

Speaker 1 ([00:00](#)):

Whew. Now, if all roads lead to the vaccine, what is motivating all roads to lead to the vaccine? Why is everyone falling in lockstep? Why aren't there people who are looking at this logically and saying, you know, even if you get vaccinated, there's a good chance that you could have a breakthrough. Particularly now there was a while back where they were saying that breakthroughs are incredibly rare. They're not incredibly rare at all anymore. I know 12, 13 people that have gotten COVID post vaccination. And I know a few of 'em that were hospitalized, trying to avoid hospitalization should be a priority for everybody include people that are already vaccinated. Why is there no emphasis on this? What's the motivation? Like what is the motivation for all roads to lead to the vaccine in this binary approach that it's only the vaccine that can help us?

Speaker 2 ([00:56](#)):

Well, let's be fair to the vaccines. Uh, and I think this is important to mention. I was, uh, under oath, testified in the us Senate and they asked the very last question they asked our panel was, do you have any problems with the vaccines timeframe? November 19th, 2020? None of us said a word, cuz all we had was press releases. Joe. We learned that the vaccines out of the clinical trials over a two month period had 90% vaccine efficacy, 90%. Now what that meant is if you had a clinical trial and you had, uh, 18,000 people in each group that vaccine versus placebo, that when you looked at the number of cases, there would be a hundred cases of COVID in the control group, placebo group and 10 cases in the vaccine group. That's 90% vaccine efficacy, a hundred versus 10 just giving sample numbers. That looked terrific.

Speaker 2 ([01:46](#)):

Um, uh, uh, but interestingly wait a minute, 18,000 in each group. What's the problem that meant that less than 1% of people got COVID. Now during that timeframe, our labs were recording five, 10, 15% COVID positivity rates. How did the vaccine trials recruit people with those less than 1% chance of getting COVID? How did they find these people? Well, I could tell you, we were a vaccine clinical trial center, the most fastidious people, doctors, other people, they, they, they were very careful people, uh, upper middle class WebExs who were just on WebEx. Uh, they were scared. They took, they were in the vaccine clinical trials. They recruited people who never got challenged with COVID. They never even exposed to COVID. So the vaccine clinical trials were not a good test run of if you got exposed to COVID, what would happen? So then the vaccines rolled out and you know, uh, we had December people started enrolled at young doctors in the hospital, took it, I watched it happen.

Speaker 2 ([02:39](#)):

Then they went to nursing, home seniors, February, uh, uh, January, February, and we got to worry. I was like, wait a minute. Where's the report? Uh, white house task force or the NIH or CDC or FDA. They need to come on TV and give us a report. How many people have been vaccinated? How many people have failed the vaccine and get hospitalized anyway, at how many people have been injured with a vaccine or what's the side effects, no report. So we got to February and there was no report with the vaccines. It turns out that we actually never learned what the vaccines were doing on efficacy until much later. Now once we had August, September and October, this is much later we had data come in from arrears from the spring. And we learned the following a paper by self and colleagues from the CDC show said for protection against hospitalization, there was substantial protection against hospitalization.

Speaker 2 ([03:30](#)):

Now it's confounded by the fact that healthy people take the vaccines, less healthy people. Don't take the vaccines. And the hospitalization is confounded by the act of differential testing. Meaning that once somebody takes a vaccine, the hospitals don't test 'em for COVID when they come in for gallbladders or they come in for other things, if someone doesn't take the vaccine, the hospital's testing them, right. And we know people get generate false positives. So the differential testing exaggerated the effect of the vaccines. But even with that exaggerated effect, I wanna to give your listeners a fair evaluation of efficacy. And what we know is that, uh, this reverse report that came in by self from MMWR, uh, marched through August of 2021, the vaccine efficacy for Madena was 92% for Pfizer was 77% and Johnson and Johnson, 68%. Now that's biased and that's loaded with a lot of bias, but I'm telling you the vaccines did do something in terms of reducing hospitalization and death.

Speaker 2 ([04:30](#)):

Now in the caveat they say, listen, we didn't have data on Delta. And it looks like the vaccine efficacy dropped off after six months now, 10 40 came in in Gemma and this was published, uh, in, uh, uh, the fall of this year. And they had an 85% protection overall against hospitalization. But again, don't forget, the hospitalization could be influenced by this testing bias. But if we look at the data in figure three, which is dealing with in this paper, people who really had COVID and did they progress onto the, a mechanical ventilator or did they get worse? And the answer was there was a 59% protection against getting worse, but mortality in the 10 40 papers, one of the best vaccine papers, mortality for those who took the vaccine and were ized with COVID was 6.3% and mortality for unvaccinated. And they just took their chances with COVID and the hospital was 8.6%.

Speaker 2 ([05:23](#)):

And that P value was not statistically significant. So there was a mortality benefit, but it wasn't statistically significant. And so the last paper we have to point to is by cone and colleagues cone from the VA 780,000 individuals, 700 8225 individuals in the VA. And the, they basically demonstrated that age over 65 for non COVID related death. The vaccine is associated with the reduction in non COVID related death. Meaning people who take the vaccine are less likely to die because they buy selection bias. They had about a 1% overall absolute, uh, risk reduction in death. And then the COVID protection from death due to COVID or death with COVID was about a 1.5%. That's it risk reduction. So 1% absolute risk reduction that's cone and colleagues age over 65. Now in certainly what happened is in September, the vaccine efficacy fell off a cliff for all the vaccines. And what happened in September was very important. September was about the six month anniversary of everybody, cuz most everybody took the vaccines early and September was also the first month of fully shading in on Delta. We got to 9% Delta, which basically, uh, uh, many papers show is resistant to the effect of the vaccines.

Speaker 1 ([06:46](#)):

So this one, this, this is much smaller than any of the, the reports you ever read online or see on television. This is a much smaller avenue of efficacy. Would,

Speaker 2 ([07:01](#)):

Would you well, I'm presenting the data in terms of absolute risk reduction, right? From the survival curves. There's a way of presenting it called relative risk reduction, which gives a much bigger number. But what a lot of people wanna know people on the street wanna know, listen, what's my chances dying of co O D. And I can just give you the number for us veterans. Let's let's have people listen to this. And this is after about four to six months of taking the vaccine. Those who are positive veterans over age 65,

who are COVID positive and died with COVID 19, uh, uh, let's uh, flip it around to survival Joe, uh, to survive in COVID 19. The number was, uh, basically, um, wanna be exact, since fact checkers will be looking at this was 87% for those, uh, who took the vaccine. And for those who did not take the vaccine, the number was about 78%. So that number, yeah, that number was basically, um, in the mid part, it's about 1.5% and then it extend out at the end of the survival curves to about a 10% absolute difference.

Speaker 1 ([08:23](#)):

So the vaccine efficacy drop off of six months, is this for everyone? Or is this for people? There was a, um, a study that was recently, uh, highlighted, showing the difference between the way obese people process antibodies. Is this for everyone? Is this, I mean, is it, does it more effective in healthier individuals? Is it more long lasting? Yes.

Speaker 2 ([08:48](#)):

The best paper to look at that is by, um, Nordstrom and colleague Sweden, 1.6 million pairs of vaccinated UN vaccinated. The outcome is symptomatic. COVID 19 infection, not hospitalization and death. Moderna starts out at a month at 92% vaccine efficacy. Uh, I'm sorry. Pfizer starts out at 92% vaccine efficacy and it drops off to 23%. After six months Moderna starts out at 96% and it drops down 69%. And now we have 22 studies showing that the vaccine efficacy basically markedly diminishes after six months. That's the reason why all the authorities have agreed. We have to give boosters at six months. And the, the, the groups that do the worst and this has been published are those who are immunocompromised. So the immuno compromised people worry about them. The but the bottom line is they get the least benefit of the vaccines.

Speaker 1 ([09:39](#)):

They get the least benefit of the vaccine. They're the people we worry about the, the most. And they're also the people that we don't criticize their choices because the particularly the obese ones, we don't say, which I think they should have said right off the

Speaker 2 ([09:53](#)):

Bat. Well, interesting, uh, uh, immuno by the CDC wouldn't include the obese. So it includes people with blood disorders, chronic leukemia, uh, includes those, uh, transplant recipients, the most common category that your listeners would fall into is immunocompromised or people on chronic, corticosteroids. So people with severe adult and asthma, rheumatoid lupus, yeah. That would be immunocompromised. You're talking about gen role comorbidity categories like diabetes, obesity, heart, and lung disease, kidney disease, chronic cancer. Those are basically risk factors for hospitalization and death with COVID. And there's the reason why, by the way, particularly obesity, you know what it is. Yeah. We

Speaker 1 ([10:30](#)):

Talked about it, but please explain it cuz I, I can't repeat it. The virus

Speaker 2 ([10:35](#)):

SARS COVID two, the virus has got two very unique things as a viral syndrome. The first is this cytokine storm or this hyper immune activation. And that cytokine storm leads with the most unique cytokine. Interlukin six. We've never seen this before. Interlukin six is produced by human fat cells. So the virus triggers human fat cells to produce a ton of interleukin six, which itself is damaging. And so those who

are fat have a much greater Depot and an ability to produce the cytokine storm. That's the reason why obesity isn't as exquisite risk factor for mortality is because the unique cytokine signature of, of SARS co two. The other thing that's unique about the infection is blood clotting. We've never seen an infection that causes blood clotting. This blood clotting is in the final pathway to death with this virus because of the spike protein, the spike protein attaches to solid acid residues on the surface of red blood cells. It causes micro, uh, a right blood cell aggregation trips off the coagulation cascade in an interesting way. And we can see this in patients where we see a D Dier level that's elevated and doctors learned to actually as a signature of COVID 19, the D Dier levels, when they're elevated, it actually means this, this coagulation process is likely going on.

Speaker 1 ([11:57](#)):

So the compromise of the immune system that comes about from obesity is it's scalable. Is it like if you are a hundred pounds overweight, is it much worse than if you are 40 pounds overweight, it's

Speaker 2 ([12:09](#)):

Clearly scalable.

Speaker 1 ([12:12](#)):

Um, so that's something that should have been discussed publicly along with the drugs, along with the possible early treatment options.

Speaker 2 ([12:20](#)):

Well, you know, if we could have in a perfect world, we, if we addressed all four pillars of the pandemic response, if we did what Bangladesh did and just start actually doing the oral nasal hygiene approaching bang, is that what they did right away? That's where the trials were done. They're almost down to zero COVID, there's 160 million people they're on top of each other. They're over there. They're down to almost zero COVID cuz they've got the discipline down to when they go out in public settings. When you went out with that guy with a headache, uh, when you came home, just do the oral nasal decontamination, you would've knocked down the viral particles enough where your body probably would've fought off the rest and you don't get the syndrome. Do you know my patients right now when they're coming down with COVID, we actually blast with a du dilute povidone I dine in the nose in the mouth.

Speaker 2 ([13:01](#)):

We blast, um, every four hours while awake and we knock down the viral load, particularly with Delta, Delta has 251 to a thousand times viral load in the nose. So it's replicating like mad and we can knock it down and reduce the amount of viral, uh, um, uh, inoculum in the human body. I personally had COVID Joe, it was in the fall of 2020. I didn't know about this. It baked in my nose and mouth for about three days. And I sat there. I did nothing. I was scrambling for oral drugs. Why didn't I knock it down with some type of treatment in, in the nose, you know, chronic sinusitis patients have been using nutty pots or they've been using saline. ES all we have to do is add a little peroxide or a little bit iodine to that and knock down the viral load. I could have had a much milder syndrome.