SARS II – The 2019 Coronavirus Scare

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The Coronavirus scare that emanated from Wuhan, China in December of 2019 is an epidemic of testing. There is no proof that a virus is being detected by the test and there is absolutely no concern about whether there are a significant number of false negatives and, especially, false positives on the test. What is being published in medical journals is not science, every paper has the goal of enhancing the panic by interpreting the data only in ways that benefit the viral theory, even when the data is confusing or contradictory. In other words, the medical papers are propaganda.

What I learned from studying SARS extensively, the previous big coronavirus scare, after the 2003 epidemic, was that nobody proved that a coronavirus existed, let alone was pathogenic. There was evidence against transmission (e.g., a hospital floor in Guangdong, the epidemic epicenter, where SARS and AIDS patients were mixed, and no AIDS patients got SARS), and a great deal of evidence emerged afterwards blaming the extreme treatments that patients were subjected to, the nucleoside analog Ribavirin, high dose corticosteroids, invasive respiratory assistance, and sometimes oseltamivir (Tamiflu). This is documented in my draft book chapter (mostly complete) that you can find here:

Virus Existence

Scientists are detecting novel RNA in multiple patients with pneumonia-like conditions, and are assuming that the detection of RNA (which is believed to be wrapped in proteins to form an RNA virus, as coronaviruses are believed to be) is equivalent to isolation of the virus. It is not, and one of the groups of scientists was honest enough to admit this:

“we did not perform tests for detecting infectious virus in blood” [2]

But, despite this admission, earlier in the paper they repeatedly referred to the 41 cases (out of 59 similar cases) that tested positive for this RNA as, “41 patients... confirmed to be infected with 2019-nCoV.”

Another paper quietly admitted that:

“our study does not fulfill Koch's postulates” [1]

Koch’s postulates can simply be stated as:

- Purify the pathogen (e.g. virus) from many cases with a particular illness.
- Expose susceptible animals (obviously not humans) to the pathogen.
- Verify that the same illness is produced.
• Some add that you should also re-purify the pathogen, just to be sure that it really is creating the illness.

Famous virologist Thomas Rivers stated in a 1936 speech, “It is obvious that Koch’s postulates have not been satisfied in viral diseases”. That was a long time ago, but the same problem still continues. None of the papers referenced in this article have even attempted to purify the virus. And the word ‘isolation’ has been so debased by virologists it means nothing (e.g. adding impure materials to a cell culture and seeing cell death is ‘isolation’).

Reference [1] did publish electron micrographs, but it can clearly be seen in the lesser magnified photo, that the particles believed to be coronavirus are not pure, and the quantity of material that is not claimed to be viral is much greater. Also consider that the photo included in the article will certainly be the “best” photo, i.e. the one with the greatest number of particles. Lab technicians may be encouraged to spend hours to look around to find the most photogenic image, the one that most looks like pure virus.

There is no way to tell that the RNA being used in the new coronavirus PCR test is found in those particles seen under the electron micrograph. There is no connection between the test, and the particles, and no proof that the particles are viral.

A similar situation was revealed in March 1997 concerning HIV, when two papers published in the same issue of the journal “Virology” revealed that the vast majority of what had previously been called “pure HIV” was impurities that were clearly not HIV, and the mixture also included microvesicles that look very similar to HIV under an electron microscope, but are of cellular origin.[5][6]

**Disease Definition**

Infectious diseases always have a definition, but they are usually not publicized too widely because then they would be open to ridicule. They usually have a “suspect case” category based on symptoms and exposure, and a “confirmed” category that adds some kind of testing.

Reference [13] describes a suspect case definition, based on WHO definitions for SARS and MERS (Middle East Respiratory Syndrome) that was in effect until January 18, 2020, and required all four of the following criteria:

• “fever, with or without recorded temperature”. Note that there is no universal definition of fever, so this may just be the opinion of a physician or nurse. With SARS a fever was defined as 38°C even though normal body temperature is considered to be 37°C (98.6°F).
• “radiographic evidence of pneumonia”. This can occur without illness, as was seen in [3] – a 10 year old boy with no clinical symptoms. He was diagnosed with pneumonia in the absence of symptoms.
• “low or normal white-cell count or low lymphocyte count”. This is not really a criterion as every healthy person is included. Only people with high white blood cell counts (e.g. some cancer patients) are excluded.
• One of the following three:
  o “no reduction in symptoms after antimicrobial treatment for 3 days”. This is a standard indication of a ‘viral’ pneumonia, i.e. one that does not resolve with antibiotics.
  o “epidemiologic link to the Huanan Seafood Wholesale Market”. This, and the next criterion, create the illusion of an infectious disease, as it prefers the diagnosis of connected cases.
  o “contact with other patients with similar symptoms”.

On January 18th the last, three-part category was changed to:

• One of the following:
  o “travel history to Wuhan”
  o “direct contact with patients from Wuhan who had fever or respiratory symptoms, within 14 days before illness onset”

It is not clear whether the “no reduction in symptoms after antimicrobial treatment for 3 days” criterion was still included (I’ve written to the authors, but have not received a reply). If not, this will allow the Chinese to extricate themselves from this mess, as everyone diagnosed will be in isolation, and therefore satisfying this criterion will be next to impossible. If they are lucky those diagnosed will survive the medications, isolation and other treatments, and after two weeks will be declared cured, and gradually the panic will recede.

As is normal, a “confirmed” case was defined as a suspect case with a positive coronavirus test.

By contrast, the World Health Organization definition [16] contains a flaw that, unless changed, could keep the epidemic burning forever. The definition of a Suspect Case is not unusual, basically it requires a generic respiratory symptom, and no other explanation for the illness, and travel in China, contact with a Probable Case, or presence in a hospital which had Probable or Confirmed Cases. It is the definition of Confirmed Case that is the problem: “A person with laboratory confirmation of 2019-nCoV infection, irrespective of clinical signs and symptoms.”

Unusually, to become a Confirmed Case, a person does not have to satisfy the clinical signs, the lack of another explanation, and the possibility of contact with another case. Unless changed, this will mean that cases can continue to crop up around the world, cases with no contact with previous cases or supposedly endemic regions and without even any respiratory symptoms (in reality it is unlikely that testing would be that widespread, but it could include every person arriving on an international flight from China, for example). This shows much greater faith in PCR testing than during the SARS epidemic where you could not move on to become a Confirmed Case without first satisfying the requirements of a Possible Case.

Testing

Putting aside the existence of a new coronavirus, what would a coronavirus test tell us, at this stage? Or rather, what does it not tell us?
• Without purification and exposing animals to viral particles we do not know if the virus is pathogenic (disease causing). It could be an opportunistic infection (invades unhealthy people with weakened immune systems) or a passenger virus (that is carried along by risky behavior, such as eating an animal carrier of a virus).

• We don’t know the false positive rate of the test without widespread testing of healthy people far from places where people are being diagnosed with this possible new disease. If the test is 99% accurate, in a city of over 10 million, like Wuhan, there would be about 100,000 false positives (1%). It is easy to generate a false epidemic if you just keep testing like this. And it’s worse if you restrict the test to people with symptoms, because then the flaws in the test will not be revealed for much longer.

• If someone is sick there is no proof that any or all of their symptoms are due to the virus, even if it is present. Some people may be immune, some may have some symptoms caused by the virus, but others caused by the drugs they are given, by pre-existing health conditions, and so on.

• We don’t know if the people who test negative are infected or not, especially when they show up with similar symptoms. For example, in [2], out of 59 patients, only 41 tested positive, but the researchers were clearly not sure whether the remaining 18 were uninfected or not. If they truly are not infected, they lend weight to the coronavirus not being the cause of their illness, as they had symptoms indistinguishable from the 41 positives. Testing at such an early stage of knowledge is incredibly dangerous. It spreads panic, it can put people on dangerous medications, other circumstances of their treatment can be physically and psychologically damaging (such as intubation and isolation, and even seeing all the doctors and nurses in special suits emphasizing how deathly sick you are).

Transmission – Introduction

There is lots of evidence that the virus is not as transmissible as is being implied.

“27 (66%) patients had direct exposure to Huanan seafood market [i.e. about 1/3 did not]”[2].

But later, “Of the 99 patients with 2019-nCoV pneumonia, 49 (49%) had a history of exposure to the Huanan seafood market.” [3]

Even later, a survey of the first 425 cases, showed that 72% diagnosed January 1st or later, had “No exposure to either market or person with respiratory symptoms”. [13]

“The symptom onset date of the first patient identified was Dec 1, 2019. None of his family members developed fever or any respiratory symptoms. No epidemiological link was found between the first patient and later cases”[2] (of the family of 6) “None of the family members had contacts with Wuhan markets or animals...They had no history of contact with animals, visits to
markets including the Huanan seafood wholesale market in Wuhan, or eating
game meat in restaurants.” [3]

**Transmission 1 – The Shenzhen Family**

Reference [3] attempts to show the ease with which the virus could be transmitted in a family that travelled from Shenzhen, near Hong Kong, to Wuhan in December, and then back again about a week later.

Two grandparents (patients 1 and 2), the daughter and son-in-law (3 and 4), a 10 year old grandson and a 7 year old granddaughter (5 and 6) flew to Wuhan on December 29th. On the first day, the grandmother and her daughter visited a sick relative (Relative 1, a baby boy with pneumonia) in a hospital in Wuhan (the hospital is not named, but the implication is that this child had this new disease). Outside of this they mingled with four other local relatives, of which two had also spent extensive time in the hospital. Notably the infant’s symptoms resolved one or two days after the visit, and he returned home.

On day four of the visit (January 1st), the son-in-law, who had not gone to the hospital got sick. On this basis, they declared that the coronavirus had a very short incubation time, and that people were almost immediately infectious. There’s no evidence for this, except nothing else can support their hypothesis that Relative 1 had this new coronavirus, infected Patients 1 (grandmother) and 3 (daughter), one of which then infected the son-in-law (Patient 4).

Then, like dominoes, the other visitors got sick, the daughter one day after her husband (Jan 2), the grandmother the next day (Jan 3), and then the grandfather and Relatives 2, 3, 4 and 5 (Jan 4). Symptoms were mostly fever, cough weakness. Note that the first to get sick (Patient 3, the son-in-law) did not visit the hospital with the sick infant.

On January 4th the whole family returned to Shenzhen. Note that the grandchildren, patients 5 and 6, had no symptoms during their time in Wuhan, or after returning home.

On January 9th, the grandparents and their daughter attended a clinic in Shenzhen, and the next day the grandparents visited the big hospital (University of Hong Kong-Shenzhen Hospital) for tests, the daughter one day after (January 10th).

The grandparents had significant pre-existing health conditions, such as having been treated for brain cancer (grandmother) and hypertension (both). In Wuhan they both suffered from fever, dry cough, weakness, and various lab abnormalities. They were genuinely sick.

Concern that they were infected with the new coronavirus is probably the reason why the rest of the family were brought in over the next few days for testing. The daughter and son-in-law were still sick (diarrhea, congestion, sore throat, chest pain) but by then had a normal body temperature (even lower than 37C or the famous 98.6F). They did have some lung opacities on a CT scan so were diagnosed with pneumonia despite the normal temperature.
The grandson had been a bad boy (patient 5) and had refused to wear a mask in Wuhan, so the parents insisted he get a CT scan. Despite the complete lack of symptoms, he also had lung opacities, and so was also diagnosed with pneumonia, albeit completely asymptomatic.

The granddaughter was a good girl (patient 6), and had worn a mask, and so nobody was surprised that she was not only asymptomatic, but also did not have lung abnormalities.

All six patients (apparently including patient 6 who was healthy in all ways) were tested using the new RNA test. Not surprisingly, the grandparents tested positive on nose swabs and serum samples. The son-in-law tested positive on nose and throat samples. But the daughter, Patient 3, despite doing 18 tests, more than anyone else, stubbornly tested negative on every one. But, showing shocking bias, the authors concluded, “she was still regarded as an infected case because she was strongly epidemiologically linked to the Wuhan hospital exposure and radiologically showing multifocal ground-glass lung opacities.” Another indication of bias was the omission of test results for Patient 6, who also tested similarly tested negative every time (based on four samples taken, according to personal correspondence from the authors). Obviously, the authors thought that this information was of no interest, despite being the same as Patient 3 who was listed, because they clearly had not thought about, and were not interested in, the possibility of false positive or false negative test results.

The bad grandson (patient 5) also tested positive on nose, throat and sputum samples, despite having no symptoms of illness.

Additionally, there was a relative who did not travel to Wuhan (Patient 7), who got sick with back pain and weakness four days after everyone returned to Shenzhen and, when she was tested, she also tested positive for RNA (nose, throat and sputum).

Several of the relatives who lived in Wuhan also got sick afterwards, but no coronavirus test information was provided in this paper.

No consideration was given to other causes for illness, such as exposure to food contaminated by chemicals, food that was prepared in anticipation of their visit, that was left out too long, or in unsanitary conditions. The purpose of reference [3] appears to have been to prove that the putative coronavirus is infectious, not to try to disprove it (which is what good scientists should do). Note that the relatives visited a lot over a few days, that was indeed the purpose of the trip, and one can guess that they ate more than usual, ate richer and more exotic foods (but not exotic animals) and perhaps drank more than usual. But none of this was investigated.

**Transmission 2 – The German Connection**

Reference [9] attempts to connect the illness of a German with a meeting with a Chinese woman who afterwards was diagnosed positive on the RNA test.
The sequence of events started on January 20th to January 22nd when a woman from Shanghai and a local German were in meetings together. Both were healthy at the time. The woman flew back to China on January 22nd and started to feel sick on the flight home. The German also got sick (sore throat, chills, muscle pain, fever, cough), late on the 24th, and did not return to work until the 27th. By coincidence, this was the same day that the Shanghai woman informed the German company that she had been sick and had tested positive for RNA. By this time the German man had recovered without any special medicines or interventions, but he tested positive, and so did three other colleagues who had contact with him, or the Shanghai woman, or both. It is logical that everyone who had any contact with them was tested, and likely no employees who did not have contact were tested. The paper does not say how many tested negative, and whether any of those testing negative had similar symptoms.

The article claims that all four Germans had symptoms starting on the 24th, 26th, or 27th, but what those symptoms are is not detailed for three of them. The article does not that, “so far, none of the four confirmed patients show signs of severe clinical illness”.

If the purpose of the paper was to support the idea that this illness is transmissible, it is important to accept the four positive tests on Germans as true positives, despite the fact that none of them had “severe clinical illness”. This, however, calls into question the severity of the illness, and why heroic and dangerous medical measures are needed. Because the Germans did not find out about their positive RNA test until after their period of symptoms, they probably only had to suffer quarantine, they did not have to suffer antiviral drugs, steroids or invasive respiratory assistance, which might have happened if they had shown up at an emergency department with symptoms and had been diagnosed with the 2019 coronavirus at the same time.

An alternative explanation is that the coronavirus is deadly, but that these four Germans represent four false positive tests. If this is the case, the usefulness of the test must be questioned.

**Transmission 3 – Magical**

Towards the end of January 2020, the first full month of the coronavirus panic, a paper analyzed the first 425 confirmed diagnoses in China [13]. Hidden in this paper is the stunning fact that, from January 1-22, fully 72% of the cases had, “No exposure to either market or person with respiratory symptoms”. Not just no exposure to the Huanan seafood market. Not just no exposure to someone else diagnosed with the coronavirus, but no exposure to any other person with respiratory symptoms. I say that this is hidden, because it is present in Table 1, but is not mentioned in the text, unlike other major findings, such as that the median age of cases is climbing, from 56 before January 1st, to 60 January 1-11th and 61 January 12-22nd.
Preserve the test

It seems that test results must be interpreted in such a way as to preserve the coronavirus theory. No alternative interpretation is allowed. And when there is an inconsistency, it must be ignored:

- As mentioned above, in Reference [3] the daughter, important in the chain of transmission, was interpreted as a false negative. Alternatively it could have been concluded that this woman did not have the coronavirus, but that would have badly damaged the family transmission story, and left open other reasons for the cluster of illnesses (and CT scan abnormalities).
- Also in Reference [3] the grandson tested positive without any symptoms at all, except lung abnormalities on a CT scan. Is this a false positive or evidence that the coronavirus is not terribly dangerous?
- A woman who returned from China to her Canadian university with illness, first tested negative, and then positive. This was interpreted as indicating that she had very little virus in her body at the time of the first test, and that the test was not sensitive enough. However, PCR testing is extraordinarily sensitive, and if she had so little virus, how was it that she had symptoms? An alternative explanation is that she became positive on the test in Canada, perhaps because this virus is actually quite common, or because the test is not for a virus, but is just measuring RNA created by the human body in response to disease conditions.[8]
- The four Germans [9] could be seen as showing that the RNA test produces false positives or that the illness produced by the virus is often not severe. But it will be interpreted as neither by dogmatic promoters of the coronavirus theory.
- Out of 206 Japanese evacuated from Wuhan, only three tested positive, and two were found to have “no symptoms”. Instead of considering them false positives, they are considered infected and possibly infectious.[12]
- Of 6 positive cases in Singapore reported in [14], the first had a sore throat and cough, but no pneumonia, the second and third had undescribed symptoms, and the last three had no symptoms.

Treatment

There is a strong correlation between the amount of panic (and there is certainly a lot of that in this case) and the potency of drugs being used. And this can be very dangerous. As a report commissioned by WHO after SARS was over said,

“Despite an extensive literature reporting on SARS treatments, it was not possible to determine whether treatments benefited patients during the SARS outbreak. Some may have been harmful ... Of patients treated with ribavirin, 49/138 to 67/110 (36%–61%) developed haemolytic anaemia, a recognised complication with this drug, although it is not possible to rule out the possibility that SARS-CoV infection caused the haemolytic anaemia, as there is no control group. One study noted that over 29% of SARS patients had some degree of liver dysfunction indicated by ALT levels higher than
normal, and the number of patients with this complication increased to over 75% after ribavirin treatment...In the Chinese literature, we found 14 reports in which steroids were used. Twelve studies were inconclusive and two showed possible harm. One study reported diabetes onset associated with methylprednisolone treatment. Another study (an uncontrolled, retrospective study of 40 SARS patients) reported avascular necrosis and osteoporosis among corticosteroid-treated SARS patients [which resulted in many joint replacements, particularly in Hong Kong][7]

The treatment of what is seen as a new disease is aggressive but does not appear to be as aggressive as SARS. Ribavirin is not being used, and doctors are more cautious with steroids (only 22% of the patients in [2] and 19% in [10] received them, although dosages are similar to those given to SARS patients). A paper documenting 99 “confirmed” coronavirus patients [10], reported that 76% were receiving antivirals, already including AIDS drugs lopinavir and ritonavir, along with oseltamivir and ganciclovir, but does not indicate how many were getting each antiviral. If everyone receiving antivirals was receiving all four drugs, they would have been receiving a massive dosage, greater than AIDS patients.

At the beginning of February 2020, the Chinese government announced a trial of a new Gilead antiviral drug, originally planned for Ebola, remdesivir, which, previously, “may have helped alleviate the symptoms of a 35-year-old male” diagnosed with a coronavirus infection in the US [15]. The drug will be trialed on 270 people, although it is not clear whether there will be a placebo or comparison group. A Chinese chemistry professor, Jiang Xuefeng, warned "No random, controlled, or blank samples were used in that case...The effectiveness of remdesivir cannot be determined by this single case...It can take years to fully understand the pharmacological and toxicological side effects of new drugs."

Reference [3] did indicate greater caution with respiratory assistance, only 13% were given a face mask for extra oxygen, and only 4% were subjected to invasive ventilation.

Apart from having pneumonia, and often being subject to potent drugs, many of the patients have other health problems, and are therefore much weaker than average. For example, "50 (51%) patients had chronic diseases, including cardiovascular and cerebrovascular diseases, endocrine system disease, digestive system disease, respiratory system disease, malignant tumour, and nervous system disease”[10]. They are also older than average, “The average age of the patients was 55.5 years, including 67 men and 32 women”[3]. Only about 12% of the Chinese population are 55 or over [11]. In a later study [13], the median age was 59, and only about 10% of Chinese are this age or older. In the last of three time periods of this study, January 12th through 22nd, the median age had crept up to 61.

Combine old age, pre-existing health conditions, pneumonia and powerful drugs, and you have a recipe for another iatrogenic disaster.
Conclusions

The coronavirus panic is just that, an irrational panic, based on an unproven RNA test, that has never been connected to a virus. And which won’t be connected to a virus unless the virus is purified. Furthermore, even if the test can detect a novel virus the presence of a virus is not proof that it is the cause of the severe symptoms that some people who test positive experience (but not all who test positive).

Finally, even if the test can detect a virus, and it is dangerous, we do not know what the rate of false positives is. And even a 1% false positive rate could produce 100,000 false positive results just in a city the size of Wuhan.

The use of powerful drugs because doctors are convinced that they have a particularly potent virus on their hands, especially in older people, with pre-existing health conditions, is likely to lead to many deaths. As with SARS.

References


