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The Test Set: Another Brick in the COVID-19 Disinformation Game Plan

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Do you want the true answer, or do you want the answer given by propaganda, official government versions and the mainstream media?

I will give you the true, medical answer: *the tests do not answer any of these questions, they are unreliable, they give overly simplistic answers that can be used by governments to make people believe what they want them to believe.*

There are two main types of tests:

1. **Molecular tests: RT-PCR**
2. **Serological tests:** looking for antibodies in blood

RT-PCR [1]

In cells taken from the back of the nose, RT-PCR searches for fragments of SARS-CoV-2 viral RNA, forms the corresponding DNA using the enzyme Reverse Transcriptase (RT) and amplifies (multiplies) the RNA-DNA fragments found using the polymerase chain reaction (PCR) technique. By a complicated technique, therefore subject to many missteps, we are told that this test could quantify the viral load.

This test, the results of which can take 2 to 7 days, **is supposed to prove** that you are infected **(RT-PCR +)** or not (**RT-PCR -)** by the SARS-CoV-2 coronavirus and that you **are contagious** or **not contagious.**

This is not the truth.

Yet it has guided all medical decisions around the world to categorize patients into COVID and NON-COVID, to isolate the former and confirm them as COVID-19.

The presence of a clinical picture composed of major signs (including cough, fever) and minor signs, with in some cases a chest CT scan, has led to the classification of symptomatic patients as either **suspicious (awaiting RT-PCR result**) or **confirmed (positive RT-PCR and/or evocative chest CT scan),** with minor, moderate and severe forms.

This theory based on quicksand proves that human beings always prefer a logical and reassuring lie, simplistic, to the more complex and frightening truth.

Many studies and articles by recognized experts in their field, including some from prestigious universities, have shown the unreliability of RT-PCR, which can give false

positive or false negative results or are disrupted by a lot of elements at all stages of its technique [2].

Clinical pictures and images from chest scans are not specific and can be found in any broad viral or infectious disease [3].

SARS-CoV-2 is part of a family of many similar viruses, most of which are benign: cold viruses.

It is most likely that this specific virus has had time to circulate in a large part of the population before the end of March and containment measures.

These strict isolation measures did not destroy the virus or extinguish the pandemic. On the contrary, **they destroyed the economy of many countries and many lives (unemployment, loneliness, poverty, depression, untreated diseases, anxiety, famine).**

"Kerry Pollard, a microbiologist from the Commonwealth of Pennsylvania, performs a manual extraction of the coronavirus in the extraction laboratory of the Pennsylvania Department of Health's Office of Laboratories on Friday, March 6, 2020 " Source: flickr.com

Serological tests to help COVID-19 propaganda? [4]

Serological tests are done using blood, 8 ml taken in a dry tube or a single drop in the case of rapid tests.

The biologist looks for the presence of antibodies (Ac) or immunoglobulins (Ig) specific to the SARS-CoV-2 coronavirus.

There are two main types of antibodies:

1. IgM: recent or ongoing infection, phase of contagion.
2. IgG: older infection, healing, more contagion

Some serological tests only detect IgG. Studies have shown that virtually all subjects with **symptomatic COVID-19** produced detectable IgG antibodies as long as the blood sample was taken **at least 3 weeks after the first symptoms** [5].

There are several types of IgG.

S1/S2 IgG are neutralizing antibodies, protecting against the virus.

However, not all identified IgG antibodies are protective or neutralizing; in fact, the opposite is true with the phenomenon of facilitating infection via antibodies (*ADE Antibody Dependent Enhancement*, as in dengue fever). In this case, rather than blocking the key (Spike protein of the viral envelope) that allows the virus to enter the target cells (neutralizing antibodies), these facilitating antibodies promote the penetration of the virus into the target cells! [6-7]

Rapid tests, such as the one from BioLab Sciences [8] based in Scottsdale, Arizona (USA),

allow rapid antibody detection within 10 minutes with a specificity of 98%. These are the claims of the laboratory. A drop of blood is enough, as in blood glucose tests with a fingertip prick.

There are several types of rapid tests, 12 tests approved by the FDA in the USA alone (as of June 1st), but also others in Malaysia, China or Europe.

A laboratory like the one in Scottsdale, Arizona, claims to be able to provide up to 9 million tests per week.

Interpretation of the quick-test results:

1. IgM positive alone: recent infection/contact (days), **within the previous 4 weeks at most**
2. IgM and IgG positive: infection/contact **that occurred 4-8 weeks prior to the infection**
3. IgG positive alone: infection/contact **more than 8 weeks ago**

Yes, so what?

What can we really conclude from this?

Let's take a look at the theory of human immunity to better understand [9] :

The human immune defense is composed of two main lines.

1. Innate or natural immunity
2. Acquired or adaptive immunity

A. Innate immunity is not specific, it is very rapid, intervenes first in case of aggression and **is often sufficient**. It is not based on the production of antibodies. This means that antibodies are absolutely not essential to eliminate an infection. It also means that the absence of antibodies or a low level of antibodies in the blood does not rule out a viral infection that will have been managed by the exclusive innate immunity. **This is even a sign of good immune health!**

B. Adaptive immunity is specific, it is slower, it is only activated when innate immunity is overwhelmed or insufficient, and it is **based, but not only, on the production of antibodies.**

Therefore, to sum up an individual's immune defence to his or her antibody production is as false and simplistic as summing up a country's defence to its special forces. Yet this pirouette is the main dogma of immunology, the sacred basis of vaccinology.

What does the orthodox immune theory say?

Positive test

She said that a positive serological test (the presence of sufficient SARS-CoV-2 coronavirus-specific antibodies in the blood) indicates recent (IgM-days/weeks) or past (IgG-weeks/month) infection.

It also says that a positive IgG test (a sufficient level in the blood) means that the person is protected against a new infection.

But it's not that simple.

Remember AIDS (HIV infection or HIV). Before AIDS, any seroconversion was considered a good sign, reflecting the adaptive immune system's response to an infection.

After AIDS, seroconversion (the presence of antibodies to HIV) became a bad sign, leading to the diagnosis of an active disease: HIV-positive [10].

Negative test

The orthodox theory says that a negative test (little or no IgG in the blood) means that the person has not become infected and is not protected.

However, that is not entirely true.

The absence of IgG antibodies (or a low serum level) does not mean that a person has not been infected because he or she may have relied solely on innate immunity (immunity without antibodies) or may have relied on other types of antibodies such as Immunoglobulin A (IgA) secreted locally in infected mucous membranes (nasopharyngeal mucosa).

The antibodies are secreted by activated B-lymphocytes during the late, adaptive and specific immune response. However, this adaptive immunity also relies on other cells that do not produce antibodies, such as **T lymphocytes**, which also constitute a very important antiviral and antimicrobial line of defence, not taken into account by blood serologies that only measure serum antibodies.

In addition, there is an important immunological concept, that of cross-immunity [11]. Yes, doctors should re-read their immunology courses!

The coronavirus family is a large family!

For the most part, these viruses are benign and cause colds every year. By dint of early childhood, true coronavirus immunity has developed, facilitating the innate immune response to SARS-CoV-2 so that in many people it may have been enough to shorten viral multiplication.

The adaptive (antibody-mediated) immune response in all of these people did not have time to come into play, so there were no antibodies.

This is not bad at all and means, on the contrary, that the previous colds prepared the person to react well to SARS-CoV-2 (effective cross-immunity).

In summary, a negative serology (insufficient antibodies to SARS-CoV-2) DOES NOT EXCLUDE being infected and DOES NOT EXCLUDE the existence of protective immunity to a severe form of COVID-19.

IgG serology alone will **underestimate** the true rate of cured infections and the true immunity of the population to SARS-CoV-2!

It would be more interesting to assay the entire coronavirus antibody pool, not just those

specific to SARS-CoV-2.

Immunological hypothesis to explain severe forms of COVID-19:

Severe forms (intensive care, death) have mostly been observed in elderly patients (even very elderly, >/= 80 years old) and/or with one or more chronic diseases (obesity, diabetes, hypertension, cardiovascular disease...).

These chronic Western pathologies (increasingly global and mainly linked to sweet diets associated with excessive sedentary lifestyle) have become so commonplace that they are now overly commonplace in hospitals. It has almost become "normal" to be fat, hypertensive, quickly out of breath, diabetic or inactive.

However, this is **THE** scourge of modern times, much more than the lack of vaccination!

All of these diseases and lifestyle habits severely depress the immune system [12].

a) Innate, natural immunity has been unable in these people to eliminate the virus or slow its multiplication.

b) Adaptive, specific immunity, which produces antibodies of several types, may have led to the secretion of ADE antibodies, facilitating viral invasion in tissues with specific receptors for these antibodies, leading to an excessive, exaggerated inflammatory reaction (Th2 immunological response) and more destruction than cure [13], especially in the lungs.

In this case, the very high levels of antibodies against SARS-CoV-2 rather reflected a bad situation, synonymous with severe infection and deleterious immune reactions!

CONCLUSIONS

Both molecular tests of RT-PCR type (diagnosis, contagiousness) and serological tests with IgM-IgG antibodies (diagnosis, immunity) **are unreliable**.

They do not take into account the cross-immunity to other coronaviruses (very similar to SARS-CoV-2 but more numerous and benign) which has certainly been able to play a great role in the protection of a whole section of the population, especially the young and relatively healthy individuals (60 to 85% of people are able to eliminate coronaviruses using only their innate immune system, without developing antibodies for this).

Many people are and will be protected by this cross-immunity, provided by all the ambient coronaviruses that we have been breathing without any concern or hardly (common cold) for decades and without going through the ***specific antibody*** box.

Moreover, it is not because the antibodies in question disappear quickly [14] or decrease very strongly in the bloodstream that the individual no longer has immune protection.

There are many lines of protection (helper T cells, cytotoxic, regulatory, other molecules made by B cells, innate immunity...) and to reduce everything to antibodies alone to say that you are protected or not is profoundly dishonest, or stupid.

Immunity is not only based on antibodies, far from it [15]!

Patients with moderate COVID-19 showed low levels of serum IgA and IgG specific for the

SARS-CoV-2 Spike protein.

Patients with severe COVID showed high levels of specific serum IgA and IgG, the higher the severity of the disease [16].

While the orthodox immunological theory would say that the sicker you are, the more Ac you make to protect yourself, in reality the high level of Ac is partly responsible for the severity of the disease (ADE phenomenon).

The high level of antibodies, far from reflecting protection, reflects an inadequate (maladjusted) immune response leading to a Th2 (humoral and inflammatory) rather than a Th1 (cellular) immune response. And this is not good.

Why is it not good?

Because of the overall poor health status of patients with severe IDVOC (one or more severe co-morbidities, high age)!

The most important thing is good coordination between the innate and adaptive immune systems and this is based on good health (dietary, physical, mental).

Low antibody levels may simply mean that your innate immune system has been effective and has been sufficient to protect you. That's good!

Anything can be made to say at the tests, including serological (antibody) tests, and it all depends on the intention, benevolent and honest OR malevolent and dishonest, of those who will tell you what they want you to believe.

P.S. my advice as a doctor:

Strengthen your immunity by a healthy (balanced) diet, moderate, varied and regular physical activity and daily mental hygiene (meditation, self-hypnosis, sophrology, breathing, walking in nature without masks).

And if you and your children have colds, that's fine.

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Translation from French by ***Maya****, Centre for Research on Globalization (CRG)*

Featured Image is from Pixabay

Notes:

[1] Tutoriel prélèvement nasopharyngé : Un geste technique, essentiel à la fiabilité du test COVID-19

[2] Les tests: talon d'Achille du château de cartes COVID-19, mondialisation.ca, 28 mai 2020

[3] Utilité du CT-scan thoracique pour le diagnostic et le triage des patients suspects de COVID-19, Swiss Medical Journal RMS 2020, Vol. 16, 955-957. The role of CT in the management of suspected or confirmed COVID-19 patients remains uncertain.

[4] Place des tests sérologiques dans la stratégie de prise en charge de la maladie COVID-19

[5] Le Journal du Médecin, 4 juin 2020, n° 2632

[6] Anticorps facilitants et pathogénèse du COVID 19, Swiss Medical Journal 25 April 2020. This article highlights the complexity of the immune response. Complexity that prompts us to reflect on the meaning of the presence of antibodies: can a positive serology over time say that there is immunity? Moreover, as can be suspected in some severe cases, the immune response could play a role in the pathogenesis of the disease.

[7] Molecular Mechanism for Antibody-Dependent Enhancement of Coronavirus Entry

[8] Rapid serological tests : RAPID RESULT COVID-19 TEST KITS

[9] Immunologie approfondie

[10] LE DIAGNOSTIC DE L'INFECTION PAR LE VIH, Diagnosis is made through a blood test that detects the presence of anti-HIV antibodies as early as three weeks after contamination.

[11] Immunité croisée entre les coronavirus des rhumes et SARS-CoV-2

[12] SARS-CoV-2 specific antibody responses in COVID-19 patients

[13] Antibodies to coronaviruses are higher in older compared with younger adults and binding antibodies are more sensitive than neutralizing antibodies in identifying coronavirus-associated illnesses

[14] Coronavirus : les anticorps ne resteraient que deux à trois mois dans le sang

[15] Les anticorps ne sont PAS nécessaires pour la protection contre certains virus, article source en anglais : Antibodies are not required for immunity against some viruses

[16] Systemic and mucosal antibody secretion specific to SARS-CoV-2 during mild versus severe COVID-19

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