

Engineer Analyzes PCR Coronavirus Test and Raises the Question “Does the 2019 Coronavirus Exist?”

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David Crowe is a Canadian software and telecommunications engineer with a degree in biology who is an expert in global infections such as SARS, Ebola, and flu. He says that, because the PCR test looks for RNA, there is no proof that it detects a virus. Furthermore, there is no proof that a virus causes disease. The data is being interpreted to benefit the viral theory, and there is zero concern for false positive results. He concludes that medical papers are propaganda to increase panic. -GEG

Introduction

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 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.

It is also an epidemic by definition. The definition, which assumes perfection from the test, does not have the safety valve that the definition of SARS did, thus the scare can go on until public health officials change the definition or realize that the test is not reliable.

What I learned from studying SARS, the previous big coronavirus scare, after the 2003 epidemic, was that nobody had proved a coronavirus existed, let alone was pathogenic. There was evidence against transmission, and afterwards, negative assessments of the extreme treatments that patients were subjected to, the nucleoside analog antiviral drug 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: <https://theinfectiousmyth.com/book/SARS.pdf>

Executive Summary

The world is suffering from a massive delusion based on the belief that a test for RNA is a test for a deadly new virus, a virus that has emerged from wild bats in China, supported by the western assumption that Chinese people will eat anything that moves.

If the virus exists, then it should be possible to purify viral particles. From these particles RNA can be extracted and should match the RNA used in this test. Until this is done it is possible that the RNA comes from another source, which could be the cells of the patient, bacteria, fungi etc. There might be an association with elevated levels of RNA and illness, but that is not proof that the RNA is from a virus.

Without purification and characterization of virus particles, it cannot be accepted that an RNA test is proof that a virus is present.

Officially the virus is called SARS-CoV-2 and the disease it is believed to caused, COVID-19. We will just refer to coronavirus for the current virus panic, and SARS for the 2003 panic.

Definitions of important diseases are surprisingly loose, perhaps embarrassingly so. A couple of symptoms, maybe contact with a previous patient, and a test of unknown accuracy, is all you often need. While the definition of SARS, an earlier coronavirus panic, was self-limiting, the definition of the new coronavirus disease is open-ended, allowing the imaginary epidemic to grow. Putting aside the existence of the virus, if the coronavirus test has a problem with false positives (as all biological tests do) then testing an uninfected population will produce positive tests, and the definition of the disease will allow the epidemic to go on forever.

This strange new disease, officially named COVID-19, has none of its own symptoms. Fever and cough, previously blamed on uncountable viruses and bacteria, as well as environmental contaminants, are most common, as well as abnormal lung images, despite those being found in healthy people. Yet, despite the fact that only a minority of people tested will test positive (often less than 5%), it is assumed that this disease is easily recognized. If that was the truly the case, the majority of people routed for testing by doctors should be positive.

The coronavirus test is based on PCR, a manufacturing technique. When used as a test it does not produce a positive/negative result, but simply the number of cycles required to

detect genetic material. The division between positive and negative is an arbitrary number of cycles chosen by the testers. If positive means infected and negative means uninfected, then there are cases of people going from infected to uninfected and back to infected again in a couple of days.

A lot of people say it is better to be safe than sorry. Better that some people are quarantined who are actually uninfected than risk a pandemic. But once people test positive, they are likely to be treated, with treatments similar to SARS. Doctors faced with what they believe is a deadly virus treat for the future, for anticipated symptoms, not for what they see today. This leads to the use of invasive oxygenation, high dose **corticosteroids** and antiviral drugs. In this case, some populations of those diagnosed (e.g. in China) are older and sicker than the general population and much less able to withstand aggressive treatment. After the SARS panic had subsided doctors reviewed the evidence, and it showed that these treatments were often ineffective, and all had serious side effects, such as persistent neurologic deficit, joint replacements, scarring, pain and **liver disease**.

Virus Existence

Scientists are detecting novel RNA in multiple patients with **influenza** or **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, first stated by the great German bacteriologist Robert Koch in the late 1800s, 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 purified as the quantity of material that is cellular is much greater. The paper notes that the photos are from "human airway epithelial cells". 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 in 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 38C even though normal body temperature is considered to be 37C (98.6F).
- "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. This is also strange because people suffering from an infection normally have elevated white blood cell counts (although they may drop in people dying from an infection).

One of the following three:

- "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.
- "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.

- "contact with other patients with similar symptoms".

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

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

The big problem is that, in contrast to the definition for SARS, a "confirmed case" did not originally require the criteria for a suspect case to be met. A "confirmed case" simply required a positive RNA test, without any symptoms or possibility of contact with previous cases, illustrating total faith in the PCR technology used in the test. The World Health Organization definition [15] has the same flaw.

It was the fact that the SARS definition required both a reasonable possibility of contact with a previous case, and symptoms, that allowed the epidemic to burn out. Once everyone was quarantined, new cases were highly unlikely, testing stopped, and doctors could declare victory.

The Chinese eventually woke up and, around February 16th required confirmed cases to meet the requirements for a suspected case, as well as a positive test. They may have put this new definition into practice earlier because after a massive addition of almost 16,000 confirmed cases on February 12th, the number fell dramatically each day and, by February 18th was under 500 cases, and continued to stay low.

But other countries did not learn. Korea, Japan and Italy (and perhaps other countries) have started doing tests on people with no epidemiological link, encouraging people with the vague symptoms that are part of the definition to come to hospital to get checked, and obviously following up with asymptomatic people with a connection to anybody who tests positive. Consequently, in mid to late February, cases in those countries started to skyrocket.

A New Disease?

COVID-19, to use its formal name, is described as a distinct new disease. But it clearly is not. There are no distinctive symptoms, for a start. Reference [2] showed that, among 41 early cases, the only symptoms found in more than half, were fever (98%) and cough (76%). 98% had CT Scan imaging showing problems in both lungs (although it is possible to have shadowing on a CT scan without symptoms). The high percentage of cases with fever and shadowing in both lungs is an artefact of the disease definition, fever and "radiographic evidence of pneumonia" are two of the diagnostic criteria for a probable case.

The low rate of people testing positive on the coronavirus testing is further evidence that there are no obvious symptoms. If there were recognizable symptoms, doctors should have a better than 4% chance of guessing who has the virus. While some of the people may have been tested, without symptoms, because they were on a flight or cruise, countries outside China are encouraging people with the vague symptoms that exist to check in to a

hospital, so increasingly people have symptoms of the flu or pneumonia, and are still testing negative in high numbers.

For example, as of March 9th, Korea had found 7,382 positive cases out of 179,160 people tested (4.1%) [20]. In Washington State, where they appear to be reluctant to test anyone, only 1 out of 27 tested by February 24th had tested positive (3.7%)

Perhaps if they had tested all 438 who were then under quarantine, the epidemic would have exploded from 1 to about 16 cases (3.7% of 438). By March 9th, 1,246 tests had been performed with 136 found positive (11%). Obviously, in neither location can doctors recognize cases clinically.

Testing

Assuming, for a moment, 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).

False Negatives – Big Problem

According to an article in the South China Morning Post [23], Li Yan, head of the diagnostic center at the People's Hospital of Wuhan University, noted on Chinese state

TV that because of the multi-step process, an error at any stage could result in an incorrect outcome, and Wang Chen, president of the Chinese Academy of Medical Sciences, also on CCTV, said the accuracy is only 30 to 50 percent.

Wang Chen really means, however, that the test is only ever falsely negative, and never falsely positive. In a paper documenting a cluster of illness and positives tests in a family [3], this bias is clear, as most patients had more negative tests than positive tests, but were considered positive anyway. Patient 1 had 3/11 positive (27%), patient 2 had 5/11 (45%), patient 3 had all 18 negative, patient 4 had 4/14 (29%), patient 5 had 4/17 (24%) and patient 7 was the only with a majority positive (64%).

The only way to decide logically and scientifically is to have a gold standard for presence of the virus, which can only be purification and characterization. Since this has never been accomplished, doctors get to make decisions on the fly, always leaning towards treating patients as infected.

False Positives – Best Evidence

The major attempt to define the false positive rate was in a paper describing a new test methodology, but it has a built-in conflict of interest [19]. Clearly, if the false positive rate was high, the authors' aim to "develop and deploy robust diagnostic methodology for use in public health laboratory settings", would have failed. They did, however, do more than most. They took 297 samples of nasal and throat secretions from biobanks and tested them, only finding "weak initial reactivity" in four samples which, upon retesting, disappeared. The problem with this kind of analysis is that biobank samples may not have been obtained in the same way as samples from live people in an epidemic panic. The sampling was also not blinded, something that is necessary to eliminate the possibility of unconscious bias (a real problem in medicine). Furthermore, many samples in people believed to be infected are negative, and multiple samples are tested, as described for the family cluster paper.

In sum, testing 297 samples could, at best, show that the false positive rate was 1/300, but because multiple samples are often taken, with any one positive sample over-ruling all the negatives the false positive rate could be considerably less, as the biobank samples were only tested once.

And, even if this test did have a false positive rate that was very low, it is not clear that this particular test is in use, and the false positive rate cannot be extrapolated to any other test design.

Even a small false positive rate is critically important. A 99% accurate test would produce 100,000 false positives in a city of 10 million, like Wuhan. And if the number of positives in sampling is around 4% (which it appears to be from early statistics), then 1 out of 4 positives would be false.

Positive, Negative, Positive Again – Confusion

Some people have fully recovered from illness blamed on coronavirus, started to test negative, and then tested positive again. According to a news report [22] patients are not considered cured in China until they no longer have symptoms, have clear lungs, and

have two negative coronavirus tests. Despite this, 14% of discharged patients later tested positive, but with no relapse of symptoms. This is very difficult to explain if the test is for a virus, much easier to explain if the RNA that the test is looking for is not viral in origin.

Other reports:

- (Jan 31) A woman returning to Canada from China tested negative while “mildly ill” after arriving in Canada, but later tested positive.
- (Feb 11) A sick woman in Wuhan tested negative on her first test, after days of illness, but positive on the second.
- (Feb 16) An 83-year old American woman was screened as disease free after leaving a cruise ship but tested positive twice after arrival in Malaysia. Ironically, her husband had pneumonia, but tested negative. Nobody on the ship was sick, nor had travelled to mainland China recently.
- (Mar 1) Newsweek reported an American man tested negative upon return from Wuhan, China, without any symptoms. But later he was “weakly positive” and was returned to quarantine.

References are available upon request. Dates are of the report.

Negative, Negative, Negative

A group of doctors in Marseille, France, working in a very experienced lab, that regularly does testing for respiratory viruses, reported testing 4,084 samples for the novel coronavirus, using several systems approved for use in Europe, without a single positive [25]. This included 337 people returning from China who were tested twice, and 32 people referred because of suspected coronavirus infection.

It is statistically improbable that this lab was just lucky to not get any coronavirus cases, it is more likely that they used more stringent criteria, illustrating that the performance of not just test kits, but labs, with this new test, is completely unknown. Yet, a positive test remains unquestioned in every case.

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