

1. No Clinical Symptoms (Cough, HA, Muscle Aches, Loss of Smell, Fever/Chills, Etc.)
2. Positive For Serologic Viral Antigen Load
3. Negative For Serologic IgM & IgG Antibodies

To Date This Study Has Never Been Conducted To Prove Asymptomatic Carriers Exist.

“The one thing historically that people need to realize is that even if there is some asymptomatic transmission, in all the history of respiratory-borne viruses of any type, asymptomatic transmission has never been the driver of outbreaks. The driver of outbreaks is always a symptomatic person. Even if there’s a rare asymptomatic person that might transmit, an epidemic is not driven by asymptomatic carriers.” – **Dr. Anthony Fauci**

INTERESTING STUDIES

https://www.cdc.gov/coronavirus/2019-ncov/hcp/duration-isolation.html

Telephone Response Guide

Late Sequelae of COVID-19

Infection Control +

Optimizing PPE Supplies +

Potential Exposure at Work +

First Responder Guidance

U.S. Healthcare Facilities +

Veterinary Clinics

Pandemic Planning Scenarios

Operational Considerations for Non-US Settings +

Responding to SARS-CoV-2 Infections in Acute Care Facilities

Training for Healthcare Professionals

Key findings are summarized here.

1. Concentrations of SARS-CoV-2 RNA measured in upper respiratory specimens decline after onset of symptoms (CDC, unpublished data, 2020; Midgley et al., 2020; Young et al., 2020; Zou et al., 2020; Wölfel et al., 2020; van Kampen et al., 2020).
2. The likelihood of recovering replication-competent virus also declines after onset of symptoms. For patients with mild to moderate COVID-19, replication-competent virus has not been recovered after 10 days following symptom onset (CDC, unpublished data, 2020; Wölfel et al., 2020; Arons et al., 2020; Bullard et al., 2020; Lu et al., 2020; personal communication with Young et al., 2020; Korea CDC, 2020). Recovery of replication-competent virus between 10 and 20 days after symptom onset has been documented in some persons with severe COVID-19 that, in some cases, was complicated by immunocompromised state (van Kampen et al., 2020). However, in this series of patients, it was estimated that 88% and 95% of their specimens no longer yielded replication-competent virus after 10 and 15 days, respectively, following symptom onset.
3. A large contact tracing study demonstrated that high-risk household and hospital contacts did not develop infection if their exposure to a case patient started 6 days or more after the case patient's illness onset (Cheng et al., 2020).
4. Although replication-competent virus was not isolated 3 weeks after symptom onset, recovered patients can continue to have SARS-CoV-2 RNA detected in their upper respiratory specimens for up to 12 weeks (Korea CDC, 2020; Li et al., 2020; Xiao et al, 2020). Investigation of 285 "persistently positive" persons, which included 126 persons who had developed recurrent symptoms, found no secondary infections among 790 contacts attributable to contact with these case patients. Efforts to isolate replication-competent virus from 108 of these case patients were unsuccessful (Korea CDC, 2020).
5. Specimens from patients who recovered from an initial COVID-19 illness and subsequently developed new symptoms and retested positive by RT-PCR did not have replication-competent virus detected (Korea CDC, 2020; Lu et al., 2020). The risk of reinfection may be lower in the first 3 months after initial infection, based on limited evidence from another betacoronavirus (HCoV-OC43), the genus to which SARS-CoV-2 belongs (Kiyuka et al, 2018).
6. To date, reports of reinfection have been infrequent. Similar to other human coronaviruses where studies have

References

[Annex: Quarantine of Persons Recovered from Laboratory](#)

2:02 PM 1/3/2021

10 MILLION PEOPLE TESTED

The screenshot shows a web browser displaying a Nature Communications article. The browser's address bar shows the URL: <https://www.nature.com/articles/s41467-020-19802-w>. The page header includes the 'nature communications' logo, navigation links for 'View all Nature Research journals', 'Search', and 'Login', and options for 'Sign up for alerts' and 'RSS feed'. The article title is 'Post-lockdown SARS-CoV-2 nucleic acid screening in nearly ten million residents of Wuhan, China', published on 20 November 2020. The authors listed are Shiyi Cao, Yong Gan, Chao Wang, Max Bachmann, Shanbo Wei, Jie Gong, Yuchai Huang, Tiantian Wang, Liqing Li, Kai Lu, Heng Jiang, Yanhong Gong, Hongbin Xu, Xin Shen, Qingfeng Tian, Chuanzhu Lv, Song, Xiaoxv Yin, and Zuxun Lu. The article has 1.12m accesses, 1 citation, and 19684 Altmetric mentions. A notification states 'This article has been updated'. The abstract begins with 'Stringent COVID-19 control measures were imposed in Wuhan between January 23 and April 8, 2020. Estimates of the prevalence of infection following the release of restrictions could...'. A table of contents on the right lists sections such as Abstract, Introduction, Results, Discussion, Methods, Data availability, Change history, References, Acknowledgements, Author information, and Ethics declarations. The Windows taskbar at the bottom shows various application icons and the system clock at 4:02 PM on 1/10/2021.

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Article | [Open Access](#) | Published: 20 November 2020

Post-lockdown SARS-CoV-2 nucleic acid screening in nearly ten million residents of Wuhan, China

Shiyi Cao, Yong Gan, Chao Wang, Max Bachmann, Shanbo Wei, Jie Gong, Yuchai Huang, Tiantian Wang, Liqing Li, Kai Lu, Heng Jiang, Yanhong Gong, Hongbin Xu, Xin Shen, Qingfeng Tian, Chuanzhu Lv, Song, Xiaoxv Yin & Zuxun Lu

Nature Communications **11**, Article number: 5917 (2020) | [Cite this article](#)

1.12m Accesses | 1 Citations | 19684 Altmetric | [Metrics](#)

i This article has been updated

Abstract

Stringent COVID-19 control measures were imposed in Wuhan between January 23 and April 8, 2020. Estimates of the prevalence of infection following the release of restrictions could...

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- Results
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- Acknowledgements
- Author information
- Ethics declarations

Windows taskbar: 4:02 PM 1/10/2021

300 'ASYMPTOMATIC' PCR CASES – 0 CONTAGIOUS, ALL LIKELY FALSE POSITIVE

Post-lockdown SARS-CoV-2 nucleic acid screening in nearly ten million residents of Wuhan, China

diagnosis of COVID-19, and 34,424 were recovered COVID-19 patients.

The screening of the 9,865,404 participants without a history of COVID-19 found no newly confirmed COVID-19 cases, and identified 300 asymptomatic positive cases with a detection rate of 0.303 (95% CI 0.270–0.339)/10,000. The median age-stratified Ct-values of the asymptomatic cases were shown in Supplementary Table 1. Of the 300 asymptomatic positive cases, two cases came from one family and another two were from another family. There were no previously confirmed COVID-19 patients in these two families. A total of 1174 close contacts of the asymptomatic positive cases were traced, and they all tested negative for the COVID-19. There were 34,424 previously recovered COVID-19 cases who participated in the screening. Of the 34,424 participants with a history of COVID-19, 107 tested positive again, giving a repositive rate of 0.310% (95% CI 0.423–0.574%).

Virus cultures were negative for all asymptomatic positive and repositive cases, indicating no “viable virus” in positive cases detected in this study.

All asymptomatic positive cases, repositive cases and their close contacts were isolated for at least 2 weeks until the results of nucleic acid testing were negative. None of detected positive cases or their close contacts became symptomatic or newly confirmed with COVID-19 during the isolation period. In this screening programme, single and mixed testing was performed, respectively, for 76.7% and 23.3% of the collected samples. The

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4:03 PM 1/10/2021

59% OF TRANSMISSIONS ASYMPTOMATIC?????

The screenshot shows a web browser window with multiple tabs open, including 'Weekly_Data_0106Final', 'COVID-19 in Jackson County, Ore', 'Situation in Jackson County', and 'SARS-CoV-2 Transmission From...'. The address bar shows the URL 'jamanetwork.com/journals/jamanetworkopen/fullarticle/2774707'. The page header includes the JAMA Network logo, a search bar, and a 'Sign In' button. The article title is 'SARS-CoV-2 Transmission From People Without COVID-19 Symptoms', dated January 7, 2021, by Michael A. Johansson, PhD^{1,2}; Talia M. Quandelacy, PhD, MPH¹; Sarah Kada, PhD¹; et al. The article is categorized as an 'Original Investigation' in 'Infectious Diseases'. The page features a navigation menu with options like 'CONTENTS', 'FIGURES / TABLES', 'SUPPLEMENTAL CONTENT', 'REFERENCES', 'RELATED', and 'COMMENTS'. A red advertisement on the right side reads 'JAMA Editor's Summary Now available as an Alexa Flash Briefing'. The 'Key Points' section begins with the question 'What proportion of coronavirus disease 2019 (COVID-19) transmission of severe acute respiratory syndrome coron...'. A cookie consent banner is visible at the bottom of the page.

Weekly_Data_0106Final x COVID-19 in Jackson County, Ore x Situation in Jackson County x JN SARS-CoV-2 Transmission From f x +

← → ↻ 🔒 jamanetwork.com/journals/jamanetworkopen/fullarticle/2774707 ☆ 📄 🌐 ⚙️ 👤 ⋮

📱 Apps 📁 Counties 📁 Intermittent Fasting 📁 Outreach 📁 Informed Consent 📁 COVID-19 Stats 📁 States COVID 📁 States 2 COVID 📁 CHD Articles 📁 Clackamas County... 📁 Hawaiian Dictionary... 📁 Friends of Trees »

JAMA Network

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Original Investigation | Infectious Diseases 🔒

January 7, 2021

SARS-CoV-2 Transmission From People Without COVID-19 Symptoms

Michael A. Johansson, PhD^{1,2}; Talia M. Quandelacy, PhD, MPH¹; Sarah Kada, PhD¹; et al

» Author Affiliations | Article Information

JAMA Netw Open. 2021;4(1):e2035057. doi:10.1001/jamanetworkopen.2020.35057

🌐 COVID-19 Resource Center

Key Points

Question What proportion of coronavirus disease 2019 (COVID-19) transmission of severe acute respiratory syndrome coron...

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- Methods
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JAMA Editor's Summary
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6:56 PM 1/11/2021

ZERO PARTICIPANTS...FUN WITH MATH

The screenshot shows a web browser window displaying a JAMA Network Open article. The browser's address bar shows the URL `jamanetwork.com/journals/jamanetworkopen/fullarticle/2774707`. The page header includes the JAMA Network logo, a search bar, and a 'Sign In' button. The article content is partially visible, with a blue highlight over a paragraph in the 'Methods' section. The right sidebar contains navigation options like 'CONTENTS', 'FIGURES / TABLES', 'SUPPLEMENTAL CONTENT', 'REFERENCES', 'RELATED', and 'COMMENTS'. A 'Download PDF' button and a 'Comment' button are also present. A red advertisement banner is visible on the right side of the page. The Windows taskbar at the bottom shows various application icons and the system clock indicating 6:56 PM on 1/11/2021.

Weekly_Data_0106Final | COVID-19 in Jackson County, Ore | Situation in Jackson County | SARS-CoV-2 Transmission From F

`jamanetwork.com/journals/jamanetworkopen/fullarticle/2774707`

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household contact studies indicates that asymptomatic or very mild symptomatic infections occur,¹¹⁻¹⁴ and laboratory and epidemiological evidence suggests that individuals who never develop symptoms may be as likely as individuals with symptoms to transmit SARS-CoV-2 to others.^{9,15,16}

Methods

The Centers for Disease Control and Prevention determined that this decision analytical study, which involved no enrollment of human subjects, did not require institutional review board approval. We used a simple model to assess the proportion of transmission from presymptomatic (ie, infectious before symptom onset), never symptomatic, and symptomatic individuals across a range of scenarios in which we varied the timing of the infectious period to assess different contributions of presymptomatic transmission and the proportion of transmission from individuals who never develop symptoms (ie, remain asymptomatic).

For all estimates we used data from a meta-analysis of 8 studies from China to set the incubation period at a median of 5 days with 95% of symptomatic individuals developing symptoms by day 12.¹⁷ Therefore the daily (t) probability of symptom onset (p_{so}) for individuals who develop symptoms was:

$$P_{so}(t) = F_{Log-Normal}(t, \logmean = 1.63, \logsd = 0.5).$$

To approximate a distribution of the infectious period, we assumed that the time to become infectiousness occurs on average at the same time as the

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6:56 PM 1/11/2021

COMPARISON OF STUDIES REGARDING ASYMPTOMATIC TRANSMISSION

Category	Wuhan Study	US Study
Location	Wuhan, China	None
Publishing Journal	Nature	JAMA
Publishing Date	11/20/2020	1/7/2021
Peer-Reviewed	Yes	No
Enrolled Participants	9,898,828	0
Methods	PCR, Antibody, Viral Culture	Math Assumptions Only
Suspected Asymptomatic Carriers	300 Total	NA
Actual Asymptomatic Carriers	29 Possible	NA
Asymptomatic Contacts	1,174	None
Asymptomatic Contacts Infected	0	NA
Asymptomatics w/ Replication Competent Virus	0	NA
% Asymptomatic Carriers	0.00029%	Not Stated
% Asymptomatic Transmitters	0.00000%	59%

Wuhan Study - <https://www.nature.com/articles/s41467-020-19802-w>

US Study - <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2774707>

ASYMPTOMATIC TRANSMISSION

Science is the pursuit of verifiable, reproducible data.

Projections are not data.

Projections should never supplant data.

The Wuhan Study is the largest study ever performed in human history.

It is peer-reviewed.

Its methods are solid and while missing the Viral Antigen Load Testing did attempt to culture replication-competent virus.

29 people out of 9,898,828 satisfied their criteria for Asymptomatic Carriers.

None of the Asymptomatic Carriers were contagious.

DID THE CDC VIOLATE MULTIPLE
FEDERAL LAWS
AND IN DOING SO HYPERINFLATE
CASE, HOSPITALIZATION, &
FATALITY DATA?

NVSS COVID-19 ALERT NO.2

[HTTPS://WWW.CDC.GOV/NCHS/DATA/NVSS/CORONAVIRUS/ALERT-2-NEW-ICD-CODE-INTRODUCED-FOR-COVID-19-DEATHS.PDF](https://www.cdc.gov/nchs/data/nvss/coronavirus/alert-2-new-icd-code-introduced-for-covid-19-deaths.pdf)

The screenshot shows a PDF document titled "New ICD code introduced for COVID-19 deaths" with a zoom level of 110%. The document contains several sections with underlined headings. Two red arrows point to the following sections:

- When will it be implemented?**
Immediately.
- Will COVID-19 be the underlying cause?**
The underlying cause depends upon what and where conditions are reported on the death certificate. However, the rules for coding and selection of the underlying cause of death are expected to result in COVID-19 being the underlying cause more often than not.
- What happens if certifiers report terms other than the suggested terms?**
If a death certificate reports coronavirus without identifying a specific strain or explicitly specifying that it is not COVID-19, NCHS will ask the states to follow up to verify whether or not the coronavirus was COVID-19. As long as the phrase used indicates the 2019 coronavirus strain, NCHS expects to assign the new code. However, it is preferable and more straightforward for certifiers to use the standard terminology (COVID-19).
- What happens if the terms reported on the death certificate indicate uncertainty?**
If the death certificate reports terms such as "probable COVID-19" or "likely COVID-19," these terms would be assigned the new ICD code. It is not likely that NCHS will follow up on these cases.
If "pending COVID-19 testing" is reported on the death certificate, this would be considered a pending record. In this scenario, NCHS would expect to receive an updated record, since the code will likely result in R99. In this case, NCHS will ask the states to follow up to verify if test results confirmed that the decedent had COVID-19.
- Do I need to make any changes at the jurisdictional level to accommodate the new ICD code?**
Not necessarily, but you will want to confirm that your systems and programs do not behave as if U07.1 is an unknown code.
- Should "COVID-19" be reported on the death certificate only with a confirmed test?**
COVID-19 should be reported on the death certificate for all decedents where the disease caused **or is assumed to have caused or contributed to death.** Certifiers should include as much detail as possible based on their knowledge of the case, medical records, laboratory testing, etc. If the decedent had other chronic conditions such as COPD or asthma that may have also contributed, these conditions can be reported in Part II. (See attached Guidance for Certifying COVID-19 Deaths)

GUIDANCE FOR CERTIFYING DEATHS DUE TO COVID-19

[HTTPS://WWW.CDC.GOV/NCHS/DATA/NVSS/VSRG/VSRG03-508.PDF](https://www.cdc.gov/nchs/data/nvss/vsrg/vsrg03-508.pdf)

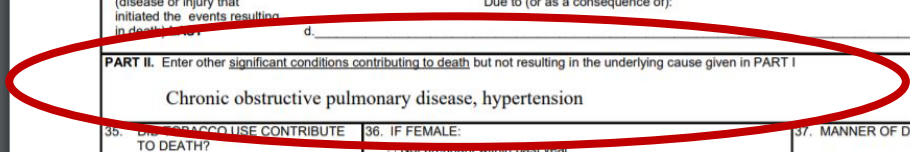
A 77-year-old male with a 10-year history of hypertension and chronic obstructive pulmonary disease (COPD) presented to a local emergency department complaining of 4 days of fever, cough, and increasing shortness of breath. He reported recent exposure to a neighbor with flu-like symptoms. He stated that his wheezing was not improving with his usual bronchodilator therapy. Upon examination, he was febrile, hypoxic, and in

Comment: In this case, the immediate cause of death was acute respiratory acidosis with infection, which was reported as a part of the causal sequence reported in Part II.

Scenario I

CAUSE OF DEATH (See instructions and examples)		
32. PART I. Enter the <u>chain of events</u> —diseases, injuries, or complications—that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE. Enter only one cause on a line. Add additional lines if necessary.		
IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. Acute respiratory acidosis	3 days
	Due to (or as a consequence of):	
	b. COVID-19	1 week
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	
Sequentially list conditions, if any, leading to the cause listed on line a. Enter the UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST		
PART II. Enter other <u>significant conditions contributing to death</u> but not resulting in the underlying cause given in PART I		
Chronic obstructive pulmonary disease, hypertension		
35. DID TOBACCO USE CONTRIBUTE TO DEATH?	36. IF FEMALE:	37. MANNER OF DEATH
<input type="checkbox"/> Yes <input type="checkbox"/> Probably <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Not pregnant within past year <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Not pregnant, but pregnant within 42 days of death <input type="checkbox"/> Not pregnant, but pregnant 43 days to 1 year before death <input type="checkbox"/> Unknown if pregnant within the past year	<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Homicide <input type="checkbox"/> Accident <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined

CAUSE OF DEATH (See instructions and examples)		
32. PART I. Enter the <u>chain of events</u> —diseases, injuries, or complications—that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE. Enter only one cause on a line. Add additional lines if necessary.		
IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. Cardiac Arrest Resulting From Acute Respiratory Acidosis	3 days
	Due to (or as a consequence of):	
	b. Influenza H1N1	1 week
	Due to (or as a consequence of):	
	c. Hypertension	10 years
	Due to (or as a consequence of):	
	d. Chronic Obstructive Pulmonary Disease (COPD)	10 years
Sequentially list conditions, if any, leading to the cause listed on line a. Enter the UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST		
PART II. Enter other <u>significant conditions contributing to death</u> but not resulting in the underlying cause given in PART I		
Fever & Hypoxia		
33. WAS AN AUTOPSY PERFORMED?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
34. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> No		
35. DID TOBACCO USE CONTRIBUTE TO DEATH?	36. IF FEMALE:	37. MANNER OF DEATH
<input type="checkbox"/> Yes <input type="checkbox"/> Probably <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Not pregnant within past year <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Not pregnant, but pregnant within 42 days of death <input type="checkbox"/> Not pregnant, but pregnant 43 days to 1 year before death <input type="checkbox"/> Unknown if pregnant within the past year	<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Homicide <input type="checkbox"/> Accident <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined



WHAT PERCENTAGE OF DEATH
CERTIFICATES HAD SIGNIFICANT
COMORBIDITIES?

94% OF ALL DEATH CERTIFICATES HAD 4.0 COMORBIDITIES ON AVERAGE

https://www.cdc.gov/nchs/nvss/vsrr/covid_weekly/index.htm#comorbidities

COVID-19 Provisional Counts - W x +

cdc.gov/nchs/nvss/vsrr/covid_weekly/index.htm#Comorbidities

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Comorbidities and other conditions

Table 3 shows the types of health conditions and contributing causes mentioned in conjunction with deaths involving coronavirus disease 2019 (COVID-19). The number of deaths that mention one or more of the conditions indicated is shown for all deaths involving COVID-19 and by age groups. For over 5% of these deaths, COVID-19 was the only cause mentioned on the death certificate. For deaths with conditions or causes in addition to COVID-19, on average, there were 4.0 additional conditions or causes per death. For data on deaths involving COVID-19 by time-period, jurisdiction, and other health conditions, [Click here to download](#).

Table 3. Number of COVID-19 deaths with contributing conditions, by time-period, jurisdiction of occurrence, and age-group. Data as of: 10/17/2021

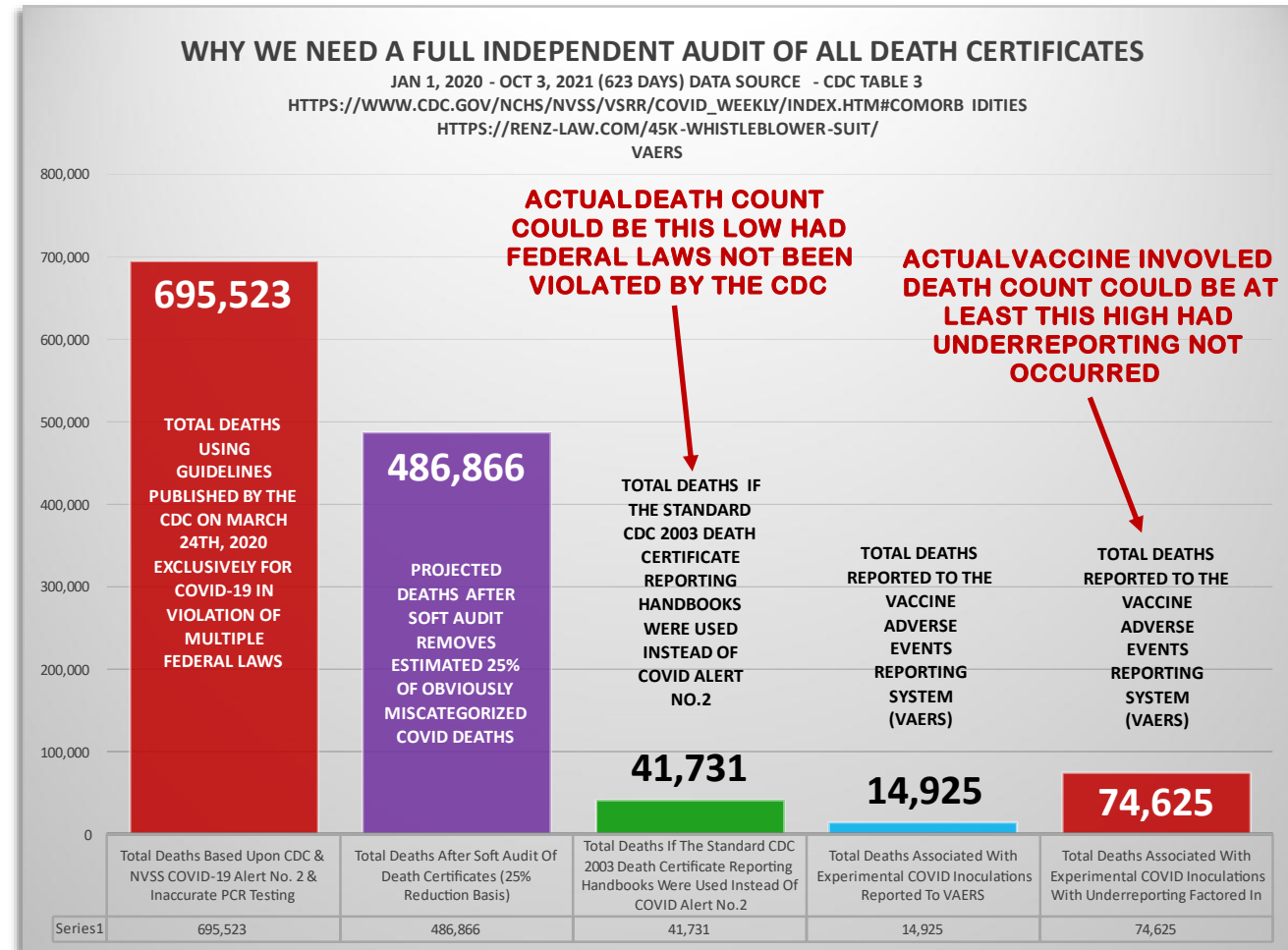
State	Attribute	Condition Group	Condition											
United States	COVID-19 Deaths	All	All	Year in which death occurred	Conditions contributing to deaths where COVID-19 was listed on the death certificate [1]	All Ages	0-24 years	25-34 years	35-44 years	45-54 years	55-64 years	65-74 years	75-84 years	85+ years
				2020/2021	Influenza and pneumonia	342,184	769	3,498	9,144	23,684	52,883	83,294	90,481	78,424
				2020/2021	Chronic lower respiratory diseases	61,722	94	269	618	1,846	6,909	15,536	20,175	16,274
				2020/2021	Adult respiratory distress syndrome	76,298	291	1,144	3,012	7,773	15,735	21,467	17,059	9,816
				2020/2021	Respiratory failure	275,980	565	2,403	6,667	17,733	41,413	68,439	75,594	63,161
				2020/2021	Respiratory arrest	14,913	35	142	324	835	1,920	3,106	3,947	4,604
				2020/2021	Other diseases of the respiratory system	31,815	131	401	927	2,236	5,061	7,718	8,355	6,986
				2020/2021	Hypertensive diseases	135,900	58	519	2,174	6,695	17,659	30,851	37,202	40,740
				2020/2021	Ischemic heart disease	75,271	21	130	523	2,237	7,677	16,559	23,351	24,772
				2020/2021	Cardiac arrest	85,927	236	981	2,543	6,579	14,010	20,554	21,343	19,680
				2020/2021	Cardiac arrhythmia	52,213	44	152	415	1,419	4,396	10,094	15,998	19,695
				2020/2021	Heart failure	52,859	34	169	474	1,476	4,388	9,685	15,294	21,338

Windows taskbar: 10:09 AM 10/25/2021 52°F

IS THE DEATH COUNT
ACCURATE?

WHICH NUMBER IS ACCURATE?

- How Many Deaths Were **Caused** By COVID?
- How Many Deaths Did COVID **Contribute** To?
- How Many Deaths Were Due To Comorbidities **Initiated** By COVID?
- Currently We Don't Know, They're All Grouped Together And As Of Dec 13th Can Include **COVID Vaccine Induced Fatalities** As Well.
- We Need A Full **Independent Audit** With Health Histories & PCR Results & Vaccine History.
- In June of 2021, the Santa Clara County California public health department performed a 'soft' audit of death certificate records where COVID was listed as the cause of death [and found that the data was hyperinflated by 22%](#).
- In July of 2021, the Alameda County California public health department performed a 'soft' audit of death certificate records where COVID was listed as the cause of death [and found that the data was hyperinflated by 25%](#).



WHAT STEPS WERE TAKEN TO
ENSURE THE SAME PERSON
COULDN'T BE COUNTED
MULTIPLE TIMES?

CSTE POSITION PAPER – ADOPTED BY CDC APRIL 14, 2020

[HTTPS://CDN.YMAAWS.COM/WWW.CSTE.ORG/RESOURCE/RESMGR/2020PS/INTERIM-20-ID-01_COVID-19.PDF](https://cdn.ymaaws.com/www.cste.org/resource/resmgr/2020ps/interim-20-id-01_covid-19.pdf)

Exhibit E - CDC Adopted April 2020 CSTE Position Paper.pdf - Adobe Acrobat Pro DC (32-bit)

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6 / 10 129%

B. Criteria to distinguish a new case of this disease or condition from reports or notifications which should not be enumerated as a new case for surveillance

N/A until more virologic data are available.

VIII. Period of Surveillance

Ongoing

IX. Data sharing/release and print criteria

CSTE recommends the following case statuses* be included in the 'case' count released outside of the public health agency:

- Confirmed
- Probable
- Suspect
- Unknown

* Which case statuses are included in the case counts constitute the "print criteria."

Jurisdictions (e.g., States and Territories) conducting surveillance under this case definition can voluntarily submit de-identified case information to CDC, if requested and in a mutually agreed upon format.

Production of national data summaries and national data re-release for non-NNCs:

- Prior to release of national data summaries CDC should follow the CDC/ATSDR Policy on Releasing & Sharing Data, issued on April 16, 2003 and referenced in 11-SI-01 and

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WHAT WAS THE MINIMAL
SYMPTOM PRESENTATION
NECESSARY IN ORDER TO BE
CLASSIFIED AS COVID POSITIVE?

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[HTTPS://CDN.YMAAWS.COM/WWW.CSTE.ORG/RESOURCE/RESMGR/2020PS/INTERIM-20-ID-01_COVID-19.PDF](https://cdn.ymaaws.com/www.cste.org/resource/resmgr/2020ps/interim-20-id-01_covid-19.pdf)

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A. Narrative: A description of suggested criteria for case ascertainment of a specific condition.

Symptoms of COVID-19 are non-specific and the disease presentation can range from no symptoms (asymptomatic) to severe pneumonia and death. COVID-19 is a mild to moderate illness for approximately 80% of individuals evaluated with the disease; 15% are severe infection requiring supplemental oxygen; and 5% are critical infections requiring mechanical ventilation.² People with COVID-19 generally develop signs and symptoms, including mild respiratory symptoms and fever ~5 days after infection (mean incubation period 5-6 days, range 1-14 days).³

A1. Clinical Criteria for Reporting

In outpatient or telehealth settings at least two of the following symptoms: fever (measured or subjective), chills, rigors, myalgia, headache, sore throat, new olfactory and taste disorder(s)

OR

- at least one of the following symptoms: cough, shortness of breath, or difficulty breathing

OR

Severe respiratory illness with at least one of the following:

- Clinical or radiographic evidence of pneumonia, or
- Acute respiratory distress syndrome (ARDS).

AND

No alternative more likely diagnosis

A2. Laboratory Criteria for Reporting

- Detection of SARS-CoV-2 RNA in a clinical specimen using a molecular amplification detection test.
- Detection of specific antigen in a clinical specimen.

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WAS THE HYPERINFLATION OF DATA
FINANCIALLY INCENTIVIZED?

YES, COVID DIAGNOSIS WAS FINANCIALLY INCENTIVIZED

[HTTPS://WWW.USATODAY.COM/STORY/NEWS/FACTCHECK/2020/04/24/FACT-CHECK-MEDICARE-HOSPITALS-PAID-MORE-COVID-19-PATIENTS-CORONAVIRUS/3000638001/](https://www.usatoday.com/story/news/factcheck/2020/04/24/fact-check-medicare-hospitals-paid-more-covid-19-patients-coronavirus/3000638001/)

The screenshot shows a web browser window displaying a USA Today article. The browser's address bar shows the URL: <https://www.usatoday.com/story/news/factcheck/2020/04/24/fact-check-medicare-hospitals-paid-more-covid-19-patients-coronavirus/3000638001/>. The page features a blue header with the USA Today logo and navigation links. A prominent blue banner at the top reads "On-the-ground reporting with a national perspective" and includes a subscription offer: "subscribe now \$4.99 per month save 50%". Below the banner, there are several article teasers, including "ONE WOMAN'S INCREDIBLE JOURNEY Escaping the Taliban", "CORONAVIRUS NUMBERS Virus numbers by state", "NOT VACCINATED? Questions + answers", and "NEWS TO YOUR INBOX Start the day smarter". The main article is titled "Coronavirus Conversations: Are we close to a cure?" and includes a "LIVE" tag. The article text is partially highlighted in blue, showing a quote from Jensen: "Hospital administrators might well want to see COVID-19 attached to a discharge summary or a death certificate. Why? Because if it's a straightforward, garden-variety pneumonia that a person is admitted to the hospital for – if they're Medicare – typically, the diagnosis-related group lump sum payment would be \$5,000. But if it's COVID-19 pneumonia, then it's \$13,000, and if that COVID-19 pneumonia patient ends up on a ventilator, it goes up to \$39,000." The browser's taskbar at the bottom shows various application icons and the system clock indicating 8:18 PM on 10/24/2021.

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LIVE

Coronavirus Conversations: Are we close to a cure?

What does the pipeline look like for a cure for coronavirus? Reporters from the USA TODAY Network talk about America's most urgent questions. *Just the FAQs, USA TODAY*

On April 19, he doubled down on his assertion via video on his Facebook page.

Jensen said, "Hospital administrators might well want to see COVID-19 attached to a discharge summary or a death certificate. Why? Because if it's a straightforward, garden-variety pneumonia that a person is admitted to the hospital for – if they're Medicare – typically, the diagnosis-related group lump sum payment would be \$5,000. But if it's COVID-19 pneumonia, then it's \$13,000, and if that COVID-19 pneumonia patient ends up on a ventilator, it goes up to \$39,000."

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WHO WERE THE SUBJECT MATTER
EXPERTS ADVISING THE CSTE?

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Subject Matter Expert (SME) Consultants:

(1) Judith C Lovchik, PhD D(ABMM) Assistant Commissioner Public Health Protection and Laboratory Services Indiana State Department of Health 317-921-5808 jlovchik@isdh.in.gov	(5) Sandra W. Roush, MT, MPH Surveillance Officer National Center for Immunization and Respiratory Diseases Centers for Disease Control and Prevention 404-639-8741 srous@cdc.gov
(2) Kirsten St. George, MAppSc, PhD Chief, Viral Diseases Wadsworth Center New York State Department of Health (518) 474 4177 Kirsten.StGeorge@health.ny.gov	(6) Tom Shimabukuro, MD, MPH, MBA Immunization Safety Office Division of Healthcare Quality Promotion National Center for Emerging and Zoonotic Infectious Diseases Centers for Disease Control and Prevention 404-498-0679 TShimabukuro@cdc.gov
(3) Susan I. Gerber, MD Chief, Respiratory Viruses Branch Division of Viral Diseases National Center for Immunization and Respiratory Diseases Centers for Disease Control and Prevention 404-639-3002 bhx1@cdc.gov	
(4) Aron J. Hall, DVM, MSPH, Dipl ACVPM Division of Viral Diseases National Center for Immunization and Respiratory Diseases Centers for Disease Control and Prevention (404) 639-1869 ahall@cdc.gov	

Agencies for Response

(1) Centers for Disease Control and Prevention
Robert R. Redfield, MD
Director
1600 Clifton Road NE
Atlanta, GA 30329
(404) 639-7000
rrredf@cdc.gov

Agencies for Information:
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HAVE OUR FINDINGS SURVIVED
PEER-REVIEW?

YES, THESE FINDINGS HAVE

Exhibit B - COVID Data A Historical Retrospective IPAK v24.pdf - Adobe Acrobat Pro DC (32-bit)

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1 / 25 103%

Bookmarks

- Introduction
- COVID-19 Data Historical Timeline
- Did the CDC Violate Federal Law?
- The CDC Actions Violated Data Quality, Objectivity, Utility, and Integrity Requirements
- How Aware Was the CDC of Their Responsibility to Be In Full Compliance With IQA & PRA?
- The Impact of Potential PRA & IQA Violations Upon the Current COVID-19 Data
- COVID-19 Fatality Data Using 2003 CDC Published Guidelines
- Implications for Public Health Policy
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Science, Public Health Policy, and The Law
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October 12, 2020

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COVID-19 Data Collection, Comorbidity & Federal Law: A Historical Retrospective

Henry Ealy ^{*,†}, Michael McEvoy ^{‡§}, Daniel Chong [,], John Nowicki [,], Monica Sava [¶], Sandeep Gupta ^{||}, David White ^{**}, James Jordan [,], Daniel Simon ^{††}, Paul Anderson ^{‡‡}

Abstract
According to the Centers for Disease Control and Prevention (CDC) on August 23, 2020, "For 6% of the deaths, COVID-19 was the only cause mentioned. For deaths with conditions or causes in addition to COVID-19, on average, there were 2.6 additional conditions or causes per death."^[1] For a nation tormented by restrictive public health policies mandated for healthy individuals and small businesses, this is the most important statistical revelation of this crisis. This revelation significantly impacts the published fatalities count due to COVID-19. More importantly, it exposes major problems with the process by which the CDC was able to generate inaccurate data during a crisis. The CDC has advocated for social isolation, social distancing, and personal protective equipment use as primary mitigation strategies in response to the COVID-19 crisis, while simultaneously refusing to acknowledge the promise of inexpensive pharmaceutical and natural treatments. These mitigation strategies were promoted largely in response to projection model fatality forecasts that have proven to be substantially inaccurate. Further investigation into the legality of the methods used to create

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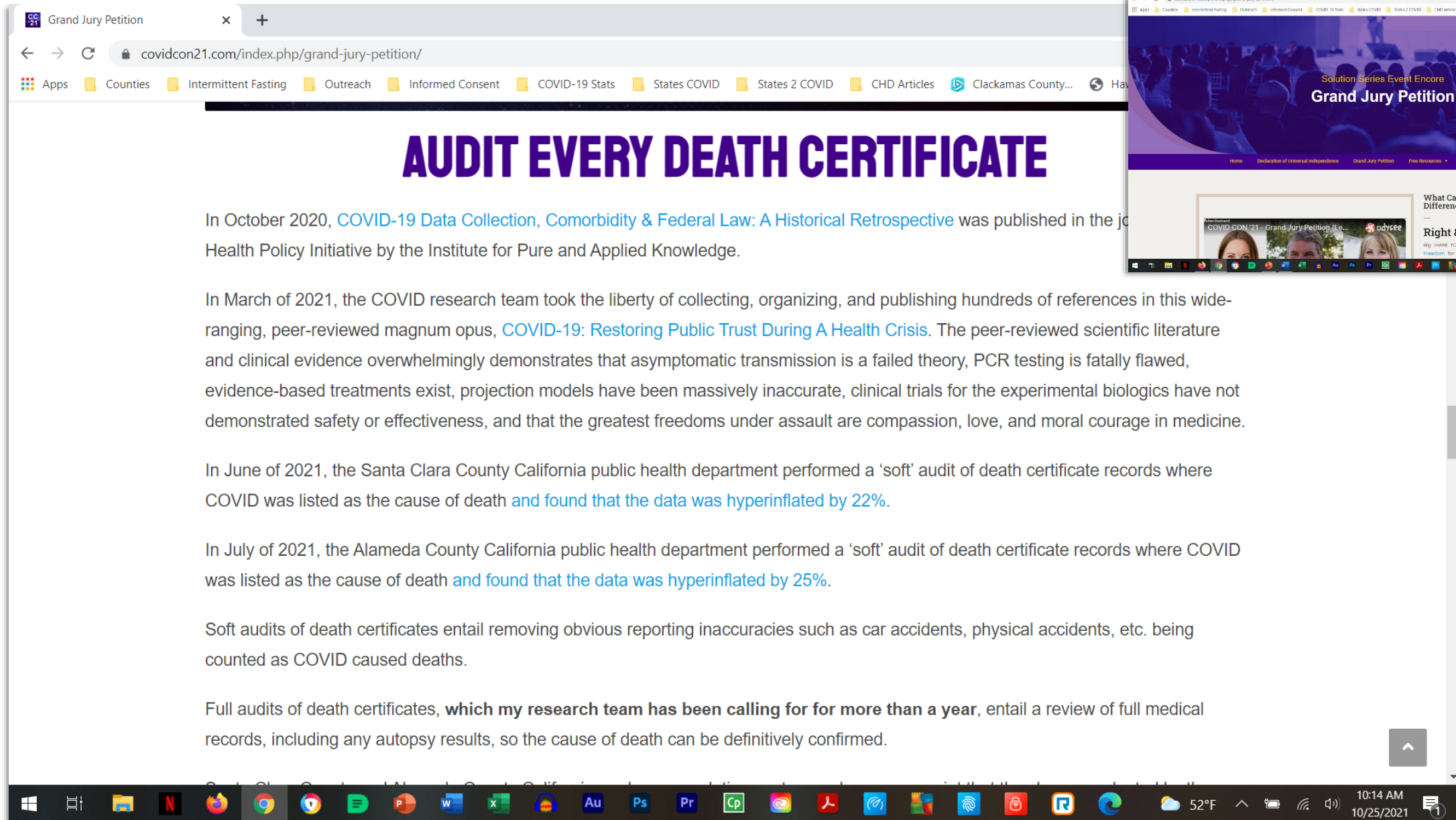
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WHAT'S BEING DONE?

GRAND JURY PETITION FILED



The screenshot shows a web browser window with the address bar displaying "covidcon21.com/index.php/grand-jury-petition/". The page features a navigation menu with items like "Apps", "Counties", "Intermittent Fasting", "Outreach", "Informed Consent", "COVID-19 Stats", "States COVID", "States 2 COVID", "CHD Articles", and "Clackamas County...". The main heading is "AUDIT EVERY DEATH CERTIFICATE" in large, bold, purple letters. Below the heading, there are several paragraphs of text, each starting with a date in 2020 or 2021, describing various audits and research findings related to COVID-19 death certificates. The text is followed by a Windows taskbar at the bottom with various application icons and a system tray showing the time as 10:14 AM on 10/25/2021.

Grand Jury Petition

covidcon21.com/index.php/grand-jury-petition/

Apps Counties Intermittent Fasting Outreach Informed Consent COVID-19 Stats States COVID States 2 COVID CHD Articles Clackamas County...

AUDIT EVERY DEATH CERTIFICATE

In October 2020, [COVID-19 Data Collection, Comorbidity & Federal Law: A Historical Retrospective](#) was published in the [Journal of Law, Medicine & Ethics](#) as part of the [COVID-19 Health Policy Initiative](#) by the Institute for Pure and Applied Knowledge.

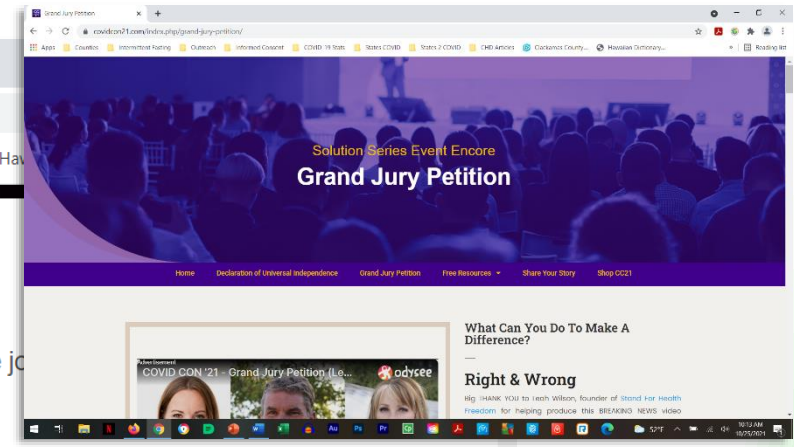
In March of 2021, the COVID research team took the liberty of collecting, organizing, and publishing hundreds of references in this wide-ranging, peer-reviewed magnum opus, [COVID-19: Restoring Public Trust During A Health Crisis](#). The peer-reviewed scientific literature and clinical evidence overwhelmingly demonstrates that asymptomatic transmission is a failed theory, PCR testing is fatally flawed, evidence-based treatments exist, projection models have been massively inaccurate, clinical trials for the experimental biologics have not demonstrated safety or effectiveness, and that the greatest freedoms under assault are compassion, love, and moral courage in medicine.

In June of 2021, the Santa Clara County California public health department performed a 'soft' audit of death certificate records where COVID was listed as the cause of death [and found that the data was hyperinflated by 22%](#).

In July of 2021, the Alameda County California public health department performed a 'soft' audit of death certificate records where COVID was listed as the cause of death [and found that the data was hyperinflated by 25%](#).

Soft audits of death certificates entail removing obvious reporting inaccuracies such as car accidents, physical accidents, etc. being counted as COVID caused deaths.

Full audits of death certificates, **which my research team has been calling for for more than a year**, entail a review of full medical records, including any autopsy results, so the cause of death can be definitively confirmed.



[HTTPS://WWW.COVIDCON21.COM/
INDEX.PHP/GRAND-JURY-PETITION/](https://www.covidcon21.com/index.php/grand-jury-petition/)

WHAT ARE
THE GAIN OF BENEFIT _{VS}
RISK OF INJURY STATISTICS
FOR THE EXPERIMENTAL
INOCULATIONS?

RISK VS BENEFIT ANALYSIS

COVID-19 US Risk vs Benefit Analysis By Age - GREEN = Low Risk, RED = High Risk, BLUE = Only Demographics That Should Be Experimental Inoculation Eligible

Data Source CDC COVID Data Tracker - Thru Aug 22, 2021

SARS-CoV-2 Infection Data

Demographic	Cases ¹	Deaths ²	Recoveries ³	Recovery Rate	Gain of Benefit
Age 0 to 4	664,936	147	641,542	99.978%	0.022%
Age 5 to 17	3,201,308	324	3,089,064	99.990%	0.010%
Age 18 to 39	11,677,068	9,709	11,259,122	99.917%	0.083%
Age 40 to 49	4,387,635	16,211	4,218,030	99.631%	0.369%
Age 50 to 64	5,908,030	80,606	5,620,876	98.636%	1.364%
Total 0 to 64	25,838,977	106,997	24,828,635	99.586%	0.414%
Age 65 to 74	2,163,251	112,284	1,975,339	94.81%	5.191%
Age 75+	1,735,001	300,605	1,373,739	82.67%	17.326%
Total 65 & Over	3,898,252	412,889	3,349,078	89.41%	10.592%
Total	29,737,229	519,886	28,177,713	98.25%	1.748%

Data Source CDC COVID Data Tracker & VAERS - Thru Aug 13, 2021

Experimental Inoculation Data

Demographic	People Inoculated	Reported Injuries ⁴	Reported Deaths ⁵	Risk Of Injury	Risk vs Benefit ⁶
Age <12	200,375	208	3	0.104%	4.7 Times Greater Risk Than Benefit Age <12
Age 12 to 17	11,354,161	17,887	18	0.158%	15.8 Times Greater Risk Than Benefit Age 12 to 17
Age 18 to 39	54,110,388	150,702	299	0.279%	3.4 Times Greater Risk Than Benefit Age 18 to 39
Age 40 to 49	26,233,660	86,083	282	0.328%	Almost Equivocal Risk To Benefit
Age 50 to 64	46,591,119	124,430	1,176	0.267%	5.1 Times Greater Benefit Than Risk Age 50 to 64
Total 0 to 64	138,489,703	379,310	1,778	0.274%	-----
Age 65 to 74	27,749,040	84,628	2,730	0.181%	28.7 Times Greater Benefit Than Risk Age 65 to 74
Age 75+	18,994,427	24,212	3,604	0.069%	251.1 Times Greater Benefit Than Risk Age 75+
Unknown Age	16,192,615	107,472	4,946	0.049%	-----
Total	201,425,785	595,622	13,058	0.296%	-----

Data Source Cases, Fatalities, People Inoculated - NVSS Published By CDC - <https://covid.cdc.gov/covid-data-tracker>

Data Source Reported Injuries - VAERS By CDC - <https://wonder.cdc.gov/> - Data Processed Through Aug 13th, 2021

1 - Data Published from Jan 1st, 2020 to Aug 22, 2021 (595 Days). Typically Data Collection Is Reset Every Jan 1st. That Has Not Happened For COVID Data

2 - Deaths May Include Some People Who Died Due To Experimental COVID Inoculation As Well As Some People Who Were Incorrectly Categorized As A COVID Death

3 - Recoveries Are Estimates Based Upon CDC Guidelines For 10 Days & Current Death & Current Hospitalization Data. Recoveries = Cases 10 Days Prior - Current Hospitalizations - Current Deaths

4 - Reported Injuries From VAERS Do Not Match Each COVID Data Tracker By Age Demographics. Age 65 to 74 Includes VAERS Data Age 65 to 79, Age 75+ Includes VAERS Data Age 80+

5 - Reported Deaths To VAERS Does Not Include The More Than 1,505 Spontaneous Miscarriages Related To The Experimental COVID Inoculations As Of Aug 13, 2021.

6 - Children Under 12 Years of Age Are Not Authorized To Receive The Experimental Inoculations, but 195,577 Already Have According To the CDC. Inoculation Data Is Insufficient Currently To Gain A Complete Picture Of Risk.

STATISTICALLY SPEAKING,
IS THIS AN EMERGENCY
FOR EVERYONE OR
AN EMERGENCY FOR
THE HIGH-RISK?

NATIONAL - RECOVERY RATES

Is This An Emergency?

Data Source CDC COVID Data Tracker - Thru Oct 6, 2021

Demographic	Cases ¹	Deaths ²	% Of Deaths	Recoveries ³	Recovery Rate
Age 0 to 4	847,589	214	0.04%	822,166	99.97%
Age 5 to 17	4,160,595	444	0.08%	4,036,408	99.99%
Age 18 to 39	13,324,287	12,244	2.14%	12,915,758	99.91%
Age 40 to 49	5,015,543	20,188	3.52%	4,846,185	99.60%
Age 50 to 64	6,656,629	93,783	16.37%	6,364,868	98.59%
Total 0 to 64	30,004,643	126,873	22.14%	28,985,385	99.58%
Age 65 to 74	2,458,058	124,808	21.78%	2,260,144	94.92%
Age 75+	1,931,204	321,335	56.08%	1,552,432	83.36%
Total 65 & Over	4,389,262	446,143	77.86%	3,812,576	89.84%
Total	34,393,905	573,016		32,797,961	98.33%

Data Source Cases, Fatalities, People Inoculated - NVSS Published By CDC - <https://covid.cdc.gov/covid-data-tracker>

1 - Data Published from Jan 1st, 2020 to Oct 6, 2021 (644 Days). Typically Data Collection Is Reset Every Jan 1st. That Has Not Happened For COVID Data

2 - Deaths May Include Some People Who Died Due To Experimental COVID Inoculation As Well As Some People Who Were Incorrectly Categorized As A COVID Death

3 - Recoveries Are Calculated By Subtracting An Age Demographic Estimate Of New Cases OverThe Previous 10 Days, The Number Of Hospitalizations & the Number Of Deaths From Total Published Cases

According to the Centers for Disease Control and Prevention (CDC) on August 23, 2020, ***“For 6% of the deaths, COVID-19 was the only cause mentioned. For deaths with conditions or causes in addition to COVID-19, on average, there were 2.6 additional conditions or causes per death.”***

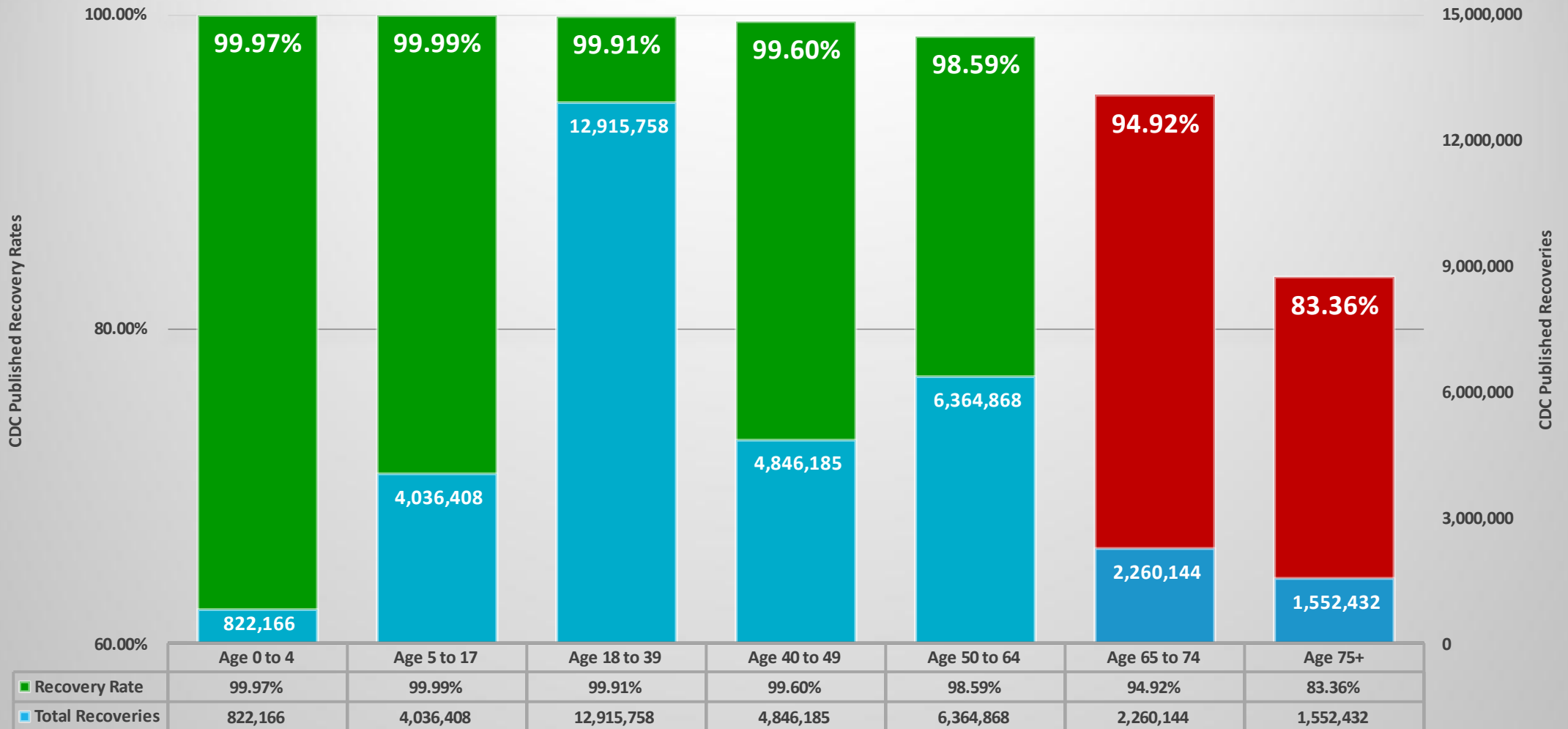
According to the Centers for Disease Control and Prevention (CDC) on October 3, 2021, ***“For Over 5% of the deaths, COVID-19 was the only cause mentioned. For deaths with conditions or causes in addition to COVID-19, on average, there were 4.0 additional conditions or causes per death.”***

NATIONAL - RECOVERY RATES

Recovery Rates Nationwide By Age - Is This An Emergency?

JAN 1, 2020 - OCT 6, 2021 (644 DAYS) VACCINE RECOVERIES PERCENTS & TOTALS

DATA SOURCES - [HTTPS://COVID.CDC.GOV/COVID-DATA-TRACKER](https://COVID.CDC.GOV/COVID-DATA-TRACKER)



WHILE PCR SHOULD NEVER BE
USED DIAGNOSTICALLY,
WHAT SHOULD THE CYCLE
THRESHOLD HAVE BEEN SET TO?

PROPOSED PCR DIAGNOSTIC

PROPOSAL FOR CALIBRATING COVID RT-qPCR TESTING BASED UPON VIRAL REPLICATION-COMPETENCE

DIAGNOSTIC INTERPRETATION	CYCLE THRESHOLD	PROPOSED ACTION
Infectious	< 25.00	Quarantine/Isolation Until No Longer Symptomatic + 2 Days. Administration Of Evidence-Based Nutritional Guidance. Retest Serologic Antibodies To Confirm (+ IgG, - IgM).
Possibly Infectious	25.00 - 33.99	Confirmatory Lab Testing. Serologic Antigen Or Live Human Cell Culture. Quarantine/Isolation Until Confirmed. Administration Of Evidence-Based Nutritional Guidance As Precaution.
Not Infectious	≥ 34.00	Recommendation Of Evidence-Based Nutritional Guidance As Precaution.

Oxford Academic (Jefferson) - <https://academic.oup.com/cid/advance-article/doi/10.1093/cid/ciaa1764/6018217>

NEMJ Hospital Study - <https://www.nejm.org/doi/full/10.1056/NEJMc2027040>

Caco-2 Cell Human Cell Line Infectiveness - <https://pubmed.ncbi.nlm.nih.gov/32966582/>

VERO Monkey, HUH7.0 Human, 293T Human Cell Line Infectiveness - https://wwwnc.cdc.gov/eid/article/26/6/20-0516_article

WHAT IS THE CYCLE THRESHOLD
SET TO AND HOW LONG HAS IT
BEEN SET TO THIS LEVEL?

CT < 40.00 = POSITIVE

CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel - Instructions for Use 37 / 80

Expected Performance of Controls Included in the CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel

Control Type	External Control Name	Used to Monitor	2019 nCoV_N1	2019 nCoV_N2	RP	Expected Ct Values
Positive	nCoVPC	Substantial reagent failure including primer and probe integrity	+	+	+	< 40.00 Ct
Negative	NTC	Reagent and/or environmental contamination	-	-	-	None detected
Extraction	HSC	Failure in lysis and extraction procedure, potential contamination during extraction	-	-	+	< 40.00 Ct

If any of the above controls do not exhibit the expected performance as described, the assay may have been set up and/or executed improperly, or reagent or equipment malfunction could have occurred. Invalidate the run and re-test.

3:38 PM 1/28/2021

IS THERE EMPIRICAL EVIDENCE
SUPPORTING NUTRITION FOR
PREVENTION & EARLY
TREATMENT?

LINUS PAULING INSTITUTE - OSU

- Premier Nutrient Research Center in the US
- 267 Peer-Reviewed References for Nutrition and Natural Adaptive Immunity Alone


Key Nutrients

- Vitamin A
 - Vitamin C
 - Vitamin D
 - Vitamin E
 - Zinc
 - Iron, Selenium
 - Omega 3 Fatty Acids
 - Mitochondrial Nutrients (B-Complex)
- <https://lpi.oregonstate.edu/mic/health-disease/immunity>
 - <https://lpi.oregonstate.edu/sites/lpi.oregonstate.edu/files/lpi-immunity-infographic.pdf>
 - Section 9 - Vitamins modulating the immune system during COVID-19
 - <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7547582/#s0045title>

KEY FEATURES OF THE IMMUNE RESPONSE

OXIDATIVE BURST

- Certain immune cells produce a concentrated burst of reactive oxygen species (ROS), damaging substances that help kill invading organisms



Important nutrients

- Vitamin C
- Vitamin E
- Iron
- Zinc
- Copper
- Selenium

Connection

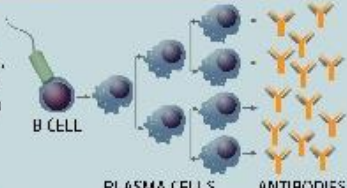
- Prolonged and continuous exposure to ROS can lead to damage and disease
- The listed antioxidant nutrients protect immune cells and keep the oxidative burst in check

PROLIFERATION

- Refers to an increase in the number or amount of something

- The immune system is constantly producing cells, chemicals, and proteins to carry out its functions

- When it encounters a foreign invader, it ramps up production to respond as needed



Important nutrients

- Vitamin A
- Vitamin D
- Folate
- Vitamin B₁₂
- Vitamin B₆
- Iron
- Zinc


Connection

- Proliferation requires energy, building blocks, and cofactors to produce the many cells and substances needed to mount an effective immune response
- The listed micronutrients have essential roles in the production and development of all new cells in the body, including immune cells

INFLAMMATION

- Isolates the injured or infected area

- Helps deliver immune cells, chemical messengers, and antibodies to sites of injury or infection



Important nutrients

- EPA
- DHA

Connection

- Inappropriate activation or the inability to turn off inflammation can lead to tissue damage and chronic disease
- EPA and DHA have anti-inflammatory activity that can help keep inflammation in check

NHANES STUDIES SUMMARY – THRU 2004

■ All NHANES Data Is Published By The CDC

- National Health And Nutrition Examination Survey (NHANES)
- Serologic Nutrient Studies Confirming Extensive Nutrient Deficiencies In Americans For Decades

NHANES Key Results

- **Vitamin A** – 44% of Americans had inadequate dietary intakes of RDA 700-900micrograms/day (2,333- 3,000 IU/day).
- **Vitamin C** – 31% of Americans had inadequate dietary intakes of RDA 75-90mg/day.
 - 2002, 21 Million Americans have serious Vitamin C deficiency, and 66 million more will develop serious deficiency including smokers/vapers and citizens in low-income groups.
- **Vitamin D** – 66% of Americans had inadequate dietary intakes of RDA 600-800 IU/day and Vitamin D requirements increase in all people over 70 years of age. Most Americans over 50 years of age regardless of gender did not meet minimal daily intakes.
- **Vitamin E** – 93% of Americans had inadequate dietary intakes of RDA 15mg/day (22 IU/day).
- **Zinc:** NHANES III data: 35%–45% of adults aged 60 years or older had zinc intakes below the estimated average requirement of 6.8 mg/day for elderly females and 9.4 mg/day for elderly males. When the investigators considered intakes from both food and dietary supplements, they found that 20%–25% of older adults still had inadequate zinc intakes.
- **Lower Household Income** – Americans in lower income brackets consistently had a higher prevalence of inadequate intake of Vitamin A, Vitamin C, Vitamin B6, Folate. All nutrients essential for healthy natural adaptive immune response.
- https://www.nutri-facts.org/en_US/news/u-s---nhanes.html
- <https://www.cdc.gov/nchs/nhanes/index.htm>
- Schleicher R. L. et al. Serum vitamin C and the prevalence of vitamin C deficiency in the United States: 2003–2004 National Health and Nutrition Examination Survey (NHANES). Am J Clin Nutr, August 2009.
- <https://ods.od.nih.gov/factsheets/Zinc-HealthProfessional/#en24>

NHANES STUDIES SUMMARY – 2005 TO 2016

Dietary Intake Only

Sample Size & Age of Participants

- 26,282 adults (Age >19 years)

Study Findings: Dietary Inadequacies:

- **Vitamin A:** 45% of U.S. population does not meet dietary EAR (estimated average requirement)
 - Average Vitamin A Intake from Diet: 639ug (2,130 IU). EAR=700-900ug (2,333- 3,000 IU/day).
- **Vitamin C:** 46% of U.S. population does not meet dietary EAR (estimated average requirement)
 - Average Vitamin C Intake from Diet: 83mg. **Optimal Daily Intake = 200mg**
- **Vitamin D:** 95% of U.S. population does not meet dietary EAR (estimated average requirement)
 - Average Vitamin D Intake from Diet: 188 IU RDA = 600-800 IU
 - **(NOTE: Endocrine Society recommends 1,500-2,000 IU)**
- **Vitamin E:** 84% of U.S. population does not meet dietary EAR (estimated average requirement)
 - Average Vitamin E Intake from Diet: 9mg (13 IU). RDA = 15mg/daily (22 IU/day)
 - Recommendation for Older Adults For Immune Health: 134mg/daily (200 IU/day)
- **Zinc:** 15% of U.S. population does not meet dietary EAR (estimated average requirement)
 - Average Zinc Intake from Diet: 12mg. RDA = 8-11mg for healthy populations;
 - **Optimal Intake for Higher Risk Populations: 30mg**

1. Reider, C. A., Chung, R.-Y., Devarshi, P. P., Grant, R. W., & Hazels Mitmesser, S. (2020). Inadequacy of Immune Health Nutrients: Intakes in US Adults, the 2005–2016 NHANES. *Nutrients*, 12(6), 1735. doi:10.3390/nu12061735
2. Balz Frei, Ines Birlouez-Aragon, Jens Lykkesfeldt: Authors' perspective: What is the optimum intake of vitamin C in humans? *Crit Rev Food Sci Nutr.*2012;52(9):815-29. doi: 10.1080/10408398.2011.649149.
3. Simin Nikbin Meydani, Erin Diane Lewis, Dayong Wu; Perspective: Should Vitamin E Recommendations for Older Adults Be Increased? *Advances in Nutrition*, Volume 9, Issue 5, September 2018, Pages 533–543, <https://doi.org/10.1093/advances/nmy035>
4. Barnett, J.B.; Dao, M.C.; Hamer, et al. Effect of zinc supplementation on serum zinc concentration and T cell proliferation in nursing home elderly: A randomized, double-blind, placebo-controlled trial. *Am. J. Clin. Nutr.* 2016, 103, 942–951, doi:10.3945/ajcn.115.115188

NHANES NUTRIENT DATA: 2005-2016

NHANES NUTRITIONAL ANALYSIS STUDIES - SUMMARY

Nutrient	RDA/EAR/ODI	Adults 2005-2016	Nutritional Deficit For Minimum Requirements	% US Population Deficient*
Vitamin A	2,333-3,000 IU	2,130 IU	870 IU	35-45%
Vitamin C	75-200 mg	83 mg	117 mg	37-46%
Vitamin D	600-800 IU	188 IU	612 IU	65-95%
Vitamin E	22-200 IU	13 IU	187 IU	60-84%
Zinc	8-30 mg	12 mg	18 mg	11-15%

Data Source - NVSS Published By CDC - <https://www.cdc.gov/nchs/nhanes/index.htm>

*Low End Of Range Adjusted For Supplemental Nutrient Intake Plus Dietary Intake - Reider, C. A., Chung, R.-Y., Devarshi, P. P., Grant, R. W., & Hazels Mitmesser, S. (2020). Inadequacy of Immune Health Nutrients: Intakes in US Adults, the 2005–2016 NHANES. *Nutrients*, 12(6), 1735. doi:10.3390/nu12061735

Statistical Interpretation

- An Alarming & Statistically Significant Percentage of Adult **Americans Over 19 Years of Age are Nutritionally Deficient in Minimum Requirements for Key Nutrients** that Engage the Natural Adaptive Immune Response at the Cellular Level.
- Americans Deficient in these Key Nutrients, particularly Americans with Underlying Medical Conditions and at Advanced Age, are at **VERY HIGH-RISK for Prolonged Recovery Times, Adverse Events & Fatality** from ALL Respiratory Infections including, but not limited to the SARS-CoV-2 Virus.
- Addressing These Nutrient Deficiencies Are Key Factors In Developing Effective Treatments & Limiting the Spread of the SARS-CoV-2 Virus.
- **NUTRITIONAL GUIDANCE MUST BE ISSUED FOR ALL AMERICANS IMMEDIATELY (see later slides)**

VITAMIN D

- <http://orthomolecular.activehosted.com/index.php?action=social&chash=b73ce398c39f506af761d2277d853a92.164&s=a3b8ba524fa5d84e9ad7899052087eb7>

Key Results

- **Philippine Study** - With a deficient vitamin D status (<50nmol/L) the probability of becoming Severe or Critical with COVID-19 was 72.8% against 7.2% with adequate vitamin D (>75nmol/L).
- **Indonesian Study** - With a deficient vitamin D status (<50nmol/L) the mortality rate from COVID-19 was 98.8% against 4.1% with adequate vitamin D (>75nmol/L).
- 3 studies referenced show that a vitamin D3 blood level of at least 75 nmol/L (30 ng/ml) is needed for protection against COVID-19. Government recommendations for vitamin D intake - 600 IU/day for the USA (800 IU for >70 years) are based primarily on bone health. This is woefully inadequate in the pandemic context. An adult will need to take 4000 IU/day of vitamin D3 for 3 months to reliably achieve a 75 nmol/L level. Persons of color may need twice as much. These doses can reduce the risk of infection but are not for treatment of an acute viral infection. And since vitamin D is fat-soluble and its level in the body rises slowly, for those with a deficiency, **taking a initial [loading] dose of 5-fold the normal dose (20,000 IU/day) for 2 weeks can help to raise the level up to an adequate level to lower infection risk.**

Other essential nutrients can help

- As mentioned above, many studies have shown that for those deficient in essential nutrients, a protocol that includes vitamin D, vitamin C, magnesium, and zinc can decrease the risk of infection for viruses, including those similar to COVID-19.[1] **Recommended preventive adult doses are vitamin C, 3000 mg/day (in divided doses, to bowel tolerance), magnesium, 400 mg (in malate, citrate, or chloride form), zinc, 20 mg. [1]**

VITAMIN D, MAGNESIUM, B12

- <https://www.medrxiv.org/content/10.1101/2020.06.01.20112334v2>

Methods

- Cohort observational study of all consecutive hospitalized COVID-19 patients aged 50 and above in a tertiary academic hospital who received DMB compared to a recent cohort who did not. Patients were administered **oral vitamin D3 1000 IU OD, magnesium 150mg OD and vitamin B12 500mcg OD (DMB)** upon admission if they did not require oxygen therapy.

Conclusions

- DMB combination in older COVID-19 patients was associated with a **significant reduction in proportion of patients with clinical deterioration requiring oxygen support and/or intensive care support.**

VITAMIN D

- https://www.grassrootshealth.net/wp-content/uploads/2020/04/Grant-GRH-Covid-paper-2020.pdf?fbclid=IwAR1On0EDZ_Nb6xTBWGjztDhx7PhmENIjllAGlp9ZRWEalmoAE2geBBca5ww
- Evidence that Vitamin D Supplementation Could Reduce Risk of Influenza and COVID-19 Infections and Deaths
- 157 References

Key Findings

- To reduce the risk of infection, it is recommended that people at risk of influenza and/or COVID-19 consider taking **10,000 IU/d of vitamin D3 for a few weeks to rapidly raise 25(OH)D concentrations, followed by 5000 IU/d**. The goal should be to raise 25(OH)D concentrations above 40–60 ng/mL (100–150 nmol/L). For treatment of people who become infected with COVID-19, higher vitamin D3 doses might be useful.
- A study involving 33 participants, including seven taking 4000 IU/d of vitamin D3 and six who took 10,000 IU/d of vitamin D3 for 8 weeks, reported that 25(OH)D concentrations increased from 20 ± 6 to 39 ± 9 for 4000 IU/d and from 19 ± 4 to 67 ± 3 for 10,000 IU/d and improved gut microbiota with no adverse effects [138]
- **A recent review suggested using vitamin D loading doses of 200,000–300,000 IU in 50,000-IU capsules to reduce the risk and severity of COVID-19 [43]**

VITAMIN D

- Castillo, M. E., Entrenas Costa, L. M., Vaquero Barrios, J. M., Alcalá Díaz, J. F., Miranda, J. L., Bouillon, R., & Quesada Gomez, J. M. (2020). **“Effect of Calcifediol Treatment and best Available Therapy versus best Available Therapy on Intensive Care Unit Admission and Mortality Among Patients Hospitalized for COVID-19: A Pilot Randomized Clinical study.”** The Journal of Steroid Biochemistry and Molecular Biology, 105751. doi:10.1016/j.jsbmb.2020.105751

Key Findings

- Vitamin D3 significantly reduced ICU admission rates, as well as reduced the severity COVID-19 disease. Of the 50 total patients who received vitamin D3, 1 was admitted to the ICU (2%). Of the 26 patients who were not administered vitamin D3, 13 were admitted to the ICU (50%). **Of the 50 patients treated with vitamin D3, 0 deaths occurred, and all 50 patients were eventually discharged without complications.**

VITAMIN D

- Marcos Pereira, Alialdo Dantas Damascena, Laylla Mirella Galvão Azevedo, Tarcio de Almeida Oliveira & Jerusa da Mota Santana (2020) **Vitamin D deficiency aggravates COVID-19: systematic review and meta-analysis**, Critical Reviews in Food Science and Nutrition, DOI: 10.1080/10408398.2020.1841090

Key Findings

- Vitamin D deficiency was associated with increased hospitalizations (OR = 1.81, 95% CI = 1.41–2.21), and increased mortality (OR = 1.82, 95% CI = 1.06–2.58). Severe cases of COVID-19 were 64% more likely to be vitamin D deficient than mild cases of COVID-19 (OR = 1.64; 95% CI = 1.30–2.09). **Vitamin D deficiency is associated with higher infection rates, increased incidence of sepsis, and increased mortality risk, among critically ill populations.**

VITAMIN D

- Kaufman HW, Niles JK, Kroll MH, Bi C, Holick MF (2020) SARS-CoV-2 positivity rates associated with circulating 25-hydroxyvitamin D levels. PLoS ONE 15(9): e0239252. <https://doi.org/10.1371/journal.pone.0239252>

Key Findings

- A total of 191,779 patients were included (median age, 54 years [interquartile range 40.4–64.7]; 68% female. The SARS-CoV-2 positivity rate was 9.3% (95% C.I. 9.2–9.5%) and the mean seasonally adjusted 25(OH)D was 31.7 (SD 11.7). **The SARS-CoV-2 positivity rate was higher in the 39,190 patients with “deficient” 25(OH)D values (<20 ng/mL) (12.5%, 95% C.I. 12.2–12.8%) than in the 27,870 patients with “adequate” values (30–34 ng/mL) (8.1%, 95% C.I. 7.8–8.4%) and the 12,321 patients with values \geq 55 ng/mL (5.9%, 95% C.I. 5.5–6.4%).** The association between 25(OH)D levels and SARS-CoV-2 positivity was best fitted by the weighted second-order polynomial regression, which indicated strong correlation in the total population ($R^2 = 0.96$) and in analyses stratified by all studied demographic factors. The association between lower SARS-CoV-2 positivity rates and higher circulating 25(OH)D levels remained significant in a multivariable logistic model adjusting for all included demographic factors (adjusted odds ratio 0.984 per ng/mL increment, 95% C.I. 0.983–0.986; $p < 0.001$). **SARS-CoV-2 positivity is strongly and inversely associated with circulating 25(OH)D levels, a relationship that persists across latitudes, races/ethnicities, both sexes, and age ranges.** Our findings provide impetus to explore the role of vitamin D supplementation in reducing the risk for SARS-CoV-2 infection and COVID-19 disease.

VITAMIN D

- Lorenz Borsche, Bernd Glauner, Julian von Mendel doi: <https://doi.org/10.1101/2021.09.22.21263977>

Key Findings

- **Results** One population study and seven clinical studies were identified, which reported D3 blood levels pre-infection or on the day of hospital admission. They independently showed a negative Pearson correlation of D3 levels and mortality risk ($r(17)=-.4154$, $p=.0770$ / $r(13)=-.4886$, $p=.0646$). For the combined data, median (IQR) D3 levels were 23.2 ng/ml (17.4 – 26.8), and a significant Pearson correlation was observed ($r(32)=-.3989$, $p=.0194$). **Regression suggested a theoretical point of zero mortality at approximately 50 ng/ml D3.**
- **Conclusions** The two datasets provide strong evidence that low D3 is a predictor rather than a side effect of the infection. **Despite ongoing vaccinations, we recommend raising serum 25(OH)D levels to above 50 ng/ml to prevent or mitigate new outbreaks** due to escape mutations or decreasing antibody activity.

VITAMIN C

- <https://isom.ca/article/intravenous-ascorbic-acid-for-supportive-treatment-in-hospitalized-covid-19-patients/>
- Intravenous Ascorbic Acid (IVAA) is an FDA Approved Nutraceutical Therapy

Key Results

- Chinese facility patient load: 358 total COVID-19 patients as of March 17th, 2020.
- Facility treated approximately **50 cases** (of the 358) of **moderate to severe COVID-19** infection with IVAA.
- The IVAA dosing was moderate and affordable and dose determined by clinical status.
- Dose Strategy successful in managing Cytokine Storms.
- **All patients who received IVAA improved.**
- **There was no mortality in the IVAA group.**
- There were no side effects reported from any patients in the IVAA group.
- Average COVID-19 patients had a 30-day hospital stay, but **COVID-19 patients that received IVAA had a hospital stay that was 3 to 5 days shorter than the non IVAA treated patients.**
- Treatment cost per patient is approximately \$12.00 – 24.00 per day of treatment.

Technical Notes & Updates

- Literature to date indicates that 2-8g Vitamin C daily may reduce the incidence and duration of respiratory infections and intravenous vitamin C (6–24 g/day) has been shown to reduce mortality, intensive care unit (ICU) and hospital stays, and time on mechanical ventilation for severe respiratory infections [3]. <https://www.mdpi.com/2072-6643/12/12/3760>
- A study of 21 critically ill COVID-19 patients admitted to ICU in the US found a mean level of 22 µmol/L, thus a majority had hypovitaminosis. The mean level for 11 survivors was 29 µmol/L compared to 15 µmol/L for the 10 non-survivors; of these five (50%) had ≤11 µmol/L [1].
- Cohort ICU study found that 94.4% of COVID-19 ARDS (acute respiratory distress syndrome) patients had undetectable levels of Vitamin C [2]

1. Arvinte, C.; Singh, M.; Marik, P.E. Serum levels of vitamin C and vitamin D in a cohort of critically ill COVID-19 patients of a north American community hospital intensive care unit in May 2020: A pilot study. *Med. Drug Discov.* 2020, doi:10.1016/j.medidd.2020.100064

2. Luis Chiscano-Camón, Juan Carlos Ruiz-Rodríguez, et al: Vitamin C levels in patients with SARS-CoV-2-associated acute respiratory distress syndrome; *Critical Care* volume 24, Article number: 522 (2020) <https://ccforum.biomedcentral.com/articles/10.1186/s13054-020-03249-y>

3. Holford, P., Carr, A. C., Jovic, et al. Vitamin C—An Adjunctive Therapy for Respiratory Infection, Sepsis and COVID-19. *Nutrients*, 12(12), 2020 3760. doi:10.3390/nu12123760

ZINC

- <https://pubmed.ncbi.nlm.nih.gov/32920234/>
- COVID-19: Poor outcomes in patients with zinc deficiency

Key Findings

- **Results:** COVID-19 patients (n = 47) showed significantly lower zinc levels when compared to healthy controls (n = 45): median 74.5 (interquartile range 53.4-94.6) $\mu\text{g}/\text{dl}$ vs 105.8 (interquartile range 95.65-120.90) $\mu\text{g}/\text{dl}$ ($p < 0.001$). Amongst the COVID-19 patients, 27 (57.4%) were found to be zinc deficient. **These patients were found to have higher rates of complications ($p = 0.009$), acute respiratory distress syndrome (18.5% vs 0%, $p = 0.06$), corticosteroid therapy ($p = 0.02$), prolonged hospital stay ($p = 0.05$), and increased mortality (18.5% vs 0%, $p = 0.06$).** The odds ratio (OR) of developing complications was 5.54 for zinc deficient COVID-19 patients.
- **Conclusions:** The study data clearly show that a significant number of COVID-19 patients were zinc deficient. These zinc deficient patients developed more complications, and the deficiency was associated with a prolonged hospital stay and increased mortality.

NUTRITIONAL COMBINATION THERAPY: VITAMINS A,C,D, IODINE & HYDROGEN PEROXIDE

- Brownstein, Ng, Rowen, et al: A Novel Approach to Treating COVID-19 Using Nutritional and Oxidative Therapies; Science, Public Health Policy, and The Law Volume 2:4-22, July, 2020
- https://cf5e727d-d02d-4d71-89ff-9fe2d3ad957f.filesusr.com/ugd/adf864_cc5004cfa84a46d3b1a0338d4308c42c.pdf

Key Findings

- **Study Design:** 107 consecutive COVID-19 patients treated with nutritional & oxidative therapies in a family practice clinic in a Detroit, MI suburb. Patient age range: 2-85. Median Age: 56.5. Gender distribution: Female: 75%, Male: 25%
- **Most Common Symptoms:** Fever (81%), upper respiratory symptoms (69%) (rhinorrhea, drippy eyes, cough, congestion), shortness of breath (68%), G.I. symptoms (27%)
- **Oral Nutritional Dosing** given to 99% of patients for first 4 days of symptom onset: Vitamins A (100,000 I.U.), Vitamin C (1,000mg/hour during waking times), Vitamin D (50,000 I.U.daily) and Lugol's Iodine (25mg/daily)
- **Nebulize (vaporous inhalation):** Most patients instructed to nebulize solution 0.04% H₂O₂ in saline with 1CC Mg Sulfate
- **If symptoms worsened**, patients were treated with I.V. nutrition or I.M: I.V. Vitamin C (35%), I.V. H₂O₂ (30%) & I.M. Ozone (35%)
- **Symptomatic Improvement After Intervention:** 1st Improvement: 2.5 days, Mostly Better: 4.5 days, Completely Better: 7 Days
- **Outcome: 100% improvement in all 107 patients treated**

MASKS, DISTANCE & NUTRITION

- Perhaps the best defense is a well-nourished immune system

Preliminary Recommendations for Teens & Adults

- **Vitamin A** – 5,000 IU per day 6 days per week
- **Vitamin C** – 3,000 to 5,000 mg per day
- **Vitamin D** – 14-Day Loading Dose 10,000 IU per day, followed by 5,000 IU per day 6 days per week.
- **Vitamin E** – 200 to 600 IU per day
- **Zinc** – 25mg per day
- **Multivitamin** – 6 days per week
- **Omega 3 Fatty Acids** – 6 days per week

- <https://lpi.oregonstate.edu/mic/health-disease/immunity>
- <https://lpi.oregonstate.edu/sites/lpi.oregonstate.edu/files/lpi-immunity-infographic.pdf>
- Section 9 - Vitamins modulating the immune system during COVID-19
- <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7547582/#s0045title>

NUTRITION AND THE IMMUNE SYSTEM

The immune system is constantly working to protect the body from infection, injury, and disease.

OVERVIEW OF THE IMMUNE SYSTEM

The immune system consists of various organs, tissues, and cells located throughout the body.

The infographic features a central human silhouette with various organs and tissues labeled: TONSILS, LYMPH NODES, THYMOUS, SPLEEN, PEYER'S PATCHES, LYMPH VESSELS, and BONE MARROW. To the right, a circular inset titled 'WHITE BLOOD CELLS (WBCs)' lists their functions and types. Below this, a section titled 'THERE ARE SEVERAL TYPES OF WBCs' shows six types of cells with their names and functions: NEUTROPHILS (Engulf & destroy), MONOCYTES (MACROPHAGES) (Engulf & destroy), EOSINOPHILS (Fight parasitic infections), BASOPHILS (Release histamine), LYMPHOCYTES (Attack specific pathogens), and PLASMA CELLS (Produce antibodies). At the bottom, a section titled 'The immune system provides three levels of defense against disease-causing organisms:' lists: 1. BARRIERS (Prevent entry), 2. INNATE IMMUNITY (General defense), and 3. ACQUIRED IMMUNITY (Specific defense).

WHITE BLOOD CELLS (WBCs)

- The cells of the immune system
- Made inside bone marrow
- WBCs travel through the body inside lymph vessels, which are in close contact with the bloodstream

THERE ARE SEVERAL TYPES OF WBCs

NEUTROPHILS Engulf & destroy	MONOCYTES (MACROPHAGES) Engulf & destroy	EOSINOPHILS Fight parasitic infections
BASOPHILS Release histamine	LYMPHOCYTES Attack specific pathogens	PLASMA CELLS Produce antibodies

The immune system provides three levels of defense against disease-causing organisms:

- 1 BARRIERS**
Prevent entry
 - Skin and mucus membranes
 - Stomach acid and digestive enzymes
 - Beneficial bacteria that live in the colon (the gut microbiota)
- 2 INNATE IMMUNITY**
General defense
 - WBCs called neutrophils and macrophages engulf and destroy foreign invaders and damaged cells
- 3 ACQUIRED IMMUNITY**
Specific defense
 - WBCs called T lymphocytes (T cells) target and destroy infected or cancerous cells
 - WBCs called B lymphocytes (B cells) and plasma cells produce antibodies that target and destroy infected or cancerous cells

THERAPEUTIC RANGE

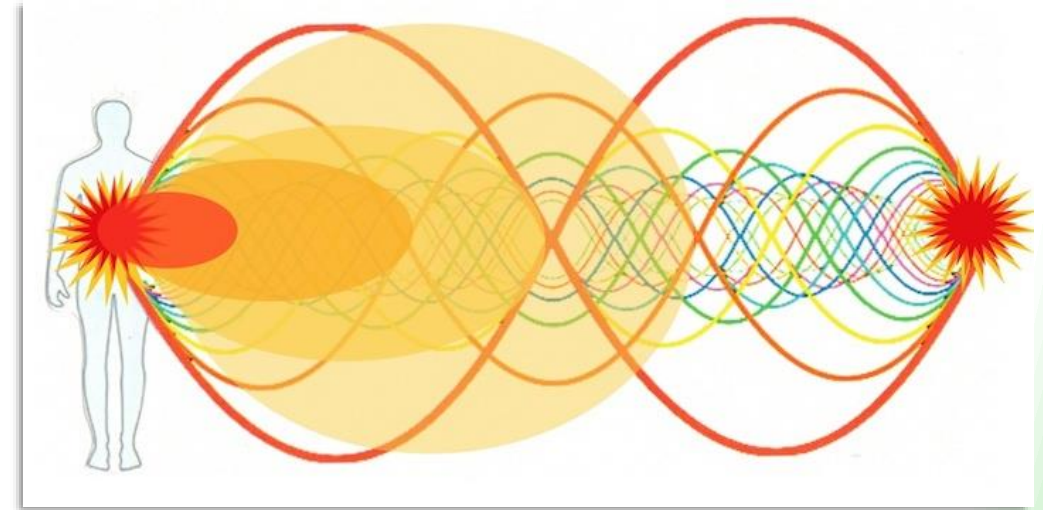
- ***Therapeutic Range is a Clinical Guideline for the amount of Daily Nutrient Density required to Fire Up the Mitochondria, amplify Cellular Enzymatic Production, & achieve Cellular Healing Resonance.***

Therapeutic Range is a compilation of the following resources:

- Suggested Optimal Nutrient Allowance (SONAs)
- Linus Pauling Institute Micronutrient Center Research
- Summary of Well Known Naturopathic Clinical Texts (Murray, Pizzorno, Marz, Mateljan, Etc.)
- Pubmed & Google Scholar Research Updates, Thorne Research, Pure Encapsulations Research, Research of Trusted Nutraceutical Companies
- Observations in My Private Clinical Practice Shared and Confirmed by Colleagues & Student Practitioners since 2007. (n>3500)

Cool Mitochondrial Factoid

- Did you know the average person has literally hundreds to thousands of Mitochondria per cell that make up approximately 10% of their total body weight?



SENIORS, ADULTS & TEENS

KEY NUTRIENTS	THERAPEUTIC RANGE	RDA
VITAMIN A (Beta-Carotene)	5,000 IU	1,500-2,167 IU
VITAMIN C	3000-5000 mg	65-125 mg
VITAMIN D3	10,000 IU (14-Days) 5,000 IU (After)	600-800 IU
VITAMIN E	200-600 IU	22-28 IU
ZINC	25-40 mg (min 30mg for High-Risk)	8-11 mg

- **Age 13 & Up**
- **For All Genders**
- **Includes Expecting Mothers & Breastfeeding Mothers As Well**
- **Nutrients Should Be Taken With Small Amount Of Food To Minimize Any Nausea**
- **Multivitamin & Omega 3 Fatty-Acids Recommended As Well**

CHILDREN AGE 5 TO 12

KEY NUTRIENTS	THERAPEUTIC RANGE	RDA
VITAMIN A (Beta-Carotene)	5,000 IU	1,000-2,000 IU
VITAMIN C	2,000-4,000 mg	25-45 mg
VITAMIN D3	5,000 IU (14-Days) 2,000 IU (After)	200 IU
VITAMIN E	100 IU	10-17 IU
ZINC	25 mg	8 mg

- Age 5 To 12
- For All Genders
- Nutrients Should Be Taken With Small Amount Of Food To Minimize Any Nausea
- Multivitamin & Omega 3 Fatty-Acids Recommended As Well

CHILDREN AGE 1 TO 4

KEY NUTRIENTS	THERAPEUTIC RANGE	RDA
VITAMIN A (Beta-Carotene)	2,000 IU	1,000-1,500 IU
VITAMIN C	500-1,000 mg	15-50 mg
VITAMIN D3	1,000-2,000 IU	200 IU
VITAMIN E	50 IU	6-9 IU
ZINC	10 mg	3 mg

- Age 1 To 4
- For All Genders
- For Infants No Longer Breast Feeding
- Liquid Multivitamin & Omega 3 Fatty-Acids Recommended As Well

SAFE CLASSROOMS – UV LIGHTS

- <https://www.jpost.com/health-science/tel-aviv-research-999-percent-of-covid-19-germs-dead-in-30-seconds-with-uv-leds-653315>
- <https://www.sciencedirect.com/science/article/abs/pii/S1011134420304942?via%3Dihub>
- Ultraviolet radiation is a common method of killing bacteria and viruses. Now, **researchers from Tel Aviv University have proven that the novel coronavirus, SARS-CoV-2, can be killed efficiently, quickly and cheaply using ultraviolet (UV) light-emitting diodes (UV-LEDs) at specific frequencies.**
- “We discovered that it is quite simple to kill the coronavirus using LED bulbs that radiate ultraviolet light,” said Prof. Hadas Mamane, head of the Environmental Engineering Program at Tel Aviv University's School of Mechanical Engineering, who led the study with Prof. Yoram Gerchman and Dr. Michal Mandelboim.
- She said that the **UV-LED bulbs require less than half a minute to destroy more than 99.9% of the coronaviruses.**
- The study is the first of its kind in the world. An article about it was published earlier this month in the *Journal of Photochemistry and Photobiology B: Biology*.

SAFE CLASSROOMS – DEIONIZERS?

- <https://www.newscientist.com/article/dn3228-air-ionisers-wipe-out-hospital-infections/>
- From the UK, 2003
- Repeated airborne infections of the bacteria acinetobacter in an intensive care ward have been eliminated by the installation of a negative air ioniser.
- In the first such epidemiological study, researchers found that the infection rate fell to zero during the year long trial. **“We were absolutely astounded to find such clear cut results,”** engineer Clive Begg at the University of Leeds, UK, told New Scientist.
- Stephen Dean, a consultant at the St James’s Hospital in Leeds where the trial took place says: **“The results have been fantastic – so much so that we have asked the university to leave the ionisers with us.”**

SAFE CLASSROOMS – GREEN CLEANERS

- <https://www.housebeautiful.com/lifestyle/cleaning-tips/a32291832/epa-approves-thymol-cleaners/>
- <https://www.epa.gov/pesticide-registration/list-n-disinfectants-coronavirus-covid-19>
- <https://cleanwelltoday.com/>

- The EPA's extensive list includes a few all-natural products containing the ingredient thymol.
- Thymol is a component found in thyme oil, which is a naturally occurring mixture of compounds from, yup, the thyme plant, according to the [EPA](#).
- Four cleaning products that contain thymol make the EPA's list. Two of these products come from eco-friendly brand [CleanWell](#). While CleanWell's entire line uses thymol, only the Benefect Botanical Daily Cleaner Disinfectant Spray and the Benefect Botanical Daily Cleaner Disinfectant Towelette made the EPA's cut. According to the brand's website, "**each of CleanWell's thymol cleaning products contains a 0.05% concentration of thymol and is designed to kill 99.9% of germs, bacteria, and viruses..**" Not only that, but these products are alcohol-free, non-toxic, and safe for food surfaces.

ORAL HYGIENE – MOUTH RINSES

- <https://www.rutgers.edu/news/certain-mouthwashes-might-stop-covid-19-virus-transmission>
- The study found two other mouthwashes showed promise in potentially providing some protection in preventing viral transmission: Betadine, which contains Povidone-iodine, and Peroxal, which contains hydrogen peroxide. However, only Listerine and Chlorhexidine disrupted the virus with little impact on skin cells inside the mouth that provide a protective barrier against the virus.
- “Both Povidone-iodine and Peroxal caused significant skin cell death in our studies, while both Listerine and Chlorhexidine had minimal skin-cell killing at concentrations that simulated what would be found in daily use,” said Fine.

HAS EVEN MORE EMPIRICAL
EVIDENCE EMERGED
SUPPORTING NUTRITION &
OFF-LABEL THERAPEUTIC
INTERVENTIONS?

YES, THERE IS OVERWHELMING EVIDENCE

Contacts | My Energetic Health Institute - Er | Prevention - What You Can Do

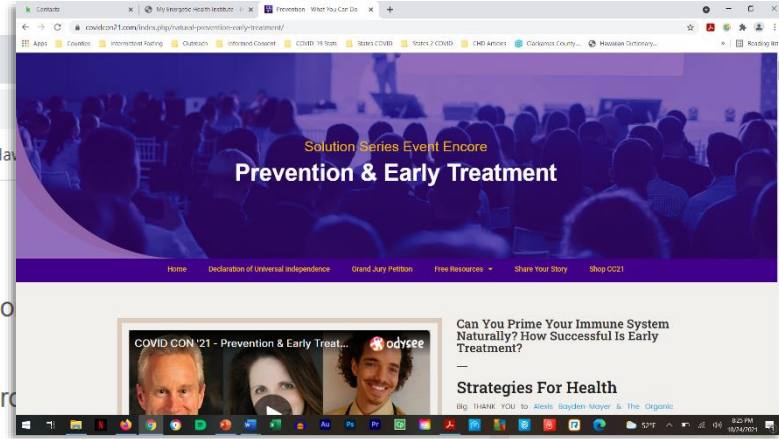
covidcon21.com/index.php/natural-prevention-early-treatment/

Apps | Counties | Intermittent Fasting | Outreach | Informed Consent | COVID-19 Stats | States COVID | States 2 COVID | CHD Articles | Clackamas County...

With this information, we can now explore the key nutrients for immune priming and their mechanism of action.

- **Vitamin D** – Coordinates Immune Response, Stimulates Antimicrobial Peptides, Cytokines and Immune Cell Proliferation
- **Vitamin E** – Antioxidant. Protects Healthy Cells. Enhances B And T Cell Response.
- **Vitamin C** – Antioxidant. Protects Healthy Cells Including Activated Immune Cells. Antiviral. Increases Systemic Interferon And Serum Antibody Levels.
- **Vitamin A** – Coordinates Cellular Immune Response, Promotes Immune Cell Proliferation, Enhances Mucosal Integrity.
- **Zinc** – Essential For Binding Capacity And Optimizing Lethality Of Immune Cells. Promotes Antiviral Enzyme Blocking Viral Replication.
- **Quercetin** – Zinc Ionophore, Essential For Helping Zinc Get Into Cells. Enhances Nerve Conduction & Perception. Green Tea Also Has Zinc Ionophore Capability.
- **Bifidobacterium** – Probiotic, Essential For Healthy Microbiome & Management Of Pro-Inflammatory Response Post-Infection. Calms Anxiety.
- **Additional Consideration** – Multivitamin With Pantothenic Acid (Vitamin B5) 100mg Or Higher Per Serving To Drive ATP Energy Production. ATP Energy Production Maximizes The Cellular Effectiveness Of The Aforementioned Nutrients And Overall Immunological Response.
- **Energy Production Leads To Enzyme Production. Enzyme Production Leads To Optimized Immunological Response.**

KEY NUTRIENTS (AGES 13 & UP)	DAILY THERAPEUTIC RANGE	RDA
Vitamin D3	10,000 IU (14-Days) 5,000 IU (After)	600-800 IU
Vitamin E	200-600 IU	22-28 IU



[HTTPS://WWW.COVIDCON21.COM/
INDEX.PHP/NATURAL-PREVENTION-
EARLY-TREATMENT/](https://www.covidcon21.com/index.php/natural-prevention-early-treatment/)

YES, THERE IS OVERWHELMING EVIDENCE

The screenshot displays the Adobe Acrobat Pro DC interface. The main window shows a PDF document with the following content:

- Title:** COVID-19: Restoring Public Trust During A Global Health Crisis
- Date:** March 23, 2021
- Subtitle:** An Evidence-Based Position Paper to Ensure Ethical Conduct

The document features a teal header with white text and a black image of a person's face below it. The Adobe Acrobat interface includes a top menu bar (File, Edit, View, E-Sign, Window, Help), a toolbar with various icons, and a right-hand sidebar with a search tool and a list of actions such as Create PDF, Edit PDF, Export PDF, Comment, Organize Pages, Scan & OCR, Protect, Fill & Sign, Prepare Form, Compare Files, and More Tools. At the bottom, a Windows taskbar is visible with various application icons and a system tray showing the time as 8:50 PM on 10/24/2021.

[HTTPS://CDN.GREENMEDINFO.COM
/SITES/DEFAULT/FILES/CDN/POSITIO
N_PAPER_V24_FINAL.PDF](https://cdn.greenmedinfo.com/sites/default/files/cdn/position_paper_v24_final.pdf)

MUCH MORE EVIDENCE

The screenshot shows a web browser window with the URL c19ivermectin.com. The page features a navigation menu with links to Home, COVID-19 treatment studies for Ivermectin, and Select treatment. A sidebar on the left lists various medications such as Aspirin, Bamlanivimab, and Ivermectin. The main content area is dominated by a large blue box with the following text:

IVERMECTIN FOR COVID-19
64 TRIALS, 627 SCIENTISTS, 48,637 PATIENTS
30 RANDOMIZED CONTROLLED TRIALS
86% IMPROVEMENT IN 14 PROPHYLAXIS TRIALS RR 0.14 [0.08-0.25]
67% IMPROVEMENT IN 29 EARLY TREATMENT TRIALS RR 0.33 [0.24-0.47]
36% IMPROVEMENT IN 21 LATE TREATMENT TRIALS RR 0.64 [0.52-0.79]
56% IMPROVEMENT IN 26 MORTALITY RESULTS RR 0.44 [0.32-0.60]
56% IMPROVEMENT IN 30 RANDOMIZED CONTROLLED TRIALS RR 0.44 [0.31-0.63]
SUMMARY OF RESULTS REPORTED IN IVERMECTIN TRIALS FOR COVID-19. 10/25/21. IVMMETA.COM

Below this box, a grey text box states: "Database of all ivermectin COVID-19 studies. 126 studies, 82 peer reviewed, 64 with results comparing treatment and control groups. FLCCC provides treatment recommendations. Submit updates/corrections." At the bottom of the page, there is a search bar and filter options for "Restrict: All, Early, Late, Prophylaxis". A search result snippet is visible, dated "Oct 24", with the text: "Early... Covid Analysis (Preprint) (met... meta-analysis v137 Ivermectin for COVID-19: real-time meta analysis of 64 studies Details • Meta analysis using the most serious outcome reported shows 67% [53-76%] and 86% [75-92%] improvement for early treatment and prophylaxis, with ...". The Windows taskbar at the bottom shows the time as 10:03 AM on 10/25/2021.

MUCH MORE EVIDENCE

The screenshot shows a web browser window with the URL c19hcq.com. The page features a navigation bar with links to Home, COVID-19 treatment studies for Hydroxychloroquine, and Select treatment. A sidebar on the left lists various treatments: Aspirin, Bamlanivimab, Bromhexine, Budesonide, Casirivimab/i., Colchicine, Conv. Plasma, Curcumin, Favipiravir, Fluvoxamine, Hydroxychloro., Iota-carragee., Ivermectin, Melatonin, Metformin, Molnupiravir, Nigella Sativa, Nitazoxanide, Povidone-iod., Probiotics, Proxalutamide, Quercetin, Remdesivir, Sotrovimab, Vitamin A, and Vitamin C.

The main content area features a large heading **HCQ FOR COVID-19** followed by a summary of results:

- 294 TRIALS, 4,723 SCIENTISTS, 412,766 PATIENTS**
- 64% IMPROVEMENT IN 32 EARLY TREATMENT TRIALS RR 0.36 [0.29-0.46]**
- 75% IMPROVEMENT IN 13 EARLY TREATMENT MORTALITY RESULTS RR 0.25 [0.16-0.40]**
- 46% IMPROVEMENT IN 8 EARLY TREATMENT RCT RESULTS RR 0.54 [0.35-0.84]**
- 19% IMPROVEMENT IN 199 LATE TREATMENT TRIALS RR 0.81 [0.76-0.86]**
- 21% IMPROVEMENT IN 45 RANDOMIZED CONTROLLED TRIALS RR 0.79 [0.67-0.95]**

SUMMARY OF RESULTS REPORTED IN HCQ STUDIES FOR COVID-19. 10/25/21. HCQMETA.COM

Below the summary, a text box provides additional context: "Database of all HCQ COVID-19 studies. 360 studies, 263 peer reviewed, 294 comparing treatment and control groups. HCQ is not effective when used very late with high dosages over a long period (RECOVERY/SOLIDARITY), effectiveness improves with earlier usage and improved dosing. Early treatment consistently shows positive effects. Negative evaluations typically ignore treatment time, often focusing on a subset of late stage studies. *In Vitro* evidence made some believe that therapeutic levels would not be attained, however that was incorrect, e.g. see [Ruiz]. Submit updates/corrections."

At the bottom, there is a search bar and a "Restrict:" dropdown menu currently set to "All", with other options for "Early", "Late", "PrEP", and "PEP".

MUCH MORE EVIDENCE

The screenshot shows a web browser window with the URL c19vitamind.com. The page features a navigation bar with links for Home, COVID-19 treatment studies for Vitamin D, and Select treatment. A sidebar on the left lists various medical treatments. The main content area contains a large blue box with the following text:

VITAMIN D FOR COVID-19
128 STUDIES BY 1,100 SCIENTISTS
81 SUFFICIENCY STUDIES WITH 40,421 PATIENTS
47 TREATMENT TRIALS WITH 50,837 PATIENTS
40% IMPROVEMENT IN 47 TREATMENT TRIALS RR 0.60 [0.53-0.68]
55% IMPROVEMENT IN 81 SUFFICIENCY STUDIES RR 0.45 [0.39-0.53]
51% IMPROVEMENT IN 29 TREATMENT MORTALITY RESULTS RR 0.49 [0.37-0.66]
SUFFICIENCY STUDIES ANALYZE OUTCOMES BASED ON SERUM LEVELS. 10/25/21. VDMETA.COM

Below this box is a text box explaining the database: "Database of all vitamin D COVID-19 studies. Sufficiency studies analyze outcomes based on vitamin D levels, confounding factors may be significant. Treatment studies directly analyze the effect of vitamin D treatment. vitamind4all.org provides treatment recommendations. Submit updates/corrections."

At the bottom, there is a search bar and a "Restrict:" dropdown menu set to "All". Below the search bar, there are search results for "Levels" and "Details" related to a study by Al-Anouti et al. in *Nutrients*, showing a 68.1% improvement in severe cases (p=0.0007). The date "Oct 20" is visible on the left side of the results.

The browser's taskbar at the bottom shows various application icons and the system clock indicating 10:04 AM on 10/25/2021.

[HTTPS://C19EARLY.COM/](https://c19early.com/)

WHAT IS THE LIKELIHOOD OF
REINFECTION POST-RECOVERY
FROM INFECTION?

MAX 0.8%, KAISER STUDY

Contacts | My Energetic Health Institut | Prevention - What You Can | Assessment of protection a | Rate and severity of susper | COVID-19 Breakthrough Ci | +

ncbi.nlm.nih.gov/pmc/articles/PMC8373524/

Apps | Counties | Intermittent Fasting | Outreach | Informed Consent | COVID-19 Stats | States COVID | States 2 COVID | CH

Eiserver Public Health Emergency Collection

Rate and severity of suspected SARS-CoV-2 reinfection in a cohort of PCR-positive COVID-19 patients

Jeff Slezak,^{1*} Katia Bruzovoi,¹ Heidi Fischer,¹ Benjamin Broder,^{1,2} Bradley Ackerson,³ and Sara Tartof^{1,4}

* Author information | Article notes | Copyright and License information | Disclaimer

Abstract

Objectives
To estimate the burden and severity of suspected reinfection with severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2).

Methods
A retrospective cohort of members of Kaiser Permanente Southern California with PCR-positive SARS-CoV-2 infection between 1st March 2020 and 31st October 2020 was followed through electronic health records for subsequent positive SARS-CoV-2 tests (suspected reinfection) ≥ 90 days after initial infection, through 31st January 2021. Incidence of suspected reinfection was estimated using the Kaplan–Meier method. Cox proportional hazards models estimated the association of suspected reinfection with demographic and clinical characteristics, hospitalization, and date of initial infection.

Results
The cohort of 75 149 was predominantly Hispanic (49 648/75 149, 66.1%) and included slightly more females than males (39 736, 52.9%), with few immunocompromised patients (953, 1.3%); 315 suspected reinfections were identified, with a cumulative incidence at 270 days of 0.8% (95% confidence interval (CI) 0.7–1.0%). Hospitalization was more common at suspected reinfection (36/315, 11.4%) than initial infection (4094/75 149, 5.4%). Suspected reinfection rates were higher in females (1.0%, CI 0.8–1.2% versus 0.7%, CI 0.5–0.9%, p 0.002) and immunocompromised patients (2.1%, CI 1.0–4.2% versus 0.8%, CI 0.7–1.0%, p 0.004), and lower in children than adults (0.2%, CI 0.1–0.4% versus 0.9%, CI 0.7–1.0%, p 0.023). Patients hospitalized at initial infection were more likely to have suspected reinfection (1.2%, CI 0.6–1.7% versus 0.8%, CI 0.7–1.0%, p 0.030), as were those with initial infections later in 2020 (150-day incidence 0.4%, CI 0.2–0.5% September–October versus 0.2%, CI 0.1–0.3% March–May and 0.3%, CI 0.2–0.3% June–August, p 0.008). In an adjusted Cox proportional hazards model, being female (hazard ratio (HR) 1.44, CI 1.14–1.81), adult (age 18–39, HR 2.71, CI 1.38–5.31, age 40–59 HR 2.22, CI 1.12–4.41, age ≥ 60 HR 2.52, CI 1.23–5.17 versus < 18 years), immunocompromised (HR 2.48, CI 1.31–4.68), hospitalized (HR 1.60, CI 1.07–2.38), and initially infected later in 2020 (HR 2.26, CI 1.38–3.71 September–October versus March–May) were significant independent predictors of suspected reinfection.

Conclusions

Reinfection with SARS-CoV-2 is uncommon, with suspected reinfections more likely in women, adults, immunocompromised subjects, and those previously hospitalized for coronavirus 2019 (COVID-19). This suggests a need for continued precautions and vaccination in patients with COVID-19 to prevent reinfection.

Keywords: COVID-19, Epidemiology, Hospitalization, Reinfection, Risk factors

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Rate and severity of suspected SARS-CoV-2 reinfection in a cohort of PCR-positive COVID-19 patients

Jeff Slezak,^{1*} Katia Bruzovoi,¹ Heidi Fischer,¹ Benjamin Broder,^{1,2} Bradley Ackerson,³ and Sara Tartof^{1,4}

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Abstract

Objectives
To estimate the burden and severity of suspected reinfection with severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2).

Methods
A retrospective cohort of members of Kaiser Permanente Southern California with PCR-positive SARS-CoV-2 infection between 1st March 2020 and 31st October 2020 was followed through electronic health records for subsequent positive SARS-CoV-2 tests (suspected reinfection) ≥ 90 days after initial infection, through 31st January 2021. Incidence of suspected reinfection was estimated using the Kaplan–Meier method. Cox proportional hazards models estimated the association of suspected reinfection with demographic and clinical characteristics, hospitalization, and date of initial infection.

Results
The cohort of 75 149 was predominantly Hispanic (49 648/75 149, 66.1%) and included slightly more females than males (39 736, 52.9%), with few immunocompromised patients (953, 1.3%); 315 suspected reinfections were identified, with a cumulative incidence at 270 days of 0.8% (95% confidence interval (CI) 0.7–1.0%). Hospitalization was more common at suspected reinfection (36/315, 11.4%) than initial infection (4094/75 149, 5.4%). Suspected reinfection rates were higher in females (1.0%, CI 0.8–1.2% versus 0.7%, CI 0.5–0.9%, p 0.002) and immunocompromised patients (2.1%, CI 1.0–4.2% versus 0.8%, CI 0.7–1.0%, p 0.004), and lower in children than adults (0.2%, CI 0.1–0.4% versus 0.9%, CI 0.7–1.0%, p 0.023). Patients hospitalized at initial infection were more likely to have suspected reinfection (1.2%, CI 0.6–1.7% versus 0.8%, CI 0.7–1.0%, p 0.030), as were those with initial infections later in 2020 (150-day incidence 0.4%, CI 0.2–0.5% September–October versus 0.2%, CI 0.1–0.3% March–May and 0.3%, CI 0.2–0.3% June–August, p 0.008). In an adjusted Cox proportional hazards model, being female (hazard ratio (HR) 1.44, CI 1.14–1.81), adult (age 18–39, HR 2.71, CI 1.38–5.31, age 40–59 HR 2.22, CI 1.12–4.41, age ≥ 60 HR 2.52, CI 1.23–5.17 versus < 18 years), immunocompromised (HR 2.48, CI 1.31–4.68), hospitalized (HR 1.60, CI 1.07–2.38), and initially infected later in 2020 (HR 2.26, CI 1.38–3.71 September–October versus March–May) were significant independent predictors of suspected reinfection.

Conclusions

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Keywords: COVID-19, Epidemiology, Hospitalization, Reinfection, Risk factors

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Simone Scott
Died June 11, 2021

Simone Scott, 19

- <https://circleofmamas.com/health-news/19-year-old-simone-scott-dies-from-heart-failure-after-moderna-vaccine/>
- On June 11, Simone's parents were called in to say their last goodbyes. Simone passed away that Friday morning.
- "I lost my only daughter. I never thought I'd have to give up my daughter for the greater good of society. I do suspect it was the vaccine. If not directly, it played a role. I never knew that there was a risk for something as serious as this. I would have wanted to." — V. Scott, mother

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ABOUT DR. EALY

Dr. Henry Ealy (Dr. H) is the Founder of, & Executive Community Director for, the [Energetic Health Institute](#). He holds a Doctorate in Naturopathic Medicine from SCNM, a Bachelor of Science in Mechanical Engineering from UCLA, is Board Certified in Holistic Nutrition by the NANP and a proud Jackie Robinson Scholarship Alumnus. He has over 20 years of teaching & clinical experience helping people care for their amazing body by unlocking the healing potential of Natural Medicines.

Dr. H hosts a weekly nationwide program, [Energetic Health Radio](#), and is a regular writer on the America Out Loud network detailing the latest empirical evidence and research regarding the COVID crisis. You can listen to and read his volunteer effort on his [America Out Loud team page](#).

He is the executive producer for [COVID CON '21](#) and lead author for the COVID Research Team that has published 5 manuscripts including the peer-reviewed and highly acclaimed [COVID-19 Data Collection, Comorbidity & Federal Law: A Historical Retrospective](#) and the 444 page peer-reviewed position statement on willful misconduct [COVID-19: Restoring Public Trust During A Public Health Crisis](#). His team's work has been covered by Dr. Mercola, Green Med Info, USA Today, Stand for Health Freedom, the Organic Consumer's Association and many highly respected news outlets. His team is the first to submit [Formal Grand Jury Petitions](#) exposing the rampant acts of alleged willful misconduct and call for a [Congressional Investigation](#) into the CDC's violations of multiple federal laws.

As an Ordained Minister for all denominations, Dr. H has been additionally certified as a Yoga Teacher, Clinical Massage Therapist, Human Anatomy & Physiology Teacher, as well as American Kenpo Teacher.

Having taught at the university graduate and undergraduate levels, he has a strong background in and deep passion for Data Verification & Analysis, Teaching & Personal Development, Curricula Design, American History, Herbalism, Traditional Chinese Medicine, Yoga & Ayurvedic Medicine, Meditation, Clinical Massage Therapy, Lab Testing & Assessment, The Basic Human Sciences, Environmental Medicine, Climate Science, Holistic Nutrition & Naturopathic Medicine.

Dr. Ealy is the author of [Energetic Health – Interesting Insights Into Advanced Natural Medicine](#) and also holds educational copyrights on over 200 published works regarding Natural Medicine, Vaccine Education, Medical Cannabis, Cellular Cleansing & Detoxification, Release Point Therapy Clinical Massage & [Holistic Nutrition](#).

