

Mid-September COVID-19 Update

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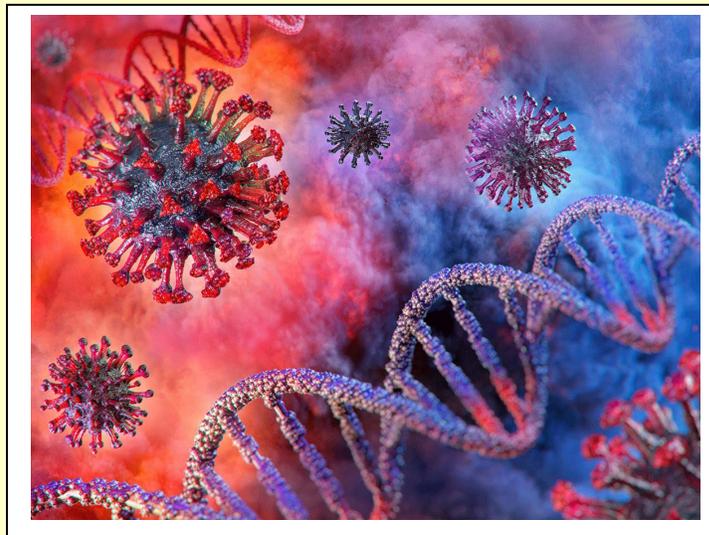
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Topics covered on COVID-19

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IMPORTANT REMINDER!!!! PLEASE READ!!!

I remind you that any medical information provided in these reports is just that...information only!! Not medical advice!! I am not your doctor, and decisions about your health require consultation with your trusted personal physicians and consultants.

The information I provide you is to empower you with knowledge, and I have repeatedly asked you to be the team leader for your OWN healthcare concerns. You should never act on anything you read in these reports. I have encouraged you to seek the advice of your physicians regarding health issues. Feel free to share this information with family and friends, but remind them about this being informational only. You must be proactive in our current medical environment.

Don't settle for a visit to your doctor without them giving you complete information about your illness, the options for treatment, care instructions, possible side effects to look for, and plans for follow up. Be sure the prescriptions you take are accurate (pharmacies make mistakes) and always take your meds as prescribed. The more you know, the better your care will be, because your doctor will sense you are informed and expect more out of them. Always write down your questions before going for a visit.

Thank you, and stay safe, *Dr. Sam*

Topics:

1. A look back and forward at COVID-19

Since I have reported on COVID-19 starting in February (9 updates), I have been discussing this virus as it was presented to me in the medical literature. I have had to revise several comments regarding the nature, severity, treatments, unintended consequences, and risk categories as the experts learned more about this new virus and

revised their thinking and treatment plans. This confused the public, but that is why medicine is such an inexact science, as new medical entities take time to understand and treat. Add politics, the media, and the public health department to the discussion changing their recommendations, and we have been taken on a confusing ride. The good news is, we are going to fight through this pandemic.

We were sabotaged by a virus that could have been contained much better, because the World Health Organization (WHO) kept the world in the dark because of their connections with the Chinese Communist Party, and it has changed the world forever. It has caused serious doubt about our relationship with China. Are we to trust the WHO in the future? What revisions have they made since this miscalculation?

The U.S. and most countries were not prepared to address a pandemic as infectious as COVID-19, even though the U.S. had prior experience with SARS and MERS, and our previous administrations in the past did not take heed. This time, the magnitude has demanded an all out war against this and any future viruses.

We found ourselves dependent on other countries for personal protective equipment (PPEs), and were not initially prepared to handle the need for a massive number of ventilators, protective gear, etc. Now, we are manufacturing our needs right here at home.

Thanks to the cooperation of the private sector and the COVID-19 Task Force, most places were able to meet their needs for artificial ventilation and PPEs, only to realize after so many deaths, that the disease was not being treated correctly, because it was thought by the experts that patients needed to be treated just like those with

another disorder called ARDS (acute respiratory distress syndrome), which requires high ventilator pressure from ventilators.

The experts were wrong! Some brave clinicians started using less pressure to send life saving oxygen into the bodies that were in distress, and the death rate plummeted. It was initially thought by the “experts” that we might be dealing with a death rate of as high as 25%, and today, we know the rate is 0.6% (flu is 0.1%).

The methodology early on was all over the maps calculating death rates. We know now it depends on what age group is getting infected and that easily computes to lower death rates, since the 18-34 age group now make up the majority of cases testing positive. Total numbers have less meaning, and we all must realize our seniors are dying of many diseases, now complicated by COVID-19.

The politicians and media have made case and death rate a mockery and have created unnecessary fear, and now it is political fodder. I wonder how COVID-19 will be perceived after November 3?

What is important is that the cases are falling in most places and the death rate is as well. The latest information is that COVID-19 is about 6 times more deadly than influenza. As we get into flu season, if we continue using common sense on protection, we may see a continuing drop in COVID-19, but also a good drop in flu cases.

Information from Johns Hopkins University Center of Health Security via WebMD.

It was clear early on that people with underlying disorders had a much greater risk than a healthy individual especially if younger than 60. Nursing home deaths continue to be the greatest source of death. Revision of

hygiene and protection in those facilities was badly needed. However, death rates in nursing homes will always remain high.

We learned that as many as 80% of people with the virus were either without symptoms or had a mild case. 90% of individuals admitted to the hospital had obesity, diabetes, heart or lung disease, were immunosuppressed, or were compromised by drugs, poor nutrition, and smoked. Because most of these people were over 60 with underlying diseases, it became very clear older people must isolate more and remain vigilant (45% of the adult population have risk factors). The country was shut down for over 2 months. Now, it is a must to reopen safely.

However, some younger people are still getting sick. In one report, of the 3200 people ages 18-34 across the U.S. that were hospitalized, 21% were admitted to the ICU, 10% required mechanical ventilation, and 3% died. 33% were obese, 18% had diabetes, and 16% has hypertension. This proves the point that underlying risk factors do not discriminate when it comes to age. If multiple risk factors are present, their risk of severe disease is similar to 50 year olds.

When the cases dropped and the death rates started to lessen, the governors tried to reopen their states, but the younger "bullet-proof" individuals disregarded all the "rules" and shot the case number right back up, because to get back to work, they had to be tested. That created the surge!

I am proud of the frontline workers and healthcare providers who have put their lives on the line to care for the sick, test the population, and tried to keep the peace, but some radical groups have added another huge factor in

this crisis, as some unfortunate deaths occurred by overzealous police officers.

We are winning the war, but we need better cooperation from the younger age groups.

We are facing the flu and COVID-19, but if we stay vigilant, we can tame both this fall.

2. What to do when respiratory symptoms occur this year...is it COVID-19 or the Flu?

It is not easy for an individual to tell if they are infected with the flu or COVID-19 or both. Therefore, if respiratory symptoms occur, with fever, and muscle aching, fatigue, etc., the most important course of action is to isolate until a person can be tested and had a conversation with their doctor for next steps.

One cannot assume that an individual has the flu alone, although it is just as likely. However, if people continue hygiene and protective measures, flu should not be as serious a threat. Getting a flu shot now will give an individual a big edge in that discussion.

If an individual has symptoms and has not been tested for both diseases, assume the individual has both, and start with symptomatic treatment (decongestants, mucus splitters (Mucinex), salt water sniffs, humidifier by bedside, hydration, NSAIDs (Aleve, Ibuprofen, etc.) and Tylenol. All of these over the counter medications and devices are standard for any respiratory illness. Once a doctor gives an individual guidance, taking into consideration age and underlying health issues, their contacts can have the necessary information to act. Remember, each case impacts several people and they must be contacted.

The use of Remdesivir, other anti-virals, corticosteroids, etc. will not be prescribed for the flu, even though there is some activity of antivirals against influenza. There are antiviral prescriptions for flu (Tamiflu, Relenza, Rapivab, Xofluza) and must be taken in the very early stages of the disease to be of any help.

People with symptoms need to depend on their doctors and other healthcare providers to guide their treatment and progress.

Even though it is estimated that COVID-19 is 6X more deadly than the flu, there are 50-80,000 people who die from the flu annually, and this fall and winter, people more than ever need to be vaccinated against the flu. DON'T PROCRASTINATE—GET VACCINATED!

It is estimated that 10-20% of the population will be infected with the flu (death rate 0.1%) while 3-5% will contract COVID-19 (death rate 0.6%). In reports from other countries where both diseases occurred simultaneously, there was a very low incidence of co-infection, according to a report from JAMA Network, August 20, 2020. Those most susceptible TO BOTH in China were those who had a prolonged hospitalization.

Does the flu vaccine protect against COVID-19?

In a study which followed people with the vaccine found they were less likely to have a severe case of COVID-19 (8% less likely to need the ICU, 18% lower incidence of need for respiratory support, and 17% lower mortality). Several countries reported fewer cases of flu early on this year when flu coexisted.

The southern hemisphere experienced fewer and less severe cases of flu this summer. This study has not been

peer reviewed yet, but it would be a great incentive to get the flu shot and potentially good news for our part of the world.

Cardiovascular deaths in influenza

Cardiovascular events are common with hospitalized flu cases, however, the flu vaccine reduces that risk.

80,000 hospitalized patients with the flu from 2010-2018 were studied, and 12% had an acute cardiac event, mostly heart failure and ischemic heart disease (similar to COVID-19). 7% of these patients died during that hospitalization.

Even though strokes from COVID-19 occur more often, they are also a consequence of the flu, making this fall more serious because of both viruses circulating simultaneously. The effect on the blood clotting mechanisms in both viruses is thought to be blood clots, emboli, and strokes.

It is known that patients experiencing more severe cases of COVID-19 have higher rates of underlying cardiovascular disease than flu. Emergency department physicians must be vigilant in looking for signs and symptoms of stroke in both viral illnesses. JAMA Neurology, July 2, 2020

With the flu vaccine helping countless older patients to prevent cardiovascular events from influenza, this is one more incentive to get vaccinated.

This fall, with flu usually hitting the younger population much harder than COVID-19, it is clear the younger generations once again will be main reason for transmission of both viruses.

What is it going to take for younger generations to get on board?

Annals of Internal Medicine, August 25, 2020

3. Back to School

Most children are thrilled to be back in school throughout the world. Preventing major side effects in children for lack of face to face contact is worth the risk in most parent's opinion. It is time to see if the school system can function safely and provide a quality education experience in the face of the pandemic. Kids are not nearly as concerned as their parents and the teachers. I hope it works out!!

Teachers who have high risk factors may have to stay at home if their health is a great concern and might interfere with their teaching capability, but substitute teachers can be called. There are plenty of people out of work to fill the void.

Asymptomatic children are rarely infectious

Less than 1% of children in the U.S. are infected with COVID-19 according to research published in the JAMA Pediatrics, August 25, 2020.

33,000 asymptomatic children who were tested as part of routine care visits had a very low percentage of positive tests and should give parents confidence that they will likely be uninfected if they are asymptomatic. By no means does this imply that strict adherence to social distancing and personal protection should not be followed.

I am more concerned that parents are going to infect their children, not the reverse, since most of the positive tests are coming from ages 18-34.

In the JAMA-Pediatrics Journal, August 25, 2020, they cited studies that found a variation of from 0-2.2% of

children tested positive with no symptoms. This study included children in 28 hospitals who were coming for some type of surgery or medical care (usually ear tubes, tonsillectomy, etc.) in April and May, 2020, when elective surgeries were resumed. This is good news that kids who have no symptoms rarely are testing positive.

Studies have shown that flu is much more likely to create a symptomatic case than COVID-19 in children.

If pediatric patients are sick enough to be admitted, they tend to be older if diagnosed with COVID-19. They were also more likely to have fever, gastrointestinal upset, cough, headache, and chest pain. However, children with symptoms during the flu season still needs to be tested for both flu and COVID-19.

4. CDC changes recommendations on who is tested (again)!

The CDC has once again changed their recommendations regarding who should and should not be tested and has created a fiery response from the medical community.

They recommended that people who are infected do not need to be tested after 14 days, and asymptomatic people do not need to be tested if they have been exposed to a person who is symptomatic as long as they maintained 6 feet distance and were not exposed for more than 15 minutes.

Since this guidance was presented by the CDC, there was outrage from medical organizations and the CDC (Director Rober Redfield) clarified their statement..."people who are exposed to a known positive person should get tested if they came in close contact". Infectious disease

organizations stated that all people should be tested with no exceptions including asymptomatic children in schools.

The latest estimate by the CDC is that 40% of individuals infected are asymptomatic. Those who are known to have been exposed are still required to quarantine for 14 days.

When the flu starts, which have the same symptoms, individuals might assume they are COVID infected, when they may have the flu. Now, it will be necessary to test for both probably increasing the numbers requesting tests this fall.

The colleges, as expected, are seeing a surge, even with precautions, because college kids are like herding cats, and are not following the rules.

5. Saliva Testing as accurate as nose swabs

Self-testing with saliva for COVID-19 was found to have more virus in them than nasopharyngeal swabs, reported by the NEJM. However, in opposite results, another study found more positive tests using swab testing than saliva.

Places that do not have easy access to swab testing, saliva testing will be very valuable. Ease of testing is a real issue and testing sites continue to be cumbersome in some areas. Providing test kits for home use will be the best answer when reliability can assured. Today, correlation with exposure, symptoms, etc., must play a role in deciding who needs testing.

Some researchers feel people who are asymptomatic should have fast result types of tests even if the false negatives might be higher. Those with symptoms need to be tested with the best tests available even if the results take longer. Testing asymptomatic individuals with a

different test would reduce the time needed to get results for people with symptoms.

6. Asthma may not be a risk factor for a more severe COVID-19

A report from a Colorado hospital did not find asthmatics more likely to be intubated than the general population. It was hypothesized that most of these patients were using cortisone/bronchodilator medihalers at home, which may have prevented a more severe case.

This continues to raise the question of the value of cortisone at the beginning of symptoms using medihalers or nebulizers with some form of cortisone. To date, it has not been recommended, however, many physicians have reported that early use of cortisone in nebulizers kept many of their patients from worsening. The debate will continue until a evidence-based research project is published.

Talk to your doctor, if you have asthma, about the best approach for this year.

7. Treatment updates

We have come a long way in just a matter of months, and many theories about this virus and how it should be treated have changed. A recent report from Medscape's Coronavirus Resource Center (September 8, 2020) has stated that their research found that COVID-19 does not cause a cytokine storm. These cytokines are found in high levels in septic shock, cardiac arrest, and trauma, but not in COVID-19 cases.

The plasma levels of the cytokines (IL-6, IL-8, and TNF) in severe COVID-19 patients were found to have low levels of cytokines in comparison to those other medical emergencies. A new study just published found the proinflammatory markers highest in these cases was bradykinin rather than the above cytokines. The

These cytokines stimulate a severe inflammatory reaction in the body thought previously to occur in severe COVID-19 cases, however, this research refutes that theory. This has also been reported in other research papers. Some feel, even at lower plasma levels, these cytokines are still causing the pathogenesis of COVID-19.

In the study pointing to bradykinin found that with this chemical, it created dilation of blood vessels especially in the lungs and creating leaking of fluid that clogged the lining of the lung's alveoli, blocking oxygen transfer.

Remdesivir

This antiviral has become a standard of care since it was proven it could substantially reduce the number of days to recovery if given early in the moderate cases of COVID-19 pneumonia. A recent study continues to show value and compared improving recovery from 15 to 10 days. A longer treatment was not statistically better than a shorter course of therapy (5 vs. 10 days). Good news since the demand for this drug is huge, and it is very expensive. It has now been approved for children. JAMA Network, August 20, 2020

Corticosteroids

These steroids are given intravenously in more severe cases (with respiratory support needed) and have been shown to reduce mortality by 20%. The research has now proven it. Now it is even helping those not needing mask or ventilator oxygen support. The news just keeps getting better, and the drug is cheap!! JAMA Network, Sept 2, 2020

Oral steroids and inhalers with corticosteroids in them have not been proven to be effective in clinical trials, however, clinicians are still prescribing them in early cases with some good results. We all want to have evidence based information to back up our treatments, but in emergency situations, time does not allow waiting for that type of information, and physicians must make hard decisions in the time of need.

Anticoagulant therapy to prevent blood clots

When it became clear that patients were having strokes and other cardiovascular events secondary to blood clots, anticoagulation with heparin was initiated and saved lives.

The cytokines stimulated by the virus in the human body caused the blood clotting factors creating clots in 42% of autopsies prior to the extensive use of anticoagulants.

A significant finding found was micro-clotting and breakdown of blood cells in the lungs blocking the lungs' ability to exchange carbon dioxide for oxygen.

Now evidence based studies are proving a 50% improvement in mortality from COVID-19, reported in American College of Cardiology Journal, August 24, 2020.

Rates of bleeding were only 2-3% from the blood thinners.

8. Recovery issues for COVID-19 patients

More studies have been reported on prolonged symptoms after being hospitalized with COVID-19. Like any significant illness, the recovery can be prolonged especially if the patient has underlying medical conditions that complicated the illness. The rule of thumb, is the length of the illness will equal the number of days to recover.

35% reported they had not returned to work 2 weeks after their tests were negative, whereas 65% felt fully recovered after 1 week from discharge. As expected the older the person, the more likely the recovery was prolonged (as many as 47% of patients over 50 compared to 26% 18-34). None continued with fever or acute illness symptoms. This Italian study reported 72% of these patients with interstitial pneumonia.

Fatigue, shortness of breath, cough, and joint pain were the most common symptoms. In a small percentage, there may be some form of "chronic fatigue syndrome" that may occur. These patients need longer term follow up to monitor their recovery especially those with pneumonia and significant underlying medical disorders.

Patients with significant pathology in their lungs should consider pulmonary rehabilitation, a form of physical therapy, which can hasten recovery.

Prolonged symptoms were much greater in COVID-19 vs Flu patients, according to the CDC.

9. Deaths from COVID-19

It has been well established that children's death rate is well below 1%, 4.28% in 70 and older, and 7.8% over 80. As we look at the death rates of these groups across the board, we see that there are a percentage of elderly especially that are dying of medical conditions regardless of testing positive for COVID-19. It is often difficult to decide just what the virus plays in death when patients are already suffering from underlying diseases. Many physicians are instructed to put the cause of death COVID-19, since the hospital is reimbursed at a higher rate for the pandemic deaths. It, however, inflates the numbers.

WebMD

10. Studies to prove it is safe to go see the doctor

I am happy to report there are studies that are being reported that visiting a doctor in their offices is not increasing the risk of being exposed to COVID-19 with the initiation of strict guidelines followed in their offices. For example, patients are called on their phone in their car when the staff can put a patient directly into an examining room.

A report from Boston gyn offices followed patients who came for prenatal visits, and found no increase in positive tests because they were seen by healthcare workers and doctors. In 333 women having an average 3.3 visits, there was no increase in positive cases.

11. How long will our immunity last if infected?

A recent study from Iceland published in NEJM, September 1, 2020 found that 1800 people infected and recovered with COVID-19 had at least 4 months of

adequate immunity to prevent reinfection. This is great relief to know there is sustained immunity for 4 months. Only time will tell how low the immune globulins and neutralizing antibodies can drop before an individual might be susceptible to reinfection. To date, there is no proof of reinfection.

As in other studies, those hospitalized had higher antibody titers. Those who had more severe symptoms had higher titers including those overweight, had cough, and loss of appetite. Those are the people we need to donate their plasma to be given to sick individuals (convalescent plasma).

Interestingly, the report found that those who were taking anti-inflammatory agents regularly (Aleve, Ibuprofen, aspirin, etc.) had lower titers of antibodies. Does that infer that they might have milder disease if they were taking anti-inflammatories? It has been reported that those patients with autoimmune disease on anti-inflammatories had no greater risk of hospitalization.

Also women have lower titers because they are more likely to have a milder case.

It is also known that there is little evidence of mutation of this virus which means a vaccine should be highly effective even if boosters are necessary.

12. Vaccine updates

Phase 1 study of mRNA-1273 vaccine against COVID-19

Presentation of older adult cohorts

One of the vaccines which has been in clinical trials is showing a good immunological response in older people. These results were reported to the CDC Immunization

Advisory Committee. The levels of neutralizing antibodies was similar in ages even above age 71. There was also a CD4-T cell response as well. This is great news, since in some immunizations the antibody response had been less than in younger individuals. This is the kind of news we need to hear.

No vaccine will be approved until safety and efficacy can be proved. Don't listen to politicians and the media about a vaccine being offered before that is solid. The timing of the release will occur hopefully in early 2021, but even Dr. Fauci has stated one or more vaccines could be ready before that.

Some surveys have cited as low as 30% of people willing to receive the COVID-19 vaccine. Is it any surprise it is falling along political lines? The flu vaccine is also very important to relieve the hospitals of sick patients with the flu clogging our ERs when and if COVID-19 might increase.

It must be understood that it takes a few weeks for the flu vaccine to be effective, so it is recommended to get vaccinated now. Children 2-8 require 2 doses of the flu vaccine (4 weeks apart), and the flu nasal spray is recommended as well this year (not recommended last year) up to age 64. Ask your doctor which type of vaccine is best for you.

9 different biopharma companies stated emphatically they will not seek FDA approval until they are totally convinced with data that their vaccine is not only safe but effective, according to a business wire service for BigPharma as reported by NEJM Journal Watch, September 8, 2020

[Biopharma company takes a pause in vaccine research](#)

AstraZenica Pharmaceuticals announced one patient developed a serious illness after receiving either the vaccine or placebo (not known which yet). It has temporarily suspended its trials for now, until this adverse effect is better evaluated and clarified. It means the companies are very serious about monitoring any side effect of a vaccine.

This particular vaccine is produced from a chimpanzee adenovirus vectored virus which expresses COVID-19 spike proteins, which would stimulate an antibody response in humans.

The person developed transverse myelitis (TM), an attack on the spinal cord which can cause weakness or abnormal sensations in the limbs, bladder and bowel incontinence. This inflammation occurs in the myelin of the spinal cord, the covering of nerves. There are several different causes of TM including many viruses including influenza.

Several bacterial infections such as Lyme disease, syphilis, and whooping cough. Some are considered autoimmune and can mimic multiple sclerosis. Vaccinations have been known to cause this very rarely.

It is diagnosed with neurological exams including spinal MRI. It can be treated with some of the same medications as COVID-19. Information taken from the National Institutes of Health.

This ends the Mid-September COVID-19 Update

The October report will include:

- 1. Update on COVID-19/Flu**
- 2. Prostate issues**
- 3. New info on how pain works**
- 4. Primary Dysmenorrhea—painful periods**
- 5. Life expectancy rises for the first time in 4 yrs.**
- 6. Sepsis from viral and bacterial infections**
- 7. Are generic drugs as good?**

Stay healthy, safe, and well, my friends, Sam
Pray for those who have lost their lives to
COVID-19, our healthcare profession, first
responders, and the families that support
them!

