Analysis of COVID-19 Pandemic Without Faulty Sars-Cov-2 Tests.
By Wojciech Rychlik, 9/1/20.

Before the current COVID-19 test had been developed medical practitioners made their diagnosis on patient's symptoms. Soon in the course of the pandemic a convenient test for the disease was developed based on the polymerase chain reaction (PCR tests). In this article I am going to prove that this test does not determine the presence of the disease, and therefore, it should not be used in COVID-19 diagnostics. An interesting feature of the disease is a huge (at least 40%) number of asymptomatic cases. This is, at least partially, not due to the true asymptomatic nature of the disease but rather due to the wrong interpretation of the PCR tests.

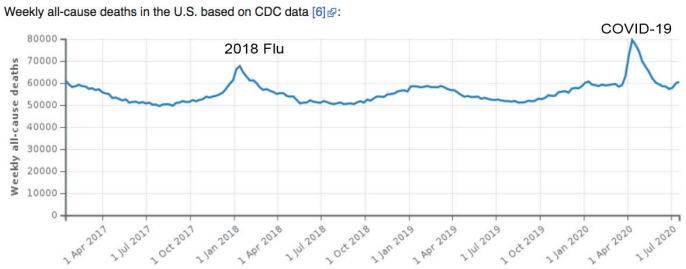
PCR was invented in the 1980's by Dr. Cary Mullis who received a Nobel Prize in 1993 for this discovery. I am a molecular biologist who in 1989 wrote the first PCR software which is still used today to design the tests (https://en.wikipedia.org/wiki/Wojciech_Rychlik).

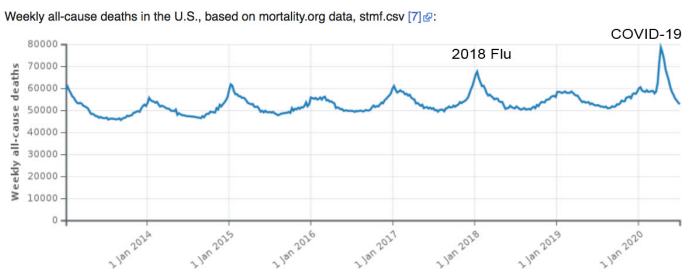
PCR test sensitivity depends on the number of enzymatic DNA multiplication rounds used. More multiplications results in higher sensitivity, but also in a higher rate of false positives*. How far the testing laboratory decides to go with the sensitivity depends on arbitrary directives of the lab director or other officials.

Another problem with PCR is a biological one. A virus particle is infectious when it is intact. Human bodies excrete lots of efficient enzymes to destroy potential viruses and bacteria. So, if a virus particle lands on your skin or the nasal pathway, the viral RNA is usually quickly chopped into several pieces rendering the virus inactive. The PCR test, however, detects only a tiny fragment of the viral genome, the result being that a dead virus piece will still make a positive PCR reaction. So, the SARS-Cov-2 test shows only whether a person was exposed to the virus but does not indicate the actual infection (penetration and multiplication of the viral RNA inside the cells).

Rapid COVID-19 antibody tests indicate only past coronavirus infections and show immunity or partial immunity to COVID-19, something that we would expect from the action of the future vaccines. In other words, successfully COVID-19 vaccinated people should be positive to antibody tests.

The SARS-Cov-2 tests are not reliable because of the two reasons mentioned above. How does one prove that the tests are not reliable? The key is to watch the total number of deaths (and not COVID-19 caused). This analysis is free of any test errors. Every year we have a flu season in the winter/spring resulting in the increase of total mortality during those months. See the figures below, copied from https://en.wikipedia.org/wiki/COVID-19_pandemic_in_the_United_States. The left chart shows mortality from 2017 until July 2020. Note the two main spikes. The first one is the flu epidemic of 2018 that killed anywhere from 31,000 to 61,000 people in the US (https://www.cdc.gov/flu/about/burden/2018-2019.html https://www.cdc.gov/flu/about/burden-averted/2017-2018.htm). The second spike is COVID-19. This is the raw data, not inflated by the faulty PCR tests and politics. USA mortality pattern for years 2013 to 2020 is shown on the right.





As you can see, our COVID-19 pandemic is over, and the number of deaths is roughly twice as high as the 2018 flu epidemics. Note that unusually elevated death rate actually started in the US during late fall of 2019. Whether this is due to the seasonal flu or actual COVID-19 is debatable. Another novel feature of 2020 pandemics is the elevated level of deaths during the summer time, probably caused by the "flattening the curve" distancing efforts. The real number of COVID-19 cases is much smaller than reported, somewhere between 60,000 and 120,000. Note that the total deaths spike is not only due to COVID-19 but also due to increased suicide rate, other social isolation related fatalities and the flu that certainly existed but was ignored. Lowering total deaths trends such as less traffic accidents in the first two months of the lockdown and lower work and school related deaths were other factors but I'd expect it is negligible. Approximately 10% increased death rate just due to the lockdown measures is reported by Colleen Huber, NMD (https://www.primarydoctor.org/public-health-lockdowns). The accurate numbers should be available next year, but this is not the point of this article. On June 8, 2020 WHO reported that asymptomatic transmission is very rare. This is mostly due to the failed interpretation of the tests, that is, lots of positive tests are in fact false positive, for several reasons mentioned here.

In summary, COVID-19 mortality is comparable to that of a strong flu. It is likely that the media and politicians created the related and unprecedented chaos and economic break down (which we will mostly see in the future). Without the existence of the SARS-Cov-2 PCR test, we would be living our normal lives by now. It is tragic that misunderstanding biology and the single PCR test technique interpretation has such a heavy impact on the entire world economy and social relations. Perhaps our open-minded physicians should be given back freedom of speech and not be bullied by the officials nor risk losing their licenses when they express opinions similar to mine. We should have been treating this COVID pandemic as we treated flu pandemics in the past. The only solid test should be watching the symptoms and acting accordingly. Labeling asymptomatic "cases" as COVID-19 is a crime. Protect your freedom: if you don't have symptoms do not subject yourself to a questionable PCR test, but if you have to, wash your sinuses with a Neti pot to minimize false positives.

**PCR technique is extremely sensitive and can be used to find a single molecule of a specific DNA sequence. Very efficient PCR reaction can be achieved when short DNA fragments are amplified (100-200 base pairs). The longer fragments can be amplified as well but the efficiency of the reaction drops down with lengthening of the DNA. So, for the detection of SARS-Cov-2 short DNA fragments need to be amplified, which are minute fragments of the virus genome (30,000 bases of RNA). Sorry to be so technical about this, but one needs to realize what the test for the "positive cases" is actually. So, for the tests, the DNA has to be synthesized first from a small selected fragment of viral RNA genome. Than, a number of reactions need to be performed. One reaction theoretically doubles the amount of DNA. So, after 40 reactions, for example, we should have 2 to the power of 40 molecules (trillion molecules, 1,000,000,000,000). This high number of short pieces of DNA could be easily visualized. The best way to check the accuracy of the reaction is to look for the correct size DNA product. The correct product should have a certain size and all other DNA pieces of different sizes than expected are artifacts. Unfortunately, one of the WHO SARS-Cov-2 primers for PCR match human sequence from chromosome 8, which is dangerous as increases false positive outcome. Because this primer was not chosen carefully, it makes me think that this important process of primer selection may have major flaws, such as positive reaction to a common cold coronaviruses. This would have devastating effect on our life as they would find thousands of "new cases" during common cold season that may lead to another lock down. The COVID test however, does not check for the expected DNA size, but it rather relies on color of the product (DNA is colorless, so just assume there is more to it than checking plain DNA). This is a big problem because artifacts can be taken as positives. The more reactions (polymerization cycles) are performed the more false positives must pop up. It's up to the lab personnel whether they allow false positives or not (they may be pressured to produce false positives because of non-scientific reasons.)*

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