President Eisenhower's Warning of Misplaced Power

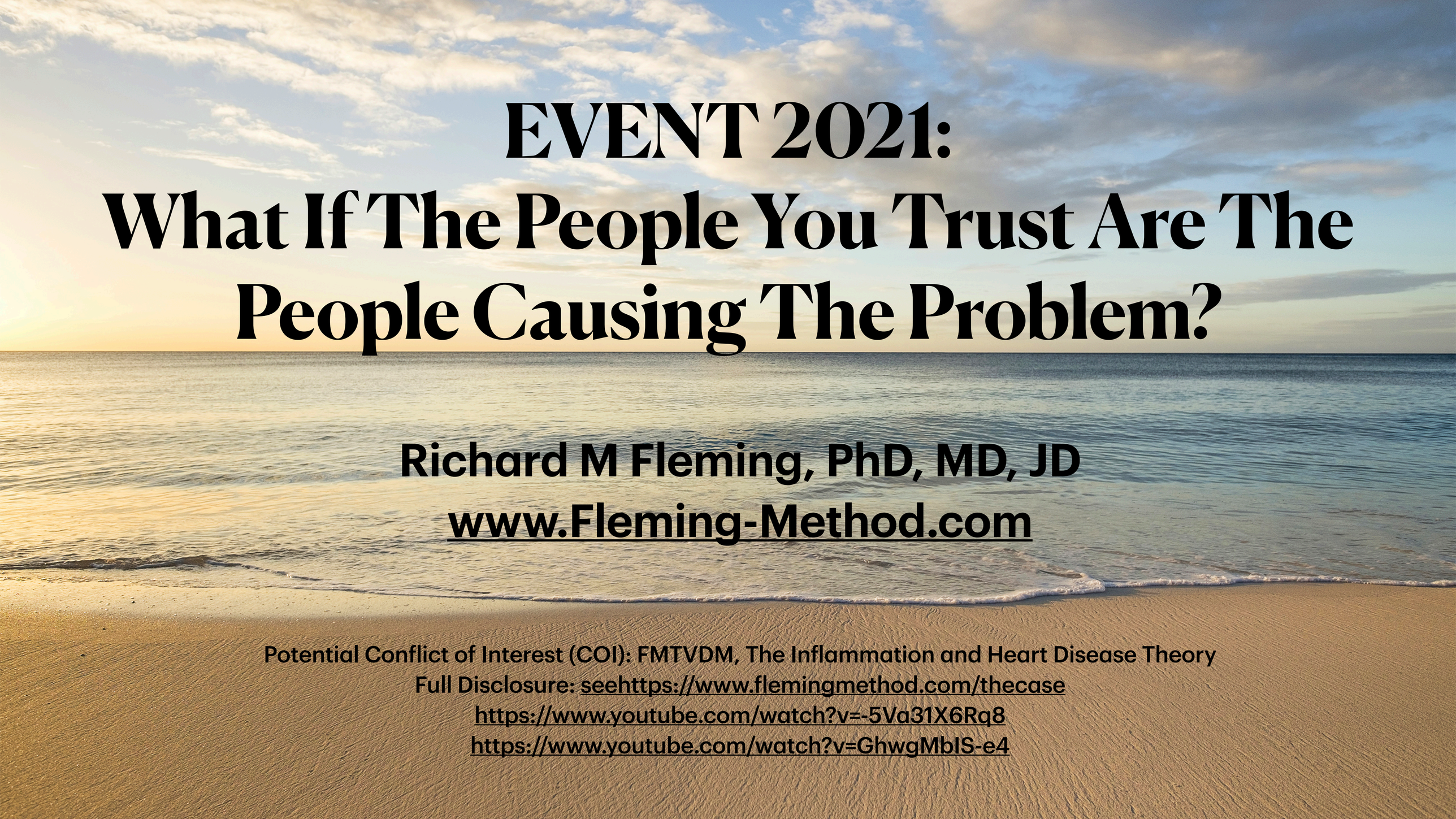


"In the councils of Government we must guard against the acquisition of unwarranted influence ... by the Military / Industrial Complex. The potential for the disastrous rise of misplaced power exists and will persist."

"We must never let the weight of this combination endanger our Liberties or Democratic processes. We should take NOTHING for granted."

"We must be alert to the equal and opposite danger that public policy could, itself, become the captive of a Scientific / Technological Elite."

https://www.youtube.com/watch?v=OyBNmecVtdU



EVENT 2021:
What If The People You Trust Are The People Causing The Problem?

Richard M Fleming, PhD, MD, JD
www.Fleming-Method.com

Potential Conflict of Interest (COI): FMTVDM, The Inflammation and Heart Disease Theory
Full Disclosure: seehttps://www.flemingmethod.com/thecase
https://www.youtube.com/watch?v=-5Va31X6Rq8
https://www.youtube.com/watch?v=GhwgMbIS-e4

The Impact

The Worldwide Pandemic has resulted in

devastating loss of life due to failure to treat,

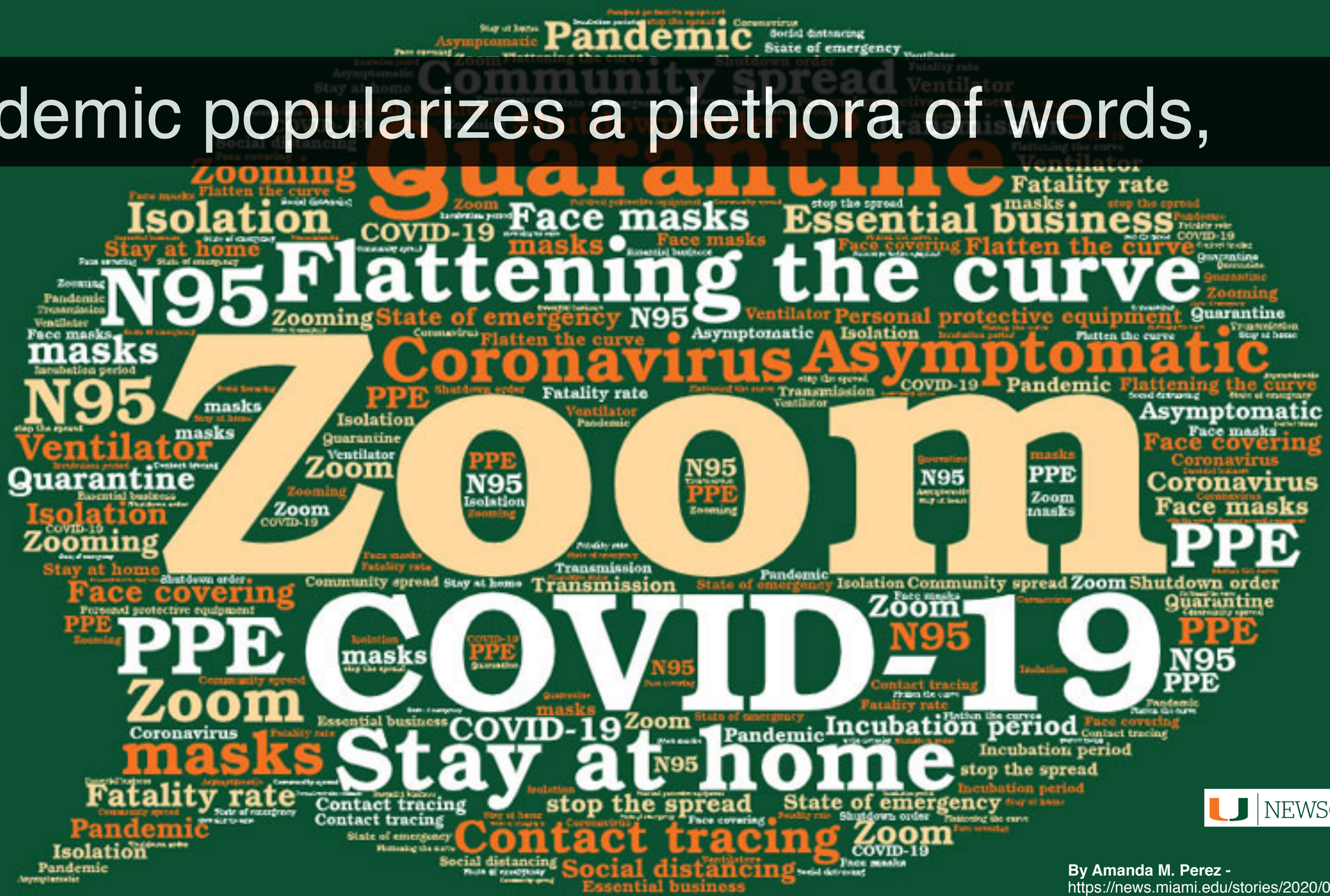
separation of family members from loved ones (hospitalized, nursing homes, family gatherings, etc.)

significant loss of personal liberty with lockdowns, restrictions of personal behaviors, unemployment, economic devastation, fear,

the circumvention of the protective mechanisms designed to protect the American people, and

the initiation of the largest experimental study in the history of mankind.

Pandemic popularizes a plethora of words,



By Amanda M. Perez -
https://news.miami.edu/stories/2020/09/pandemic-popularizes-a-plethora-of-words,-phrases.html

Format For This Presentation.

(1) Please turn your cell phones off or place on airplane mode.

(2) You do not need to take notes.

Please take this opportunity to absorb everything being said.

The slides will be available for free on www.Fleming-Method.com.

(3) Many of Your Questions will be Covered.

(4) Please write down other Questions on the Notecards, to be Answered at the End.

(5) Due to Time Limitations Please Do NOT Ask About Specific Cases.

There simply is not enough time to do this.

Questions You Probably Have That We Are Going to Answer.

(1) What you can do if you get infected with SARS-CoV-2?

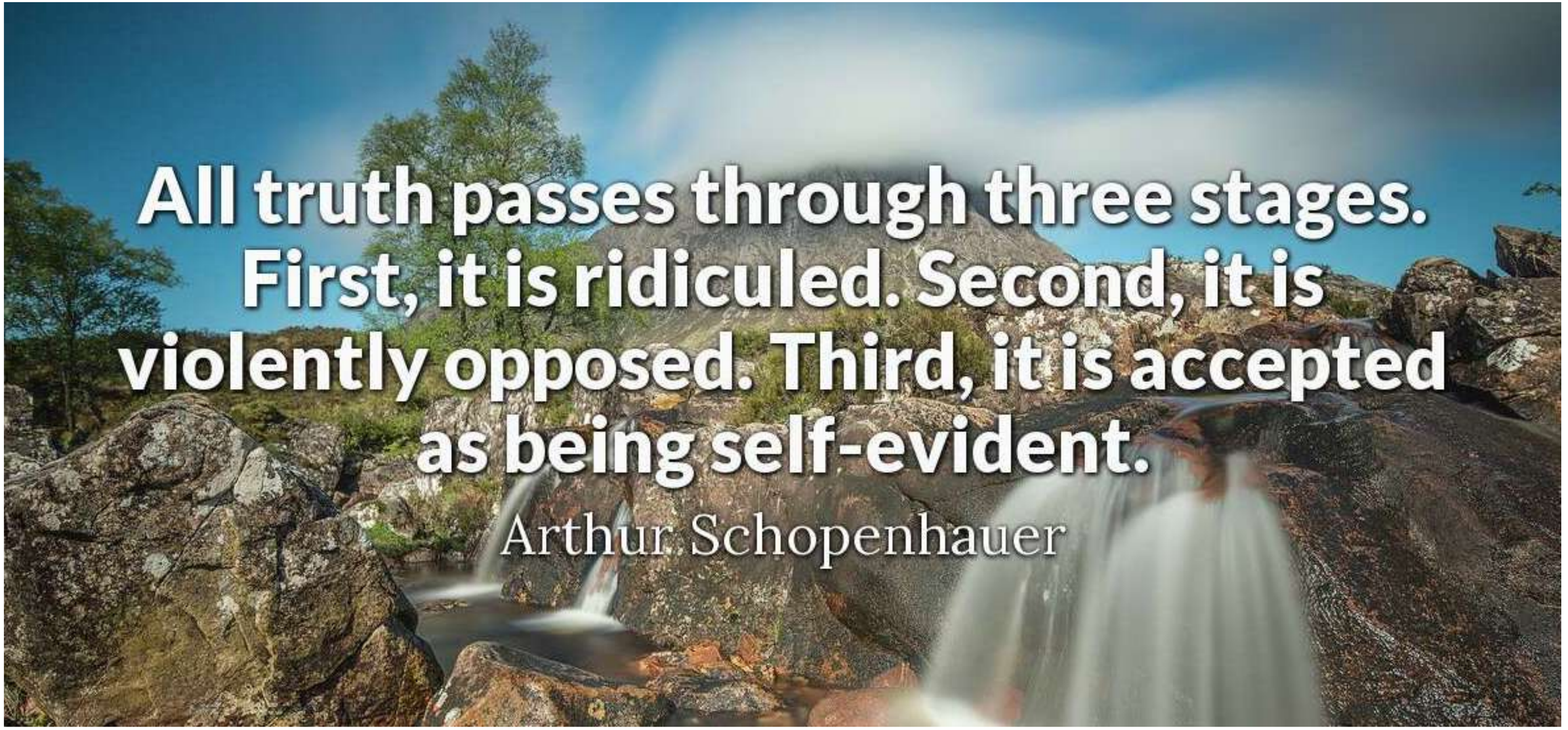
(2) What you can do if you get sick and go to the hospital with COVID?

(3) How can you stop forced vaccination of yourself & your children or people close to you?

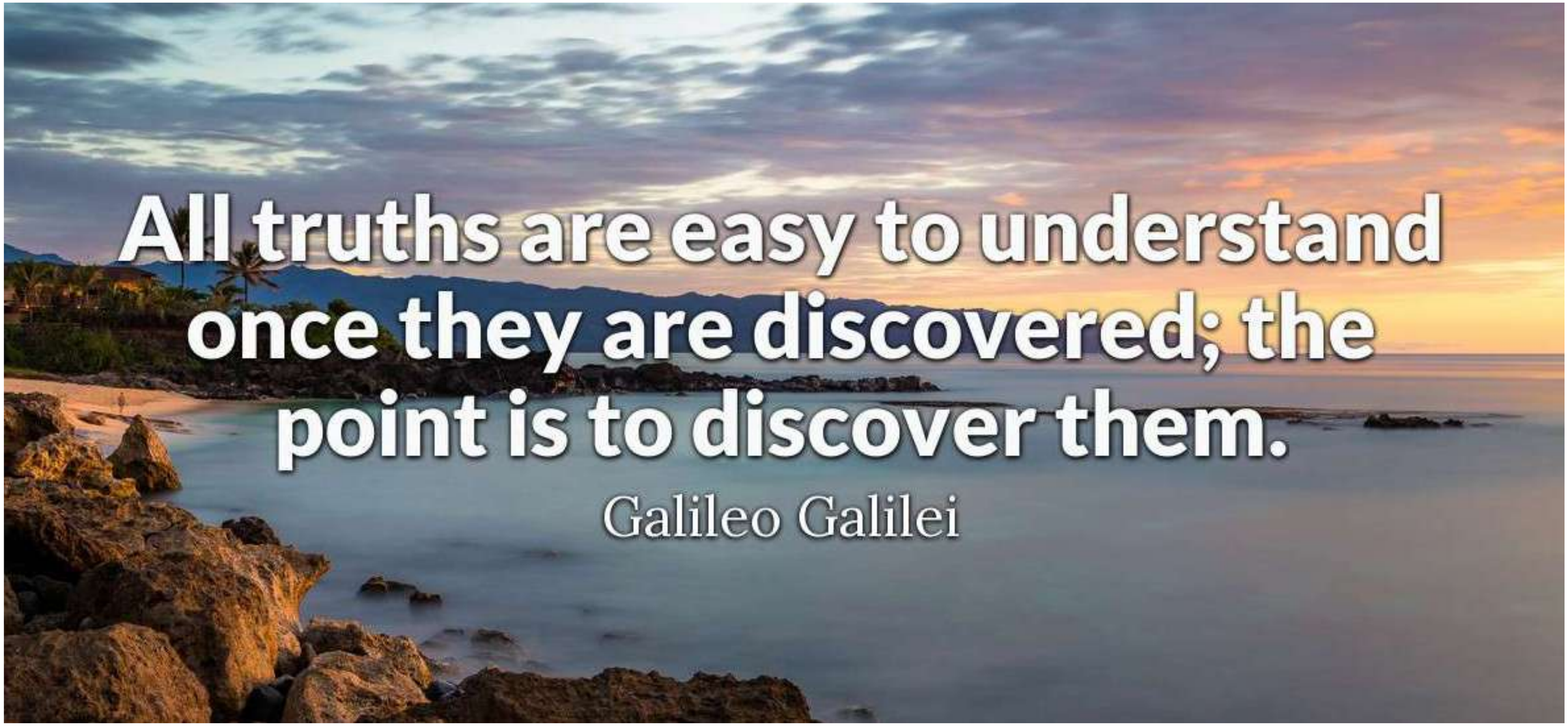
(4) What can you do if you've been exposed to someone who has been vaccinated and now you think you have been exposed?

(5) What can you do if you've been vaccinated?

TRUTH - Ridiculed, Violently Opposed, Self-Evident.



Galileo Galilei



Replacing Fear with Knowledge.

This Presentation is meant to

inform, educate,& empower you.

But it is also a call for action on your part.

The Heuristic Method

Question Everything You Hear.

Don’t take anyon’es word for anything without actual proof;

real evidence.

Don’t let anyone hide the facts & evidence from you.

It is **your duty** & **responsibility** to yourself, your family, and the world to become informed, educated, and to ACT upon what you learn here today.





EVENT 2021

Inform, Educate, Empower & HOPE

Richard M. Fleming, PhD, MD, JD

5 June 2021

Potential Conflicts of Interest (COI): FMTVDM, Inflammation and Cardiovascular Disease Theory

For More Information Please go to: www.FlemingMethod.com

Section 01

01 Inform

The SARS-CoV-2 virus & known facts

The Covid-19 disease & published treatments

02 Educate

Infectious Diseases

Vaccines efficacy and safety

The Scientific Method

The Difference Between VE, COVID-19 & Death

EUA vs Process vs Risks

03 Empower

EUA vs Process vs Risks

Stopping the Gain-of-Function Research

Government Interference with Physician-Patient Treatment & Forced Vaccination

Be Heard

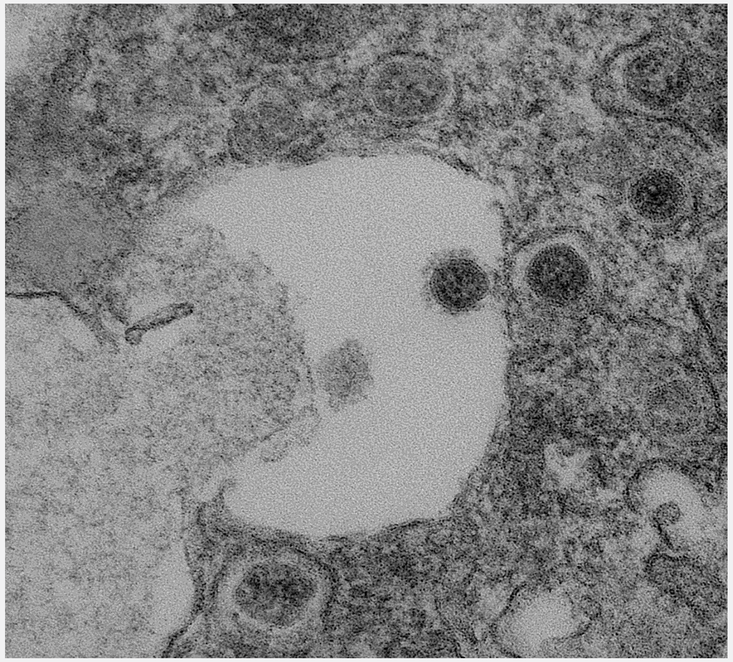
Petition

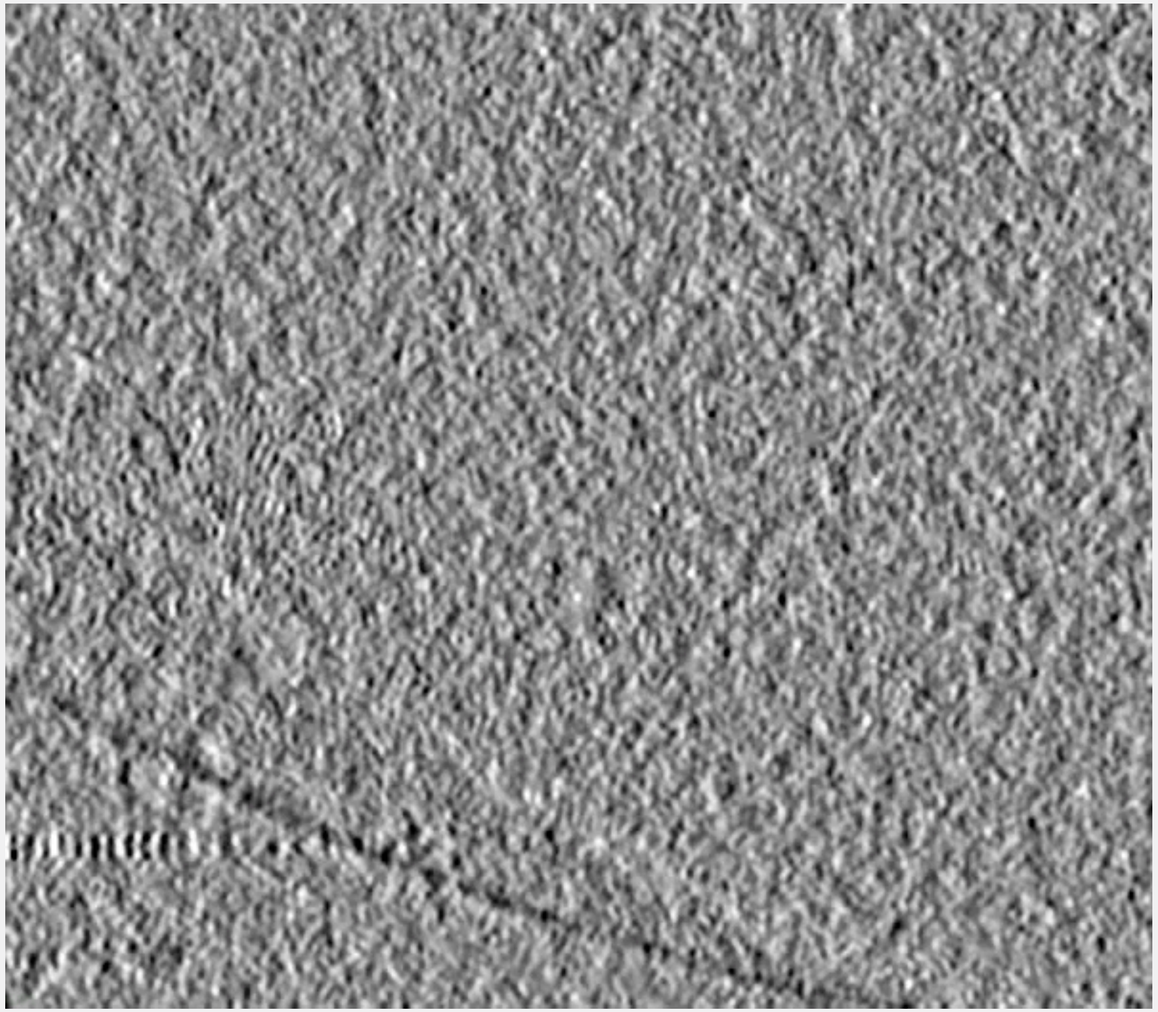
SARS-CoV-2 versus COVID-19

The Virus

Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) with it's Spike Protein.

The 7th Coronaviridae known to infect people.
80-160 nanometers (10^{-9} meters)





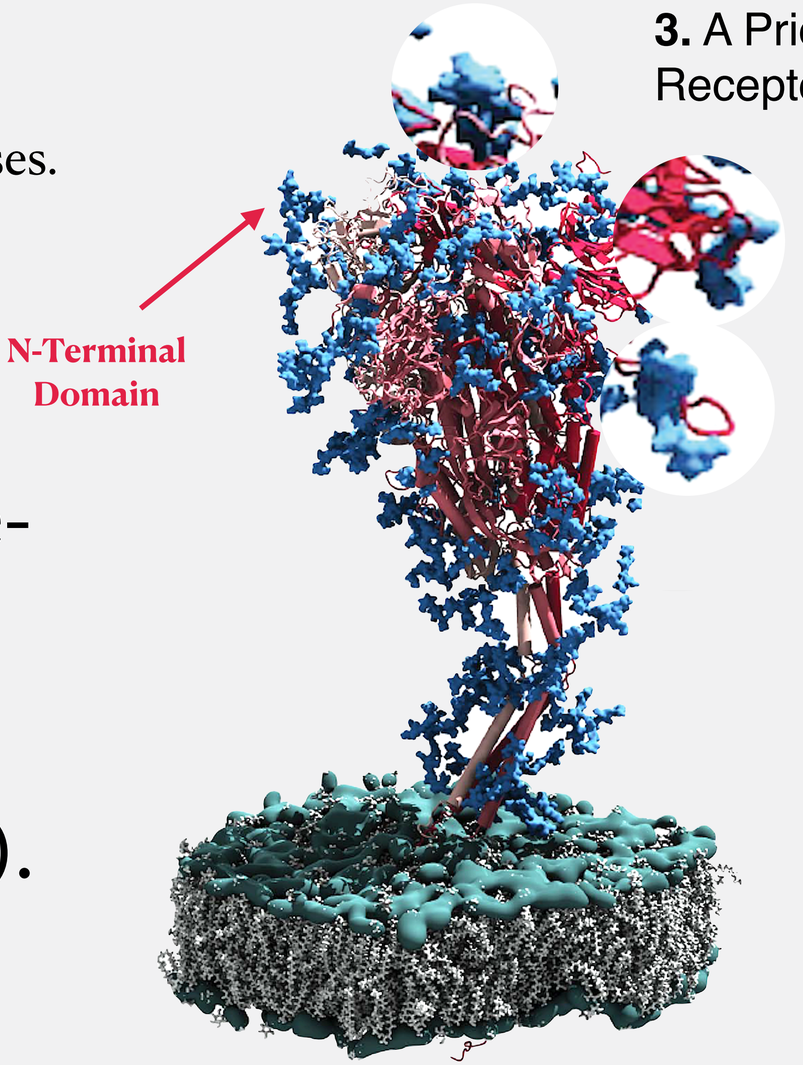
Severe acute respiratory syndrome coronavirus 2 isolate Wuhan-Hu-1, complete genome. https://www.ncbi.nlm.nih.gov/nuccore/1798174254

Where did Sars-CoV-2 Originate?

TO ANSWER THAT QUESTION CAN BE FOUND IN THE GAIN-OF-FUNCTION SPIKE PROTEIN.

Three unique regions not found in other Corona Viruses.

1. An HIV Pseudovirus glycoprotein 120.
2. A Proline-Arginine-Arginine-Alanine Insert.
3. A Prion-like Domain at the Receptor Binding Site (RBS).



3. A Prion-like Domain at the Receptor Binding Site (RBS).

1. An HIV Pseudovirus glycoprotein 120.

2. A Proline-Arginine-Arginine-Alanine Insert.

Why understanding Gain of Function is Important

GOF Reveals that SARS-CoV-2 is Man Made & Paid for by U.S Taxpayers

1999 U.S. Dept. of Health & Human Services (**HHS**) funds research amplifying the infectious character of Coronaviruses.

2000 In May* **Ralph Baric** successfully uses reverse genetics (cDNA**) to rescued infectious clone*** of SARS-CoV **Urbani.**

2002 In April Christopher M Curtis, Boyd Young & Ralph **Baric** file a **patent** for a recombinant (**chimeric**) DNA means of producing “an infectious, replication defective, coronavirus.” Funded by **NIH** Grant GM63228.

Dr. Shi **Zhengli** and colleagues increase infectivity by **combining** an **HIV** pseudovirus with SARS-CoV-1.

2003 Dr. Ralph **Baric** at UNC Chapel Hill receives NIH grant AI23946-08 officially classified as affiliated with **NIAID**.

Baric works on synthetically **altering Coronaviridae.**

2006 Chinese**** researchers combine HCV, HIV-1, SARS-CoV-1 & **SARS-CoV-2**.

* U.S. Provisional Application No. 60/206,537, filed May 21, 2000
** Complimentary DNA is Reverse Transcription (mRNA->DNA) frequently using Moloney murine leukemia virus. ***https://www.pnas.org/content/100/22/12995
**** Huang Q, Cheng Y, Guo Q, Li Q. Preparation of a Chimeric Armored RNA as a Versatile Calibrator for Multiple Virus Assays. Clinchem 2006; 52(7):1446-1448 and Supplement A.

Why understanding Gain of Function is Important

2007 **NSF** Grant IIS-0513650 (Italy, France and Indiana University) study addresses FIRST CRITICAL STEP to control a pandemic - **shut down International Travel**. Given this knowledge why did Fauci tell Trump a Travel Ban was unnecessary?

2011 Scientists express **Concerns** about **GoF** after Labs in **Wisconsin** and the **Netherlands mutate** already **lethal H5N1 Asian Avian Influenza Virus (Bird Flu) increasing infectivity.**

2013 Middle East Respiratory Virus (**MERS**) outbreak with 30-40% fatality in Saudi Arabia (**2014**) and South Korea (**2015**). Rhesus macaques show early treatement with interferon-α2b and ribavirin critical to treatment success.

Baric* and Chinese scientists isolate 3 coronaviruses from bats with **HKU4** spike protein - unable to infect human cells.

2014 **CDC** accidentally **exposes workers** to **Anthrax; ships deadly flu virus. NIH** finds 50-year old forgotten vials of **smallpox.**

Obama Administration halts Gain-of-Function Research

* Yang Y...Baric RS, et al. Receptor usage and cell entry of bat coronavirus HKU4 provide insight into bat-to-human transmission of MERS coronavirus. PNAS 2014;111(34):12516-12521. Funded with NIH grants RO1AI089728 & R21AI109094.

Why understanding Gain of Function is Important

2015 Dr. **Zhengli** et al "**reengineered HKU4 spike** aiming to build its capacity **to infect human cells**." "To this end, we introduced two single mutations…mutations in these motifs in coronavirus spikes have demonstrated **dramatic** effects on viral entry into human cells."

Baric and Zhengli announce they can make a more dangerous, virulent and infectious virus.

2017 ***Gain-of-Function Research Ban Lifted***

2018 **Zhengli** presents research at Shanghai Jiao Tong University on 14 Nov. 2018 entitled "Studies on Bat Coronavirus and its cross-species infection." This presentation has since been **deleted** from the University website.

2019 Summer **deletion** of Wuhan Institute of Virology Corona Virus data bank.

December 31 Wuhan Municipal Health Commission report** discussing COVID-19 pneumonia - **deleted**.

* Zhengli S, Baric RS, et sl. Two Mutations Were Critical for Bat-to-Human Transmission of Middle East Respiratory Syndrome Coronavirus. J Virol.2015;89(17):9199-9123. Funded by NIH grants RO1AI089728, RO1AI110700.

** Wuhan City Health Committee (WCHC). Wuhan Municipal Health and Health Commission's briefing on the current pneumonia epidemic situation in our city 2019 [updated 31 December 2019, 14 January 2020]. Available from: http://wjw.wuhan.gov.cn/front/web/showDetail/2019123108989

Italian Media - Daszik-Baric-Zhengli

In **2015**, Professor **Zhengli** works with Professor **Baric** to construct a hybrid virus.

American & Chinese scientists reengineer SARS virus Spike Protein.



Multiple Federal Agency Grants to Peter Daszak-EcoHealth

Fed. Grants & Contracts

	AGENCY	AWARD ID	YEAR	AMOUNT AWARDED	TOTAL AMOUNT	RECIPIENT	DESCRIPTION
DOD	Defense Threat Reduction Agency (DOD)	HDTRA115C0041	2015	$2,217,037.00	$4,479,678.00	ECOHEALTH ALLIANCE	BASE PERIOD - PSC: AD92 IGF::OT::IGF
			2016	$2,262,641.00			
	Defense Threat Reduction Agency (DOD)	HDTRA11710037	2017	$721,249.00	$1,604,523.00	ECOHEALTH ALLIANCE	SEROLOGICAL BIOSURVEILLANCE FOR SPILLOVER OF HENIPAVIRUSES AND FILOVIRUSES AT AGRICULTURAL AND HUNTING HUMANANIMAL INTERFACES IN PENINSULAR MALAYSIA
			2018	$883,274.00			
	Defense Threat Reduction Agency (DOD)	HDTRA11910033	2019	$998,437.00	$4,988,987.00	ECOHEALTH ALLIANCE	REDUCING THE THREAT OF RIFT VALLEY FEVER THROUGH ECOLOGY, EPIDEMIOLOGY AND SOCIO-ECONOMICS
			2020	$3,990,550.00			
	Defense Threat Reduction Agency (DOD)	HDTRA113C0029 *	2013	$1,371,611.00	$2,225,134.00	ECOHEALTH ALLIANCE	BASE PERIOD
			2014	$957,145.00			
			2015	-$103,622.00			
	DOD	HDTRA11410029 (#1)	2014	$992,699.00	$2,942,019.00	ECOHEALTH ALLIANCE	UNDERSTANDING RIFT VALLEY FEVER IN THE REPUBLIC OF SOUTH AFRICA
			2015	$978,784.00			
			2016	$970,536.00			
	Defense Threat Reduction Agency (DOD)	HDTRA11410029 (#2)	2017	$996,147.00	$1,994,340.00	ECOHEALTH ALLIANCE	UNDERSTANDING RIFT VALLEY FEVER IN THE REPUBLIC OF SOUTH AFRICA, CHANGE OF ACO TO ONR
			2018	$998,193.00			
	Defense Threat Reduction Agency (DOD)	HDTRA12010016	2020	$4,912,818.00	$4,912,818.00	ECOHEALTH ALLIANCE	REDUCING THE THREAT FROM HIGH-RISK PATHOGENS CAUSING FEBRILE ILLNESS IN LIBERIA
	Defence Threat Reduction Agency (DOD)	HDTRA11710064	2017	$782,330.00	$6,491,025.00	ECOHEALTH ALLIANCE	UNDERSTANDING THE RISK OF BAT-BORNE ZOONOTIC DISEASE EMERGENCE IN WESTERN ASIA
			2018	$2,203,917.00			
			2019	$1,995,247.00			
			2020	$1,509,531.00			
	Defense Threat Reduction Agency (DOD)	HDTRA12010018	2020	$4,995,106.00	$4,995,106.00	ECOHEALTH ALLIANCE	CRIMEAN-CONGO HEMORRHAGIC FEVER: REDUCING AN EMERGING HEALTH THREAT IN TANZANIA.
	Uniformed Services University of the Health Sciences (DOD)	HU00012010031	2020	$1,360,002.00	$1,360,002.00	ECOHEALTH ALLIANCE	STRATEGIC COORDINATION TO STRENGTHEN AFRICOM ONE HEALTH AND VETERINARY PROGRAMS FOR GLOBAL HEALTH ENGAGEMENT STRENGTHENING MULTI-SECTORAL APPROACHES TO BIODEFENSE AND BIOSURVEILLANCE IN THE CAUCASUS
	Defense Threat Reduction Agency (DOD)	HDTRA12010029	2020	$2,956,309.00	$2,956,309.00	ECOHEALTH ALLIANCE	REDUCING THE THREAT OF MIDDLE EAST RESPIRATORY SYNDROME CORONAVIRUS AND AVIAN INFLUENZA IN JORDAN&STRENGTHENING REGIONAL DISEASE SURVEILLANCE CAPACITY
HHS	National Institutes of Health (HHS)	R01TW005869	2008	$697,356.00	$3,725,160.00	ECOHEALTH ALLIANCE	THE ECOLOGY, EMERGENCE AND PANDEMIC POTENTIAL OF NIPAH VIRUS IN BANGLADESH
			2009	$1,001,985.00			
			2010	$763,008.00			
			2011	$761,374.00			
			2012	$501,437.00			
	National Institutes of Health (HHS)	K08AI067549	2007	$130,950.00	$442,844.00	ECOHEALTH ALLIANCE	RISK FOR FUTURE OUTBREAKS OF HENIPAVIRUSES IN SOUTH ASIA
			2009	$180,944.00			
			2010	$130,950.00			
	National Institutes of Health (HHS)	R56TW009502 *	2012	$300,000.00	$300,000.00	ECOHEALTH ALLIANCE	COMPARATIVE SPILLOVER DYNAMICS OF AVIAN INFLUENZA IN ENDEMIC COUNTRIES
	National Institute of Allergy and Infectious Diseases (HHS - NIH)	R01AI110964 *	2014	$666,442.00	$3,748,715.00	ECOHEALTH ALLIANCE	UNDERSTANDING THE RISK OF BAT CORONAVIRUS EMERGENCE
			2015	$630,445.00			
			2016	$611,090.00			
			2017	$597,112.00			
			2018	$581,646.00			
			2019	$661,980.00			
	CDC OFFICE OF ACQUISITION SERVICES (HHS)	HHSD2002011M41641P	2011	$59,740.00	$99,294.00	ECOHEALTH ALLIANCE	BUSHMEAT
			2013	$45,000.00			
			2016	-$5,446.00			
	National Institutes of Health (HHS)	R01AI079231	2008	$534,989.00	$2,579,553.00	ECOHEALTH ALLIANCE	RISK OF VIRAL EMERGENCE FROM BATS
			2009	$535,156.00			
			2010	$480,423.00			
			2011	$510,005.00			
			2012	$518,980.00			
	NIH NATIONAL INSTITUTE OF ALLERGY AND INFECTIOUS DISEASES (HHS)	U01AI151797	2020	$1,546,744.00	$1,546,744.00	ECOHEALTH ALLIANCE	UNDERSTANDING RISK OF ZOONOTIC VIRUS EMERGENCE IN EID HOTSPOTS OF SOUTHEAST ASIA
	Department of Health and Human Services (HHS)	U01AI153420	2020	$580,858.00	$580,858.00	ECOHEALTH ALLIANCE	STUDY OF NIPAH VIRUS DYNAMICS AND GENETICS IN ITS BAT RESERVOIR AND OF HUMAN EXPOSURE TO NIV ACROSS BANGLADESH TO UNDERSTAND PATTERNS OF HUMAN OUTBREAKS

Federal Grants Spanning Decades

NSF	National Science Foundation (NSF)	1618919	2016	$190,223.00	$499,897.00	ECOHEALTH ALLIANCE	ECOHEALTH NET 2.0: A ONE HEALTH APPROACH TO DISEASE ECOLOGY RESEARCH & EDUCATION
			2017	$309,674.00			
	NSF	1714394	2017	$138,000.00	$97,750.00	N/A REDACTED DUE TO PII	DEVELOPING A QUANTITATIVE MODEL OF ECOHEALTH JUSTICE: A CASE STUDY OF MADISON AND MILWAUKEE, WI
			2020	-$40,250.00			
	Division of Environmental Biology (NSF)	1015791	2010	$29,109.00	$72,002.00	ECOHEALTH ALLIANCE	COLLABORATIVE RESEARCH: THE COMMUNITY ECOLOGY OF VIRAL PATHOGENS - CAUSES AND CONSEQUENCES OF COINFECTION IN HOSTS AND VECTORS
			2012	$13,948.00			
			2013	$14,293.00			
			2014	$14,652.00			
	NSF	1257513	2012	$22,890.00	$22,890.00	ECOHEALTH ALLIANCE	US-CHINA ECOLOGY AND EVOLUTION OF INFECTIOUS DISEASES COLLABORATIVE WORKSHOP; KUNMING, CHINA - OCTOBER, 2012
	DIVISION OF ENVIRONMENTAL BIOLOGY (NSF)	955897	2010	$99,611.00	$497,121.00	ECOHEALTH ALLIANCE	ECOHEALTHNET: ECOLOGY ENVIRONMENTAL SCIENCE AND HEALTH RESEARCH NETWORK
			2011	$98,673.00			
			2012	$99,919.00			
			2013	$98,992.00			
			2014	$99,926.00			
	NSF	0622391	2006	$503,291.00	$932,085.00	ECOHEALTH ALLIANCE	PREDICTING SPATIAL VARIATION IN WEST NILE VIRUS TRANSMISSION
			2008	$428,794.00			
	NSF	0826779	2008	$468,673.00	$468,673.00	ECOHEALTH ALLIANCE	HSD: COLLABORATIVE RESEARCH: HUMAN-RELATED FACTORS AFFECTING EMERGING INFECTIOUS DISEASES
USAID	USAID	AID486A1300005	2013	$1,999,203.00	$2,499,147.00	ECOHEALTH ALLIANCE	LAND USE CHANGE & DISEASE EMERGENCE
			2016	$499,944.00			
DHS	SCI TECH ACQ DIV (DHS)	70RSAT19CB0000013	2019	$566,274.00	$566,274.00	ECOHEALTH ALLIANCE	RAPID EVALUATION OF PATHOGENS TO PREVENT EPIDEMICS IN LIVESTOCK (REPEL) PROJECT TO APPLY BIOLOGICAL-BASED, PATHOGEN AGNOSTIC MEDICAL COUNTERMEASURE VACCINE AND DIAGNOSTIC PLATFORMS TO DEVELOP FOREIGN ANIMAL AND EMERGING ZOONOTIC LIVESTOCK DISEASE VAC
	OFF OF HEALTH AFFAIRS ACQ DIV (DHS)	HSHQDC16C00113	2016	$271,272.00	$1,005,956.00	ECOHEALTH ALLIANCE	IGF::OT::IGF GROUND TRUTH
			2017	$327,782.00			
			2018	$406,902.00			
	SCI TECH ACQ DIV (DHS)	70RSAT18CB0031001	2017	$413,761.00	$700,583.00	ECOHEALTH ALLIANCE	IGF::CL,CT::IGF RESEARCH AND DEVELOPMENT SERVICES FOR THE DEPARTMENT OF HOMELAND SECURITY, SCIENCE AND TECHNOLOGY DIRECTORATE, CHEMICAL AND BIOLOGICAL DEFENSE DIVISION FOR PURPOSES OF DEVELOPING A WEB-BASED APPLICATION AND EARLY WARNING SYSTEM FOR GLOBAL INFECTIOUS DISEASE BIO-EVENTS THAT THREATEN THE US VIA INTERNATIONAL TRANSPORTATION NETWORKS.
			2018	$246,770.00			
			2019	$40,052.00			
DOC	EASTERN ACQUISITION DIVISION KANSAS CITY Department of Commerce (DOC)	DOCWC133F06CN0251	2006	$256,120.00	$1,241,933.00	ECOHEALTH ALLIANCE	AERIAL SURVEYS OF RIGHT WHALES
			2007	$263,228.00			
			2008	$276,685.00			
			2009	$220,700.00			
			2010	$225,200.00			
USDA	Department of Agriculture (USDA)	08-7100-0206-CA	2008	$143,000.00	$143,000.00	ECOHEALTH ALLIANCE	CONDUCT AN AVIAN INFLUENZE SURVEILLANCE PROGRAM TO DETECT THE OCCURRENCE OF HIGHLY PATHOGENIC H5N1 AVIAN INFLUENZA IN MEXICO.
		09-7100-0206-CA	2009	$100,001.00	$100,001.00	ECOHEALTH ALLIANCE	CONDUCT AN AVIAN INFLUENZE SURVEILLANCE PROGRAM TO DETECT THE OCCURRENCE OF HIGHLY PATHOGENIC H5N1 AVIAN INFLUENZA IN MEXICO.
	Animal and Plant Inspection Service (USDA)	0771000237CA	2007	$403,700.00	$403,700.00	ECOHEALTH ALLIANCE	FINANCIAL ASSISTANCE TO PROVIDE THREE WORKSHOPS IN CENTRAL AND SOUTH AMERICA IN SUPPORT OF THE NATIONAL AVIAN INFLUENZA STRATEGIC PLAN.
DOI	Department of the Interior (DOI)	F12AP01208	2012	$154,087.00	$154,087.00	ECOHEALTH ALLIANCE	ECO HEALTH ALLIANCE - GEOMYCES DESTUCTANS, IMPLICATIONS FOR THE MIGRATION OF WHITE-NOSE SYNDROME BAT
	US Fish & Wildlife Services (DOI)	F12AP01117	2012	$44,499.00	$44,499.00	ECOHEALTH ALLIANCE	DEVELOPMENT OF A GREAT APE HEALTH UNIT IN SABAH, MALAYSIA
	US Fish & Wildlife Services (DOI)	F14AP00269	2014	$29,988.00	$29,988.00	ECOHEALTH ALLIANCE	ECOSYSTEM APPROACH FOR BIODIVERSITY MONITORING AND CONSERVATION
	OFFICE OF ACQUISITION AND GRANTS - RESTON (DOI)	ING04ERSA0526	2004	$16,000.00	$61,000.00	ECOHEALTH ALLIANCE	04-2070-0909 MANATEE RESEAR
			2005	$15,000.00			
			2006	$10,000.00			
			2007	$10,000.00			
			2008	$10,000.00			
	Department of the Interior (DOI)	G05AC00002	2011	-$22,512.00	-$22,512.00	ECOHEALTH ALLIANCE	SEABIRD ECOLOGICAL ASSESSMENT NETWORK-SEANET

Totalling More than $61 Million

SUMMARY

FEDERAL GRANTS & CONTRACTS

AGENCY		TOTAL	
DoD***	Department of Defense	$38,949,941.00	2013-2020
HHS **	Health & Human Services	$13,023,168.00	2007-2020
NSF	National Science Foundation	$2,590,418.00	2006-2020
USAID	U.S. Agency for International Development	$2,499,147.00	2013-2016
DHS	Department of Homeland Security	$2,272,813.00	2016-2019
DoC	Department of Commerce	$1,241,933.00	2006-2010
USDA	U.S. Department of Agriculture	$646,701.00	2007-2009
DoI	Department of the Interior	$267,062.00	2004-2014
GRAND TOTAL			**$61,491,183.00**

** Includes NIH and CDC.

*** Also provided "Policy Advisor" David Franz. Former Commander for Fort Detrick - Principal U.S. Government Bioware/Biodefense Facility.

2001 - Baric Files Patent to Manipulate Genomes

US006593111B2

(12) **United States Patent**
Baric et al.

(10) **Patent No.: US 6,593,111 B2**
(45) **Date of Patent: Jul. 15, 2003**

(54) **DIRECTIONAL ASSEMBLY OF LARGE VIRAL GENOMES AND CHROMOSOMES**

(75) Inventors: **Ralph S. Baric**, Haw River, NC (US); **Boyd Yount**, Hillsborough, NC (US)

(73) Assignee: **University of North Carolina at Chapel Hill**, Chapel Hill, NC (US)

(*) Notice: Subject to any disclaimer, the term of this patent is extended or adjusted under 35 U.S.C. 154(b) by 0 days.

(21) Appl. No.: **09/862,847**

(22) Filed: **May 21, 2001**

(65) **Prior Publication Data**

US 2002/0177230 A1 Nov. 28, 2002

Related U.S. Application Data

(60) Provisional application No. 60/206,537, filed on May 21, 2000, and provisional application No. 60/285,320, filed on Apr. 20, 2001.

(51) **Int. Cl.**[7] **C12P 21/06**; C12N 7/00
(52) **U.S. Cl.** **435/69.1**; 435/235.1; 536/23.72
(58) **Field of Search** 435/69.1, 235.1; 536/23.72

(56) **References Cited**

U.S. PATENT DOCUMENTS

5,202,430 A 4/1993 Brian et al. 536/23.72
5,916,570 A 6/1999 Kapil 424/222.1

Lai, Michael M.C. "The making of infectious viral RNA: No size limit in sight," *PNAS.* vol. 97, No. 10, May 9, 2000, pp. 5025–5027.

Almazan et al., "Engineering the largest RNA virus genome as an infectious bacterial artificial chromosome," *Proceedings of the National Academy of Sciences of USA* 97: 5516–5521 (2000).

Thiel et al., "Infectious RNA transcribed in vitro from a cDNA copy of the human coronavirus genome cloned in vaccinia virus," 82: 1273–1281 (2001).

Yount et al., "Strategy for systematic assembly of large RNA and DNA enomes: Transmissible gastroenteritis virus model," 74: 10600–10611 (2000).

International Search Report of PCT/US01/16564 dated Dec. 7, 2002.

Primary Examiner—Hankyel T. Park
(74) *Attorney, Agent, or Firm*—Myers Bigel Sibley & Sajovec, P.A.

(57) **ABSTRACT**

Full-length, functionally intact genomes or chromosomes are directionally assembled with partial cDNA or DNA subclones of a genome. This approach facilitates the reconstruction of genomes and chromosomes in vitro for reintroduction into a living host, and allows the selected mutagenesis and genetic manipulation of sequences in vitro prior to reassembly into a full length genome molecule for reintroduction into the same or different host. This approach also provides an alternative to recombination-mediated techniques to manipulate the genomes of higher plants and animals as well as bacteria and viruses.

Inform

2014 - Ralph Baric Receives International Patent to Alter Spike Protein of Corona Viruses

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(74) Agent: MILLER, Mary L.; Myers Bigel Sibley & Sajovec, P. A., P.O. Box 37428, Raleigh, NC 27627 (US).

(81) Designated States *(unless otherwise indicated, for every kind of national protection available)*: AE, AG, AL, AM, AO, AT, AU, AZ, BA, BB, BG, BH, BN, BR, BW, BY, BZ, CA, CH, CL, CN, CO, CR, CU, CZ, DE, DK, DM, DO, DZ, EC, EE, EG, ES, FI, GB, GD, GE, GH, GM, GT, HN, HR, HU, ID, IL, IN, IR, IS, JP, KE, KG, KN, KP, KR, KZ, LA, LC, LK, LR, LS, LU, LY, MA, MD, ME, MG, MK, MN, MW, MX, MY, MZ, NA, NG, NI, NO, NZ, OM, PA, PE, PG, PH, PL, PT, QA, RO, RS, RU, RW, SA, SC, SD, SE, SG, SK, SL, SM, ST, SV, SY, TH, TJ, TM, TN, TR, TT, TZ, UA, UG, US, UZ, VC, VN, ZA, ZM, ZW.

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Published:
— *with international search report (Art. 21(3))*

(54) Title: METHODS AND COMPOSITIONS FOR CHIMERIC CORONAVIRUS SPIKE PROTEINS

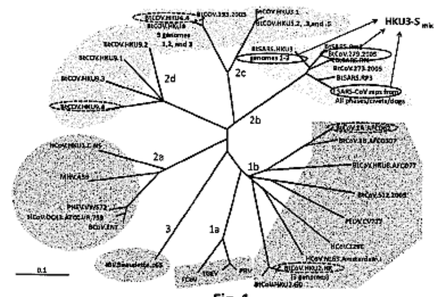


Fig. 1

(57) Abstract: The present invention provides compositions and methods comprising a chimeric coronavirus spike protein.

WO 2015/143335 A1

Making Chimeric (Gain-of-Function) Corona Virus Spike Proteins.

Funded by the NIH - Your Tax Dollars

WO 2015/143335 PCT/US2015/021773

METHODS AND COMPOSITIONS FOR CHIMERIC CORONAVIRUS SPIKE PROTEINS

STATEMENT OF PRIORITY

This application claims the benefit, under 35 U.S.C. § 1 19(e), of U.S. Provisional Application Serial No. 61/968,279, filed March 20, 2014, the disclosure of which is incorporated by reference herein in its entirety.

STATEMENT OF FEDERAL SUPPORT

This invention was made with government support under Grant No. U54AI057157 awarded by the National Institutes of Health. The government has certain rights in the invention.

Evidence of HIV gp120 Inserts

In addition to Zhengli the Statistical Analysis of the Spike Protein

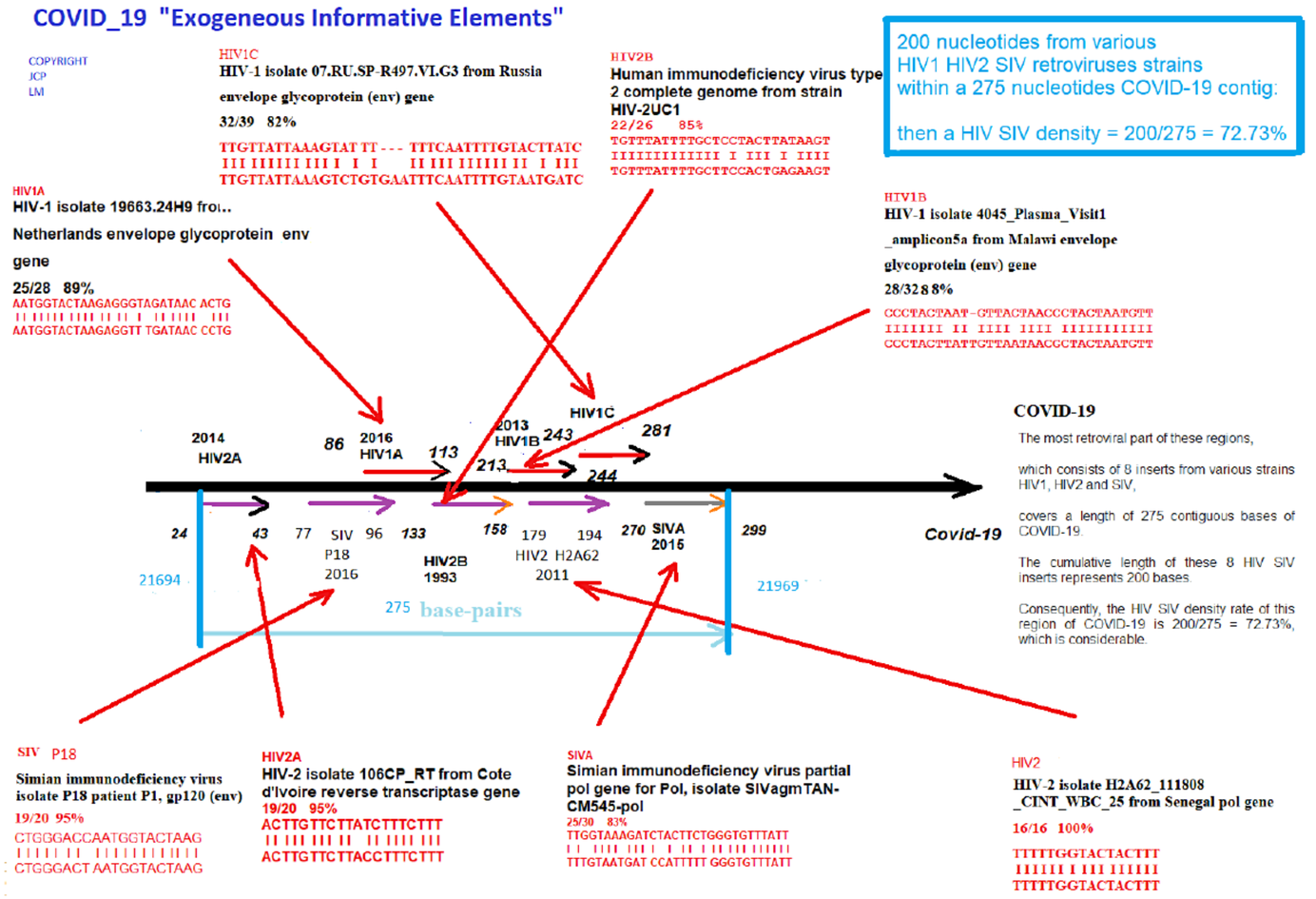
This is the French Virologist who received the **Nobel** in Physiology/Medicine for his discovery of **HIV**. He also a Research at the Paris Pasteur Institute and appointed as **University Chair** Professor in 2012 at the **Shanghai Jiao University**. This information has since been **removed** from the University website.

18 RNA fragments matching HIV & SIV (External Informative Elements; EIE).

The SPIKE PROTEIN not only has the **PRRA** insert (4 amino acids; 12 nucleotide bases) but a 590 amino acid (1770 nucleotide bases) insert matching **HIV-1**.

So, to summarize: a contiguous region representing 2.49% of the whole COVID-19 genome is 40.99% made up of 12 diverse « EIE » originating from various strains of HIV SIV retroviruses.

Figure 1 – This summary chart demonstrating visually how 200b from various HIV SIV retroviruses strains within a



concentrated 275b COVID-19 contig have a density rate equal to 72.73%.

Perez JC, Montagnier L. COVID-19, SARS AND BATS CORONAVIRUSES GENOMES PECULIAR HOMOLOGOUS RNA SEQUENCES. Intern J Research 2020;8(7):217-263.

Perez JC, Montagnier L. COVID-19, SARS and Bats Coronaviruses Genomes Unexpected Exogenous RNA Sequences. https://www.researchgate.net/publication/341756383.

The PRRA SPIKE Protein Insert Doesn't Exist in Any Other Corona Virus

What Do We Know About the SPIKE PROTEIN?

S2 is The Unstable Part of the Spike Protein - Where all the Variants are Occuring.

S1 on the other hand is where the PRRA (Furin Cleavage Site) Insert Is.

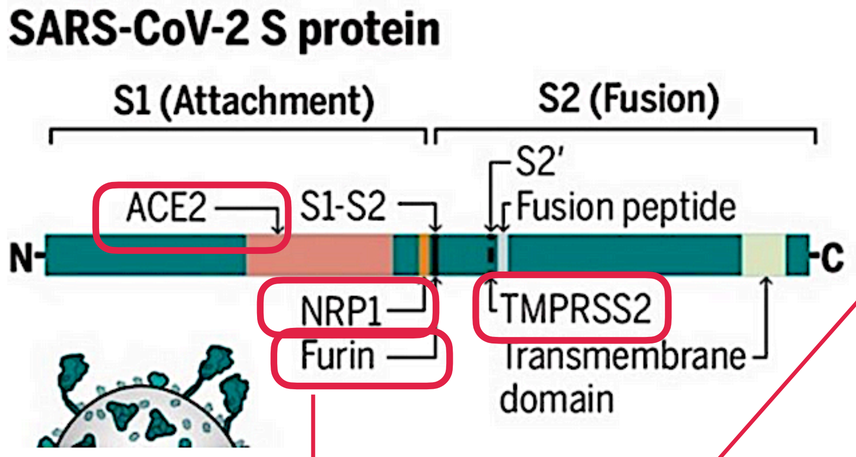


Figure 7. Two consecutive Arg residues in the -PRRA- insertion at the S1/S2 junction of SARS-CoV-2 Spike are both coded by a rare codon, CGG. *A FauI restriction site, 5'-(N)$_6$GCGGG-3', is embedded in the coding sequence of the "inserted" PRRA segment, which may be used as a marker to monitor the preservation of the introduced furin-cleavage site.*

Human SARS-CoV BJ01	655	-	GICASYHTVSLL----RSTS	-	670
Human SARS-CoV CUHK-W1	655	-	GICASYHTVSLL----RSTS	-	670
Human SARS-CoV Tor2	655	-	GICASYHTVSLL----RSTS	-	670
Human SARS-CoV Frankfurt-1	655	-	GICASYHTVSLL----RSTS	-	670
Human SARS-CoV Urbani	655	-	GICASYHTVSLL----RSTS	-	670
Civet SARS-CoV civet020	655	-	GICASYHTVSSL----RSTS	-	670
Civet SARS-CoV sz16	655	-	GICASYHTVSSL----RSTS	-	670
Racoon dog SARS-CoV A030	655	-	GICASYHTVSSL----RSTS	-	670
SARS-CoV-2	669	-	GICASYQTQTNSPRRARSVA	-	688
Pangolin CoV MP789	n/a	-	GICASYQTQTNS----RSVS	-	n/a
Bat SARSr-CoV RaTG13	669	-	GICASYQTQTNS----RSVA	-	684
Bat SARSr-CoV LYRa11	659	-	GICASYHTASLL----RNTD	-	674
Bat SARSr-CoV LYRa3	659	-	GICASYHTASLL----RNTG	-	674
Bat SARSr-CoV RsSHC014	656	-	GICASYHTVSSL----RSTS	-	671
Bat SARSr-CoV Rs4084	656	-	GICASYHTVSSL----RSTS	-	671
Bat SARSr-CoV WIV1	656	-	GICASYHTVSSL----RSTS	-	671
Bat SARSr-CoV Rs3367	656	-	GICASYHTVSSL----RSTS	-	671
Bat SARSr-CoV Rs7327	656	-	GICASYHTVSSL----RSTS	-	671
Bat SARSr-CoV Rs9401	656	-	GICASYHTVSSL----RSTS	-	671
Bat SARSr-CoV Rs4231	655	-	GICASYHTVSSL----RSTS	-	670
Bat SARSr-CoV WIV16	655	-	GICASYHTVSSL----RSTS	-	670
Bat SARSr-CoV Rs4874	655	-	GICASYHTVSSL----RSTS	-	670
Bat SARSr-CoV ZC45	646	-	GICASYHTASIL----RSTS	-	661
Bat SARSr-CoV ZXC21	645	-	GICASYHTASIL----RSTG	-	660
Bat SARSr-CoV Rf4092	634	-	GICASYHTASTL----RGVG	-	649
Bat SARSr-CoV Rf/JL2012	636	-	GICASYHTASLL----RSTG	-	651
Bat SARSr-CoV JTMC15	636	-	GICASYHTASLL----RSTG	-	651
Bat SARSr-CoV 16BO133	636	-	GICASYHTASLL----RSTG	-	651
Bat SARSr-CoV B15-21	636	-	GICASYHTASLL----RSTG	-	651
Bat SARSr-CoV YN2013	633	-	GICASYHTASTL----RSIG	-	648
Bat SARSr-CoV Anlong-103	633	-	GICASYHTASTL----RSVG	-	648
Bat SARSr-CoV Rp/Shaanxi2011	640	-	GICASYHTASVL----RSTG	-	655
Bat SARSr-CoV Rs/HuB2013	641	-	GICASYHTASVL----RSTG	-	656
Bat SARSr-CoV YNLF/34C	641	-	GICASYHTASVL----RSTG	-	656
Bat SARSr-CoV YNLF/31C	641	-	GICASYHTASVL----RSTG	-	656
Bat SARSr-CoV Rf1	641	-	GICASYHTASHL----RSTG	-	656
Bat SARSr-CoV 273	641	-	GICASYHTASHL----RSTG	-	656
Bat SARSr-CoV Rf/SX2013	639	-	GICASYHTASLL----RSTG	-	654
Bat SARSr-CoV Rf/HeB2013	641	-	GICASYHTASLL----RSTG	-	656
Bat SARSr-CoV Cp/Yunnan2011	641	-	GICASYHTASLL----RNTG	-	656
Bat SARSr-CoV Rs672	641	-	GICASYHTASTL----RSVG	-	656
Bat SARSr-CoV Rs4255	641	-	GICASYHTASTL----RSVG	-	656
Bat SARSr-CoV 4081	641	-	GICASYHTASTL----RSVG	-	656
Bat SARSr-CoV Rm1	641	-	GICASYHTASVL----RSTG	-	656
Bat SARSr-CoV 279	641	-	GICASYHTASVL----RSTG	-	656
Bat SARSr-CoV Rs/GX2013	642	-	GICASYHTASVL----RSTG	-	657
Bat SARSr-CoV Rs806	641	-	GICASYHTASLL----RSTG	-	656
Bat SARSr-CoV HKU3-1	642	-	GICASYHTASVL----RSTG	-	657
Bat SARSr-CoV Longquan-140	642	-	GICASYHTASVL----RSTG	-	657
Bat SARSr-CoV Rp3	641	-	GICASYHTASTL----RSVG	-	656
Bat SARSr-CoV Rs4247	642	-	GICASYHTASTL----RSVG	-	657
Bat SARSr-CoV Rs4237	641	-	GICASYHTASTL----RSVG	-	656
Bat SARSr-CoV As6526	641	-	GICASYHTASTL----RSVG	-	656

*** Yan LM, Kang S, Guan J, Hu S. Unusual Features of the SARS-CoV-2 Genome Suggesting Sophisticated Laboratory Modification Rather Than Natural Evolution and Delineation of Its Probable Synthetic Route. [1]Rule of Law Society & Rule of Law Foundation, New York, NY, USA. 2021

The PRRA (Furin Cleavage Site) Insert is ESSENTIAL for SARS-CoV-2 to Infect People.

Molecular Cell

CellPress

Short Article

A Multibasic Cleavage Site in the Spike Protein of SARS-CoV-2 Is Essential for Infection of Human Lung Cells

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[1]Deutsches Primatenzentrum – Leibniz Institut für Primatenforschung, Göttingen, Germany
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https://doi.org/10.1016/j.molcel.2020.04.022

SUMMARY

The pandemic coronavirus SARS-CoV-2 threatens public health worldwide. The viral spike protein mediates SARS-CoV-2 entry into host cells and harbors a S1/S2 cleavage site containing multiple arginine residues (multibasic) not found in closely related animal coronaviruses. However, the role of this multibasic cleavage site in SARS-CoV-2 infection is unknown. Here, we report that the cellular protease furin cleaves the spike protein at the S1/S2 site and that cleavage is essential for S-protein-mediated cell-cell fusion and entry into human lung cells. Moreover, optimizing the S1/S2 site increased cell-cell, but not virus-cell, fusion, suggesting that the corresponding viral variants might exhibit increased cell-cell spread and potentially altered virulence. Our results suggest that acquisition of a S1/S2 multibasic cleavage site was essential for SARS-CoV-2 infection of humans and identify furin as a potential target for therapeutic intervention.

INTRODUCTION

It is believed that the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2, previously termed nCoV-2019) was introduced into the human population from a poorly characterized animal reservoir in late 2019 (Ge et al., 2013; Wang et al., 2020; Zhou et al., 2020b; Zhu et al., 2020). The epicenter of the subsequent SARS-CoV-2 spread was Wuhan, Hubei province, China, with more than 65,000 cases occurring in this area (WHO, 2020a). However, infections have now been detected in more than 110 countries and massive outbreaks are currently ongoing in the United States, Italy, and Spain (WHO, 2020a, 2020b). Understanding which features of SARS-CoV-2 are essential for infection of human cells should provide insights into viral transmissibility and pathogenesis and might reveal targets for intervention.

The spike protein of coronaviruses is incorporated into the viral envelope and facilitates viral entry into target cells. For this, the surface unit S1 binds to a cellular receptor while the transmembrane unit S2 facilitates fusion of the viral membrane with a cellular membrane (Hoffmann et al., 2018; Hulswit et al., 2016; Millet and Whittaker, 2018). Membrane fusion depends on S protein cleavage by host cell proteases at the S1/S2 and the S2′ site (Figure 1A), which results in S protein activation (Hoffmann et al., 2018; Hulswit et al., 2016; Millet and Whittaker, 2018). Cleavage of the S protein can occur in the constitutive secretory pathway of infected cells or during viral entry into target cells and is essential for viral infectivity. Therefore, the responsible enzymes constitute potential targets for antiviral intervention.

Our previous work revealed that the activity of the cellular serine protease TMPRSS2, which activates several coronaviruses (Bertram et al., 2013; Gierer et al., 2013; Glowacka et al., 2011; Matsuyama et al., 2010; Shirato et al., 2013, 2016; Shulla et al., 2011), is also required for robust SARS-CoV-2 infection of human lung cells (Hoffmann et al., 2020). However, it is conceivable that the activity of other cellular proteases is also necessary. Thus, the Middle East respiratory syndrome coronavirus spike protein (MERS-S) is activated by a two-step process: MERS-S is first cleaved by furin at the S1/S2 site in infected cells, which is required for subsequent TMPRSS2-mediated cleavage at the S2′ site (Figure 1A) during viral entry into lung cells (Kleine-Weber et al., 2018; Park et al., 2016; Millet and Whittaker, 2014). A cathepsin B/L-dependent auxiliary activation pathway is operative in many TMPRSS2$^{-/-}$ cell lines but seems not to be available in viral target cells in the lung because TMPRSS2-dependent activation of the S protein is essential for robust MERS-CoV and SARS-CoV spread and pathogenesis in the infected host (Iwata-Yoshikawa et al., 2019; Simmons et al., 2005; Zhou et al., 2015).

The S1/S2 site in SARS-CoV-2 forms an exposed loop (Figure 1B) that harbors multiple arginine residues (multibasic) (Walls et al., 2020; Wrapp et al., 2020) that are not found in SARS-CoV-related coronaviruses (SARSr-CoV) but are present in the human coronaviruses OC43, HKU1, and MERS-CoV

2007 U.S. Government Has Patent Rights to Insertion of Furin Protease Cleavage Sites

US007223390B2

(12) **United States Patent**
Brown

(10) **Patent No.: US 7,223,390 B2**
(45) **Date of Patent: May 29, 2007**

(54) **INSERTION OF FURIN PROTEASE CLEAVAGE SITES IN MEMBRANE PROTEINS AND USES THEREOF**

(75) Inventor: **Dennis T. Brown**, Raleigh, NC (US)

(73) Assignee: **Research Development Foundation**, Carson City, NV (US)

(*) Notice: Subject to any disclaimer, the term of this patent is extended or adjusted under 35 U.S.C. 154(b) by 0 days.

(21) Appl. No.: **10/841,787**

(22) Filed: **May 7, 2004**

(65) **Prior Publication Data**

US 2004/0224391 A1 Nov. 11, 2004

Related U.S. Application Data

(60) Provisional application No. 60/469,126, filed on May 9, 2003.

(51) **Int. Cl.**
A01N 63/00 (2006.01)

(52) **U.S. Cl.** **424/93.2**; 435/6; 435/463; 435/219; 424/93.6

(58) **Field of Classification Search** 424/185.1, 424/204.1, 218.1; 536/23.1
See application file for complete search history.

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Zhang et al., "Mutations that promote furin-independent growth of semliki forest virus affect p62-E1 interactions and membrane fusion," *Virology*, 327:287-296, 2004.
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Bolt et al., "Cleavage of the respiratory syncytial virus fusion protein is required for its surface expression: role of furin," *Virus Res.*, 68:25-33, 2000.

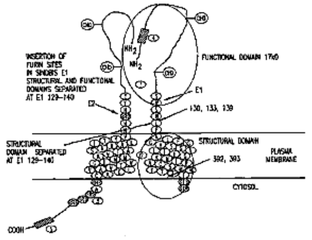
(Continued)

Primary Examiner—Brenda Brumback
Assistant Examiner—Sharon Hurt
(74) *Attorney, Agent, or Firm*—Fulbright & Jaworski LLP

(57) **ABSTRACT**

Cleavage site for the protease furin is inserted between domains of a membrane glycoprotein. Upon cleavage by furin in the trans-Golgi network, the protein is separated into individual membrane-free domain that retains its native conformation. This protocol can be used to produce virus membrane protein domains for structural analysis and for trials as vaccines.

13 Claims, 3 Drawing Sheets



Here is the U.S. Patent for Inserting Furin (PRRA) Protease Cleavage Sites. Certain Rights may be Owned by U.S. Government - NIH Grant.

1

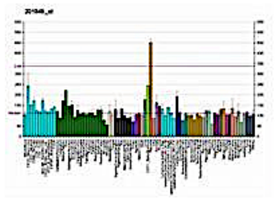
INSERTION OF FURIN PROTEASE CLEAVAGE SITES IN MEMBRANE PROTEINS AND USES THEREOF

CROSS-REFERENCE TO RELATED APPLICATION

This non-provisional patent application claims benefit of provisional patent application U.S. Ser. No. 60/469,126, filed May 9, 2003, now abandoned.

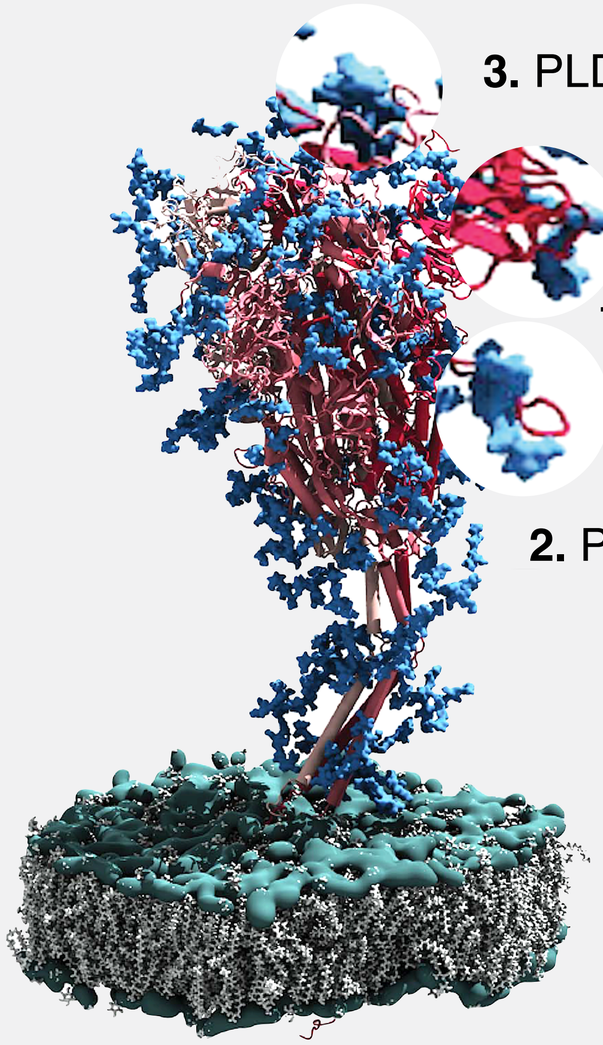
The United States government may own certain rights to this invention pursuant to grant number AI 42775 from the National Institutes of Health.

Furin is one of the proteases responsible for the proteolytic cleavage of HIV envelope polyprotein precursor gp160 to gp120 and gp41 prior to viral assembly. This gene is thought to play a role in tumor progression. The use of alternate polyadenylation sites has been found for this gene.



Furin - Wikipedia
en.wikipedia.org/wiki/Furin

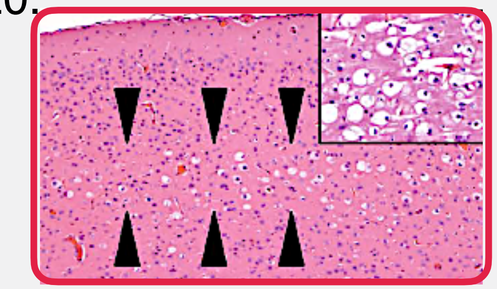
Insertions 1 & 2 Produces Prion-Like Domain



Yielding a Prion-like Domain Killing the humanized mice and Rhesus Macaques infected with it. Producing Spongiform Encephalopathy and Lewy Bodies.

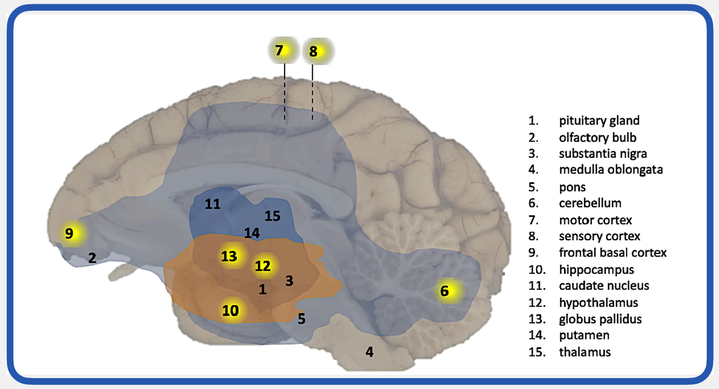
After two-weeks 95% of the humanized mice were dead and the two remaining were euthanized.

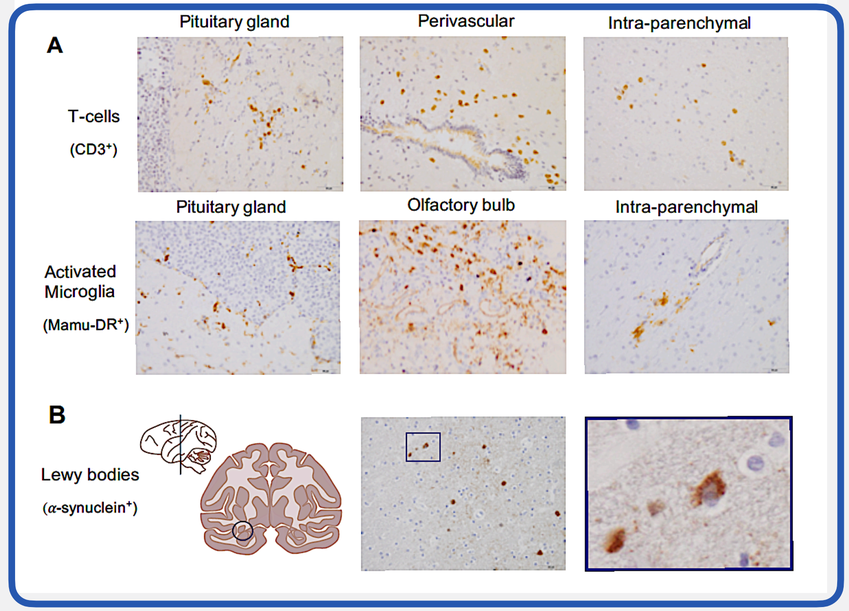
The Rhesus Macaques were euthanized after 5-6 weeks. Here is what was found.



Spongiosis (Mad Cow Disease) with nerve damage and death.

Inflammation & Lewy Bodies.

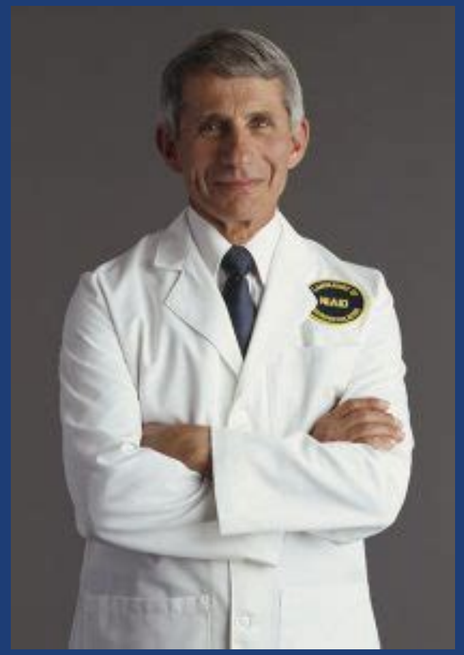


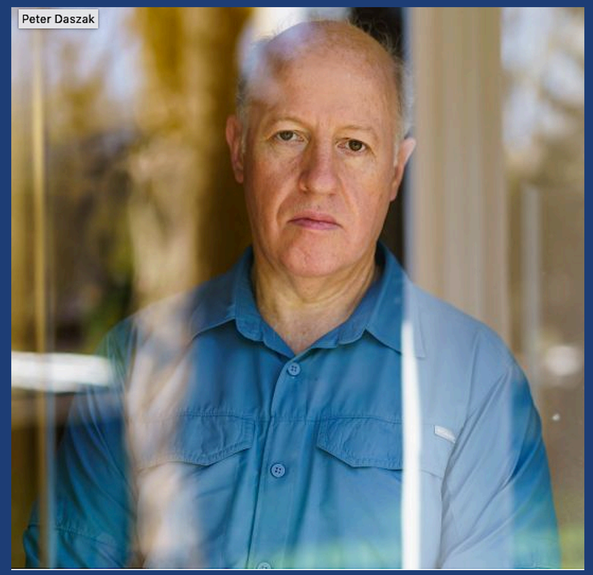


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Philippens I, et al. SARS-CoV-2 causes brain inflammation and induces Lewy body 1 formation in macaques. https://doi.org/10.1101/2021.02.23.432474

All Brought to you by the U.S. Federal Government.

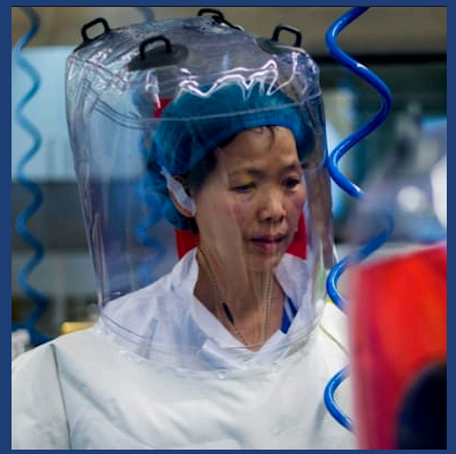
2002 to 2019 Gain-of Function Research Federal Funding to Peter Daszak (EcoHealth) to Ralph Baric (UNC) and Shi Zhengli (Wuhan Virology Institute)















What are the Symptoms of SARS-CoV-2 vs COVID-19?

The Virus

Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2)

What you should look for when you are infected.

Symptoms may appear 2-14 days after exposure to the virus. People with these symptoms may have COVID-19:

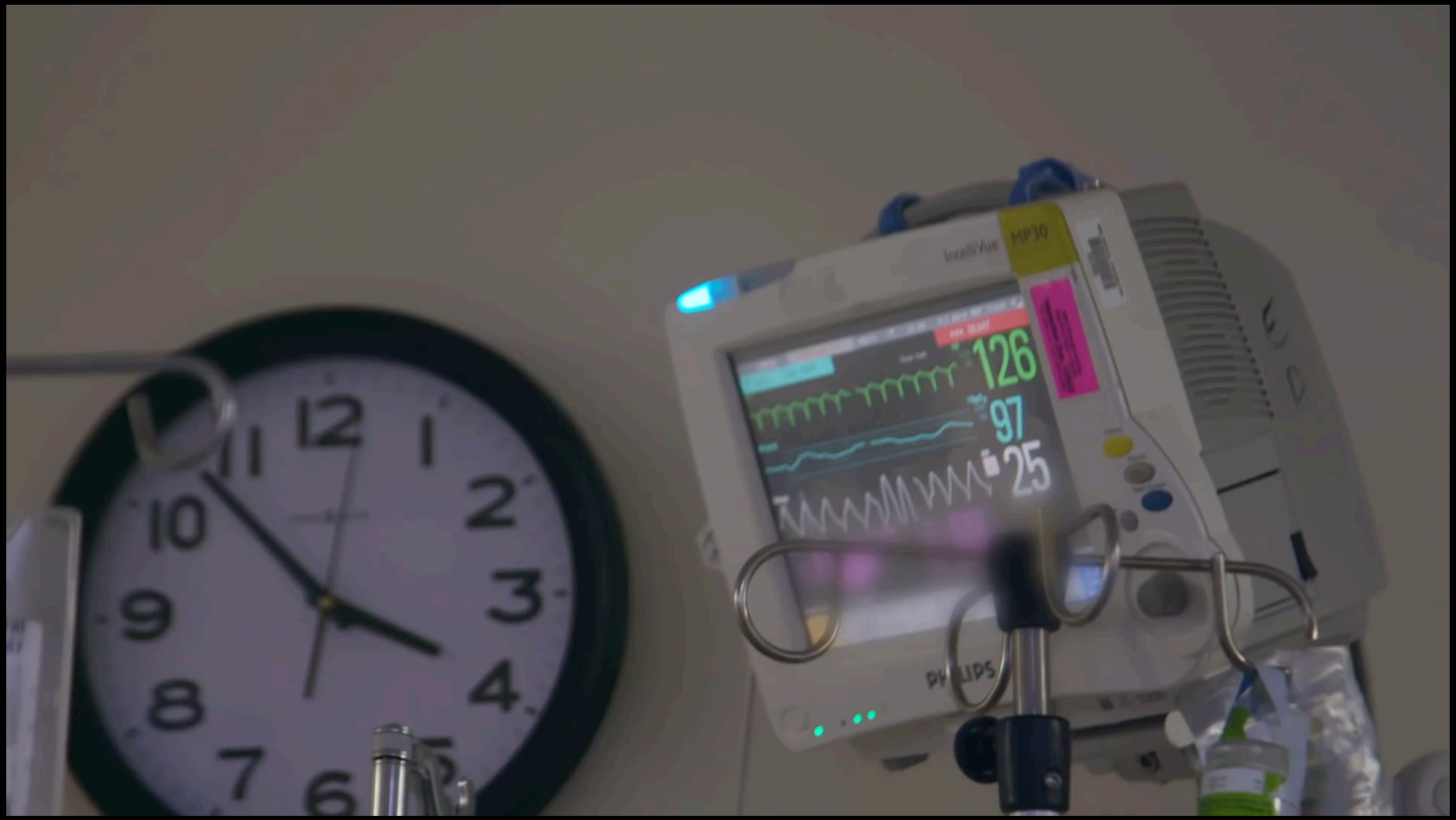
- Fever or chills
- Cough
- Shortness of breath or difficulty breathing
- Fatigue
- Muscle or body aches
- Headache
- New loss of taste or smell
- Sore throat
- Congestion or runny nose
- Nausea or vomiting
- Diarrhea

How do you know when the infection becomes disease - COVID-19.

Look for emergency warning signs for COVID-19. If someone is showing any of these signs, seek emergency medical care immediately:

Trouble breathing
Persistent pain or pressure in the chest
New confusion
Inability to wake or stay awake
Pale, gray, or blue-colored skin, lips, or nail beds, depending on skin tone

This Is COVID



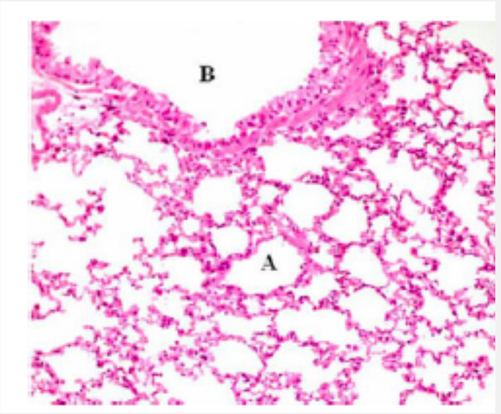
What is the Difference Between SARS-CoV-2 & COVID-19?

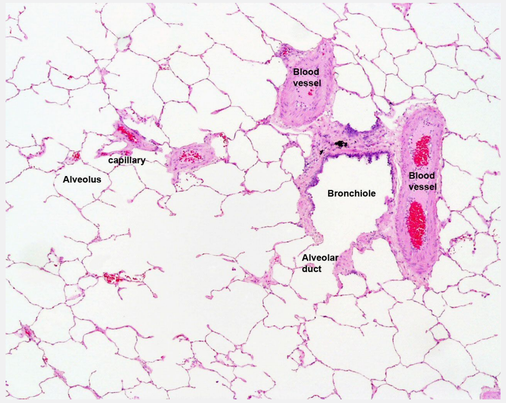
The InflammoThrombotic Response (ITR).

The Disease

Co(rona) Vi(rus) D(isease) - 2019

InflammoThrombotic Disease in people who have other InflammoThrombotic Diseases (The Comorbidites) resulting in more InflammoThrombotic Disease. When not treated people died.





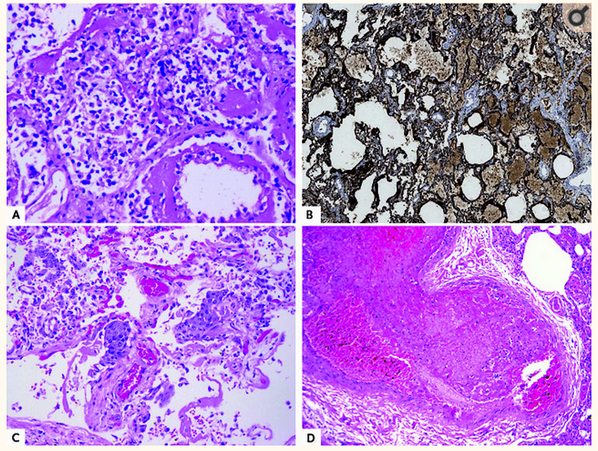


Figure 3.

Histopathologic findings.

A. Diffuse alveolar damage with hyaline membranes (case 4) (hematoxylin–eosin [H&E] stain; original magnification,×50). **B.** Hyaline membranes (case 4) (cytokeratin AE1/AE3 stain, original magnification×50). **C.** Squamous metaplasia in the lung (case 5) (H&E stain; original magnification,×100). **D.** Pulmonary embolism (case 1) (H&E stain; original magnification,×100).

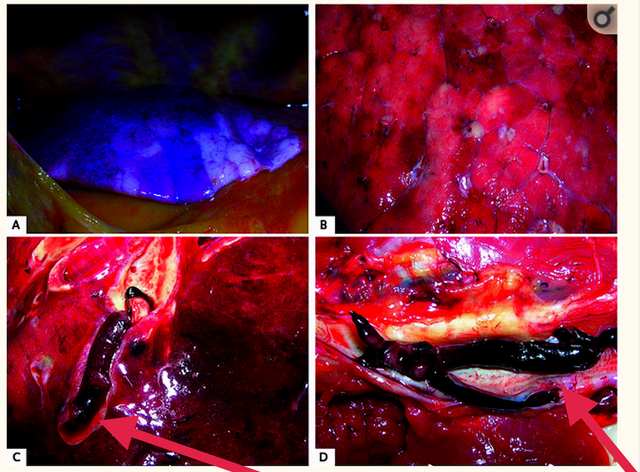
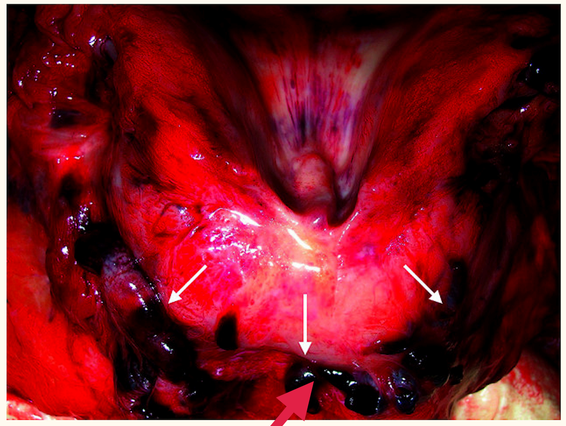


Figure 2.

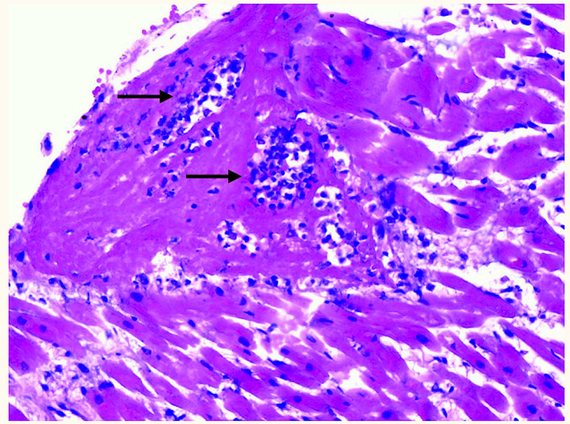
Macroscopic autopsy findings.

A. Patchy aspect of the lung surface (case 1). **B.** Cutting surface of the lung in case 4. **C.** Pulmonary embolism (case 3). **D.** Deep venous thrombosis (case 5).



Appendix Figure 1.

Thrombosis of the prostatic vein (case 1) (*arrows*).



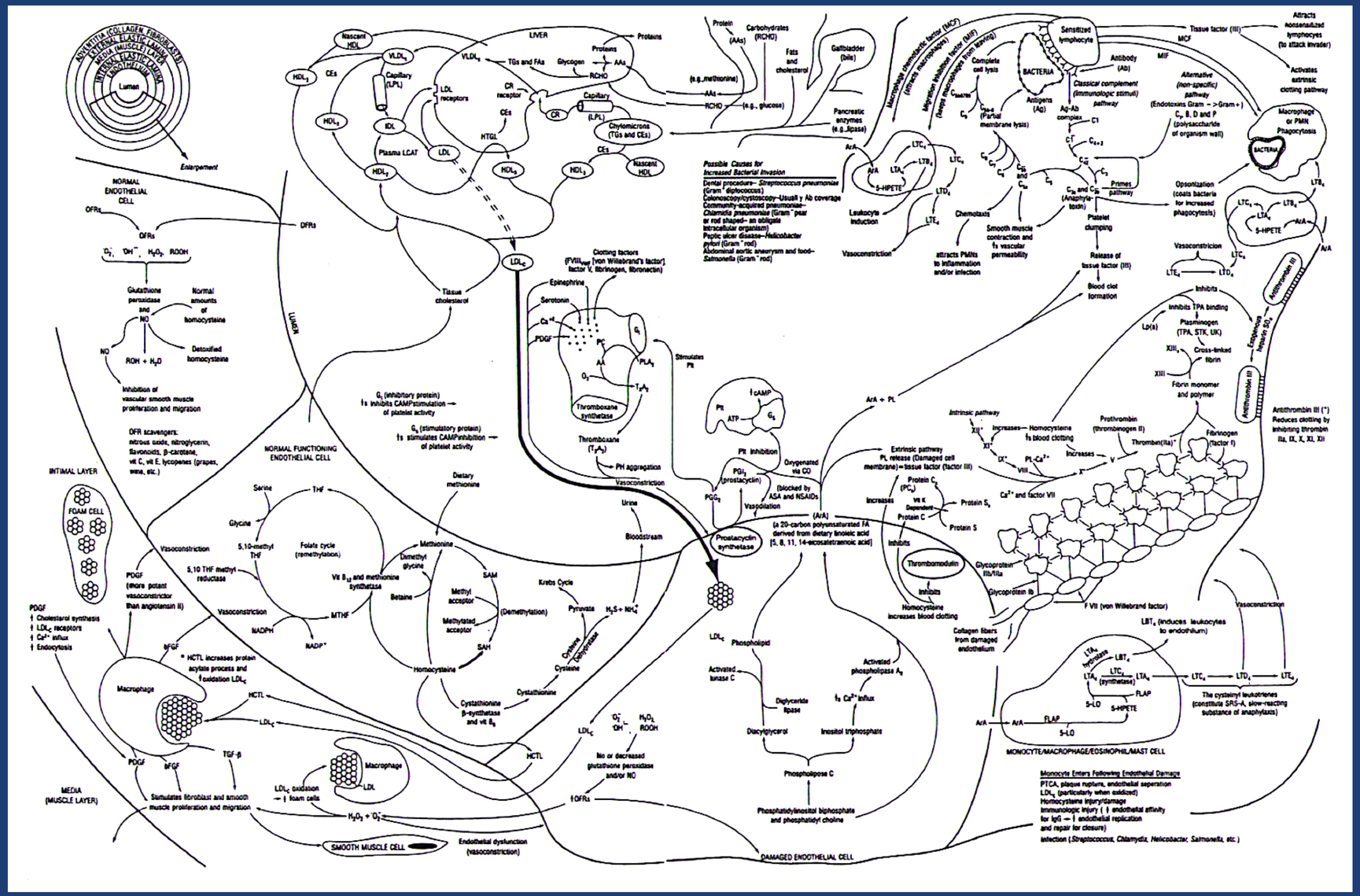
Appendix Figure 2.

Mononuclear infiltrations consisting of lymphocytes (*arrows*) in the myocardium of the right ventricle (case 3) (hematoxylin–eosin stain; original magnification,×100).

Blood Clots in Lungs, Legs, Prostate

Wichmann D, Sperhake J-P, Lütgehetmann M, et al. Autopsy Findings and Venous Thromboembolism in Patients With COVID-19. A Prospective Cohort Study. Annals of Internal Medicine 2020. 6 May 2020. DOI: 10.7326/M20-2003.

This Concept of InflammoThrombotic Response (ITR) to Viruses is NOT New!



1) LDL cholesterol
2) Triglycerides
3) Excess Weight
4) Homocysteine
5) Oxidation
6) Lack of Exercise
7) Fibrinogen
8) Growth Factors
9) Cytokines & Leukotrienes
10) Complement Cascade
11) Infectious Agents
12) Direct Physical Trauma

Fleming RM. Chapter 64. *The Pathogenesis of Vascular Disease*. *Textbook of Angiology*. John C. Chang Editor, Springer-Verlag New York, NY. 1999, pp. 787-798. doi:10.1007/978-1-4612-1190-7_64.

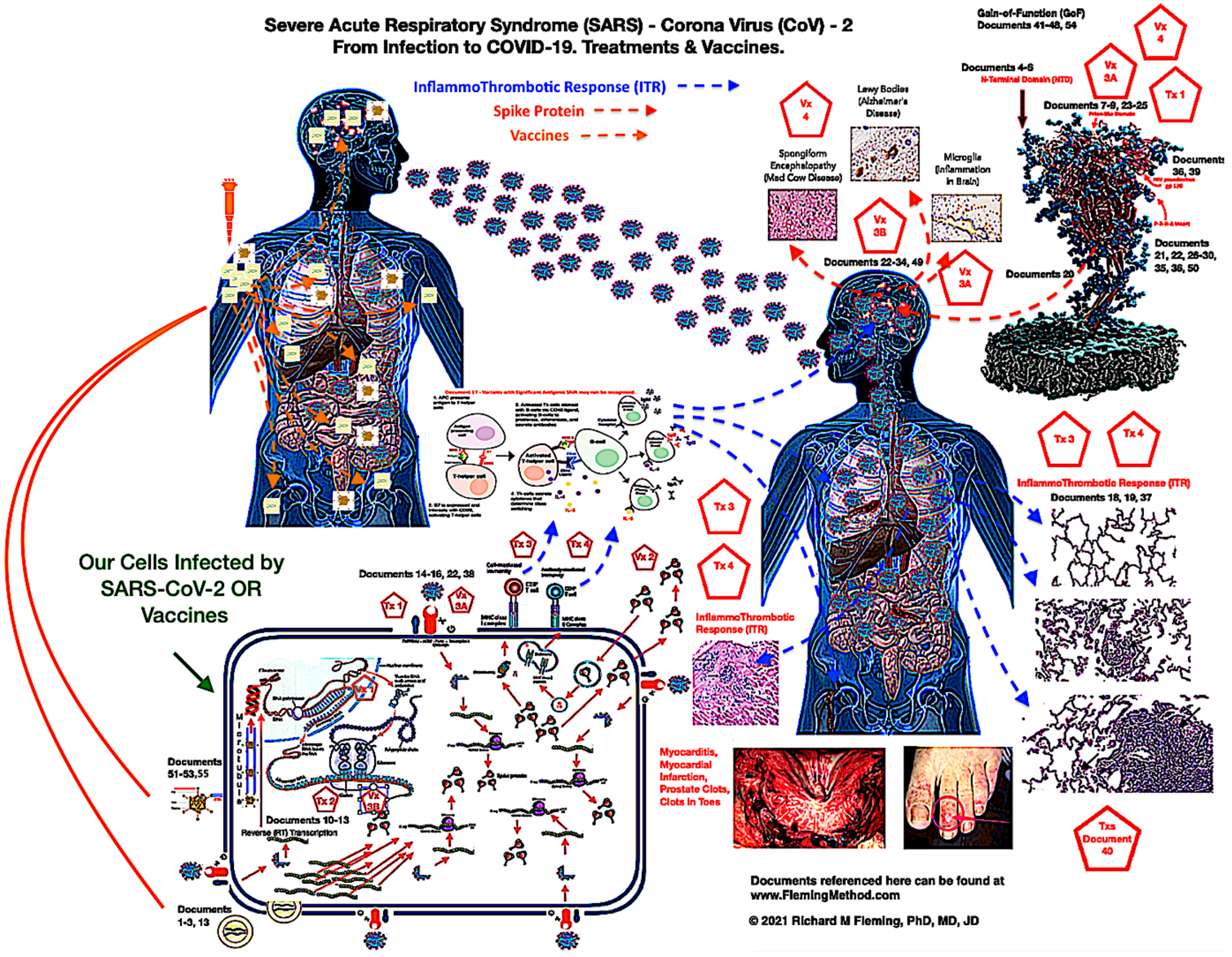
Infectious Disease -> Fleming (PCN) -> Processing of Food and Decreased Physical Activity -> Hyper Reactive ITR Diseases -> Paving the Way for Infectious Disease to Again Become #1 Cause of Death Killing with ITR.

How is the SARS-CoV-2 Virus Transmitted?

SARS-CoV-2 is spread from
person-to-person
as many viruses are.

Respiratory passage or
Gastrointestinal passage.

The following figure shows
person-to-person transmission
as well as what happens when
people are **injected** with a Drug Vaccine.



Treating SARS-CoV-2 & COVID-19

Treatment Needs to Focus On:

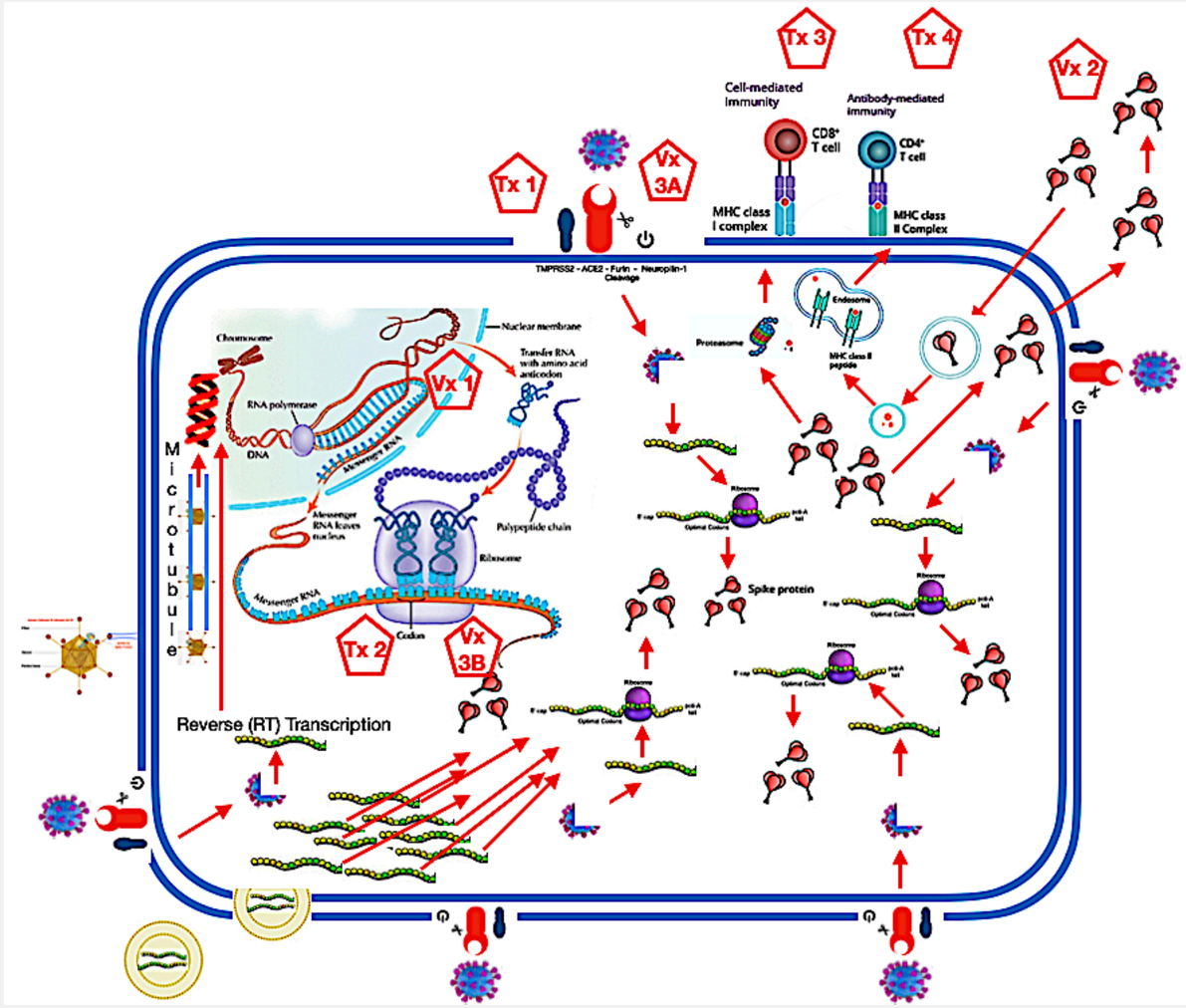
(1) Virus **attachment** & Entry into the cell.

(2) Virus **replication** once inside the cell.

(3) Reducing Inflammation & Blood Clotting (**ITR**) associated with the **T-Cell** (Innate) response to the virus.

(4) Reducing Inflammation & Blood Clotting (**ITR**) associated with the **B-cell** (Delayed Humoral) response to the virus.

As well as Medicines that improve **airflow** & reduce blood **clotting**.



How do we Know What Works? We Measured it! Quantitatively Measured Treatments That Work.

- 1800 Infected People in 7-countries.
- 501 Admitted with COVID-19.
- FMTVDM, Ferritin & IL-6 measured severity and treatment responses.
- Focusing on 10-different treatment options in 52-treatment combinations.

Study Site	Continent of Country	Start	Stop	Total Number of Patients	Outpatient HCQ Success	Outpatient Success without Rx	Phase I Patients	Phase II Patients
1	Cuba	4/16/20	4/30/20	56	32	17	7	0
2	India	4/16/20	5/11/20	49	23	17	9	0
3	India	4/16/20	5/20/20	114	39	30	18	27
4	Cuba	4/24/20	4/30/20	32	24	5	3	0
5	Philippines	4/27/20	6/15/20	34	27	1	6	0
6	Philippines	4/29/20	6/8/20	47	22	11	14	0
7	India	4/30/20	5/22/20	58	30	19	9	0
8	S. Africa	5/7/20	5/7/20	5	3	0	2	0
9	Belgium	5/11/20	5/20/20	25	9	5	11	0
10	Germany	5/11/20	6/19/20	145	82	41	22	0
11	Germany	5/14/20	6/1/20	57	22	11	24	0
12	Brazil	5/18/20	6/22/20	142	65	49	28	0
13	Belgium	5/18/20	6/18/20	135	58	38	39	0
14	Belgium	5/18/20	6/19/20	152	60	43	49	0
15	India	5/18/20	6/19/20	95	18	18	59	0
16	Germany	5/19/20	5/27/20	79	49	20	10	0
17	Germany	5/22/20	5/29/20	16	7	0	9	0
18	India	5/22/20	6/19/20	168	90	27	21	30
19	Brazil	7/9/20	8/4/20	94	51	27	0	16
20	Brazil	7/9/20	8/3/20	98	48	25	0	25
21	Philippines	7/9/20	8/5/20	93	36	36	0	21
22	Cuba	7/10/20	7/31/20	40	0	29	0	11
23	Brazil	7/13/20	8/4/20	66	0	35	0	31
Totals:		4/16/20	8/5/20	1800	795	504	340	161

Quantification of Changes in Tissue

Measuring Regional Blood Flow & Metabolism

US009566037B2

(12) **United States Patent**
Fleming

(10) **Patent No.: US 9,566,037 B2**
(45) **Date of Patent: Feb. 14, 2017**

(54) **FLEMING METHOD FOR TISSUE AND VASCULAR DIFFERENTIATION AND METABOLISM (FMTVDM) USING SAME STATE SINGLE OR SEQUENTIAL QUANTIFICATION COMPARISONS**

(71) Applicant: **Richard Max Fleming**, Studio City, CA (US)

(72) Inventor: **Richard Max Fleming**, Studio City, CA (US)

(*) Notice: Subject to any disclaimer, the term of this patent is extended or adjusted under 35 U.S.C. 154(b) by 732 days.

(21) Appl. No.: **13/986,869**

(22) Filed: **Jun. 13, 2013**

(65) **Prior Publication Data**

US 2014/0371579 A1 Dec. 18, 2014
US 2016/0374634 A9 Dec. 29, 2016

Related U.S. Application Data

(60) Provisional application No. 61/658,428, filed on Jun. 12, 2012.

(51) **Int. Cl.**
A61B 5/1455 (2006.01)
A61B 6/00 (2006.01)
A61B 6/03 (2006.01)

(52) **U.S. Cl.**
CPC ***A61B 6/503*** (2013.01); ***A61B 6/037*** (2013.01); ***A61B 6/486*** (2013.01); ***A61B 6/5217*** (2013.01)

(58) **Field of Classification Search**
CPC A61B 6/503
See application file for complete search history.

(56) **References Cited**

PUBLICATIONS

Fleming-Harrington Redistriution Wash-in washout (FHRWW) :The platinum Standard for nuclear cardiology, p. 207-250, 2011.*

* cited by examiner

Primary Examiner — Joseph M Santos Rodriguez

(57) **ABSTRACT**

The present invention defines the parameters whereby "quantification" of isotope emission may occur and be clinically applied and provides a method for detecting abnormal coronary blood flow by "quantifying" emissions of a radiopharmaceutical after stressing the heart either pharmacologically or physiologically under "same state" conditions of stress-stress for detection of ischemic vascular (IVD) disease and the ability to differentiate (a) ischemic heart disease (IHD) due to narrowed coronary lumen and subsequent reduced lumen responsiveness to demand for more coronary blood flow and (b) vulnerable inflammatory plaque (VIP) disease, which reduces lumen responsiveness to blood flow demand with potential for sudden rupture and sudden cardiac death. The present invention also provides a method of detection of myocyte viability by using the "quantitative" method to differentiate "normal" functioning cardiac tissue from non-viable "infarcted" cardiac tissue and from "stunned/hibernating" myocytes, which may benefit from intervention. The present invention further provides a method for detection of IVD by detecting enhanced thymic activity associated with IVD and treatable causes. The present invention does so while reducing total patient imaging time, patient table time, radiation isotope doses and exposure to both patient and others through primary and secondary exposure to isotope emissions. In one embodiment, the nuclear isotope is technetium-99m hexakis 2-methoxyisobutylisonitrile (sestamibi).

1 Claim, 17 Drawing Sheets

What is claimed is:

1. A method of yielding quantitative diagnosis of bodily pathologies including vascular disease, metabolism and tissue differentiation in a subject comprising the steps of:

a. either inject a pharmacologic agent or conduct physiologic changes, which produces regional blood flow differences;

b. inject into the subject's body an isotope;

c. after determining a time interval, with a computer, acquire one or multiple images at multiple time-points within the time-interval within a determined region of interest (ROI) within the patient;

d. measure, with the computer, the actual measured radioactive emissions of the injected isotope from the acquired image or images;

e. create, with the computer, a data array of radioactive emissions of the injected isotope at each time-point;

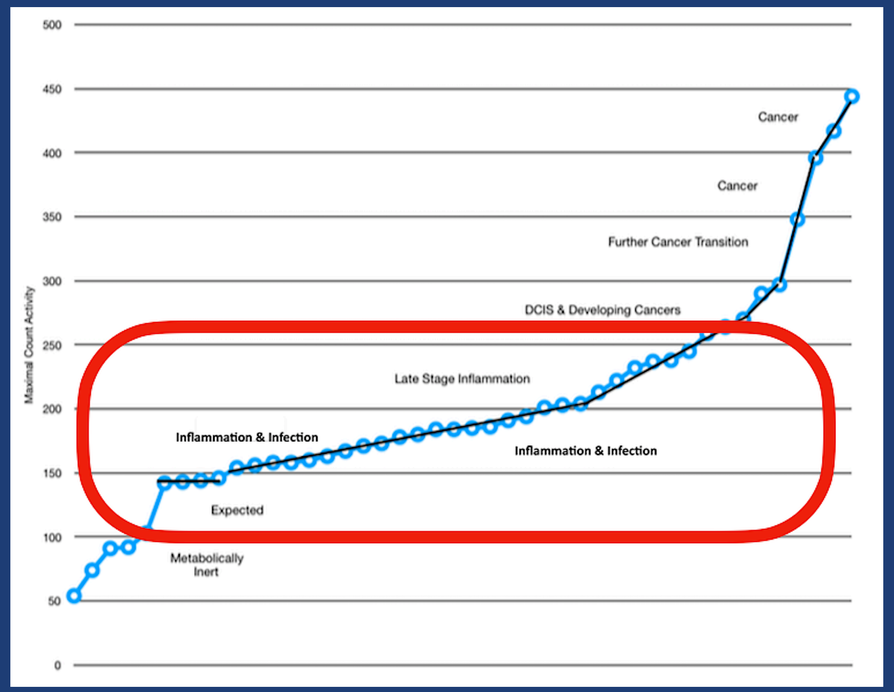
f. calculate, with the computer, the total percent gain or loss of the measured radioactive emissions for the time period between each time-point of the data array set and the subsequent data array set;

g. compare, with the computer, the calculated total percent gain or loss with the expected change resulting from the isotope radioactive decay;

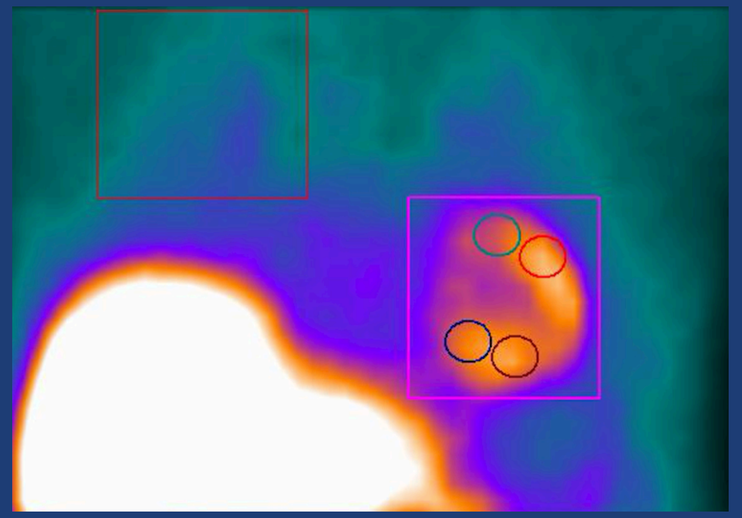
h. the degree of disease is determined, with the computer, in response to the comparison obtained in "g", this determined degree of disease is a non-linear function defined as the gain, washin, or loss, washout, which includes the differentiating of tissue and metabolism.

* * * * *

Measured COVID Severity & Treatment Response?

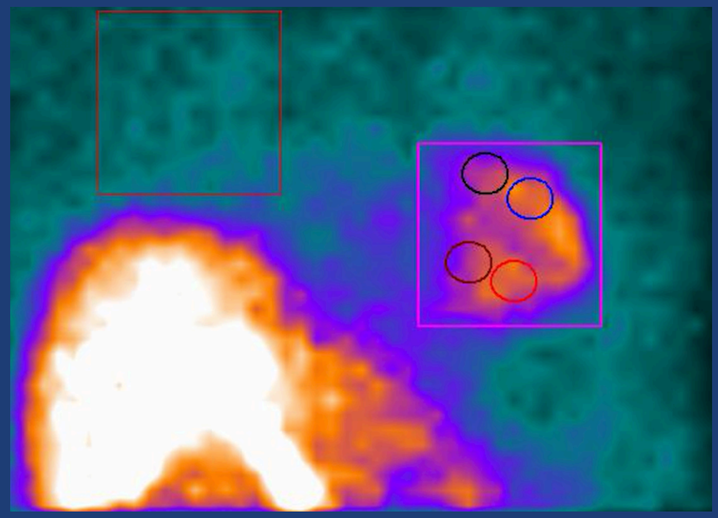


Female Patient 3/1 Entered Phase I after Treatment 1 Failed.



Day 1 FMTVDM 195 MCA;
Ferritin 302 ng/ml; IL-6 45 pg/ml

Day 4 FMTVDM 170 MCA;
Ferritin 195 ng/ml; IL-6 12 pg/ml



Treatment 8 (Methylprednisolone) Started

- Successful treatment outcomes were defined using the quantitative measurements of FMTVDM with a reduction of ≥ 25, or a level of ≤ 150, Ferritin levels < 270 ng/ml for men and < 160 ng/ml for women, and an IL-6 level of < 5 pg/ml.

Results of Outpatient Response to Treatment

When Treatment was Started within 3-4 Days of Symptoms

Total	HCQ Pre-hospital Treatment Success	HCQ Failures entered Phase I	HCQ Failures entered Phase II	Total Number of Patients Treated with HCQ	Percent Successful Treatment	Percent Treatment Failure
Treatment 1	225	20	58	303	74.20%	25.70%
Treatment 2	170	17	59	246	69.10%	30.90%
Treatment 3	189	2	2	193	97.90%	2.10%
Treatment 4	211	0	0	211	100%	0.00%

(1) **100%** Effective [Treatment Regimen 4]
- Primaquine 200 mg by mouth on day 1.
- Clindamycin 150 mg by mouth every 6-hours for 7-days.
- Hydroxychloroquine 200 mg by mouth every 8-hours for 10-days.

(2)**97.9%** Effective [Treatment Regimen 3]
- Hydroxychloroquine 200 mg by mouth every 8-hours for 10-days.
- Clindamycin 150 mg by mouth every 6-hours for 7-days.

(3) **74.2%** Effective [Treatment Regimen 1]
- Hydroxychloroquine 200 mg by mouth every 8-hours for 10-days.
- Azithromycin 500 mg by mouth on day 1, then 250 mg by mouth on days 2 through 5.

(4) **69.1%** Effective [Treatment Regimen 2]
- Hydroxychloroquine 200 mg by mouth every 8-hours for 10-days.
- Doxycycline 100 mg by mouth every 12-hours for 10-days.

Results of Inpatient Response to Treatment

99.83% Success Rate When Treatment was Started Immediately Upon Admission.

(1) With prior Aminoquinoline Treatment begin

Methylprednisolone 125 mg IV every 6-hours for 3 days;

then 125 mg IV every 12-hours for 2 days;

then 125 mg IV daily for 2 days;

then 60 mg IV daily for 2 days [with each infusion given over 30-minutes];

then Solumedrol dose pack to taper off steroids).

(2) With prior Aminoquinoline Treatment begin

Tocilizumab 8-mg/kg [IBW; not to exceed 800 mg] not to exceed 800 mg intravenously infused over 1-hour.

May be repeated every 8-hours for a maximum of 4-doses; and

Interferon α-2β (5-million units per nebulizer every 12-hours for 7-days).

(3) Without prior Aminoquinoline Treatment

Primaquine 200 mg by mouth day 1;

Clindamycin 150 mg by mouth every 6-hours for 7-days; and

Tocilizumab and Interferon-α2β - using the same doses shown in (2) above.

Inpatients Also Received … to Improve Immune Response, Open Airways, and Reduce Blood Clotting.

Immune Support:

Folate (B9), Magnesium, Calcium Carbonate, Cobalamin (B12), Pyridoxine (B6), Dehydroepiandrosterone (DHEA),

Ascorbic acid (C) 2000, Zinc, and

1,25-dihydroxycholecalciferol (D3).

Respiratory Support:

Atrovent Nebulizer or Inhaler Treatments.

Thrombosis Prophylaxis:

Heparin subcutaneously.

Fleming RM, Fleming MR. FMTVDM Quantitative Nuclear Imaging finds Three Treatments for SARS-CoV-2. Biomed J Sci & Tech Res. 2021;33(4):26041-26083. DOI: 10.26717/BJSTR.2021.33.005443. https://biomedres.us/fulltexts/BJSTR.MS.ID.005443.php

Clinicians Reporting Observed Treatment Success.

- Dr. Vladimir Zelenko (Family Practice in New York) - treatment with hydroxychloroquine, azithromycin and zinc had an 84% reduction in hospitalization. [doi: 10.20944/preprints202007.0025.v1]
- Dr. Peter A. McCullough (Baylor Dallas) - nine studies reveal patients treated with hydroxychloroquine and other drugs like doxycycline had a greater than 60% reduction in death. [https://www.researchgate.net/publication/348946216]
- AAPS - Early Treatment Saves Lives [https://aapsonline.org/early-treatment-saves-lives/]
- Dr. Harvey Risch (Yale) - Hydroxychloroquine (HCQ) produced a 34% reduction in risk of death, while HCQ and azithromycin produced a 29% reduction in risk of death in hospitalized patients with COVID-19. [https://doi.org/10.1016/j.ijid.2020.06.099]
- Dr. Richard Bartlett (Budesonide Nasal Steroids) - reports 100% success rate when started early.
- Dr Eleftheria Atalla (Brown University, R.I.) - treatment of critically ill seniors in Long Term Care Facilities with anticoagulants who had elevated markers of inflammation were 84% less likely to die. [Pathogens 2021, 10, 8. https://dx.doi.org/10.3390/pathogens10010008]

Treatments Reported to be Beneficial

01 TYPES

Prescription Support:
- Hydroxychloroquine
- Primaquine
- Ivermectin - Maybe
- Clindamycin
- Azithromycin
- Tocilizumab
- Interferon α-2β
- Methylprednisolone
- Remdesivir - ???
- Convalescent plasma
- Monoclonal antibodies

Immune Support:
- Folate
- Magnesium
- Calcium Carbonate
- Cobalamin
- Pyridoxine
- Dehydroepiandrosterone (DHEA)
- Ascorbic acid (C)
- Zinc
- Dihydroxycholecalciferol (D3)

Respiratory Support:
- Atrovent Nebulizer Treatment
- Budesenide - Maybe
- Extracoporeal Membrane Oxygenation (ECMO)
- Ventilators need to be set at 1/2 the standard Tidal Volume.

Thrombosis Prophylaxis:
- Heparin

02 USE CASES

- Trump
  HCQ, Azithromycin, Methylprednisolone

03 CONTROVERSY

- Access to therapeutics
- Medical community support
- National Guard
- Pharmacy board obstruction
- medical board obstruction
- Cease and desist letters
- Front Line Drs

What If The People You Trust Are The People Causing The Problem?

The Same People Who Helped Fund and Develop SARS-CoV-2

Have Also Controlled How Doctors, Nurses, & Other Health

Care Providers Are Treating Patients.

These People - It Turns Out - Are The Same People Who Helped Fund and Develop The Drug Vaccines.

Which, We will Talk About in the Next Section.

Section 02

01 Inform

The SARS-CoV-2 virus & known facts

The Covid-19 disease & published treatments

02 Educate

Infectious Diseases

Vaccines efficacy and safety

The Scientific Method

The Difference Between VE, COVID-19 & Death

EUA vs Process vs Risks

03 Empower

EUA vs Process vs Risks

Stopping the Gain-of-Function Research

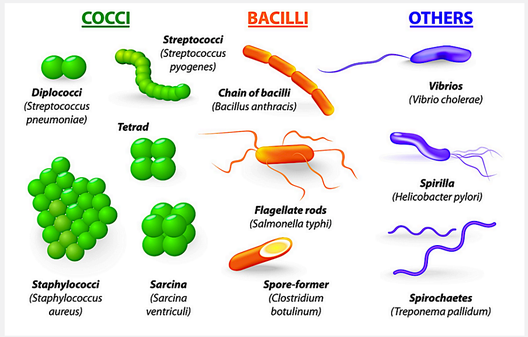
Government Interference with Physician-Patient Treatment & Forced Vaccination

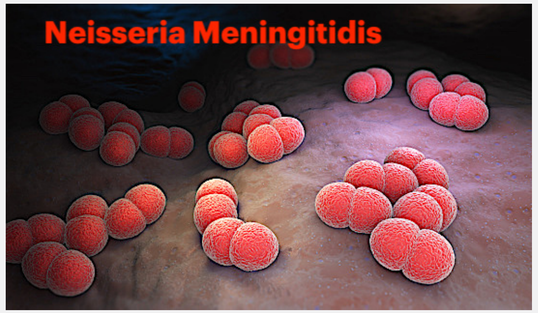
Be Heard

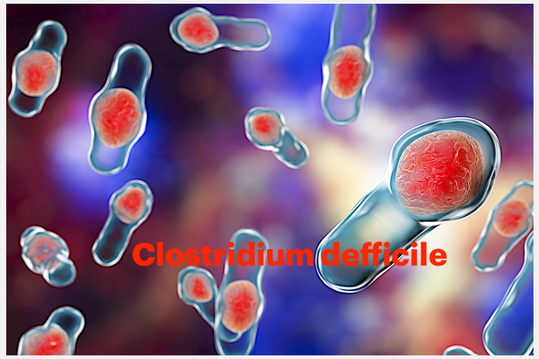
Petition

Infectious Diseases

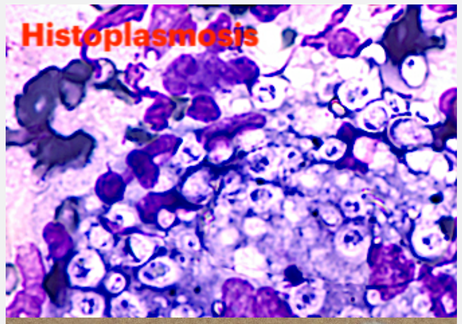
Bacteria

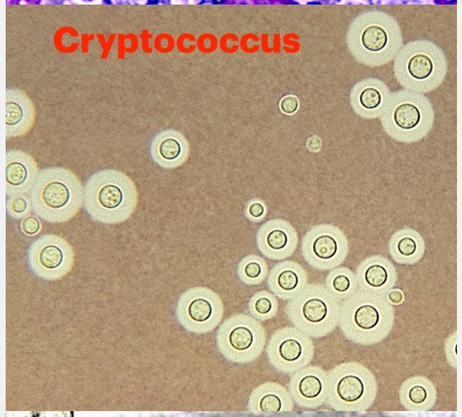


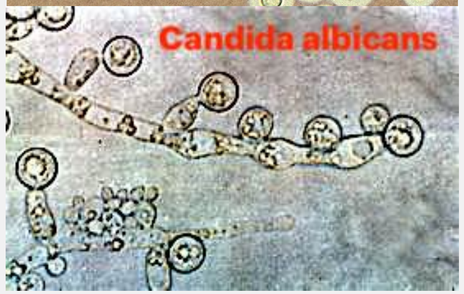




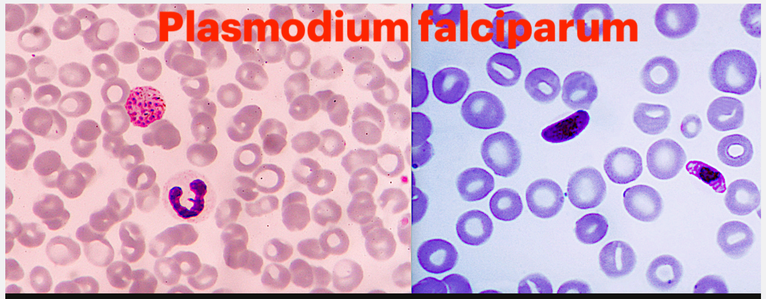
Fungi/Yeast





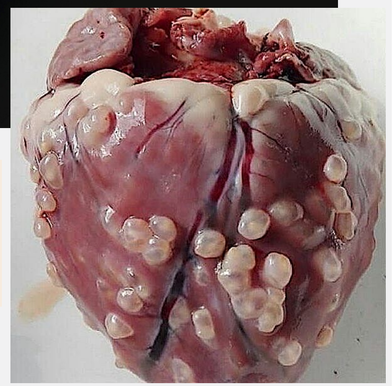


Parasites









Mycobacterium

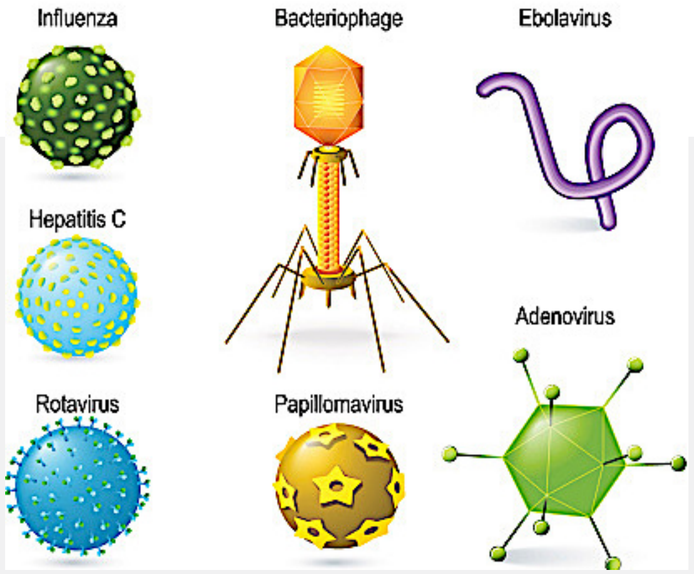


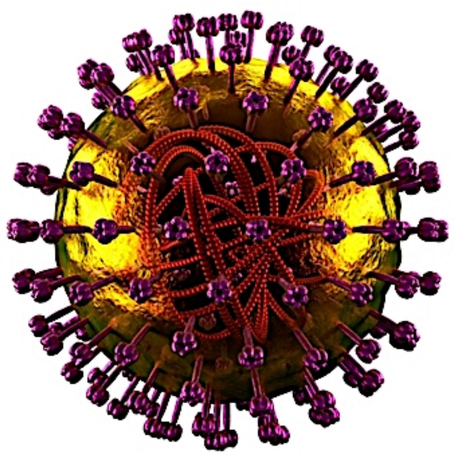




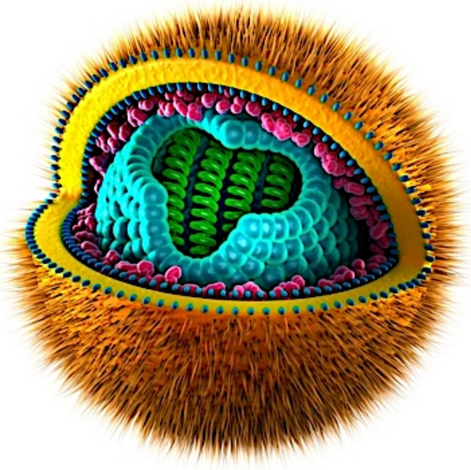
Viruses

Unlike the other Infectious Agents
Viruses do **NOT** have
a **Nucleus** or **Ribosomes**,
They can't independently reproduce, or
make their own energy (**mitochondria**/chloroplasts).

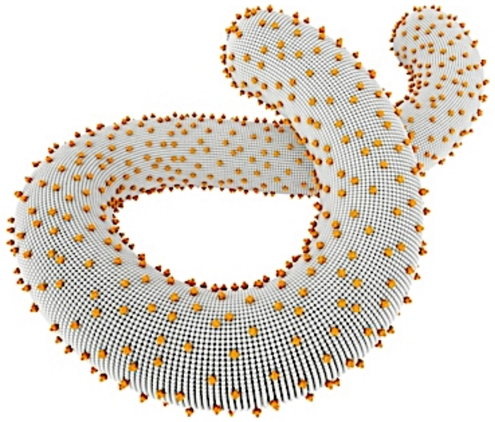




Chickenpox virus

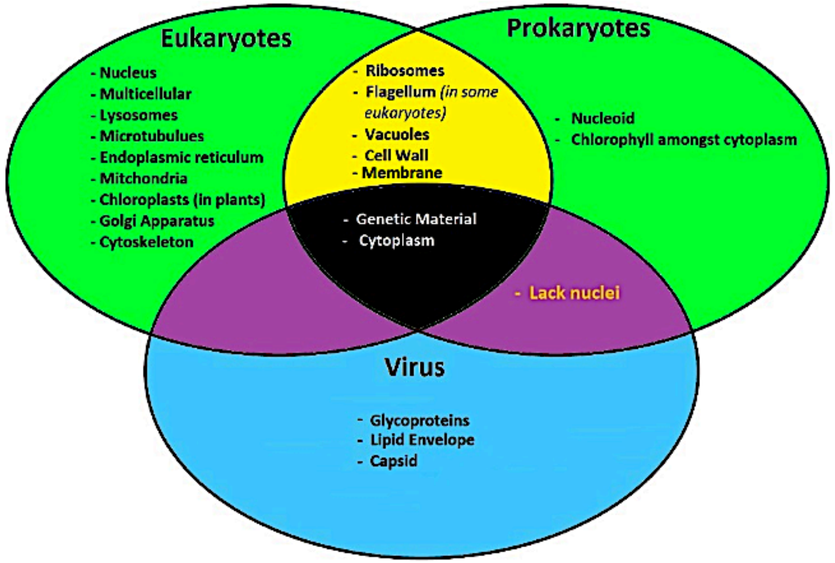


Herpes simplex virus



Ebola virus

ribosomes.



Treating Viruses

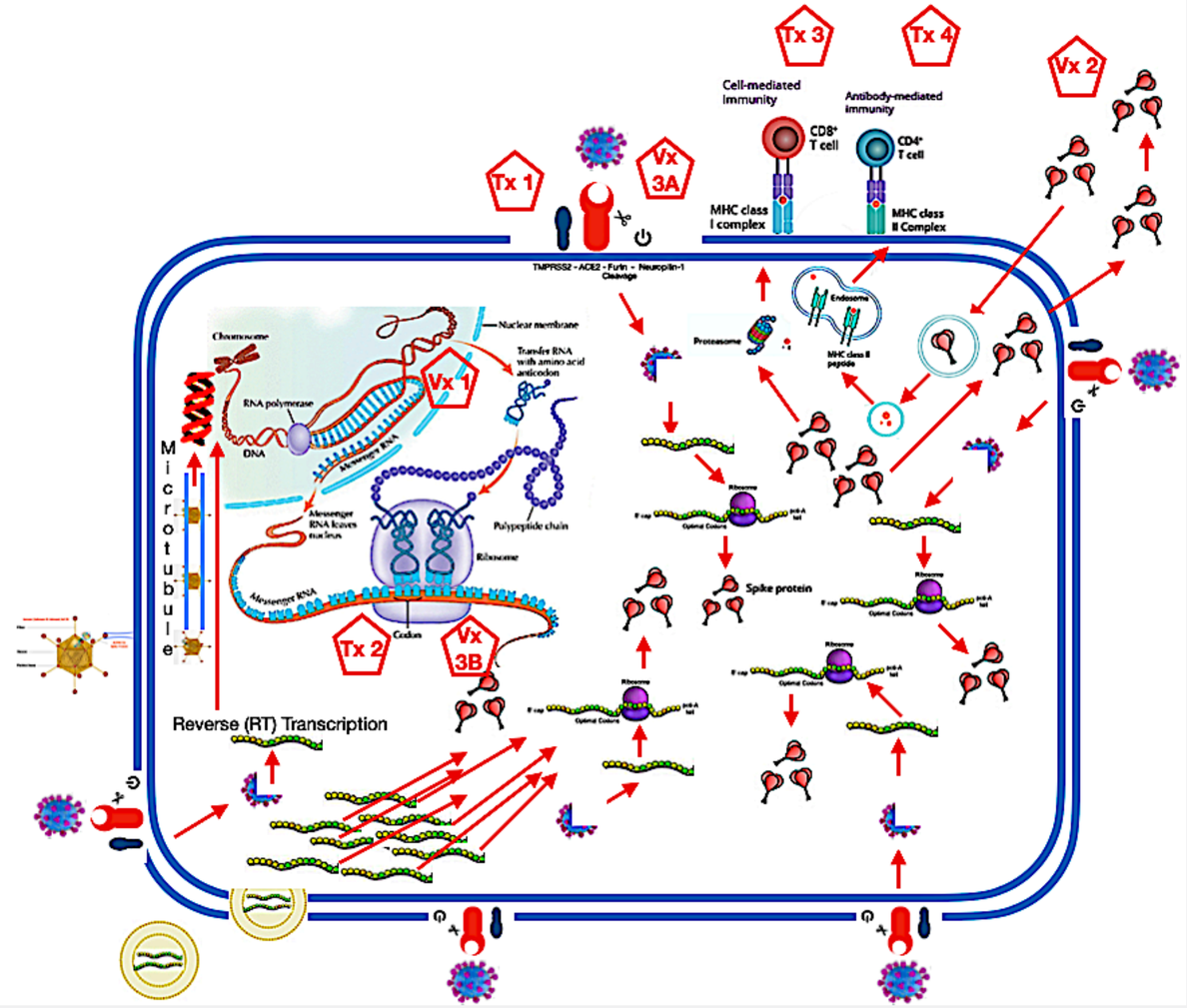
Must Focus on:

1) Viral **Attachment** and/or **Replication**.

2) Patient Oxygenation and treatment of Acute Respiratory Distress Syndrome (ARDS) - **ITR**.

3) The Initial Acute Innate T-cell Cytotoxic Response - **ITR**.

4) The Delayed Adaptive Humoral (Antibody) Response - **ITR**.



Educate

Successful Mechanisms of Action.

Treatment	Viral Attachment and Replication	Innate T-cell Cytotoxic Response	Oxygenation and ARDS**	Adaptive Humoral (Antibody) Response.
1,25-Dihydroxycholecalciferol (Vit. D3)		Improved immune response.		Improved immune response.
Ascorbic Acid (Vit. C)		Improved immune response.		Ascorbic Acid (Vit. C)
Atrovent			β–2 bronchodilator to increase airway diameter and reduce bronchial secretions without the increase in heart rate and potential QTc prolongation associated with β–1 agonists.	
Azithromycin	Inhibition of viral protein translation.			
Clindamycin	Potential inhibitor of viral attachment by inhibiting Transmembrane protease serine 2 (TMPRSS2).			
Clindamycin	Inhibition of viral protein translation.	Inhibits cytokine release decreasing tissue necrosis factor – alpha (TNF-α) and IL-1β (Interleukin-1 beta).		Inhibits cytokine release decreasing tissue necrosis factor – alpha (TNF-α) and IL-1β (Interleukin-1 beta).
Convalescent Plasma				Provides passive immunity reducing potential ITR although the increased fibrinogen levels associated with plasma transfusions may increase thrombus formation.
Cyanocobalamin (Vit. B12)		Improved immune response and reduction of inflammatory homocysteine.		Improved immune response and reduction of inflammatory homocysteine.

Treatment	Viral Attachment and Replication	Innate T-cell Cytotoxic Response	Oxygenation and ARDS**	Adaptive Humoral (Antibody) Response.
Doxycycline	Inhibition of viral protein translation.			
Folate (Vit. B9)		Improved immune response and reduction of inflammatory homocysteine.		Improved immune response and reduction of inflammatory homocysteine.
Hydroxychloroquine	Inhibits viral RNA replication.	Inhibits toll-like receptor 7 (TLR7) to reduce inflammatory response.		Inhibits glycoprotein IIb/IIIa thereby interfering with thrombus formation.
Hydroxychloroquine	Inhibits viral attachment at ACE2 receptor site.	Reduces the production of pro-inflammatory cytokines.		
Hydroxychloroquine	Enhances entry of zinc through zinc ionophore.			
Hydroxychloroquine	Increases cytosol pH to reduce removal of viral envelope required for replication.	Increases cellular pH decreasing major histocompatability complex (MHC) viral antigen presentation to β-cells thereby decreasing release of inflammatory cytokines.		
Hydroxychloroquine	Enhances production of Type I Interferons.			
Interferon α-2β	Interferes with viral replication.	Reduction of IL-6 levels.		Reduction of IL-6 levels.
Losartan***			Potential to decrease ARDS.	
Magnesium		Improved immune response and reduction of QTc prolongation potential.		Improved immune response and reduction of QTc prolongation potential.
Methylprednisolone			Stimulates β–2 receptors improving airway flow.	
Methylprednisolone			Decreases endothelial leakage producing ARDS.	
Methylprednisolone		Reduces IL-6 levels.		Reduces IL-6 levels.
Oxygen (supplemental) other than ventilator.* [Prone			Reduced inflammatory stretching of alveoli and	

Successful Mechanisms of Action.

Treatment	Viral Attachment and Replication	Innate T-cell Cytotoxic Response	Oxygenation and ARDS**	Adaptive Humoral (Antibody) Response.
positioning, BiPAP, V-V ECMO, V-A ECMO, NC, Venti Mask.]			subsequent worsening of ARDS.	
Primaquine	Inhibits entry of Virulent Newcastle Disease (VND) virus.			
Primaquine	Inhibits viral RNA replication and protein translation.			
Pyridoxine (Vit. B6)		Improved immune response and reduction of inflammatory homocysteine.		Improved immune response and reduction of inflammatory homocysteine.
Remdesivir	Interferes with formation of mRNA via RdRP.****			
Tocilizumab		Blocks IL-6 receptors reducing ITR.		Blocks IL-6 receptors reducing ITR.
Zinc	May reduce ACE2 receptor activity.			
Zinc	Interferes with RdRP and polyprotein transcription.			
Zinc		Improved immune response.		Improved immune response.

* BiPAP = Bilevel Positive Airway Pressure, V-V is vein to vein, V-A is vein to artery, ECMO = extracorporeal membrane oxygenation, NC = nasal cannula, and Venti = Venturi.
** Acute Respiratory Distress Syndrome.
*** Originally included in study design with prior pre-clinical studies in animals suggesting a possible mechanism of action inhibiting ARDS with H5N1 virus. Excluded from study after IRB review and consideration of concerns for angiotensin-converting-enzyme (ACE) inhibitors and angiotensin II receptor blockers (ARBs). Included in this table for completeness.
**** RdRP = RNA dependent RNA polymerase.

Absent Treatments We Are Left with VACCINES.

CONTROVERSY & INTERFERENCE WITH MEDICAL TREATMENTS.

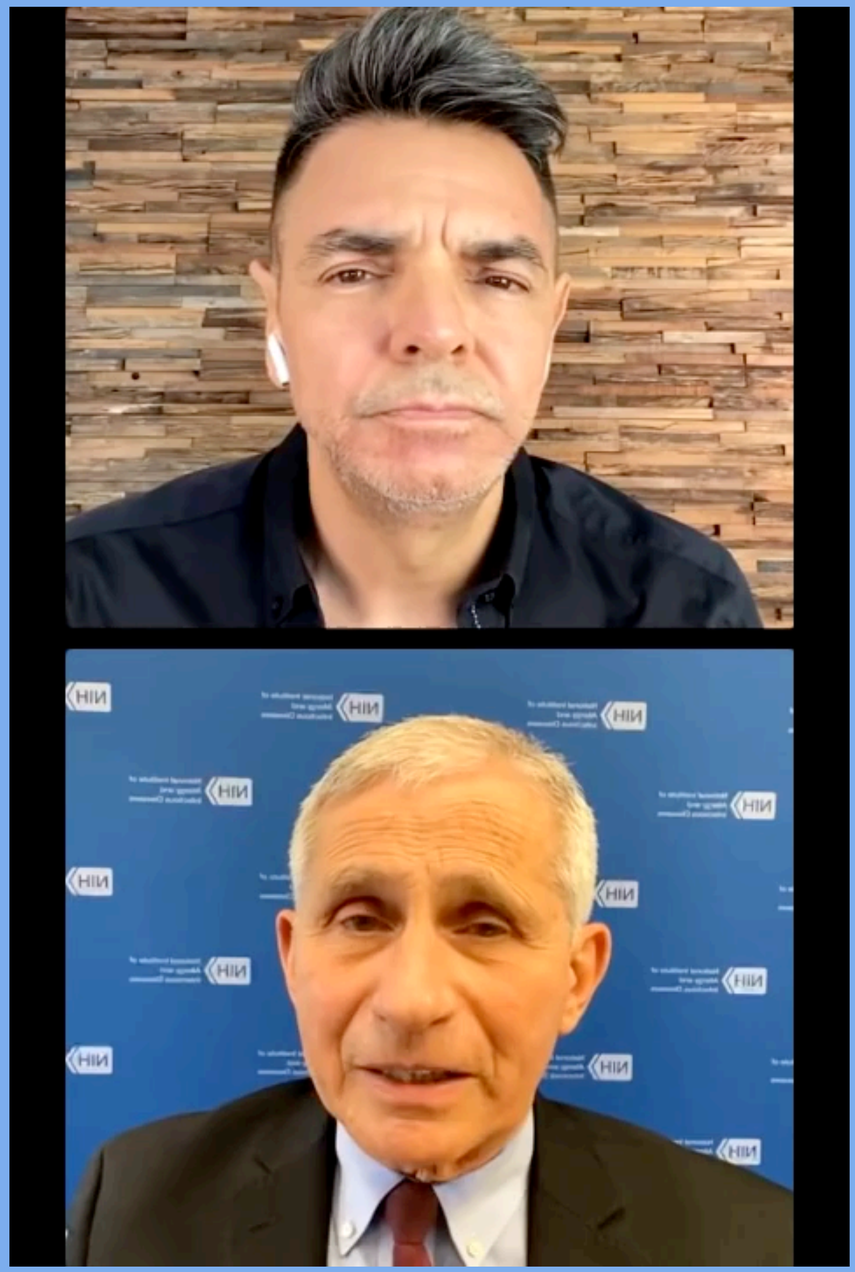
Interference with Physician Decision Making
Access to Treatments
Lack of Support for Doctors by Peers
Pharmacy board obstruction
Medical board obstruction

Vaccines do NOT

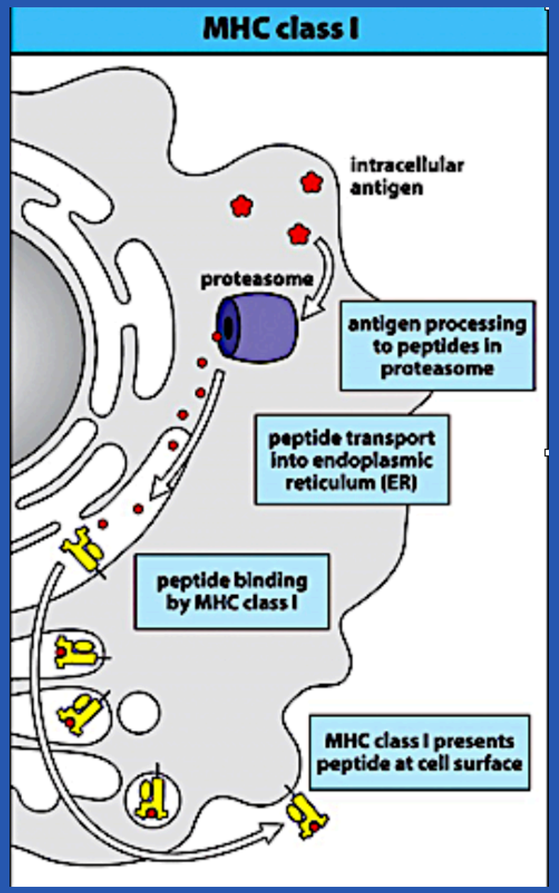
Prevent you from

Becoming Infected

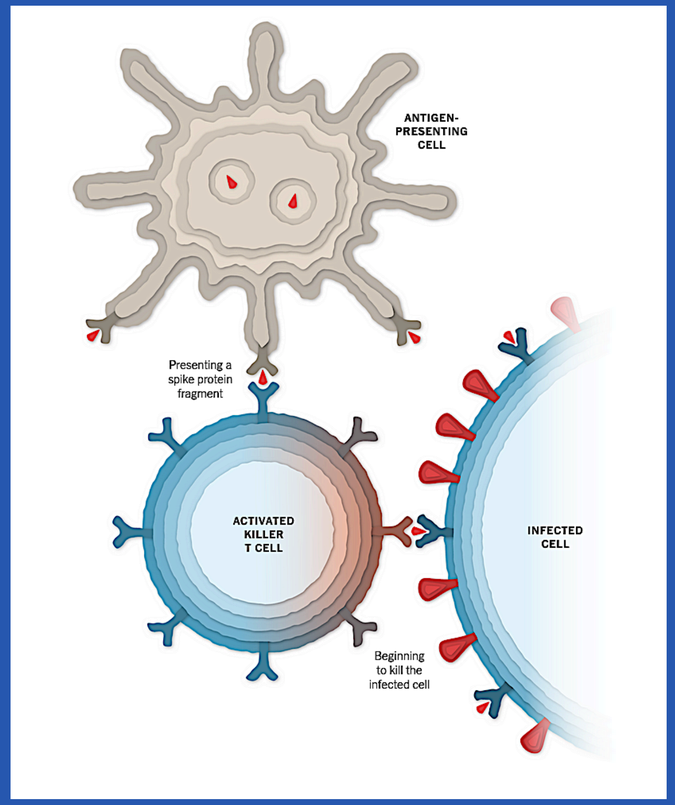
or Spreading the Infection.

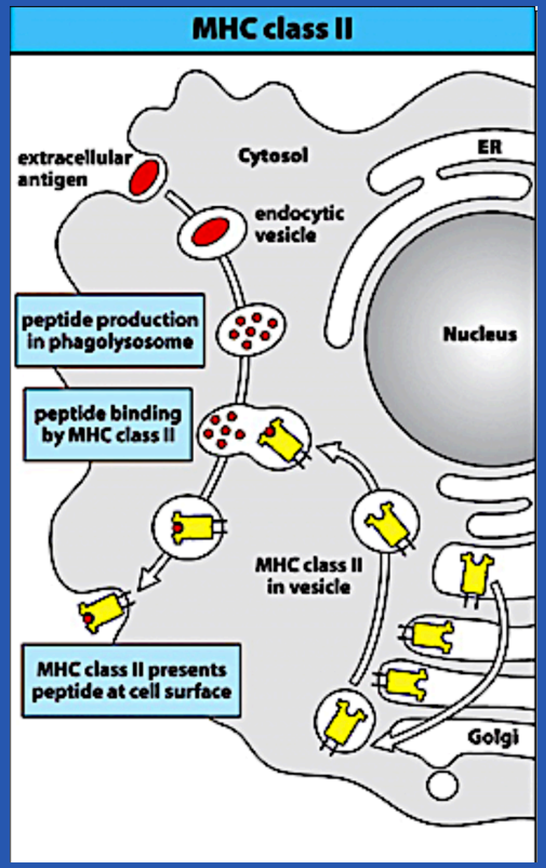


Vaccines Prepare You for When You Become Infected.

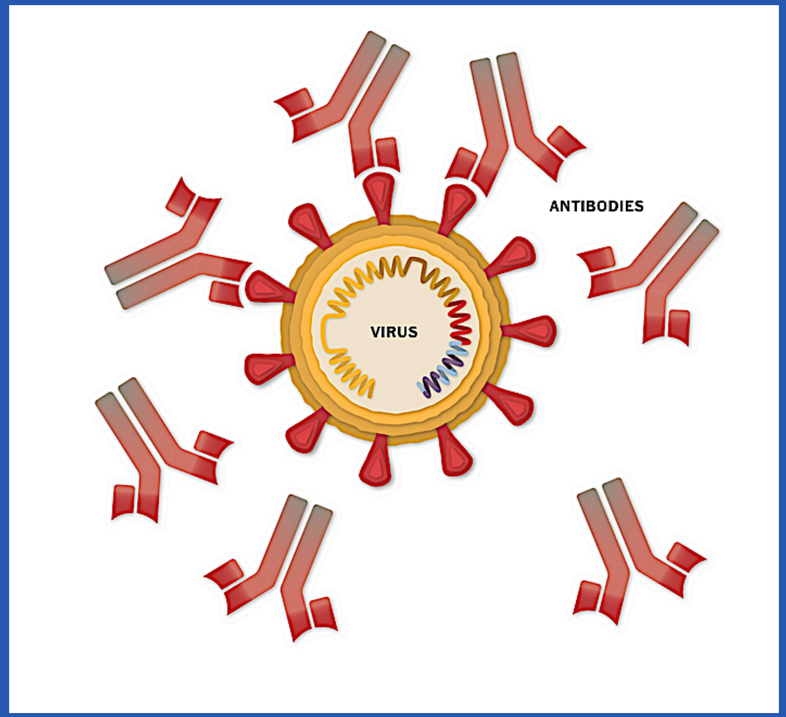


T-cells MHC-I

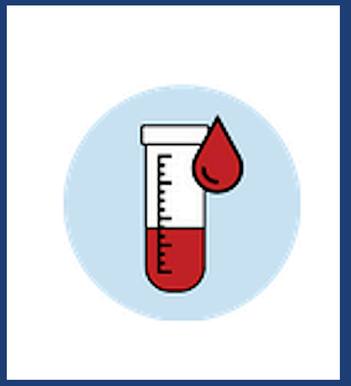




B-cells MHC-II

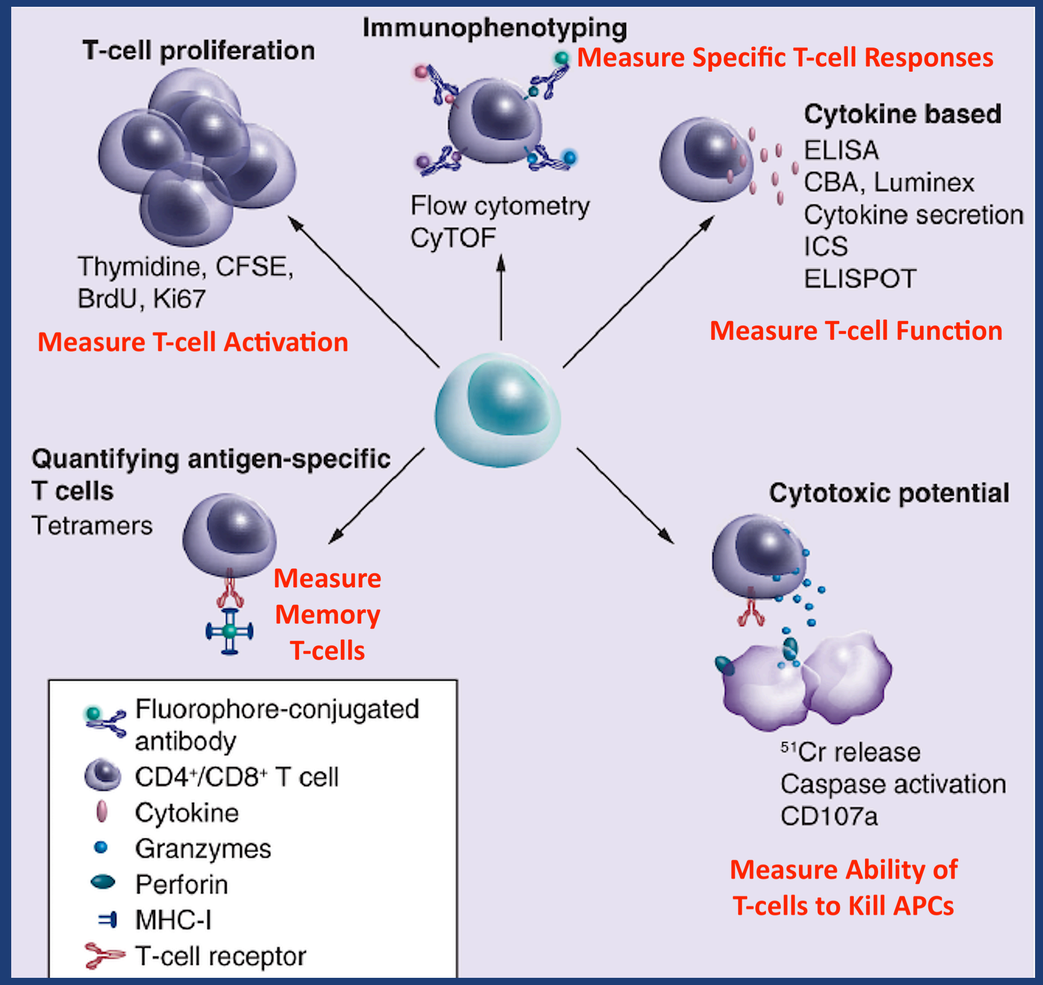


How Do Scientists Know if a Vaccine Works?



- We measure the immune response to the vaccine?
  - T-cell (cells and cytokines) and
  - B-cell (antibody) responses.

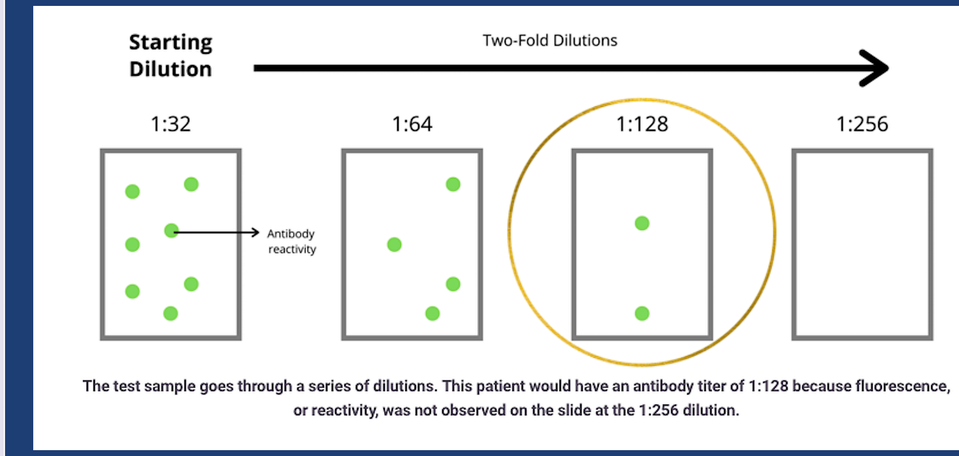
Is There a T-cell Response?



Is There a B-cell Response? - Antibody Titers.

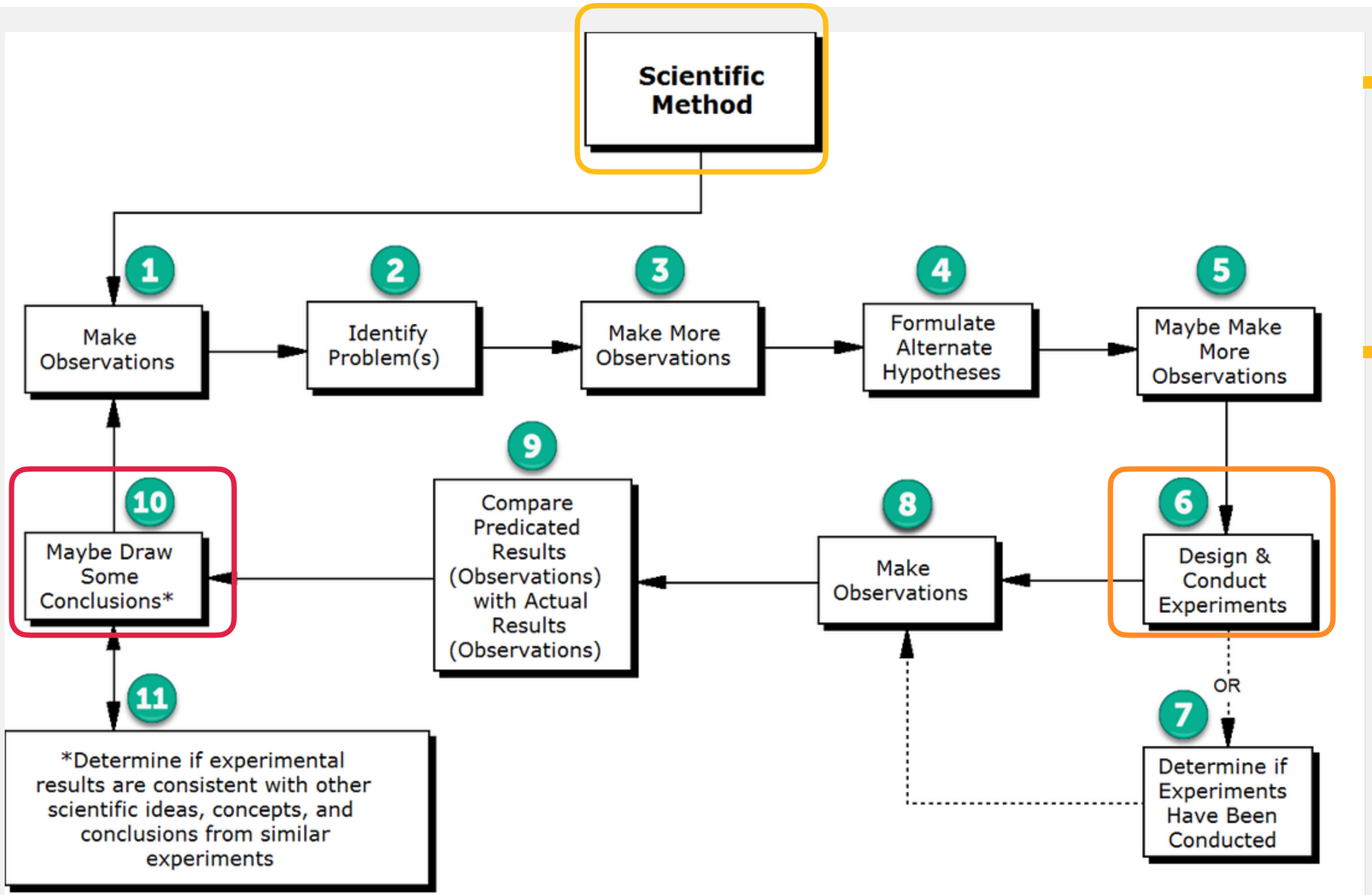
Diluting blood (1:2, 1:4, 1:8, etc.)

Measuring Ag-Ab precipitation.



So how do scientists actually know if a drug or biological (vaccine) agent works?

We Conduct Research Experiments.



Clinical Observations With Limitations

Measured Outcomes Defining Beneficial and Detrimental Treatments

Before We Ever Begin Testing People

We Begin with **Pre-Clinical** Testing.

1) When possible **computer** modeling and work on isolated **cell cultures** and **tissue**.
   At some point you need to know what happens to a **living creature**.

2) **Animal** testing has been an obligatory step **before testing on humans**.
   1) EU Directive 2001/83/EC
   2) FDA Product Development under the Animal Rule
   3) World Medical Association's "Ethical Principles for Medical Research Involving Human Subjects".
   4) 1947 Nuremburg Code
   5) International Covenant on Civil and Political Rights
   6) The American Medical Association Code of Medical Ethics

Phases of Clinical Trials.

Testing of a drug or medical procedure **takes time** to ensure Efficacy & Safety.

1) There are **3 fundamental principles** followed to protect the well-being of the research **animals**.
    1) **Reduce** the number of animals to a minimum
    2) **Reduce** or minimize the harm and injury to the animal
    3) **Replace** animal experiments with non-animal studies wherever possible.

2) Once you **know enough** from the animal studies to determine RISKS & BENEFITS, **THEN** human research trials are considered.



https://rumble.com/veoy2x-emily-and-jackie-our-most-important-message-yet.html

Phases of Clinical Trials

Clinical Trials on **Humans** to ensure **Safety** & **Efficacy**.

Phase I - Determine **Safety**. If you can't find a **safe dose**, then it doesn't matter if it works.
Small in **numbers** & **healthy** people.
Testing for:
Safety of Drug & Toxicity
Side Effects - Harm, Injury
Safe **Dosage** Range - Limits
How is the drug absorbed, metabolized, distributed and eliminated from the body.
(I.e. Pharmacokinetics; Pharmacodynamics)

Phase II (aka **Exploratory** Trials) - **If** a **Safe** Dose is Found - **Does the Drug Work?**
Larger **numbers** of people with the **disease**.
Does the drug work **for people you are intending to treat**.
Testing for:
Phase **IIA** - **How much** (dose) of the **drug** should people receive? What **dose** is safe?
Phase **IIB** - **How well** dose the drug work & for **what disease**(s)?

Phases of Clinical Trials.

Phase III - How does the drug **compare** with that **already used** for the problem?

This phase of research occurs **when** there is **compelling evidence of efficacy & safety**.

Testing for:

Demonstrate the drug is **Effective & Safe in a larger number of patients** in the target group - the people the drug is intended to treat.

Monitor side effects & risks.

Test different doses and different ways of giving the drug.

Can the drug be used at different stages of the disease being treated - early, late ….

Provide **sufficient information** about the drug for marketing approval -> **FDA**.

Phase IV - Post Marketing Surveillance Studies (aka **Pharmacovigilance**).

Testing for:

The **long-term effect** of the drug or treatment.

Study **other** impact or **use** of the drug.

Recapping Human Clinical Research Trials

(This is The Slide My Students Wish I Made for Them)

Tissue, Computer & Animal Studies - Is it Safe Enough to Test in People?

Phase I - Is it Safe?

Phase 2 - Is it Effective?

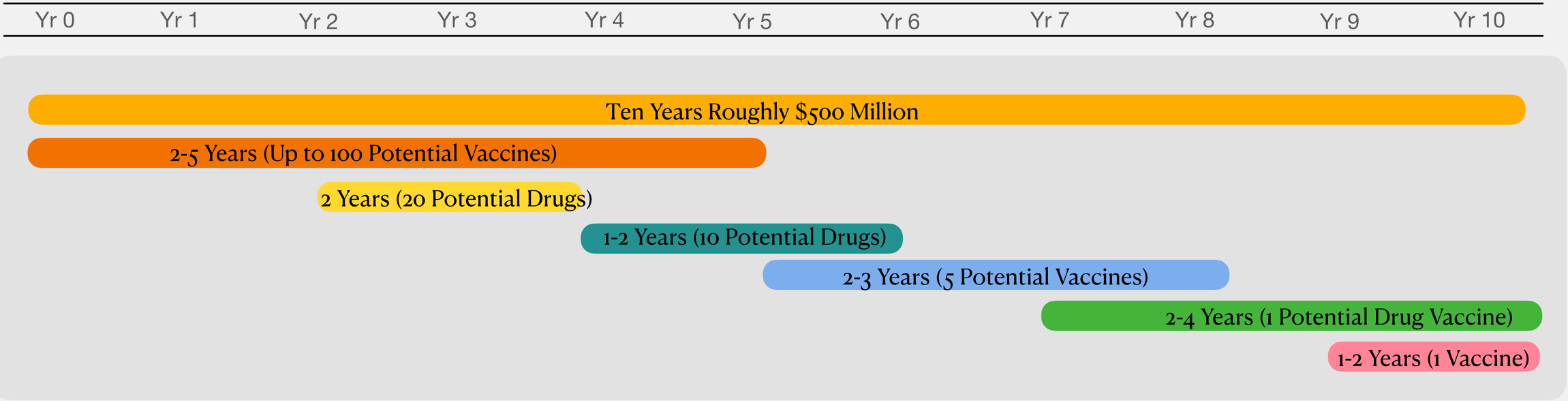
Phase 3 - Is it Better?

So How Long Does This Usually Take for Vaccines?



THE FIVE STAGES OF VACCINE DEVELOPMENT:

Discovery Research (2-5 years)
Pre-Clinical: Cells, Animals (2 years)
Phase I: Is it Safe? (1-2 years)
Phase II: Does it activate Immune Response? (2-3 years)
Phase III: Does it protect? (2-4 years)
Regulatory Review & Approval (1-2 years)



https://www.weforum.org/agenda/2020/06/vaccine-development-barriers-coronavirus/

Educate

EUA Bypass The Scientific Method

Contains Nonbinding Recommendations

Emergency Use Authorization for Vaccines to Prevent COVID-19

Guidance for Industry

October 2020

Contains Nonbinding Recommendations

Emergency Use Authorization for Vaccines to Prevent COVID-19

Guidance for Industry

This guidance represents the current thinking of the Food and Drug Administration (FDA or Agency) on this topic. It does not establish any rights for any person and is not binding on FDA or the public. You can use an alternative approach if it satisfies the requirements of the applicable statutes and regulations. To discuss an alternative approach, contact the FDA staff responsible for this guidance as listed on the title page.

In general, FDA's guidance documents, including this guidance, do not establish legally enforceable responsibilities. Instead, guidances describe the Agency's current thinking on a topic and should be

Contains Nonbinding Recommendations

viewed only as recommendations, unless specific regulatory or statutory requirements are cited. The use of the word *should* in Agency guidance means that something is suggested or recommended, but not required.

M I S R E P R E S E N T A T I O N

III. CRITERIA AND CONSIDERATIONS FOR THE ISSUANCE OF AN EUA FOR A COVID-19 VACCINE

On February 4, 2020, pursuant to section 564(b)(1)(C) of the FD&C Act (21 U.S.C. 360bbb-3(b)(1)(C)), the Secretary of HHS determined that there is a public health emergency that has a significant potential to affect national security or the health and security of United States citizens living abroad, and that involves the virus that causes COVID-19. On the basis of such determination, on March 27, 2020, the Secretary then declared that circumstances exist justifying the authorization of emergency use of drugs and biological products during the COVID-19 pandemic, pursuant to section 564(b)(1) of the FD&C Act (21 U.S.C. 360bbb-3(b)(1)).[3]

Based on this declaration and determination, FDA may issue an EUA after FDA has determined that the following statutory requirements are met (section 564 of the FD&C Act (21 U.S.C. 360bbb-3)) (Ref. 3):

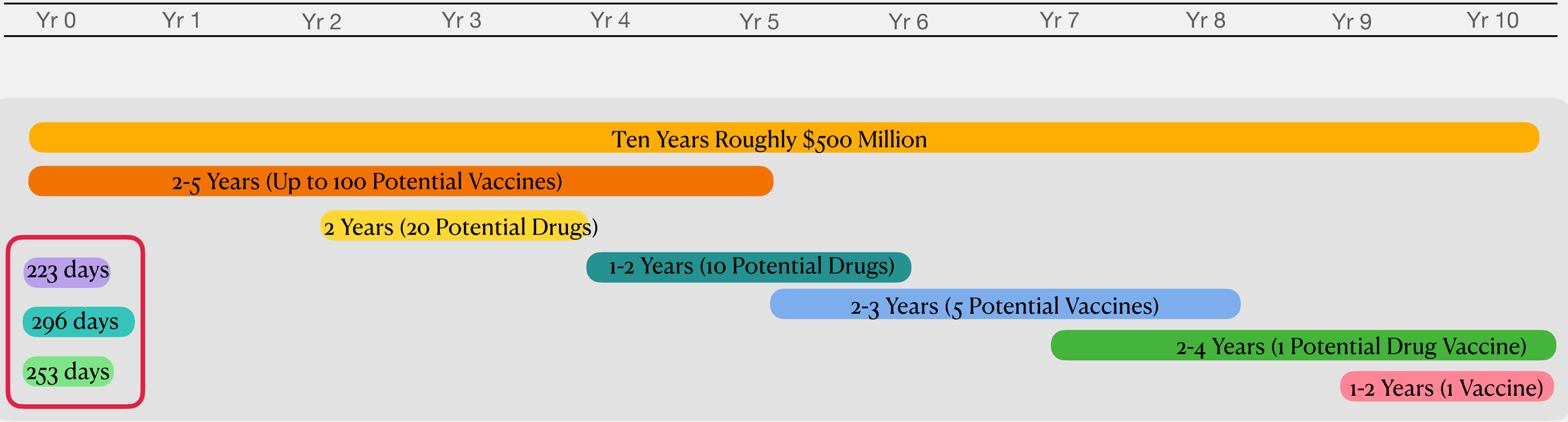
- The chemical, biological, radiological, or nuclear (CBRN) agent referred to in the March 27, 2020 EUA declaration by the Secretary of HHS (SARS-CoV-2) can cause a serious or life-threatening disease or condition.
- Based on the totality of scientific evidence available, including data from adequate and well-controlled trials, if available, it is reasonable to believe that the product may be effective to prevent, diagnose, or treat such serious or life-threatening disease or condition that can be caused by SARS-CoV-2.
- The known and potential benefits of the product, when used to diagnose, prevent, or treat the identified serious or life-threatening disease or condition, outweigh the known and potential risks of the product.
- There is no adequate, approved, and available alternative to the product for diagnosing, preventing, or treating the disease or condition.

In the case of investigational vaccines being developed for the prevention of COVID-19, any assessment regarding an EUA will be made on a case by case basis considering the target population, the characteristics of the product, the preclinical and human clinical study data on the product, and the totality of the available scientific evidence relevant to the product.

So By Definition The EUA No Longer Exists and the Use of PCR and These Experimental Drug Vaccines Are Therefore No Longer Valid.

The EUA Violation of The Scientific Method

	Pfizer BNT162b1/b2	Moderna mRNA1273	Janssen Ad26.COV2.S
	223 days	296 days	253 days
Phase I	4/30/20 NCT04368728	2/25/20 NCT04283461	6/18/20 NCT04436276
Phase II	4/30/20 NCT04368728	5/28/20 NCT04405076 Phase IIa	9/02/20 NCT04535453 Phase IIa
Phase III	4/30/20 NCT04368728	7/14/20 NCT04470427	8/10/20 NCT04505722

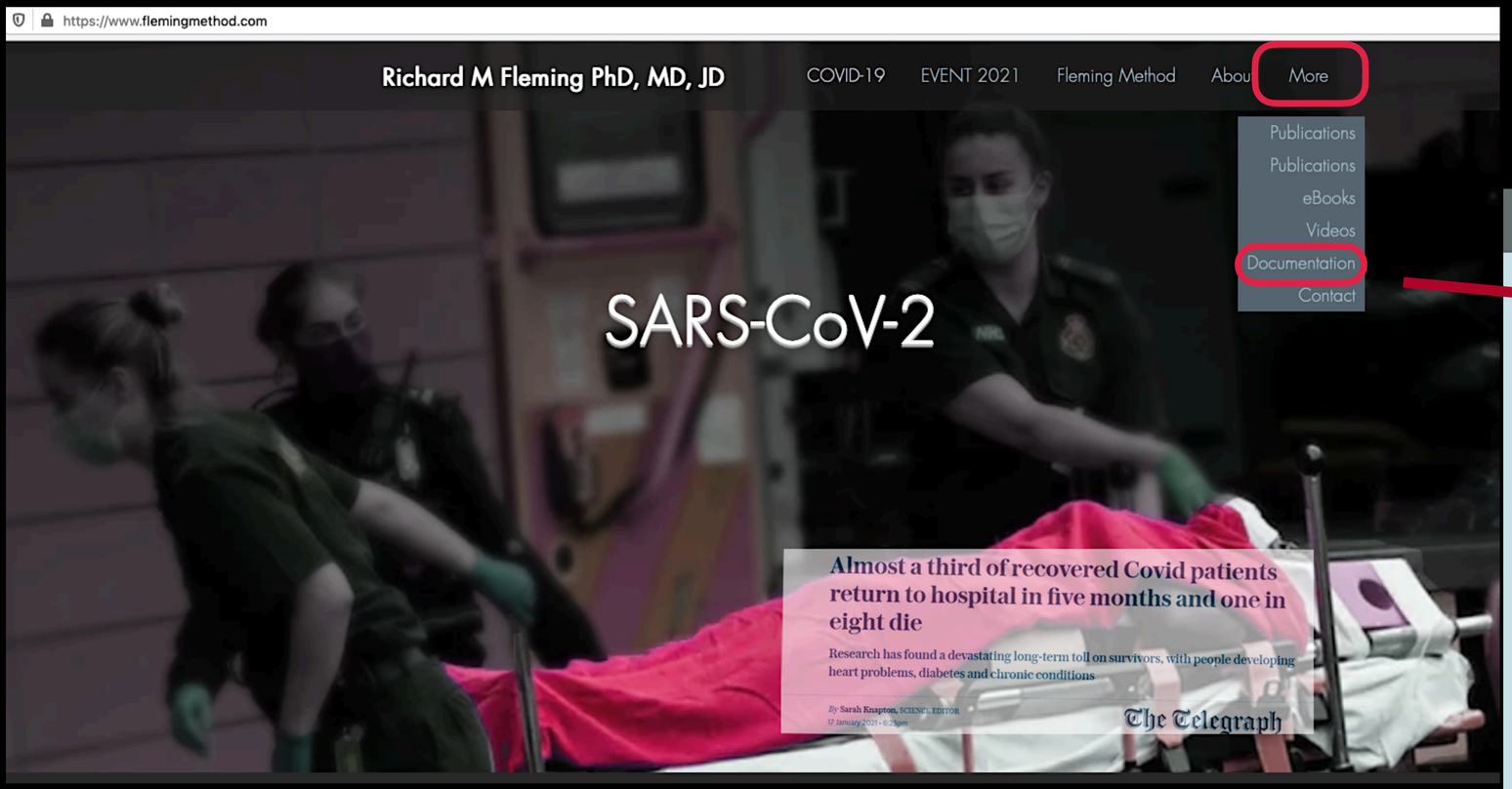


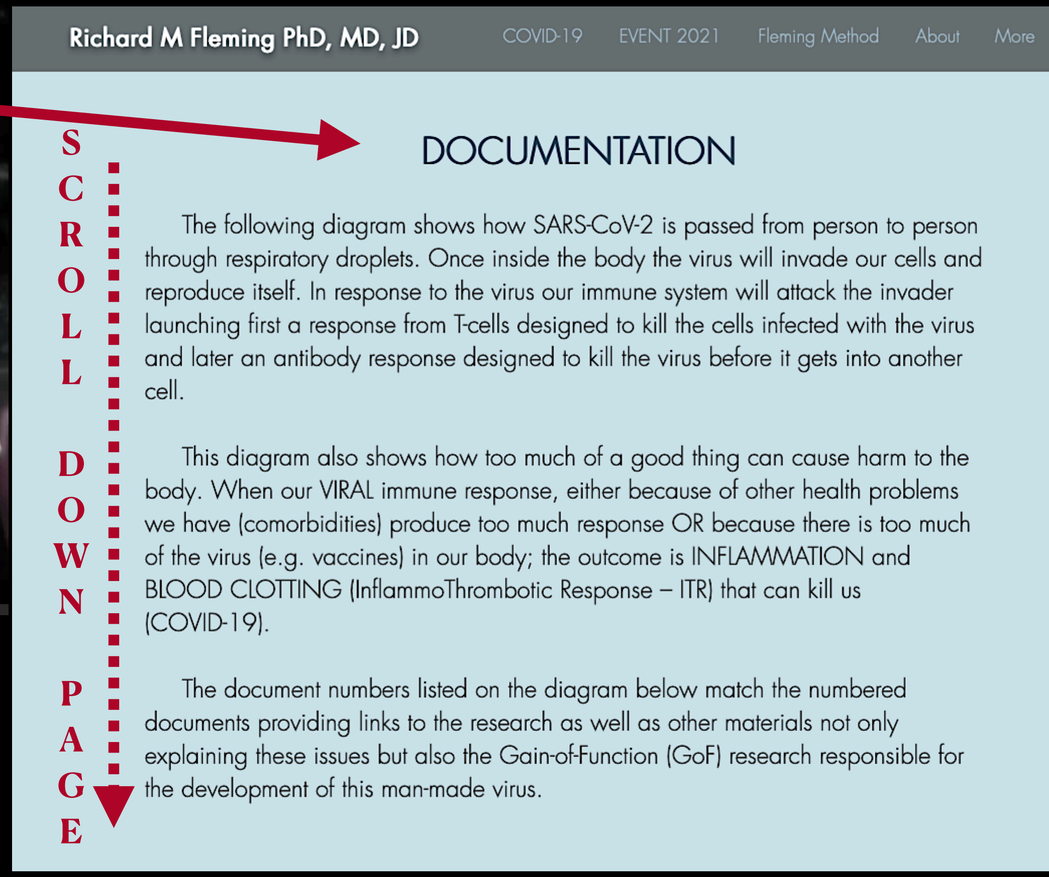
https://www.weforum.org/agenda/2020/06/vaccine-development-barriers-coronavirus/

The Swine Flu Vaccine



Let's Take an In-depth Look at These EUAs and See What They Say. www.FlemingMethod.com





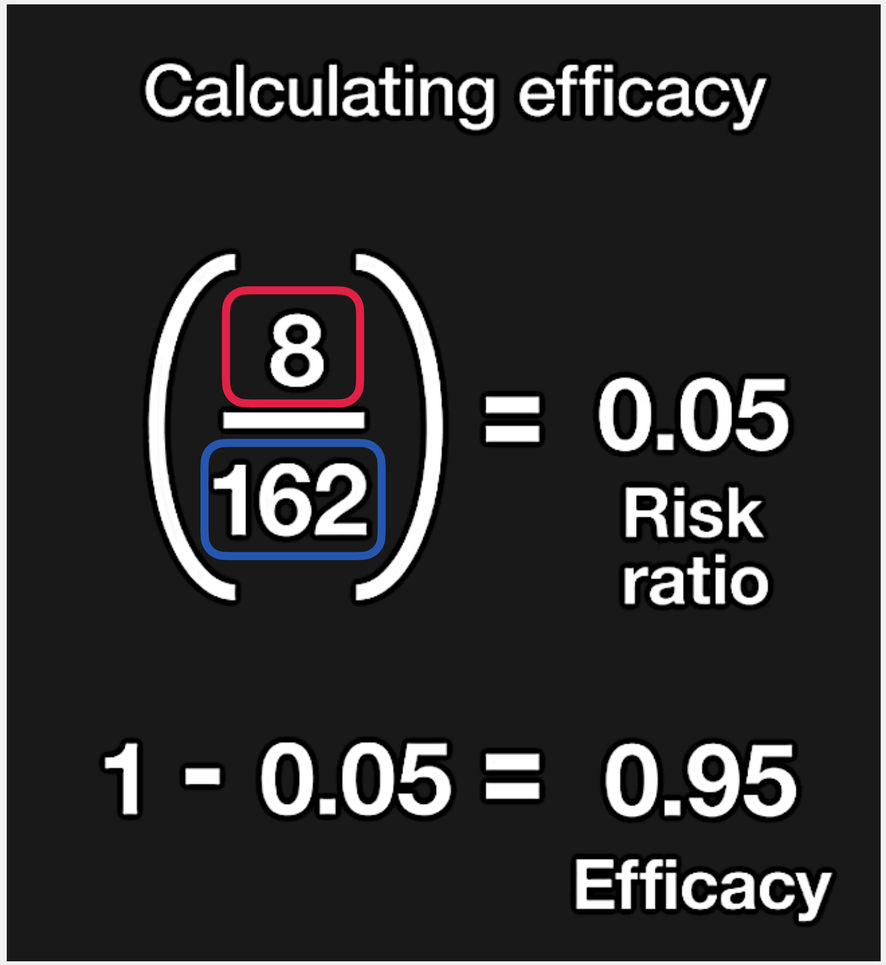
Do The Vaccines Reduce Your Risk of COVID

Relative Risk Reduction (RRR/RR)	**Absolute Risk Reduction (ARR)**	**Number Needed to Vaccinate** (NNV) = **1 ÷ ARR**
The **relative** decrease in being diagnosed with COVID between those vaccinated and those not.	The **actual** difference between those two groups - vaccinated vs non-vaccinated.	The number of people you need to vaccinate to prevent 1-person from being diagnosed with COVID.

What Does Vaccine Efficacy (RRR) Really Mean?

Vaccine Efficacy is 1 minus the Risk Ratio (x 100 for %).

Risk Ratio: The number of people diagnosed with COVID after receiving the Vaccine ÷ The number of people diagnosed with COVID who weren't vaccinated.



So How Did They Decide Who Has COVID?

Diagnosing COVID-19 in Vaccine Trials = **PCR(+) & Symptomatic**.

Pfizer

For the primary efficacy endpoint, the case definition for a confirmed COVID-19 case was the presence of at least one of the following symptoms and a positive SARS-CoV-2 NAAT within 4 days of the symptomatic period:

- Fever;
- New or increased cough;
- New or increased shortness of breath;
- Chills;
- New or increased muscle pain;
- New loss of taste or smell;
- Sore throat;
- Diarrhea;
- Vomiting.

For a secondary efficacy endpoint, a second definition, which may be updated as more is learned about COVID-19, included the following additional symptoms defined by CDC (listed at https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html):

- Fatigue;
- Headache;
- Nasal congestion or runny nose;
- Nausea.

For another secondary endpoint, the case definition for a severe COVID-19 case was a confirmed COVID-19 case with at least one of the following:

- Clinical signs at rest indicative of severe systemic illness (RR ≥30 breaths per minute, HR ≥125 beats per minute, SpO2 ≤93% on room air at sea level, or PaO2/FiO2 <300 mm Hg);
- Respiratory failure (defined as needing high-flow oxygen, noninvasive ventilation, mechanical ventilation, or ECMO);
- Evidence of shock (SBP <90 mm Hg, DBP <60 mm Hg, or requiring vasopressors)
- Significant acute renal, hepatic, or neurologic dysfunction;
- Admission to an ICU;
- Death.

Moderna

Primary Efficacy Endpoint

The primary efficacy endpoint was efficacy of the vaccine to prevent protocol-defined COVID-19 occurring at least 14 days after the second dose in participants with negative SARS-CoV-2 status at baseline (i.e., negative RT-PCR and negative serology against SARS-CoV-2 nucleocapsid on Day 1). The primary analysis was based on the Per-Protocol Set, defined as all randomized, baseline SARS-CoV-2 negative participants who received planned doses per schedule and have no major protocol deviations. For the primary efficacy endpoint, the case definition for a confirmed COVID-19 case was defined as:

- At least TWO of the following systemic symptoms: Fever (≥38°C), chills, myalgia, headache, sore throat, new olfactory and taste disorder(s), or
- At least ONE of the following respiratory signs/ symptoms: cough, shortness of breath or difficulty breathing, OR clinical or radiographical evidence of pneumonia; and
- NP swab, nasal swab, or saliva sample (or respiratory sample, if hospitalized) positive for SARS-CoV-2 by RT-PCR.

Secondary Efficacy Endpoints

Secondary endpoints based on the Per-Protocol Set included the VE of mRNA-1273 to prevent the following:

- Severe COVID-19 (as defined below)
- COVID-19 based on a less restrictive definition of disease (defined below) occurring at least 14 days after the second dose of vaccine
- Death due to COVID-19
- COVID-19 occurring at least 14 days after the first dose of vaccine (including cases that occurred after the second dose)

One additional secondary endpoint was based on the Full Analysis Set (FAS): VE of mRNA-1273 to prevent COVID-19 occurring at least 14 days after the second dose, regardless of prior SARS-CoV-2 infection.

One of the secondary efficacy endpoints assessed COVID-19 as defined by a less restrictive definition: a positive NP swab, nasal swab, or saliva sample (or respiratory sample, if hospitalized) for SARS-CoV-2 by RT-PCR **and** one of the following systemic symptoms:

- fever (temperature ≥38°C), or
- chills,
- cough,
- shortness of breath or difficulty breathing,
- fatigue,
- muscle aches or body aches,
- headache,
- new loss of taste or smell,
- sore throat,
- nasal congestion or rhinorrhea,
- nausea or vomiting, or diarrhea

Another secondary endpoint assessed cases of severe COVID-19, defined as a case of confirmed COVID-19 plus at least one of the following:

- Clinical signs at rest indicative of severe systemic illness (RR ≥30 breaths per minute, HR ≥125 beats per minute, SpO2≤93% on room air at sea level, or PaO2/FiO2<300 mm Hg);
- Respiratory failure or Acute Respiratory Distress Syndrome, (defined as needing high-flow oxygen, noninvasive ventilation, mechanical ventilation, or ECMO);
- Evidence of shock (SBP <90 mm Hg, DBP <60 mm Hg, or requiring vasopressors)
- Significant acute renal, hepatic, or neurologic dysfunction;
- Admission to an ICU;
- Death

Janssen (J&J)

Moderate COVID-19	Severe/Critical COVID-19
Any 1 of the following new or worsening signs or symptoms: • Respiratory rate ≥20 breaths/minute • Abnormal saturation of oxygen (SpO_2) but still >93% on room air at sea level • Clinical or radiologic evidence of pneumonia • Radiologic evidence of deep vein thrombosis • Shortness of breath or difficulty breathing OR **Any 2 of the following new or worsening signs or symptoms:** • Fever (≥38.0°C or ≥100.4°F) • Heart rate ≥90 beats/minute • Shaking chills or rigors • Sore throat • Cough • Malaise as evidenced by loss of appetite, fatigue, physical weakness, and/or feeling unwell • Headache • Muscle pain (myalgia) • Gastrointestinal symptoms (diarrhea, vomiting, nausea, abdominal pain) • New or changing olfactory or taste disorders • Red or bruised looking feet or toes	**Any one of the following at any time during the course of observation:** • Clinical signs at rest indicative of severe systemic illness (respiratory rate ≥30 breaths/minute, heart rate ≥125 beats/minute, oxygen saturation (SpO_2) ≤93% on room air at sea level, or partial pressure of oxygen/fraction of inspired oxygen (PaO_2/FiO_2) <300 mmHg) • Respiratory failure (defined as needing high-flow oxygen, non-invasive ventilation, mechanical ventilation, or extracorporeal membrane oxygenation [ECMO]) • Evidence of shock (defined as systolic blood pressure <90 mmHg, diastolic blood pressure <60 mmHg, or requiring vasopressors) • Significant acute renal, hepatic, or neurologic dysfunction • Admission to the ICU • Death

*Kary Mullis & PCR

Let’s Look at Pfizer Vaccine Efficacy.

The calculated Vaccine Efficacy was 95%. Page 24 of EUA.

Table 6. Final Analysis of Efficacy of BNT162b2 Against Confirmed COVID-19 From 7 Days After Dose 2 in Participants Without Evidence of Prior SARS-CoV-2 Infection - Evaluable Efficacy Population

Pre-specified Age Group	BNT162b2 N[a] = 18198 Cases n1[b] Surveillance Time[c] (n2[d])	Placebo N[a] =18325 Cases n1[b] Surveillance Time[c] (n2[d])	Vaccine Efficacy % (95% CI)	Met Predefined Success Criterion*
All participants	8 2.214 (17411)	162 2.222 (17511)	95.0 (90.3, 97.6)[e]	Yes
16 to 55 years	5 1.234 (9897)	114 1.239 (9955)	95.6 (89.4, 98.6)[f]	NA
> 55 years and older	3 0.980 (7500)	48 0.983 (7543)	93.7 (80.6, 98.8)[f]	NA

*Success criterion: the posterior probability that true vaccine efficacy > 30% conditioning on the available data is >99.5% at the final analysis

[a] N = number of participants in the specified group.

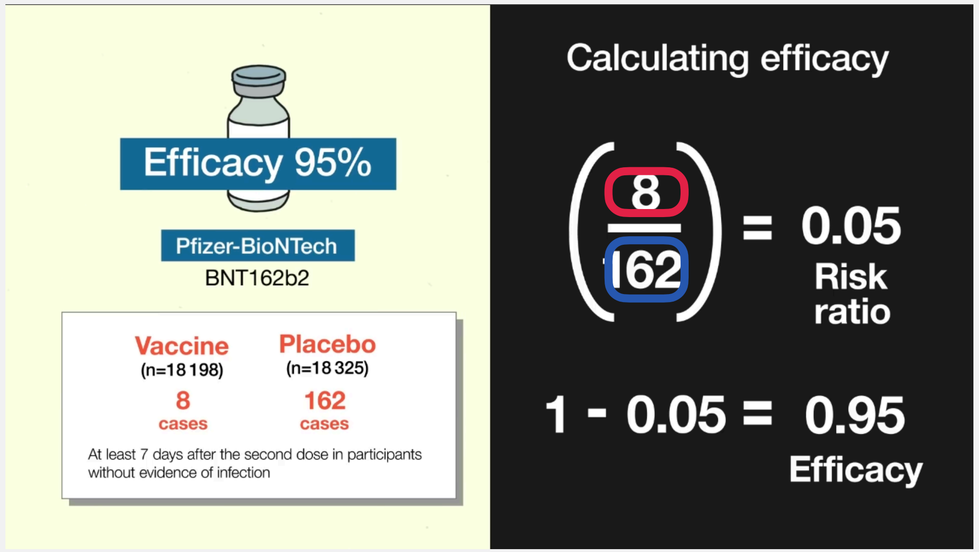
[b] n1 = Number of participants meeting the endpoint definition.

[c] Total surveillance time in 1000 person-years for the given endpoint across all participants within each group at risk for the endpoint. Time period for COVID-19 case accrual is from 7 days after Dose 2 to the end of the surveillance period.

[d] n2 = Number of participants at risk for the endpoint.

[e] Credible interval for VE was calculated using a beta-binomial model with prior beta (0.700102, 1) adjusted for surveillance time.

[f] Confidence interval (CI) for VE is derived based on the Clopper and Pearson method adjusted to the surveillance time.



But the Goal is to Prevent COVID

Did The Pfizer Vaccine Do Better at Preventing COVID Than Having No Vaccine?

7 Days after 2nd Injection there were fewer cases of COVID but The Difference in the number of cases wasn't statistically significant. *p=NS*

Table 6. Final Analysis of Efficacy of BNT162b2 Against Confirmed COVID-19 From 7 Days After Dose 2 in Participants Without Evidence of Prior SARS-CoV-2 Infection - Evaluable Efficacy Population

Pre-specified Age Group	BNT162b2 N[a] = 18198 Cases n1[b] Surveillance Time[c] (n2[d])	Placebo N[a] =18325 Cases n1[b] Surveillance Time[c] (n2[d])	Vaccine Efficacy % (95% CI)	Met Predefined Success Criterion*
All participants	8 2.214 (17411)	162 2.222 (17511)	95.0 (90.3, 97.6)[e]	Yes
16 to 55 years	5 1.234 (9897)	114 1.239 (9955)	95.6 (89.4, 98.6)[f]	NA
> 55 years and older	3 0.980 (7500)	48 0.983 (7543)	93.7 (80.6, 98.8)[f]	NA

*Success criterion: the posterior probability that true vaccine efficacy > 30% conditioning on the available data is >99.5% at the final analysis

[a] N = number of participants in the specified group.

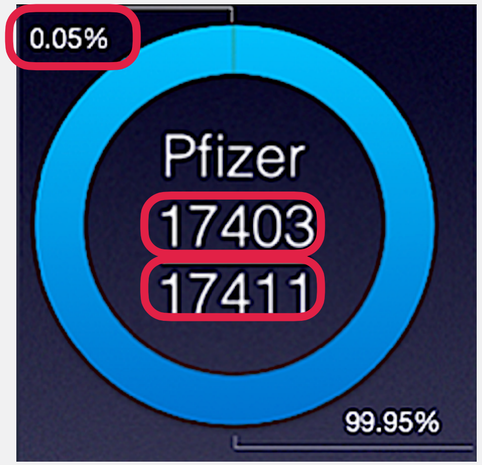
[b] n1 = Number of participants meeting the endpoint definition.

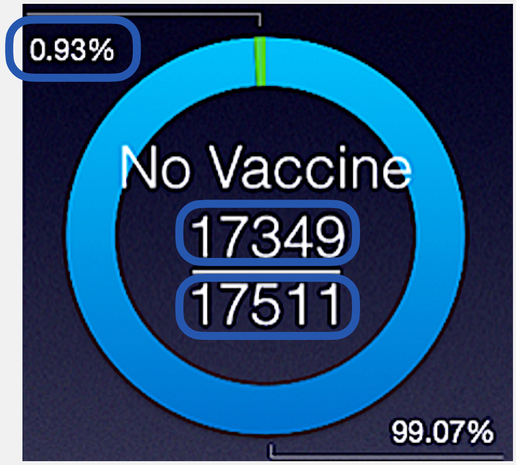
[c] Total surveillance time in 1000 person-years for the given endpoint across all participants within each group at risk for the endpoint. Time period for COVID-19 case accrual is from 7 days after Dose 2 to the end of the surveillance period.

[d] n2 = Number of participants at risk for the endpoint.

[e] Credible interval for VE was calculated using a beta-binomial model with prior beta (0.700102, 1) adjusted for surveillance time.

[f] Confidence interval (CI) for VE is derived based on the Clopper and Pearson method adjusted to the surveillance time.





	Observed	Expected	*Marginal Row Totals*
Pfizer	17403 (17326.25) [0.34]	17249 (17325.75) [0.34]	34652
Nothing	17349 (17425.75) [0.34]	17502 (17425.25) [0.34]	34851
Marginal Column Totals	34752	34751	69503 (Grand Total)

The chi-square statistic is 1.3561. The *p*-value is .244218. *Not* significant at $p < .05$.

The chi-square statistic with Yates correction is 1.3385. The *p*-value is .247304. *Not* significant at $p < .05$.

Absolute Risk Reduction (ARR) = 0.93% minus 0.05% = 0.88%

Did the Pfizer Vaccine Reduce COVID Deaths?

Going to the Pfizer EUA Documents (page 41) Where We Find this Information.

Deaths

A total of six (2 vaccine, 4 placebo) of 43,448 enrolled participants (0.01%) died during the reporting period from April 29, 2020 (first participant, first visit) to November 14, 2020 (cutoff date). Both vaccine recipients were >55 years of age; one experienced a cardiac arrest 62 days after vaccination #2 and died 3 days later, and the other died from arteriosclerosis 3 days after vaccination #1. The placebo recipients died from myocardial infarction (n=1), hemorrhagic stroke (n=1) or unknown causes (n=2); three of the four deaths occurred in the older group (>55 years of age). All deaths represent events that occur in the general population of the age groups where they occurred, at a similar rate.

Issue	Pfizer	No Vaccine
Death	2 of 21621 (0.0%)	4 of 21631 (0.0%)
MI		1
Cardiac arrest	1	
ASCAD	1	
Hemorrhagic CVS		1
Unknown		2

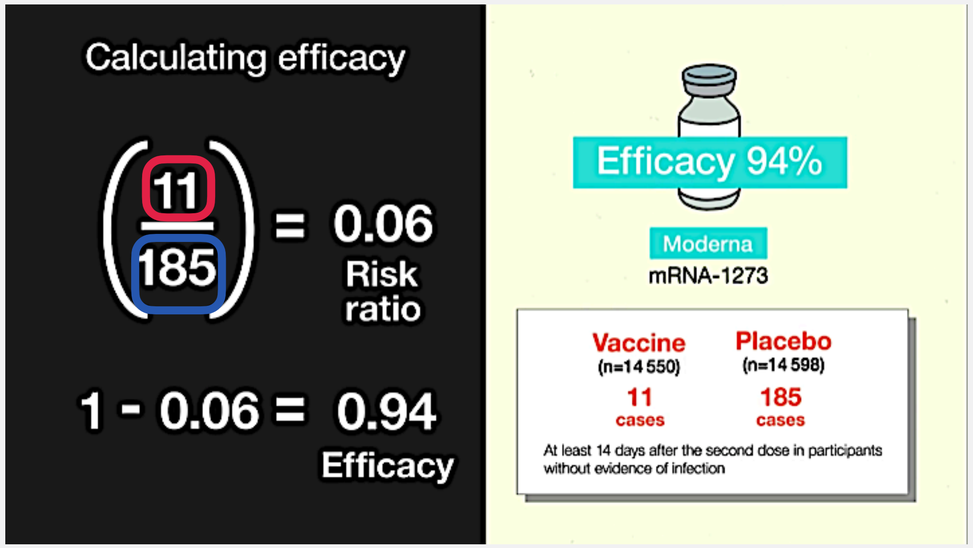
There is no statistically significant difference in the numbers of deaths and they represent what is seen in the general population.

Let’s Look at Moderna Vaccine Efficacy.

The calculated Vaccine Efficacy was 94%. Page 29 of EUA.

Table 17. Final Scheduled Efficacy Analysis, Primary Endpoint, COVID-19 Starting 14 Days After the Second Dose per Adjudication Committee Assessments, Per-Protocol Set

Primary Endpoint: COVID-19 (per adjudication committee assessment)	Vaccine Group N=13934 Cases n (%) (Incidence Rate per 1,000 person-years)*	Placebo Group N=13883 Cases n (%) (Incidence Rate per 1,000 person-years)*	Vaccine Efficacy (VE) % (95% CI)**	Met Predefined Success Criterion***
All participants	11 (<0.1) 3.328	185 (1.3) 56.510	94.1% (89.3%, 96.8%)	Yes
18 to <65 years[1]	7/10551 (<0.1) 2.875	156/10521 (1.5) 64.625	95.6%; (90.6%, 97.9%)	NA
65 years and older[2]	4/3583 (0.1); 4.595	29/3552 (0.8); 33.728	86.4%; (61.4%, 95.5%)	NA



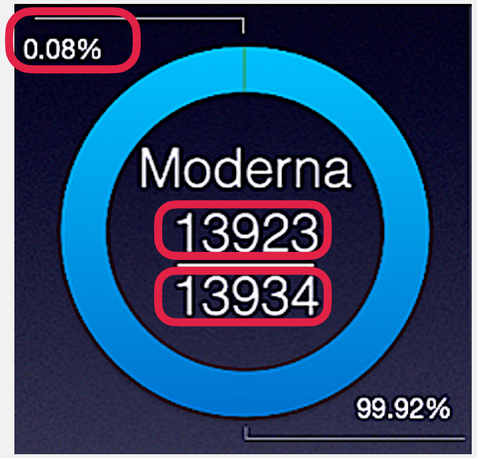
But the Goal is to Prevent COVID

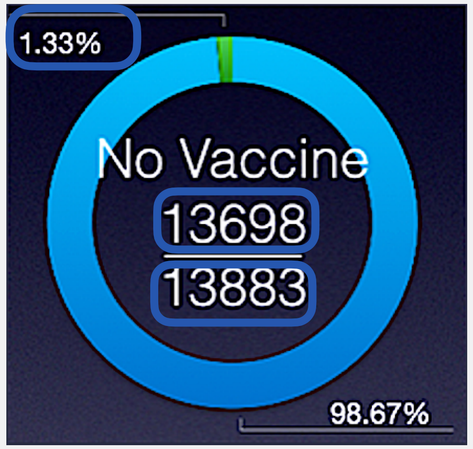
Did The Moderna Vaccine Do Better at Preventing COVID Than Having No Vaccine?

14 Days after 2nd Injection there were fewer cases of COVID but The Difference in the number of cases wasn't statistically significant. *p=NS*

Table 17. Final Scheduled Efficacy Analysis, Primary Endpoint, COVID-19 Starting 14 Days After the Second Dose per Adjudication Committee Assessments, Per-Protocol Set

Primary Endpoint: COVID-19 (per adjudication committee assessment)	Vaccine Group N=13934 Cases n (%) (Incidence Rate per 1,000 person-years)*	Placebo Group N=13883 Cases n (%) (Incidence Rate per 1,000 person-years)*	Vaccine Efficacy (VE) % (95% CI)**	Met Predefined Success Criterion***
All participants	11 (<0.1) 3.328	185 (1.3) 56.510	94.1% (89.3%, 96.8%)	Yes
18 to <65 years[1]	7/10551 (<0.1) 2.875	156/10521 (1.5) 64.625	95.6%; (90.6%, 97.9%)	NA
65 years and older[2]	4/3583 (0.1); 4.595	29/3552 (0.8); 33.728	86.4%; (61.4%, 95.5%)	NA





	Observed	Expected	Marginal Row Totals
Moderna	13923 (13836) [0.55]	13749 (13836) [0.55]	27672
Nothing	13698 (13785) [0.55]	13872 (13785) [0.55]	27570
Marginal Column Totals	27621	27621	55242 (Grand Total)

The chi-square statistic is 2.1923. The *p*-value is .138706 *Not* significant at $p < .05$.

The chi-square statistic with Yates correction is 2.1671. The *p*-value is .140989. *Not* significant at $p < .05$.

Absolute Risk Reduction (ARR) = 1.33% minus 0.08% = 1.25%

Did the Moderna Vaccine Reduce COVID Deaths?

Going to the Moderna EUA Documents (pages 42-43) We Find this Information.

Deaths

As of December 3, 2020, 13 deaths were reported (6 vaccine, 7 placebo). Two deaths in the vaccine group were in participants >75 years of age with pre-existing cardiac disease; one

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Moderna COVID-19 Vaccine
VRBPAC Briefing Document

participant died of cardiopulmonary arrest 21 days after dose 1, and one participant died of myocardial infarction 45 days after dose 2. Another two vaccine recipients were found deceased at home, and the cause of these deaths is uncertain: a 70-year-old participant with cardiac disease was found deceased 57 days after dose 2, and a 56-year-old participant with hypertension, chronic back pain being treated with opioid medication died 37 days after dose 1 (The official cause of death was listed as head trauma). One case was a 72-year-old vaccine recipient with Crohn's disease and short bowel syndrome who was hospitalized for thrombocytopenia and acute kidney failure due to obstructive nephrolithiasis 40 days after dose 2 and developed complications resulting in multiorgan failure and death. One vaccine recipient died of suicide 21 days after dose 1. The placebo recipients died from myocardial infarction (n=3), intra-abdominal perforation (n=1), systemic inflammatory response syndrome in the setting of known malignancy (n=1), COVID-19 (n=1), and unknown cause (n=1). These deaths represent events and rates that occur in the general population of individuals in these age groups.

Issue	Moderna	No Vaccine
Death	6 of 15,184 (0.04%)	7 of 15,165 (0.05%)
MI	1	3
Cardiac arrest	1	
Thrombocytopenia and Multiorgan failure	1	
Suicide	1	
Cancer		1
Abdominal Perforation		1
Head Trauma	1	
Unknown	1	1

There is no statistically significant difference in the numbers of deaths and they represent what is seen in the general population.

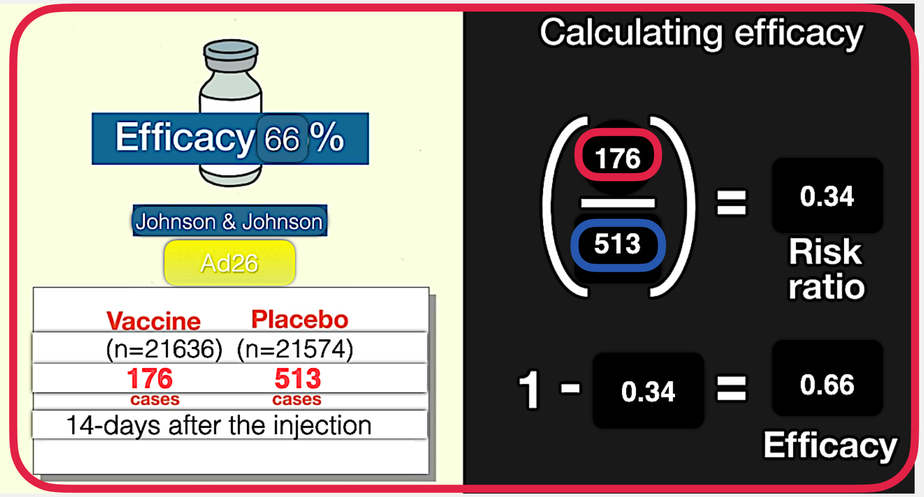
Let’s Look at Janssen Vaccine Efficacy.

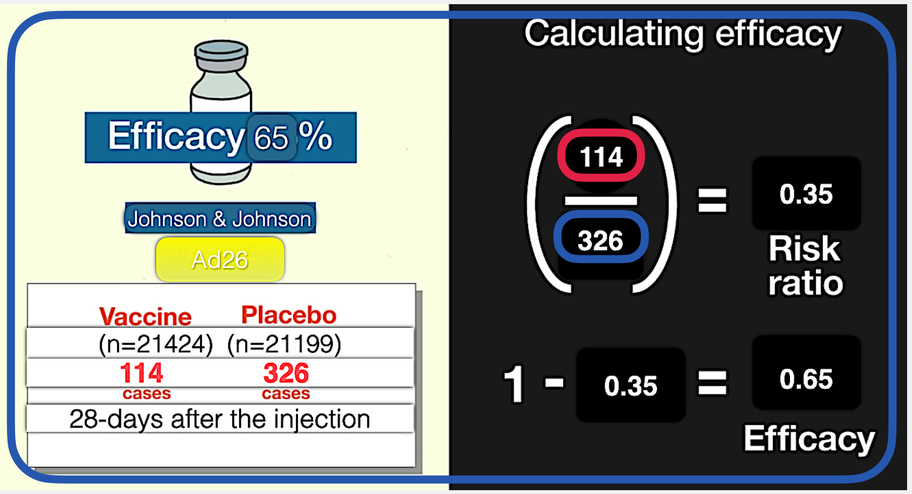
The calculated Vaccine Efficacy was 66.1% (14 days) or 65.5% (28 days). Page 30 of EUA.

Table 14. Vaccine Efficacy of First Occurrence of Moderate to Severe/Critical COVID-19, Including Non-centrally Confirmed Cases, With Onset at Least 14 or at Least 28 Days After Vaccination, by Baseline SARS-CoV-2 Status[a], Per Protocol Set

	Onset at Least 14 Days			Onset at Least 28 Days		
Baseline SARS-CoV-2 Serostatus[a]	Ad26.COV2.S Cases (N) Person-yrs	Placebo Cases (N) Person-yrs	VE% (95% CI)	Ad26.COV2.S Cases (N) Person-yrs	Placebo Cases (N) Person-yrs	VE%[b] (95% CI)
Regardless of baseline SARS-CoV-2 status	176 (21636) 3450.2	513 (21574) 3409.8	66.1% (59.7, 71.6)	114 (21424) 3436.3	326 (21199) 3385.9	65.5% (57.2, 72.4)
Positive	3 (2122) 336.3	4 (2030) 320.8	28.5% (-322.8, 89.5)	1 (2118) 336.1	2 (2021) 320.0	
Negative	173 (19514) 3113.9	509 (19544) 3089.1	66.3% (59.9, 71.8)	113 (19306) 3100.3	324 (19178) 3065.9	65.5% (57.2, 72.4)

Source: Sponsor tables GEFPE07A, GEFPE07C
N=Total number of participants at risk per category
[a] Based on serological test at baseline
[b] If fewer than 6 cases are observed for an endpoint then the VE is not shown





But the Goal is to Prevent COVID

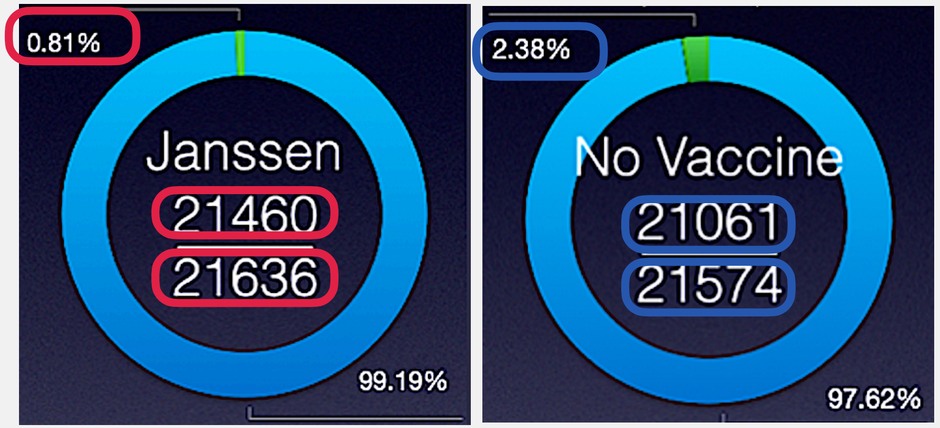
Did The Janssen Vaccine Do Better at Preventing COVID Than Having No Vaccine?

14 Days after the Injection there were fewer cases of COVID & The Difference in the number of cases was statistically significant. $p \leq 0.05$

Table 14. Vaccine Efficacy of First Occurrence of Moderate to Severe/Critical COVID-19 Including Non-centrally Confirmed Cases, With Onset at Least 14 or at Least 28 Days After Vaccination, by Baseline SARS-CoV-2 Status[a], Per Protocol Set

	Onset at Least 14 Days			Onset at Least 28 Days		
Baseline SARS-CoV-2 Serostatus[a]	Ad26.COV2.S Cases (N) Person-yrs	Placebo Cases (N) Person-yrs	VE% (95% CI)	Ad26.COV2.S Cases (N) Person-yrs	Placebo Cases (N) Person-yrs	VE%[b] (95% CI)
Regardless of baseline SARS-CoV-2 status	176 21636 3450.2	513 (21574) 3409.8	66.1% (59.7, 71.6)	114 (21424) 3436.3	326 (21199) 3385.9	65.5% (57.2, 72.4)
Positive	3 (2122) 336.3	4 (2030) 320.8	28.5% (-322.8, 89.5)	1 (2118) 336.1	2 (2021) 320.0	
Negative	173 (19514) 3113.9	509 (19544) 3089.1	66.3% (59.9, 71.8)	113 (19306) 3100.3	324 (19178) 3065.9	65.5% (57.2, 72.4)

Source: Sponsor tables GEFPE07A, GEFPE07C
N=Total number of participants at risk per category
[a] Based on serological test at baseline
[b] If fewer than 6 cases are observed for an endpoint then the VE is not shown



	Observed	Expected	Marginal Row Totals
Johnson & Johnson	21460 (21290.75) [1.35]	21121 (21290.25) [1.35]	42581
Nothing	21061 (21230.25) [1.35]	21399 (21229.75) [1.35]	42460
Marginal Column Totals	42521	42520	85041 (Grand Total)

The chi-square statistic is 5.3895. The p-value is .020258. Significant at $p < .05$.

The chi-square statistic with Yates correction is 5.3577. The p-value is .020631. Significant at $p < .05$.

N.B. On page 6 of the EUA,

Absolute Risk Reduction (ARR) = 2.38% minus 0.81% = 1.57%

But the Goal is to Prevent COVID

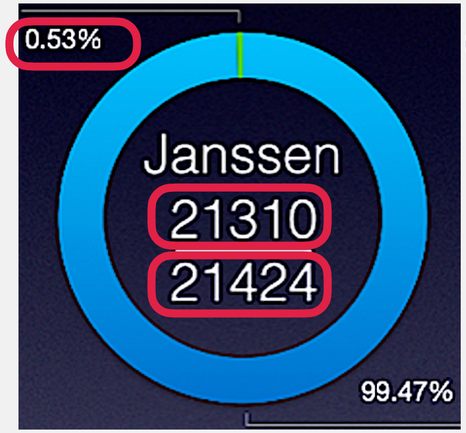
Did The Janssen Vaccine CONTINUE to do Better at Preventing COVID Than Having No Vaccine?

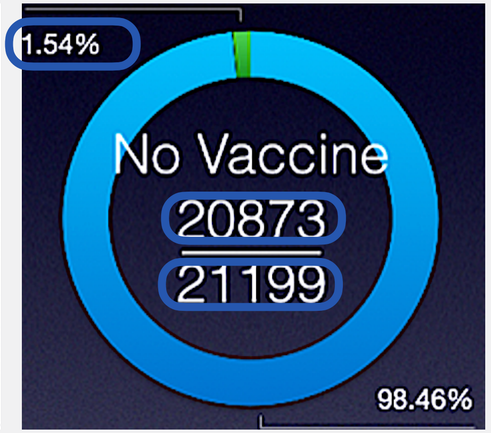
28 Days after the Injection there were fewer cases of COVID but The Difference was NO LONGER statistically significant. *p=NS*

Table 14. Vaccine Efficacy of First Occurrence of Moderate to Severe/Critical COVID-19 Including Non-centrally Confirmed Cases, With Onset at Least 14 or at Least 28 Days After Vaccination, by Baseline SARS-CoV-2 Status[a], Per Protocol Set

	Onset at Least 14 Days			Onset at Least 28 Days		
Baseline SARS-CoV-2 Serostatus[a]	Ad26.COV2.S Cases (N) Person-yrs	Placebo Cases (N) Person-yrs	VE% (95% CI)	Ad26.COV2.S Cases (N) Person-yrs	Placebo Cases (N) Person-yrs	VE%[b] (95% CI)
Regardless of baseline SARS-CoV-2 status	176 (21636) 3450.2	513 (21574) 3409.8	66.1% (59.7, 71.6)	114 (21424) 3436.3	326 21199 3385.9	65.5% (57.2, 72.4)
Positive	3 (2122) 336.3	4 (2030) 320.8	28.5% (-322.8, 89.5)	1 (2118) 336.1	2 (2021) 320.0	
Negative	173 (19514) 3113.9	509 (19544) 3089.1	66.3% (59.9, 71.8)	113 (19306) 3100.3	324 (19178) 3065.9	65.5% (57.2, 72.4)

Source: Sponsor tables GEFPE07A, GEFPE07C
N=Total number of participants at risk per category
[a] Based on serological test at baseline
[b] If fewer than 6 cases are observed for an endpoint then the VE is not shown





	Observed	Expected	*Marginal Row Totals*
Johnson & Johnson	21310 (21202.5) [0.55]	21094 (21201.5) [0.55]	42404
Nothing	20873 (20980.5) [0.55]	21087 (20979.5) [0.55]	41960
Marginal Column Totals	42183	42181	84364 (Grand Total)

The chi-square statistic is 2.1916. The *p*-value is .138761 *Not* significant at $p < .05$.

The chi-square statistic with Yates correction is 2.1713. The *p*-value is .140607. *Not* significant at $p < .05$.

Absolute Risk Reduction (ARR) = 1.54% minus 0.53% = 1.01%

But Are These the Table 14 Numbers The Correct COVID Numbers to Use?

Page 14 Janssen EUA: "Molecular **confirmation** of SARS-CoV-2 infection (using the Abbott Real Time SARS-CoV-2 RT-PCR assay) by the **central laboratory** was required to meet the co-primary and secondary efficacy endpoint case definitions."

Table 14. Vaccine Efficacy of First Occurrence of Moderate to Severe/Critical COVID-19, Including Non-centrally Confirmed Cases, With Onset at Least 14 or at Least 28 Days After Vaccination, by Baseline SARS-CoV-2 Status[a], Per Protocol Set

	Onset at Least 14 Days			Onset at Least 28 Days		
Baseline SARS-CoV-2 Serostatus[a]	Ad26.COV2.S Cases (N) Person-yrs	Placebo Cases (N) Person-yrs	VE% (95% CI)	Ad26.COV2.S Cases (N) Person-yrs	Placebo Cases (N) Person-yrs	VE%[b] (95% CI)
Regardless of baseline SARS-CoV-2 status	176 (21636) 3450.2	513 (21574) 3409.8	66.1% (59.7, 71.6)	114 (21424) 3436.3	326 (21199) 3385.9	65.5% (57.2, 72.4)
Positive	3 (2122) 336.3	4 (2030) 320.8	28.5% (-322.8, 89.5)	1 (2118) 336.1	2 (2021) 320.0	
Negative	173 (19514) 3113.9	509 (19544) 3089.1	66.3% (59.9, 71.8)	113 (19306) 3100.3	324 (19178) 3065.9	65.5% (57.2, 72.4)

Source: Sponsor tables GEFPE07A, GEFPE07C
N=Total number of participants at risk per category
[a] Based on serological test at baseline
[b] If fewer than 6 cases are observed for an endpoint then the VE is not shown

Table 15. Vaccine Efficacy Against Centrally Confirmed COVID-19[a] With Onset at Least 14 or at Least 28 Days After Vaccination, Per-Protocol Set, Study 3001

	Onset at Least 14 Days			Onset at Least 28 Days		
	Ad26.COV2.S Cases (N) Person-yrs	Placebo Cases (N) Person-yrs	VE% (95% CI)	Ad26.COV2.S Cases (N) Person-yrs	Placebo Cases (N) Person-yrs	VE% (95% CI)
Symptomatic COVID-19, any severity[a]	117 (19514) 3116.5	351 (19544) 3095.9	66.9% (59.1, 73.4)	66 (19306) 3102.0	195 (19178) 3070.5	66.5% (55.5, 75.1)
FDA harmonized COVID-19 cases	114 (19514) 3116.6	345 (19544) 3096.3	67.2% (59.3, 73.7)	65 (19306) 3102.0	193 (19178) 3070.6	66.7% (55.6, 75.2)

Source: Sponsor tables TEFSUM01_A, TEMSUM01_C
N=Total number of participants at risk per category
[a] Includes mild, moderate, and severe/critical cases

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There were 32.2 to 42.1 % fewer COVID cases Confirmed by the Central Lab.

And Finally When we Remove “Mild” COVID Cases.

Also from page 6 of the Janssen EUA: Note What Happens to these Numbers when the “Mild” Cases of COVID are Removed From the Centrally Confirmed Laboratory?

	Vaccinated (14 days)	Placebo (14 days)	Vaccinated (28 days)	Placebo (28 days)
Table 14 (Not Centrally Confirmed) Moderate to Severe	176	513	114	326
Table 15 (Centrally Confirmed) Mild - Moderate - Severe	117	351	66	195
EUA page 6 (Centrally Confirmed) Moderate to Severe	116 (65.9%)	348 (67.8%)	66 (57.9%)	193 (59.8%)

There were 32.2 to 42.1 % fewer COVID cases Confirmed by the Central Lab.

Did the Janssen Vaccine Reduce COVID Deaths?

Going to the Janssen EUA Documents (page 53) We Find this Information.

As of February 5, 2021, a total of 25 deaths were reported in the study (5 vaccine, 20 placebo). These deaths represent events and rates that occur in the general population of individuals in these age groups and include 7 deaths in the placebo group due to COVID-19 infection. Non-fatal serious adverse events, excluding those due to COVID-19, were infrequent and balanced between treatment groups with respect to rates and types of events (0.4% in both groups). A serious event of a hypersensitivity reaction, not classified as anaphylaxis, beginning 2 days following vaccination was likely related to receipt of the vaccine.

Page 34.
All of the reported COVID deaths were from South Africa with Comorbidities.

COVID-19 Related Deaths

As of February 5, 2021, there were 7 COVID-19-related deaths reported in the study. All participants had a documented positive SARS-CoV-2 RT-PCR around the time of the event, but not all have been centrally confirmed to date. All 7 deaths occurred in the placebo group and were in study sites in South Africa. All of these participants had one or more comorbidities which placed them at higher risk for severe COVID-19. One death was in a participant PCR positive at baseline, who had onset of illness 10 days after vaccination. These results suggest that the vaccine is efficacious against mortality associated with COVID-19. Outcomes related to an exploratory all-cause mortality endpoint are discussed in a separate section below.

Table 19. COVID-19 Related Deaths

Arm	Study Day[c]	Age	Comorbidity
Placebo	15	63	Obesity, Hypertension
Placebo	18[a]	52	Obesity, Diabetes
Placebo	31	54	Obesity, Hypertension, Diabetes, Heart failure
Placebo	38	49	Obesity, Hypertension
Placebo	39	68	Obesity
Placebo	49[b]	60	Obesity
Placebo	55	60	Asthma

[a] Participant with positive SARS-CoV-2 PCR at baseline
[b] Reported after the primary analysis cutoff date of January 22, 2021
[c] Study day of death

No autopsy results are reported and 64% of the cases are reported as either dying from COVID or UNKNOWN causes.

Issue	Janssen	No Vaccine
Death	5 of 21424 (0.02%)	20 of 21199 (0.09%)
MI		1
Suicide		1
Pnuemonia	2	2
Dyspnea	1	
Drug Overdose		1
Malaise		1
Unknown	2	7
COVID	0	7

There is no statistically significant difference in the numbers of deaths and they represent what is seen in the general population.

Janssen Vaccine Thromboembolic Events.

The EUA Documents reveal issues with Thrombotic and Neurologic Consequences beginning with page 7.

Among all adverse events collected through the January 22, 2021 data cutoff, a numerical imbalance was seen in non-serious urticaria events reported in the vaccine group (n=5) compared to placebo group (n=1) within 7 days following vaccination which is possibly related to the vaccine. Numerical imbalances were observed between vaccine and placebo recipients for thromboembolic events (15 versus 10) and tinnitus (6 versus 0). Data at this time are insufficient to determine a causal relationship between these events and the vaccine. There were no other notable patterns or numerical imbalances in the available data as of the cutoff date between treatment groups for specific categories of adverse events that would suggest a causal relationship to Ad26.COV2.S.

Numerical "Imbalances"	Janssen	No Vaccine
Thromboembolic	15	10
Tinnitus	6	0
Non-fatal Urticaris	5	0
Convulsions	4	1

Table 31. SAEs Considered Related by Investigator, Full Analysis Set, Study 3001

Investigational Product	SAE (PT)	Age/Sex	Day of Onset	Resolution Status	Grade	Related (Sponsor Assessment)
Ad26.COV2.S	Radiculitis brachial	30/M	1	Unresolved	3	Yes (Reassessed as injection site pain)
Ad26.COV2.S	Post-vaccination syndrome	35/M	2	Resolved	3	Yes (Reassessed as reactogenicity)
Ad26.COV2.S	Facial paralysis	62/M	3	Resolving	2	No
Ad26.COV2.S	Vaccination site hypersensitivity	42/M	3	Resolved	3	Likely
Ad26.COV2.S	Facial paralysis	43/M	16	Resolving	2	No
Ad26.COV2.S	Guillain-Barre Syndrome	60/F	16	Unresolved	4	Possibly
Ad26.COV2.S	Pericarditis	68/M	17	Resolved	4	Possibly
Placebo	Deep vein thrombosis	44/M	6	Resolving	4	Indeterminate

50

Janssen Ad26.COV2.S (COVID-19) Vaccine
VRBPAC Briefing Document

Investigational Product	SAE (PT)	Age/Sex	Day of Onset	Resolution Status	Grade	Related (Sponsor Assessment)
Placebo	Epstein-Barr infection[a]	69/M	14	Resolved	3	No
Placebo	Atrial flutter[a]	69/M	21	Resolving	3	No

[a] Events occurred the same study participant

If I've Already Been Infected Should I Get Vaccinated?

INSUFFICIENT DATA

Pfizer EUA page 27

Pfizer-BioNTech COVID-19 Vaccine
VRBPAC Briefing Document

Efficacy Endpoint Subgroup	BNT162b2 N[a]=19965 Cases n1[b] Surveillance Time[c] (n2[d])	Placebo N[a]=20172 Cases n1[b] Surveillance Time[c] (n2[d])	Vaccine Efficacy % (95% CI)[e]
Not Hispanic or Latino	6 1.681 (13380)	114 1.693 (13509)	94.7 (88.1, 98.1)
Race			
American Indian or Alaska native	0 0.011 (104)	1 0.010 (104)	100.0 (-3511.0, 100.0)
Asian	1 0.095 (796)	4 0.097 (808)	74.4 (-158.7, 99.5)
Black or African American	0 0.187 (1758)	7 0.188 (1758)	100.0 (30.4, 100.0)
Native Hawaiian or other Pacific Islander	0 0.006 (50)	1 0.003 (29)	100.0 (-2112.1, 100.0)
White	7 1.975 (15294)	153 1.990 (15473)	95.4 (90.3, 98.2)
Multiracial	1 0.047 (467)	1 0.042 (424)	10.4 (-6934.9, 98.9)
Not reported	0 0.010 (90)	2 0.013 (112)	100.0 (-581.6, 100.0)
Baseline SARS-CoV-2 Status			
Positive[h]	1 0.056 (526)	1 0.060 (567)	-7.1 (-8309.9, 98.6)
Negative[i]	8 2.237 (17637)	164 2.242 (17720)	95.1 (90.1, 97.9)
Unknown	0 0.039 (396)	4 0.043 (421)	100.0 (-68.9, 100.0)

[a] N = number of participants in the specified group.
[b] n1 = Number of participants meeting the endpoint definition.
[c] Total surveillance time in 1000 person-years for the given endpoint across all participants within each group at risk for the endpoint. Time period for COVID-19 case accrual is from 7 days after Dose 2 to the end of the surveillance period.
[d] n2 = Number of participants at risk for the endpoint.
[e] Confidence interval (CI) for VE is derived based on the Clopper and Pearson method adjusted to the surveillance time.
[f] At risk is defined as having at least one of the Charlson comorbidity index (Appendix B, page 52) category or obesity (BMI ≥30 kg/m^2).
[g] Obese is defined as BMI ≥30 kg/m^2.
[h] Positive N-binding antibody result at Visit 1, positive NAAT result at Visit 1, or medical history of COVID-19.
[i] Negative N-binding antibody result at Visit 1, negative NAAT result at Visit 1, and no medical history of COVID-19.

Moderna EUA page 25

Only 2.2% of participants had evidence of prior infection at study enrollment, and there was only one COVID-19 case starting 14 days after dose 2 reported from this subgroup, which was in a participant in the placebo group. There is insufficient data to conclude on the efficacy of the vaccine in previously infected individuals.

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Janssen EUA page 6

In general, VE among the subgroups (age, comorbidity, race, ethnicity) appears to be similar to the VE in the overall study population. A lower VE estimate was observed for the subgroup of participants 60 years of age and older with comorbidities compared with the overall population, but with an observed trend of increasing VE with narrower confidence intervals as numbers of cases included in the analysis increased (i.e., counting cases from 14 days rather than 28 days and including cases not yet centrally confirmed). There were no COVID-19-related deaths and no COVID-19 cases requiring medical intervention occurring 28 days or more post-vaccination among participants age 60 years or older with medical comorbidities in the vaccine group. The VE results for some other subgroups with small numbers of participants (≥75 years of age, certain racial subgroups) have limited interpretability. Data were insufficient to assess VE in participants with evidence of prior SARS-CoV-2 infection.

6

COVID-19 Vaccine Efficacy & Effectiveness

	RRR (RR)	ARR	NNV	Combining Vaccine Efficacy with Different Background Risks of COVID-19.
Pfizer	95%	0.84%	117	0.9%
Moderna	94%	1.2%	76	1.4%
Gamaleya	90%	0.93%	80	1.0%
Janssen	67%	1.2%	84	1.8%
AstraZeneca	67%	1.3%	78	1.9%

Olliaro P, Torreele E, Vaillant M. COVID-19 vaccine efficacy and effectiveness — the elephant (not) in the room. Lancet Microbe 2021; https://doi.org/10.1016/ S2666-5247(21)00069-0

Why Did I Put You Through All Those Slides?

So You & I Could Do the Scientific Review of the EUAs that the FDA Didn't.

1) Based Upon the FDA (EUA) Documents:

There is no statistical reduction in COVID rates.

There is no statistical reduction in COVID death rates.

There is an unacceptable VAERS death and adverse event rates.

The vaccine Absolute Risk Reduction (ARR) rate for developing COVID is really only

0.8 to 1.3%. Not the 67 to 95% you've been lead to believe.

2) Why did we go through these slides?

To provide you with the answers you need, when someone is trying to force you to get vaccinated.

Because the FDA, the Federal Government and the Media failed to do their job.

They failed to ask the Scientific Questions that should have been asked.

3 Ways to Lower Risk of COVID-19 or Death

1) **Reduce** your overall risk by addressing **comorbidities** associated with an increased ITR.

   Diet, Lifestyle, control of chronic inflammatory diseases;

2) **Receive Medical Treatment** for SARS-CoV-2 Infection and/or COVID-19, focusing on:

   Reducing Infection & Replication of the Virus, and
   Reducing the InflammoThrombotic Response (ITR);

   OR

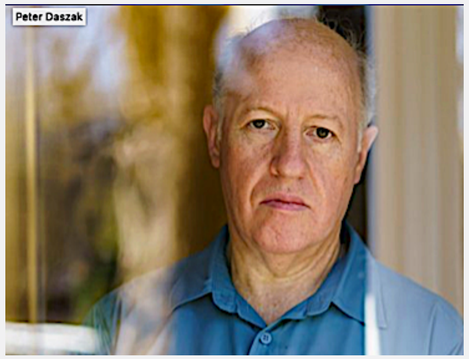
3) **Enroll** in the **Control (non-vaccine) Group** of any Drug Vaccine Study outside of South Africa.

Like the iPhone, The Evidence Shows SARS-CoV-2 Was Designed and Paid for by the U.S. & Built in China.



https://rumble.com/vfy3xf-lethal-deception.html

What are the Motives of Those Involved?









Organization That Funded Wuhan Lab Got Another Taxpayer Bailout In 2021

(LEAVE A COMMENT)

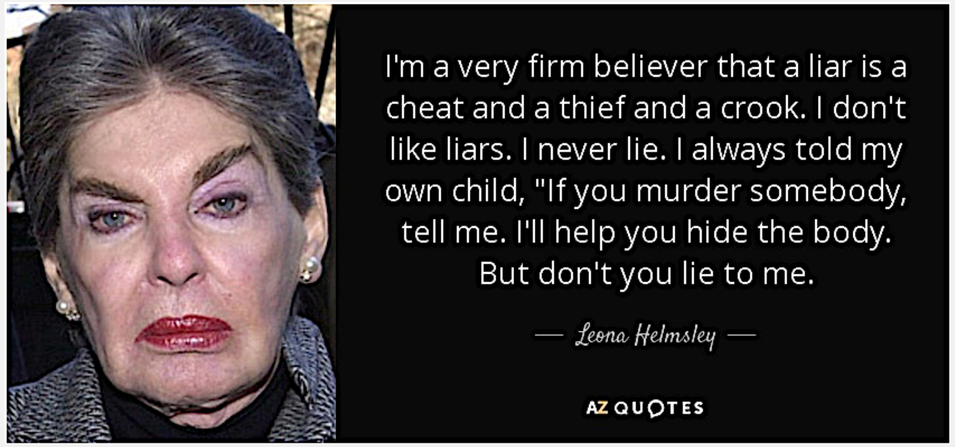


April 17, 2021

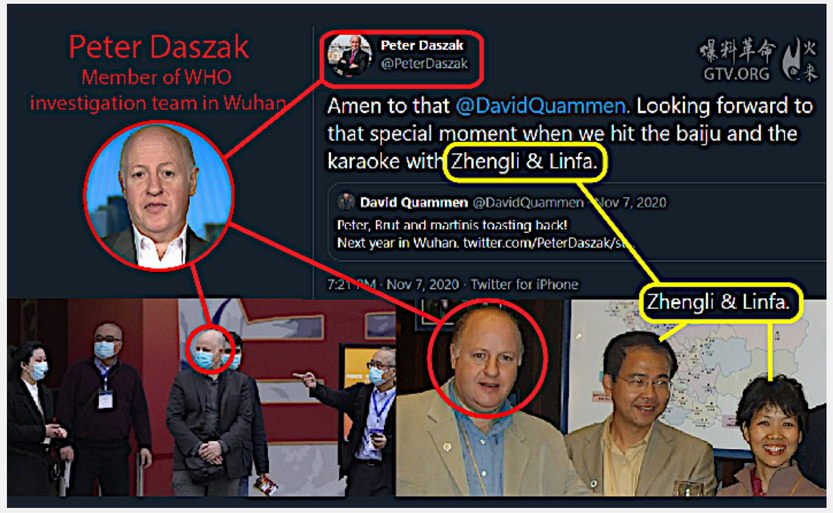
Non-profit EcoHealth Alliance, which funneled millions of taxpayer dollars in National Institutes of Health grants to the Wuhan Institute of Virology, received yet another taxpayer-funded bailout in February 2021.

The bailout was the second received by EcoHealth since the start of the COVID-19 pandemic. After receiving $738,861 in a bailout in May 2020, EcoHealth got an additional $719,570 in February of this year, according to a new report from watchdog group Whitecoat Waste.





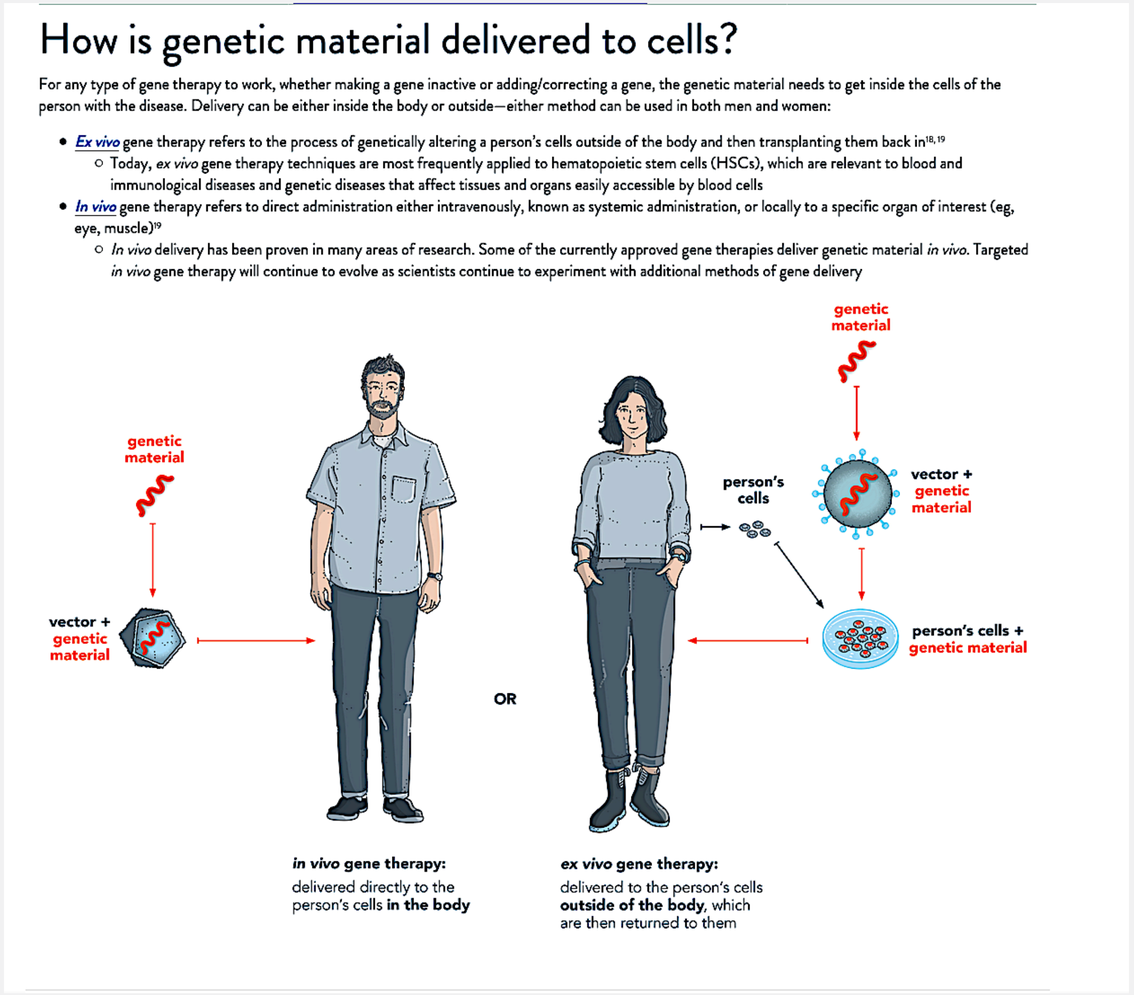




We Know These People Are Involved in CRISPR Research Altering Human DNA

Like **Gain-of-Function** (GoF), CRISPR can be used for altruistic purposes or nefarious purposes.

CRISPR: Clustered Regularly Interspaced Short Palindromic Repeat, is a method for **removing** segments of DNA or RNA and replacing it with NEW genetic code.



https://www.thegenehome.com/how-does-gene-therapy-work/techniques?msclkid=038da1e7273418d28b4ec1677222eb34&utm_source=bing&utm_medium=cpc&utm_campaign=Crispr%20%20Standard&utm_term=crispr%20gene%20therapy&utm_content=Crispr

Using CRISPR to Make Synthetic Biology

Controlling Human DNA

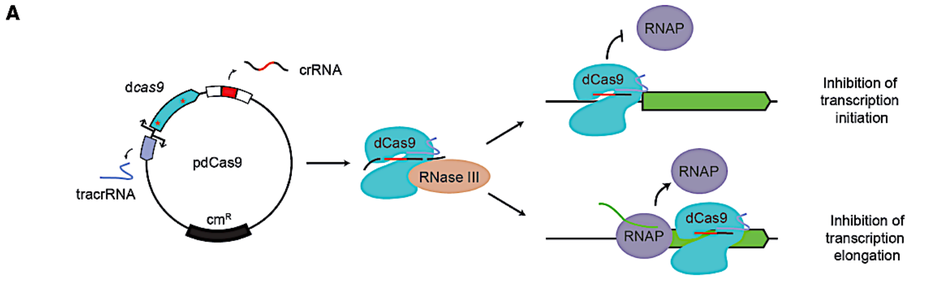
Published online 12 June 2013

Nucleic Acids Research, 2013, Vol. 41, No. 15 7429–7437
doi:10.1093/nar/gkt520

Programmable repression and activation of bacterial gene expression using an engineered CRISPR-Cas system

David Bikard[1,*], Wenyan Jiang[1], Poulami Samai[1], Ann Hochschild[2], Feng Zhang[3,4,5,6] and Luciano A. Marraffini[1,*]

[1]Laboratory of Bacteriology, The Rockefeller University, 1230 York Avenue, New York, NY 10065, USA, [2]Department of Microbiology and Immunobiology, Harvard Medical School, 4 Blackfan Circle, Boston, MA 02115, USA, [3]Broad Institute of MIT and Harvard, 7 Cambridge Center, Cambridge, MA 02142, USA, [4]McGovern Institute for Brain Research, Massachusetts Institute of Technology, Cambridge, MA 02139, USA, [5]Department of Brain and Cognitive Sciences, Massachusetts Institute of Technology, Cambridge, MA 02139, USA and [6]Department of Biological Engineering, Massachusetts Institute of Technology, Cambridge, MA 02139, USA



ABSTRACT

The ability to artificially control transcription is essential both to the study of gene function and to the construction of synthetic gene networks with desired properties. Cas9 is an RNA-guided double-stranded DNA nuclease that participates in the CRISPR-Cas immune defense against prokaryotic viruses. We describe the use of a Cas9 nuclease mutant that retains DNA-binding activity and can be engineered as a programmable transcription repressor by preventing the binding of the RNA polymerase (RNAP) to promoter sequences or as a transcription terminator by blocking the running RNAP. In addition, a fusion between the omega subunit of the RNAP and a Cas9 nuclease mutant directed to bind upstream promoter regions can achieve programmable transcription activation. The simple and efficient modulation of gene expression achieved by this technology is a useful asset for the study of gene networks and for the development of synthetic biology and biotechnological applications.

FUNDING

Harvey L. Karp Discovery Award and the Bettencourt Schuller Foundation (to D.B.); Helmsley Postdoctoral Fellowship for Basic and Translational Research on Disorders of the Digestive System at The Rockefeller University (to P.S.); NIH grant [R01 GM044025 to A.H.]; NIH Director's Pioneer Award [DP1MH100706], Transformative R01, the Keck, McKnight, Gates, Damon Runyon, Searle Scholars, Klingenstein, and Simons Foundations, Bob Metcalfe, Mike Boylan and Jane Pauley (to F.Z.); Searle Scholars Program, the Rita Allen Scholars Program, an Irma T. Hirschl Award and a NIH Director's New Innovator Award [1DP2AI104556-01 to L.A.M.]. Funding for open access charge: NIH Director's New Innovator Award [1DP2AI104556-01].

Conflict of interest statement. None declared.

Figure 1. dCas9-mediated repression in *E. coli*. (**A**) Plasmid pdCas9 encodes a *cas9* mutant containing D10A and H840A substitutions (red asterisks) that abrogate nuclease activity. dCas9 binds to a tracrRNA:precursor crRNA and recruits RNase III to process the precursor and liberate the crRNA. The crRNA directs binding of dCas9 to promoter or open reading frame regions to prevent RNAP binding or elongation, respectively.

Educate

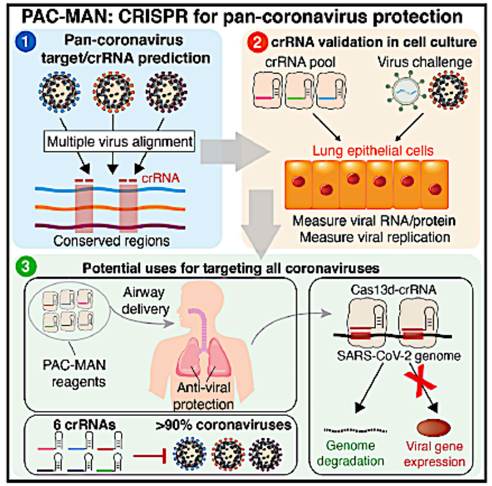
Prior to LNP There Were Problems Getting CRISPR Into Cells

Cell

Article

Development of CRISPR as an Antiviral Strategy to Combat SARS-CoV-2 and Influenza

Graphical Abstract



Highlights

- PAC-MAN is a CRISPR-based strategy for RNA-guided viral RNA inhibition and degradation
- Cas13d PAC-MAC is effective at targeting and cleaving SARS-CoV-2 sequences
- Cas13d PAC-MAC can reduce H1N1 IAV load in respiratory epithelial cells
- A group of six crRNAs can target more than 90% of all coronaviruses

Authors

Timothy R. Abbott, Girija Dhamdhere, Yanxia Liu, ..., Marie F. La Russa, David B. Lewis, Lei S. Qi

Correspondence

mlarussa@stanford.edu (M.F.L.R.), dblewis@stanford.edu (D.B.L.), stanley.qi@stanford.edu (L.S.Q.)

In Brief

A CRISPR-based strategy is developed to target conserved sequences across coronaviruses and other pathogenic viruses.

Abbott et al., 2020, Cell *181*, 865–876
May 14, 2020 © 2020 Elsevier Inc.
https://doi.org/10.1016/j.cell.2020.04.020

CellPress

CRISPER Limitations overcome with LNP and Nasal Sprays

Limitations and Future Directions

The biggest barrier to deploying PAC-MAN clinically is the development of effective and safe *in vivo* delivery methods. There are several attractive delivery options that could be employed for the *in vivo* expression of PAC-MAN components. Cas13d and its cognate crRNAs could be delivered in RNA form within chemical polymers or lipid nanoparticles (LNPs) (Hendel et al., 2015; McKinlay et al., 2017; Sago et al., 2018; Xu et al., 2019). DNA-based liposomal delivery strategies, such as lipitoids or the recently developed HEDGES platform, are also attractive (Handumrongkul et al., 2019; Huang et al., 1998). Another strategy would be to deliver a ribonucleoprotein complex containing the Cas13d protein assembled with crRNAs (Amirkhanov and Stepanov, 2019; Xu et al., 2019). Other work successfully used engineered amphiphilic peptides to deliver Cas9-guide RNA complexes to airway epithelia, which provides a promising approach for delivering PAC-MAN Cas13d complexes (Krishnamurthy et al., 2019). In addition, recent advances in gene therapy delivery strategies optimized for cystic fibrosis that can deliver mRNA or plasmid DNA, such as self-assembled peptide-poloxamine nanoparticles, may also be an option (Guan et al., 2019). We anticipate that one of the above-mentioned strategies can potentially be administered to patients or healthy populations via a nebulizer system or nasal spray as an antiviral strategy.

ACKNOWLEDGMENTS

The authors thank all members from the Stanley Qi lab and David Lewis lab for facilitating experiments and useful discussions. The authors thank the researchers who generated and contributed the SARS-CoV-2 sequence data to GISAID (https://www.gisaid.org/). The authors would also like to thank Dr. Elodie Ghedin (NYU) for her advice on targeting influenza with Cas13 and insights about influenza replication. The project is supported by a contract grant from Defense Advanced Research Projects Agency (DARPA) (HR001119C0060). L.S.Q. is also supported by the Li Ka Shing Foundation.

DARPA

Agency of the U.S. Department of Defense responsible for the development of new technologies

darpa.mil

The Defense Advanced Research Projects Agency is a research and development agency of the United States Department of Defense responsible fo... en.wikipedia.org

A Perspective from Tal Zaks **Moderna CEO** 2017

Vision

The Software of Life and manipulation of human DNA



Perspective of Bill Gates Microsoft CEO Feb 2020

Vision

Intentional Pandemic disrupting economies, healthcare & cause more than 10 Million excess deaths. Introducing GENE Drives passed on to your children.



Silencing DNA Resistant to Immune Recognition

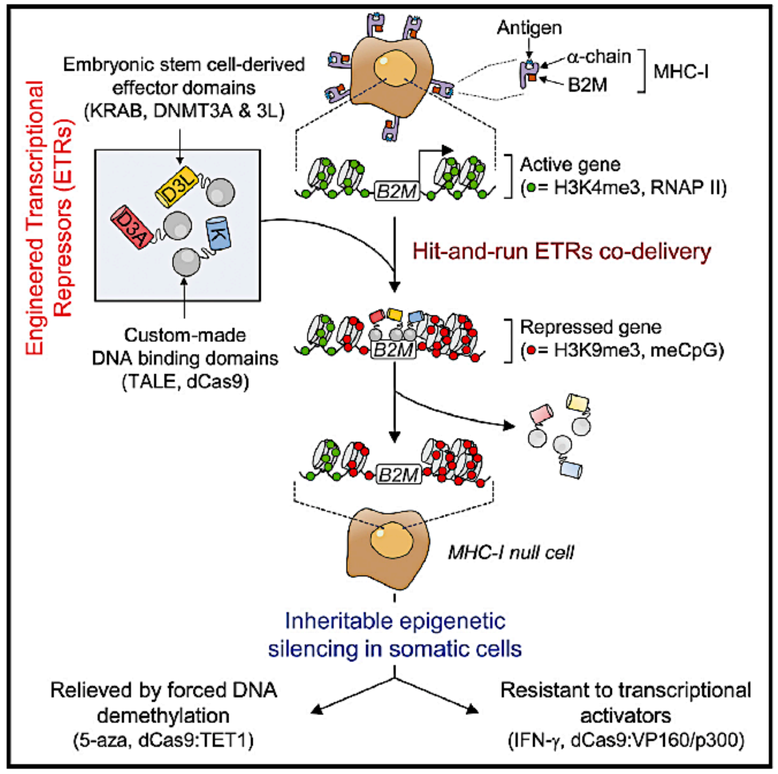
Resource

Cell

Cell 167, 219–232, September 22, 2016

Inheritable Silencing of Endogenous Genes by Hit-and-Run Targeted Epigenetic Editing

Graphical Abstract



Authors

Angelo Amabile, Alessandro Migliara, Paola Capasso, Mauro Biffi, Davide Cittaro, Luigi Naldini, Angelo Lombardo

Correspondence

naldini.luigi@hsr.it (L.N.), lombardo.angelo@hsr.it (A.L.)

In Brief

Transient co-expression of engineered transcriptional repressors (ETRs) allows for stable and highly specific epigenetic silencing of endogenous genes, which is amenable to multiplexing and can be reverted by targeted DNA demethylation.

Resistant to your Immune system.

SUMMARY

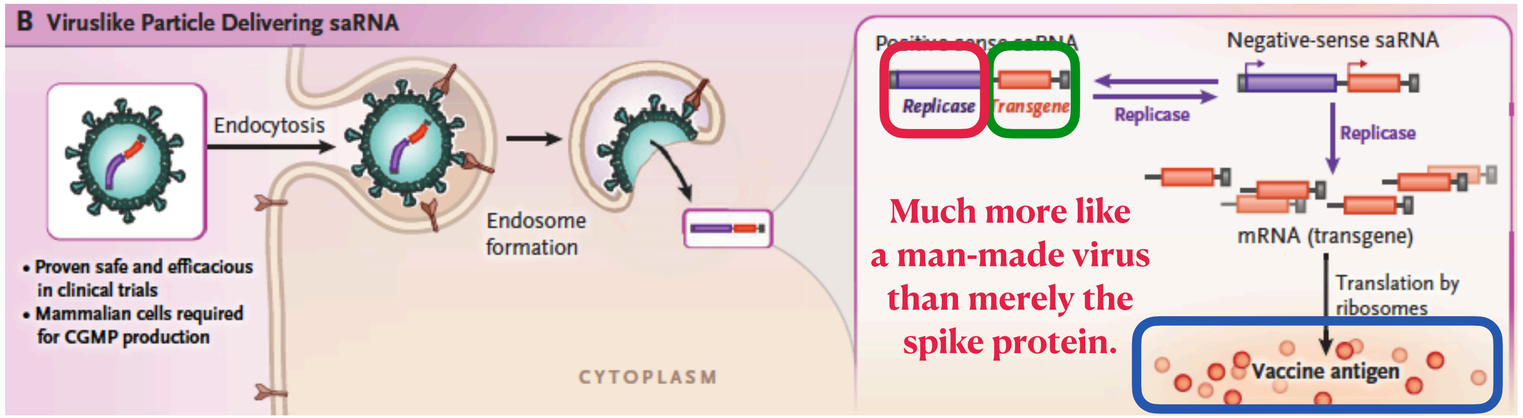
Gene silencing is instrumental to interrogate gene function and holds promise for therapeutic applications. Here, we repurpose the endogenous retroviruses' silencing machinery of embryonic stem cells to stably silence three highly expressed genes in somatic cells by epigenetics. This was achieved by transiently expressing combinations of engineered transcriptional repressors that bind to and synergize at the target locus to instruct repressive histone marks and de novo DNA methylation, thus ensuring long-term memory of the repressive epigenetic state. Silencing was highly specific, as shown by genome-wide analyses, sharply confined to the targeted locus without spreading to nearby genes, resistant to activation induced by cytokine stimulation, and relieved only by targeted DNA demethylation. We demonstrate the portability of this technology by multiplex gene silencing, adopting different DNA binding platforms and interrogating thousands of genomic loci in different cell types, including primary T lymphocytes. Targeted epigenome editing might have broad application in research and medicine.

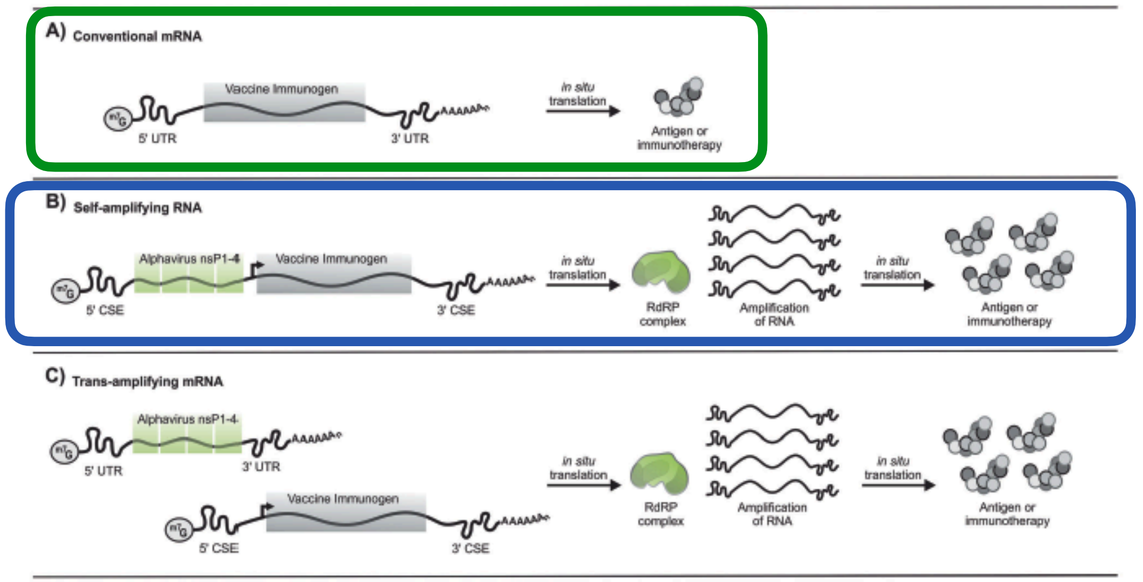
Gates-DOD-Viruses-GOD Gene



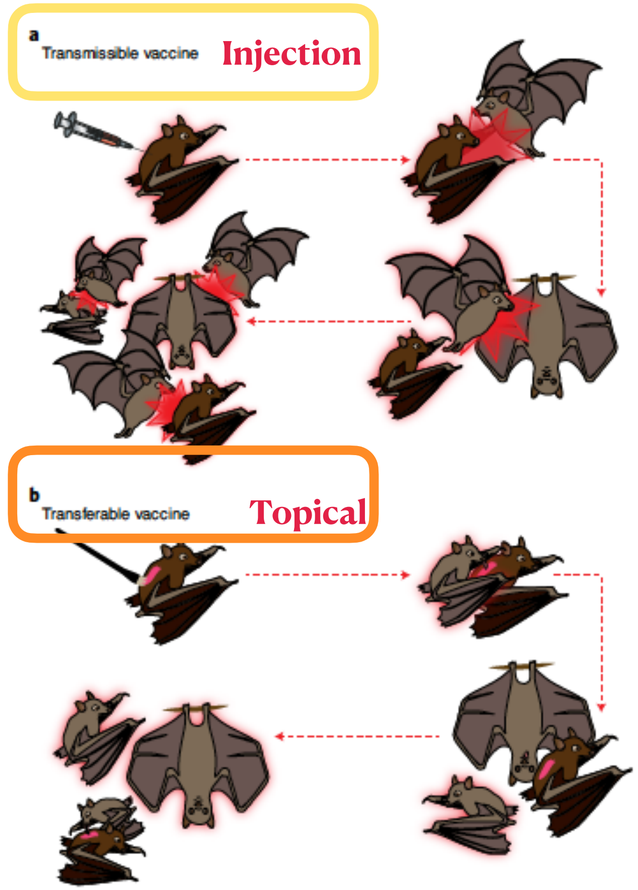
The Question of Shedding.

Self Amplifying mRNA Vaccines (SAM)* & Transmissible Vaccines**





Recombinant Vector Attenuated Viral



* Fuller DH, Berglund P. Amplifying RNA Vaccine Development. N Engl J Med 2020 382(25):2469-2471.

** Nuismer SL, Bull JJ. Self-disseminating vaccines to suppress zoonoses. Nature Ecology & Evolution 2020;4:1168-1173.

Educate

Is This New?

It Dates Back to At Least 2000

JOURNAL OF VIROLOGY, Feb. 2000, p. 1114–1123 Vol. 74, No. 3
0022-538X/00/$04.00+0
Copyright © 2000, American Society for Microbiology. All Rights Reserved.

Horizontal Transmissible Protection against Myxomatosis and Rabbit Hemorrhagic Disease by Using a Recombinant Myxoma Virus

JUAN BÁRCENA,[1] MÓNICA MORALES,[1] BELÉN VÁZQUEZ,[1] JOSÉ A. BOGA,[2] FRANCISCO PARRA,[2] JAVIER LUCIENTES,[3] ALBERT PAGÈS-MANTÉ,[4] JOSÉ M. SÁNCHEZ-VIZCAÍNO,[1] RAFAEL BLASCO,[1] AND JUAN M. TORRES[1]*

Centro de Investigación en Sanidad Animal (CISA-INIA), Valdeolmos, 28130 Madrid,[1] Departamento de Bioquímica y Biología Molecular, Instituto Universitario de Biotecnología de Asturias (CSIC), Universidad de Oviedo, 33006 Oviedo,[2] Departamento de Patología Animal, Facultad de Veterinaria, Universidad de Zaragoza, Zaragoza,[3] and Laboratorios Hipra S.A. Amer., 1710 Girona,[4] Spain

Received 1 July 1999/Accepted 1 November 1999

We have developed a new strategy for immunization of wild rabbit populations against myxomatosis and rabbit hemorrhagic disease (RHD) that uses recombinant viruses based on a naturally attenuated field strain of myxoma virus (MV). The recombinant viruses expressed the RHDV major capsid protein (VP60) including a linear epitope tag from the transmissible gastroenteritis virus (TGEV) nucleoprotein. Following inoculation, the recombinant viruses induced specific antibody responses against MV, RHDV, and the TGEV tag. Immunization of wild rabbits by the subcutaneous and oral routes conferred protection against virulent RHDV and MV challenges. The recombinant viruses showed a limited horizontal transmission capacity, either by direct contact or in a flea-mediated process, promoting immunization of contact uninoculated animals.

Is There Any Evidence This is Being Used with SARS-CoV-2?

Gene Therapy (2021) 28:117–129
https://doi.org/10.1038/s41434-020-00204-y

REVIEW ARTICLE

Self-amplifying RNA vaccines for infectious diseases

Kristie Bloom[1] · Fiona van den Berg[1] · Patrick Arbuthnot[1]

Received: 19 June 2020 / Revised: 29 September 2020 / Accepted: 8 October 2020 / Published online: 22 October 2020
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Table 1 Clinical and preclinical synthetic saRNA vaccine studies for infectious diseases.

Infectious disease	Replicon	Immunogen	Delivery	Animal	Year (reference)
Clinical studies					
Rabies		Glycoprotein G	CNE	Human	2019 (NCT04062669)
COVID-19	VEE	Spike protein	LNP	Human	2020 (ISRCTN17072692)
Preclinical studies					
RSV	SFV	F glycoprotein	Naked	Mice[b]	2001 [80]
	VEE–SINV	F glycoprotein	LNP	Mice, rats[b]	2012 [81]
	VEE–SINV	F glycoprotein	CNE	Mice	2014 [68]
Influenza	SFV	NP	Naked	Mice	1994 [79]
	SFV	HA	Naked	Mice[b]	2001 [80]
	VEE–SINV	HA	LNP	Mice	2013 [14]
	CSFV	HA/NP	Chitosan NGA	Mice, rabbit	2014 [71]
	VEE–SINV	HA	CNE	Mice[b], ferret[b]	2015 [125]
	VEE–SINV	NP	LNP	Mice	2015 [126]
	VEE–SINV	M1/NP	LNP	Mice[b]	2016 [85]
	VEE	HA	MDNP	Mice[b]	2016 [127]
	CSFV	HA/NP	CPP PEI	Pigs	2017 [128]
	CSFV	NP	Cationic lipid	Mice	2018 [129]
	–	HA	PEI	Mice[b]	2018 [12]
	VEE	HA	Neutral LPP	Mice	2019 [55]
	–	HA	MLNP	Mice	2019 [54]
	Trans-amplifying	HA	Naked	Mice[b]	2020 [62]
	VEE	HA	pABOL	Mice[b]	2020 [50]
Coronavirus	VEE	Spike protein	LNP	Mice	2020 [86]
LIV	SFV	prM-E	Naked	Mice[b]	2001 [80]
TBEV	TBEV	Δ TBEV capsid	Gene gun	Mice[b]	2004 [130]
	TBEV	Δ TBEV capsid	Gene gun	Mice[b]	2005 [131]
HIV	VEE–SINV	Env	LNP	Mice	2012 [81]
	VEE–SINV	Env	Electroporation	Mice	2013 [132]
	VEE–SINV	Env	CNE	Rabbit	2014 [68]
	VEE–SINV	Env	CNE	NHP	2015 [121]
	SFV	Gag/Pol mosaic	PEI	Mice	2019 [123]
	VEE	eOD-GT8	LNP	Mice	2019 [120]
	VEE	Env	Exterior LNP	Mice	2019 [58]
CMV	VEE–SINV	gB/pp65-IE1	CNE	NHP	2014 [68]
Ebola	VEE	Glycoprotein	MDNP	Mice[b]	2016 [127]
Toxoplasma gondii	VEE	Multimer[a]	MDNP	Mice[b]	2016 [127]
	SFV	NTPase-II	LNP	Mice[b]	2017 [133]
GAS	VEE–SINV	SLOdm	CNE	Mice[b]	2017 [134]
GBS	VEE–SINV	BP-2a	CNE	Mice[b]	2017 [134]
Zika	VEE	prM-E	MDNP	Mice	2017 [91]
	VEE	prM-E	NLC	Mice[b], guinea pigs	2018 [90]
	VEE	prM-E	Naked	Mice[b]	2019 [89]
VEE	VEE	Attenuated VEE	CNE	Mice[b]	2019 [88]
Rabies	VEE–SINV	Glycoprotein G	CNE	Rats	2020 [92]
	VEE–SINV	Glycoprotein G	Liposome, nanoparticle, CNE	Mice	2020 [59]

BP-2a GBS pilus 2a backbone protein, *CMV* cytomegalovirus, *CSFV* classical swine fever virus, *CNE* cationic nanoemulsion, *Env* envelope, *GAS* group A streptococci, *GBS* group B streptococci, *gB* glycoprotein B, *HA* haemagglutinin, *HIV* human immunodeficiency virus, *LIV* louping ill virus, *LNP* lipid nanoparticle, *LPP* lipopolyplexes, *M1* matrix protein 1, *MLNP* manosylated LNP, *MDNP* modified dendrimer nanoparticle, *NGA* nanogel alginate, *NHP* nonhuman primate, *NLC* nanostructured lipid carrier, *NP* nucleoprotein, *pABOL* poly(CBA-co-4-amino-1-butanol (ABOL)), *PEI* polyethylenimine, *Pol* polymerase, *prM-E* premembrane and envelope glycoproteins, *RSV* respiratory syncytial virus, *SFV* Semliki forest virus, *SINV* Sindbis virus, *SLOdm* double-mutated GAS Streptolysin-O, *TBEV* tick-borne encephalitis virus, *VEE* Venezuelan equine encephalitis virus, *VEE–SINV* alphavirus chimera based on the VEE and SINV replicons.

[a]Multimer comprised of granule protein 6 (GRA6), rhoptry protein 2A (ROP2A), rhoptry protein 18 (ROP18), surface antigen 1 (SAG1), surface antigen 2A (SAG2A), and apical membrane antigen 1 (AMA1).

[b]Vaccination conferred protection.

What If The People You Trust Are The People Causing The Problem?

NIH Director's Blog

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CRISPR-Based Anti-Viral Therapy Could One Day Foil the Flu—and COVID-19

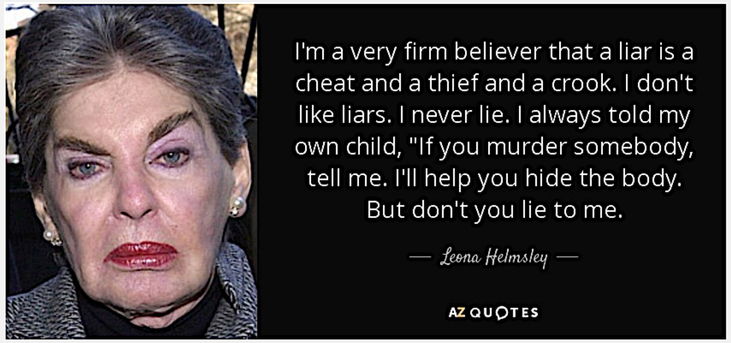
Posted on March 16th, 2021 by Dr. Francis Collins

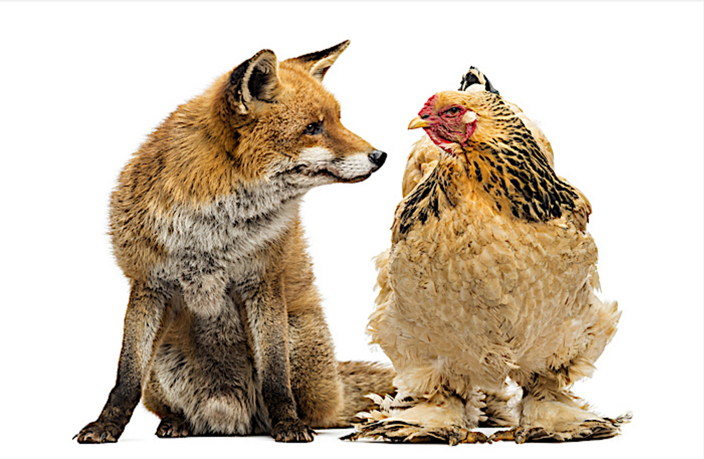


CRISPR gene-editing technology has tremendous potential for making non-heritable DNA changes that can treat or even cure a wide range of devastating disorders, from HIV to muscular dystrophy Now, a recent animal study shows that another CRISPR system—targeting viral RNA instead of human DNA—could work as an inhaled anti-viral therapeutic that can be preprogrammed to seek out and foil potentially almost any flu strain and many other respiratory viruses, including SARS-CoV-2, the coronavirus that causes COVID-19.

How can that be? Other CRISPR gene-editing systems rely on a sequence-specific guide RNA to direct a scissor-like, bacterial enzyme (Cas9) to just the right spot in the genome to cut out, replace, or repair disease-causing mutations. This new anti-viral CRISPR system also relies on guide RNA. But the guide instead directs a different bacterial enzyme, called Cas13a, to the right spot in the viral genome to bind and cleave viral RNA and stop viruses from replicating in lung cells.

I'll help you hide the body (the evidence).





Gain-of-Function,
CRISPR,
LNP, Nasal,
SAM,
Transmissible/Transferable Biologics.

Section 03

01 Inform

The SARS-CoV-2 virus & known facts

The Covid-19 disease & published treatments

02 Educate

Infectious Diseases

Vaccines efficacy and safety

The Scientific Method

The Difference Between VE, COVID-19 & Death

EUA vs Process vs Risks

03 Empower

EUA vs Process vs Risks

Stopping the Gain-of-Function Research

Government Interference with Physician-Patient Treatment & Forced Vaccination

Be Heard

Petition

Blindly Following Makes it Easy to Be Manipulated By Those in Power.

During his 1947 Nuremberg Trial Göring Said The Following.

… it is the leaders of the country who determine the policy and it is always a simple matter to drag the people along, whether it is a democracy or a fascist dictatorship or a Parliament or a Communist dictatorship.



…voice or no voice, the people can always be brought to the bidding of the leaders. That is easy. *All you have to do is tell them they are being attacked and denounce the pacifists for lack of patriotism and exposing the country to danger.* It works the same way in any country.

Carpe Diem Quam Minimum Credula Postero!





What If The People You Trust Are The People Causing The Problem?
Vaccines - a Little Hope. Treatment & Holding Those Accountable - Real Hope.



Lockdowns: A Response to Fear



Masks: A Response to Fear

India Today

The age of fear: How Covid has impacted our mental health

Suhani Singh - Thursday





A line of refrigerated trucks that are being used as morgues sit outside Bellevue Hospital Center in Manhattan on Sunday





https://www.msn.com/en-in/health/wellness/the-age-of-fear-how-covid-has-impacted-our-mental-health/ar-AAKu39Q
https://www.dukehealth.org/blog/wear-face-mask-protect-each-other#:~:text=%20Wear%20a%20Face%20Mask%20to%20Protect%20Each,the%20virus%20cannot%20live%20for%20more...%20More%20
https://www.dailymail.co.uk/news/article-8166105/New-York-hospitals-set-refrigerated-trailers-used-makeshift-morgues.html

Fauci & Masks

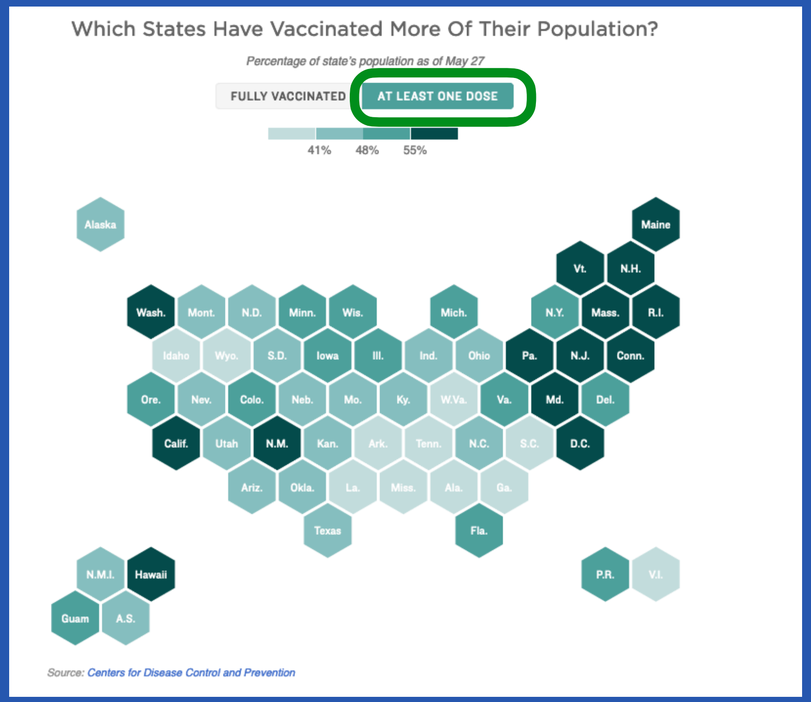


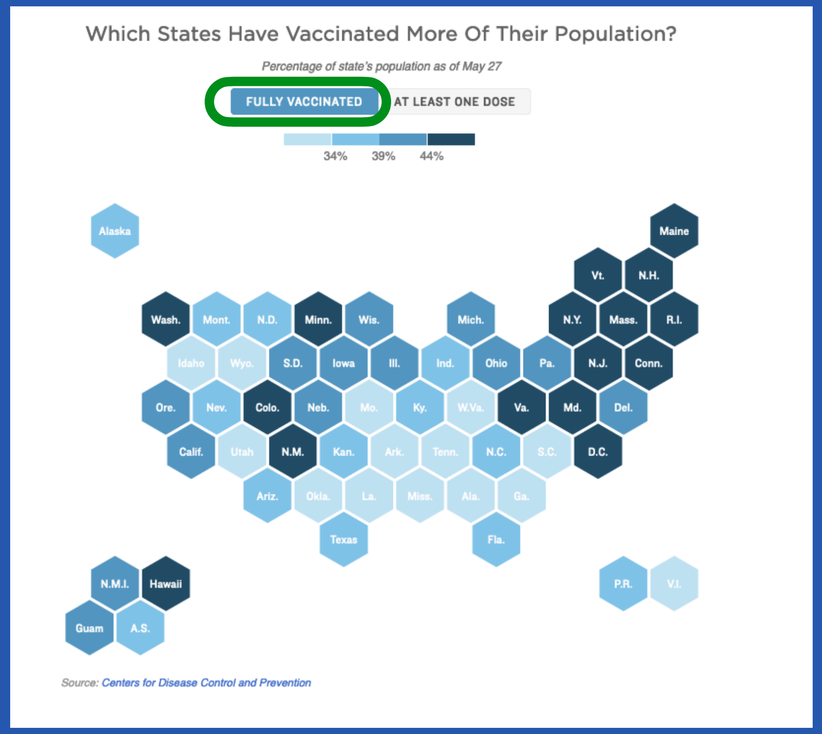
https://www.youtube.com/watch?v=4vcdJ2Zsc8U&t=13s

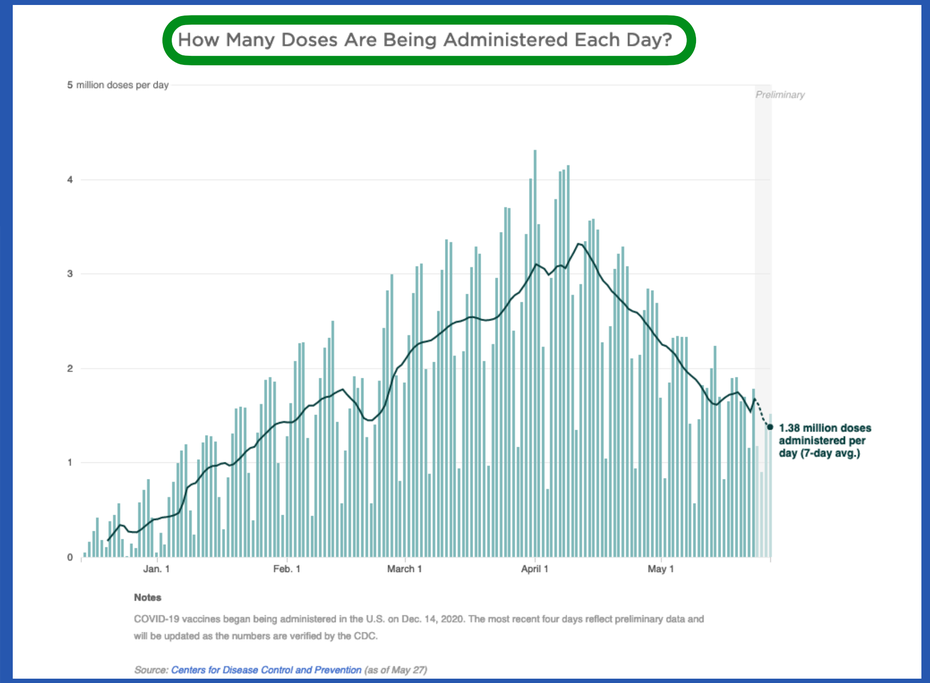
Empower

Vaccinations: A Response to Fear & Hope

The More Fear
The More Vaccinations







The People Who Have Been Vaccinated are not the Enemy and Many of Them are Now Fearful of What Might Be Happening to Them and Those They Love.

https://www.npr.org/sections/health-shots/2021/01/28/960901166/how-is-the-covid-19-vaccination-campaign-going-in-your-state

Hope Shattered by Reality

https://vaers.hhs.gov/index.html

As of **19 April 2021** the Centers for Disease Control (CDC) reported on its Vaccine Adverse Event Reporting System (VAERS)

68,347 Adverse Events

Including

2,602 Deaths

8,285 Serious Injuries

As of **23 April 2021** the Centers for Disease Control (CDC) reported on its Vaccine Adverse Event Reporting System (VAERS)

118,902 Adverse Case Events

Including

3,544 Deaths

12,619 Serious Injuries

As of **7 May 2021** the Centers for Disease Control (CDC) reported on its Vaccine Adverse Event Reporting System (VAERS)

192,954 Adverse Case Events

Including

4,057 Deaths

17,190 Serious Injuries

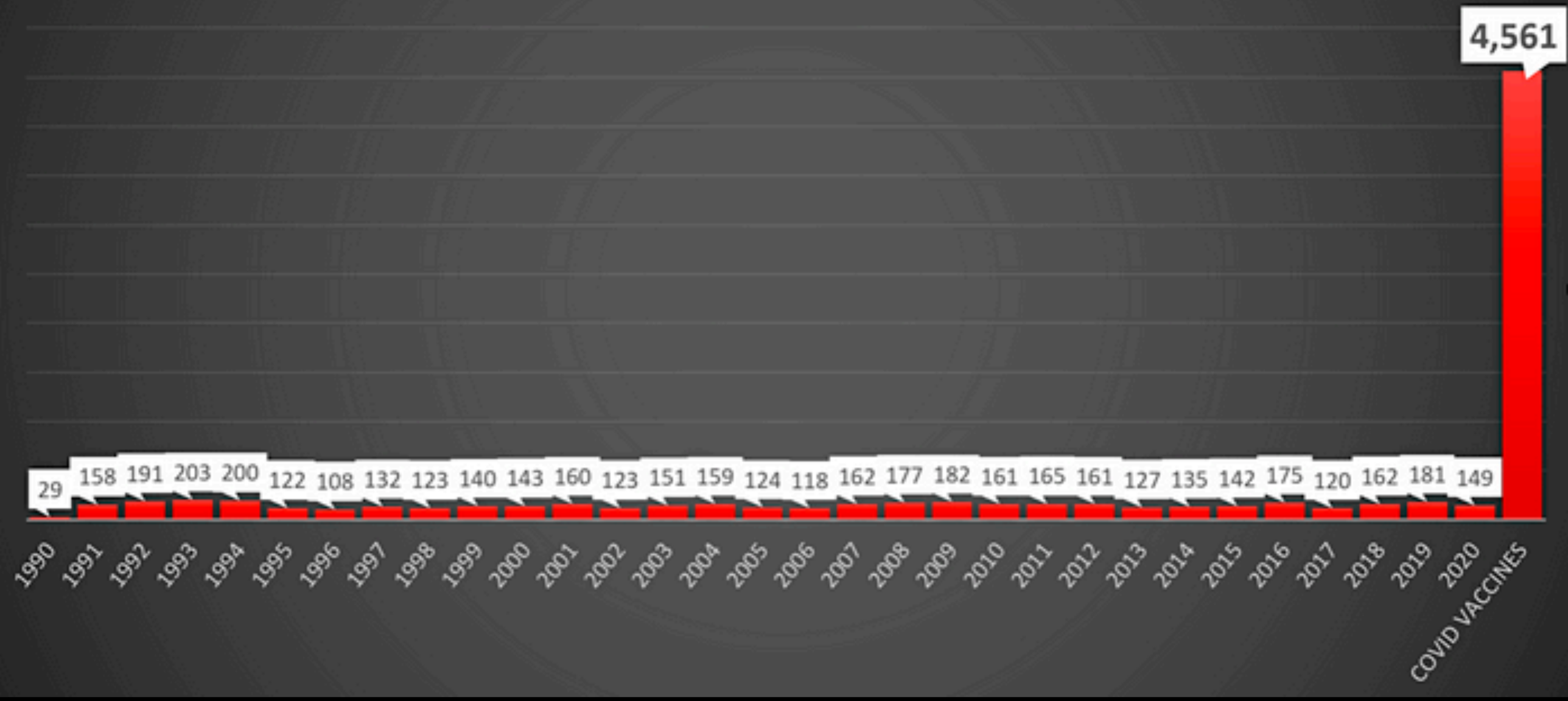
https://www.lifesitenews.com/news/latest-vaers-data-show-reports-of-blood-clotting-disorders-after-all-three-emergency-use-authorization-vaccines

https://childrenshealthdefense.org/defender/vaers-significant-jump-reported-injuries-deaths-after-covid-vaccine/

https://childrenshealthdefense.org/defender/vaers-cdc-data-reported-deaths-covid-vaccines-kids-12-now-eligible/

Deaths Reports in VAERS as of May 28, 2021

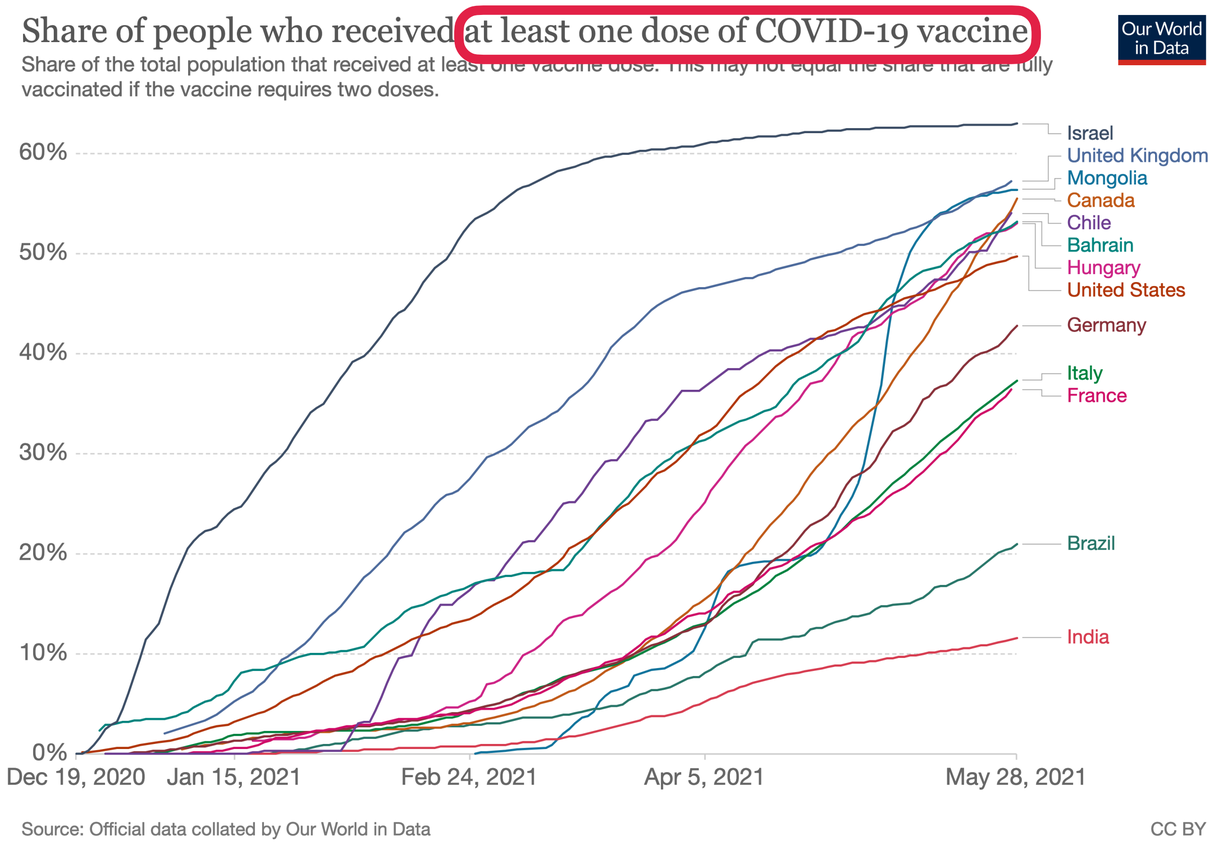
2020 total excludes 16 deaths after COVID vaccination included in last column



https://www.revolver.news/2021/06/REVOLVER-PART-ONE-COVID-VAERS-DEATHS-COVER-UP/

European Database (EudraVigilance)

22 May 2021

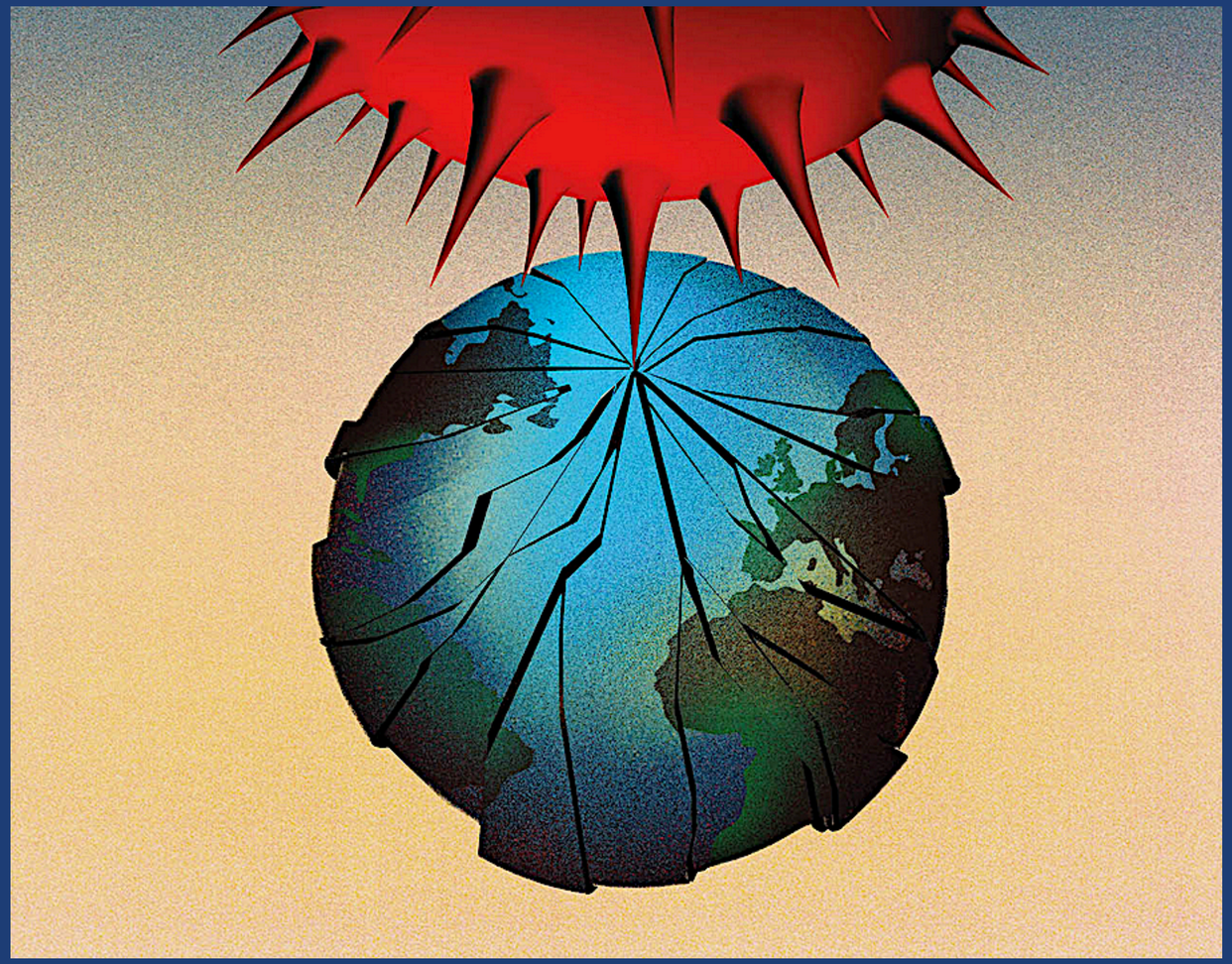


22 May 2021	Reported Cases	Deaths	All Multiple Symptoms	Serious Injuries
AstraZeneca	237,648	2,489	655,534	372,019
Pfizer BioNTech	191,215	5,961	452,779	186,308
Moderna	29,616	3,365	72,596	38,704
Janssen	4,997	369	15,281	7,713
Total	463,476	12,184	1,196,190	604,744

https://ourworldindata.org/covid-vaccinations

https://www.globalresearch.ca/12184-dead-1196190-injuries-europe

Crimes Against Humanity.



crime a·gainst hu·man·i·ty

noun

1. **a deliberate act, typically as part of a systematic campaign, that causes human suffering or death on a large scale:**

   "he was handed over to the International Criminal Court in The Hague to face charges of crimes against humanity"

Powered by Oxford Dictionaries

PLOS

Discovery of a rich gene pool of bat SARS-related coronaviruses provides new insights into the origin of SARS coronavirus

"... we successfully cultured an additional novel SARSr-CoV Rs4874 from a single fecal sample... we constructed a group of infectious bacterial artificial chromosome (BAC) clones with the backbone of WIV1 and variants of S genes from 8 different bat SARSr-CoVs. Only the infectious clones for Rs4231 and Rs7327 led to cytopathic effects in Vero E6 cells after transfection..."

Peter Daszak, Zheng-Li Shi and others
November 30, 2017

Immediate Call to Action Items - STOP:

(1) Gain-of-Function Research;

(2) Interference of Physician Treatment of Patients;

(3) Promotion and Coercion of Experimental Vaccines;

(4) Experimenting on People without Informed Consent; and

(5) Hold Those Responsible Criminally Accountable.

Violations of The Biological Weapons Convention (BWC) Treaty

The Biological Weapons Convention (BWC) At A Glance

FACT SHEETS & BRIEFS

Last Reviewed: March 2020

Contact: Daryl Kimball, *Executive Director,* (202) 463-8270 x107

The Biological Weapons Convention (BWC) is a legally binding treaty that outlaws biological arms. After being discussed and negotiated in the United Nations' disarmament forum starting in 1969, the BWC opened for signature on April 10, 1972, and entered into force on March 26, 1975. It currently has 183 states-parties, including Palestine, and four signatories (Egypt, Haiti, Somalia, Syria, and Tanzania). Ten states have neither signed nor ratified the BWC (Chad, Comoros, Djibouti, Eritrea, Israel, Kiribati, Micronesia, Namibia, South Sudan and Tuvalu).

Terms of the Treaty

The BWC bans:

- The development, stockpiling, acquisition, retention, and production of:
  1. Biological agents and toxins "of types and in quantities that have no justification for prophylactic, protective or other peaceful purposes;"
  2. Weapons, equipment, and delivery vehicles "designed to use such agents or toxins for hostile purposes or in armed conflict."
- The transfer of or assistance with acquiring the agents, toxins, weapons, equipment, and delivery vehicles described above.

The convention further requires states-parties to destroy or divert to peaceful purposes the "agents, toxins, weapons, equipment, and means of delivery" described above within nine months of the convention's entry into force. The BWC does not ban the use of biological and toxin weapons but reaffirms the 1925 Geneva Protocol, which prohibits such use. It also does not ban biodefense programs.

The BWC bans biological agents that have NO justification for prophylactic, protective or other "peaceful" purposes.

Seventh Review Conference

The seventh BWC review conference was held in December 2011. The Final Declaration document concluded that "under all circumstances the use of bacteriological (biological) and toxin weapons is effectively prohibited by the Convention and affirms the determination of States parties to condemn any use of biological agents or toxins other than for peaceful purposes, by anyone at any time."

"under all circumstances ... biological and toxic weapons ... effectively prohibited ... condemn any use...

Empower

Violation of The 1947 Nuremberg Code

BRITISH MEDICAL JOURNAL No 7070 Volume 313: Page 1448,
7 December 1996.

Introduction

The judgment by the war crimes tribunal at Nuremberg laid down 10 standards to which physicians must conform when carrying out experiments on human subjects in a new code that is now accepted worldwide.

This judgment established a new standard of ethical medical behaviour for the post World War II human rights era. Amongst other requirements, this document enunciates the requirement of *voluntary informed consent* of the human subject. The principle of voluntary informed consent protects the right of the individual to control his own body.

This code also recognizes that the risk must be weighed against the expected benefit, and that unnecessary pain and suffering must be avoided.

This code recognizes that doctors should avoid actions that injure human patients.

The principles established by this code for medical practice now have been extended into general codes of medical ethics.

The Nuremberg Code (1947)

Permissible Medical Experiments

The great weight of the evidence before us to effect that certain types of medical experiments on human beings, when kept within reasonably well-defined bounds, conform to the ethics of the medical profession generally. The protagonists of the practice of human experimentation justify their views on the basis that such experiments yield results for the good of society that are unprocurable by other methods or means of study. All agree, however, that certain basic principles must be observed in order to satisfy moral, ethical and legal concepts:

1. The voluntary consent of the human subject is absolutely essential. This means that the person involved should have legal capacity to give consent, should be so situated as to be able to exercise free power of choice, without the intervention of any element of force, fraud, deceit, duress, overreaching, or other ulterior form of constraint or coercion; and should have sufficient knowledge and comprehension of the elements of the subject matter involved as to enable him to make an understanding and enlightened decision. This latter element requires that before the acceptance of an affirmative decision by the experimental subject there should be made known to him the nature, duration, and purpose of the experiment; the method and means by which it is to be conducted; all inconveniences and hazards reasonably to be expected; and the effects upon his health or person which may possibly come from his participation in the experiment.

   The duty and responsibility for ascertaining the quality of the consent rests upon each individual who initiates, directs, or engages in the experiment. It is a personal duty and responsibility which may not be delegated to another with impunity.

2. The experiment should be such as to yield fruitful results for the good of society, unprocurable by other methods or means of study, and not random and unnecessary in nature.

3. The experiment should be so designed and based on the results of animal experimentation and a knowledge of the natural history of the disease or other problem under study that the anticipated results justify the performance of the experiment.

4. The experiment should be so conducted as to avoid all unnecessary physical and mental suffering and injury.

5. No experiment should be conducted where there is an a priori reason to believe that death or disabling injury will occur; except, perhaps, in those experiments where the experimental physicians also serve as subjects.

6. The degree of risk to be taken should never exceed that determined by the humanitarian importance of the problem to be solved by the experiment.

7. Proper preparations should be made and adequate facilities provided to protect the experimental subject against even remote possibilities of injury, disability or death.

8. The experiment should be conducted only by scientifically qualified persons. The highest degree of skill and care should be required through all stages of the experiment of those who conduct or engage in the experiment.

9. During the course of the experiment the human subject should be at liberty to bring the experiment to an end if he has reached the physical or mental state where continuation of the experiment seems to him to be impossible.

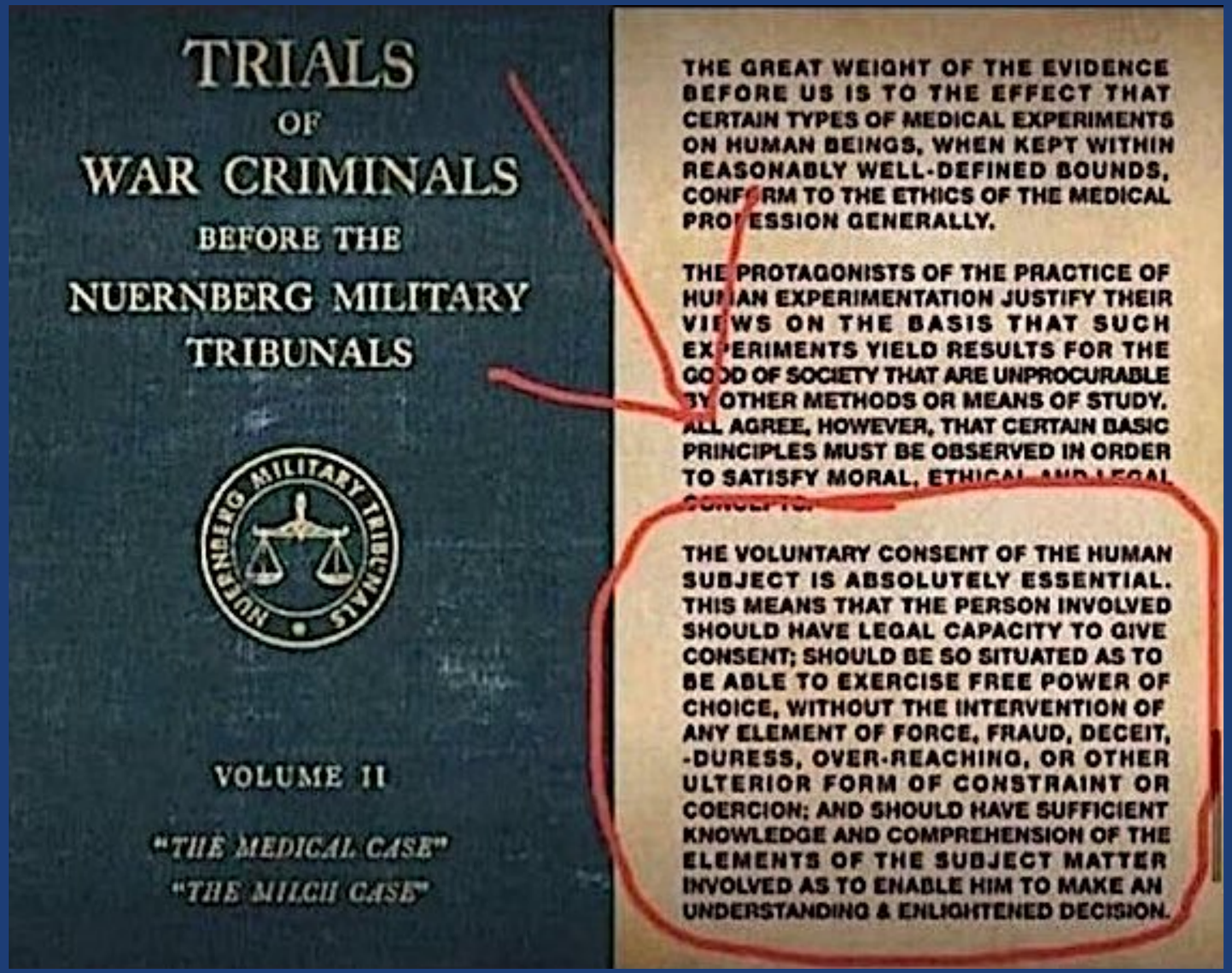
10. During the course of the experiment the scientist in charge must be prepared to terminate the experiment at any stage, if he has probable cause to believe, in the exercise of the good faith, superior skill and careful judgment required of him, that a continuation of the experiment is likely to result in injury, disability, or death to the experimental subject.

For more information see Nuremberg Doctor's Trial, *BMJ* 1996;313(7070):1445-75.

Human Medical experimentation must be conducted by trained personnel based upon animal studies and following informed consent.

Empower

The 1947 Nuremberg Code



TRIALS
OF
WAR CRIMINALS
BEFORE THE
NUERNBERG MILITARY
TRIBUNALS

VOLUME II

"THE MEDICAL CASE"
"THE MILCH CASE"

THE GREAT WEIGHT OF THE EVIDENCE BEFORE US IS TO THE EFFECT THAT CERTAIN TYPES OF MEDICAL EXPERIMENTS ON HUMAN BEINGS, WHEN KEPT WITHIN REASONABLY WELL-DEFINED BOUNDS, CONFORM TO THE ETHICS OF THE MEDICAL PROFESSION GENERALLY.

THE PROTAGONISTS OF THE PRACTICE OF HUMAN EXPERIMENTATION JUSTIFY THEIR VIEWS ON THE BASIS THAT SUCH EXPERIMENTS YIELD RESULTS FOR THE GOOD OF SOCIETY THAT ARE UNPROCURABLE BY OTHER METHODS OR MEANS OF STUDY. ALL AGREE, HOWEVER, THAT CERTAIN BASIC PRINCIPLES MUST BE OBSERVED IN ORDER TO SATISFY MORAL, ETHICAL AND LEGAL CONCEPTS:

THE VOLUNTARY CONSENT OF THE HUMAN SUBJECT IS ABSOLUTELY ESSENTIAL. THIS MEANS THAT THE PERSON INVOLVED SHOULD HAVE LEGAL CAPACITY TO GIVE CONSENT; SHOULD BE SO SITUATED AS TO BE ABLE TO EXERCISE FREE POWER OF CHOICE, WITHOUT THE INTERVENTION OF ANY ELEMENT OF FORCE, FRAUD, DECEIT, -DURESS, OVER-REACHING, OR OTHER ULTERIOR FORM OF CONSTRAINT OR COERCION; AND SHOULD HAVE SUFFICIENT KNOWLEDGE AND COMPREHENSION OF THE ELEMENTS OF THE SUBJECT MATTER INVOLVED AS TO ENABLE HIM TO MAKE AN UNDERSTANDING & ENLIGHTENED DECISION.

Violation Declaration of Helsinki

Established International **Research Ethics** June **1964** in Helsinki, Finland.

A Set of Ethical Principles for Conducting Human Research.

Article 8: Respect for Individual.

Articles 20, 21, 22: Informed Consent.

Article 27: Conflicts of Interest.

Articles 2, 3, 10: Investigators Duty is to Patient.

Article 11: Responsibility for Thorough Scientific Knowledge of Research.

Articles 16, 17: Careful Assessment of Risks & Benefits.

Unethical Human Experimentation in the U.S.

Numerous experiments which were performed on human test subjects in the United States are considered unethical, because they were illegally performed or they were performed without the knowledge, consent, or informed consent of the test subjects. Such tests were performed throughout American history, but most of them were performed during the 20th century. The experiments included the exposure of humans to many chemical and biological weapons (including infections with deadly or debilitating diseases), human radiation experiments, injections of toxic and radioactive chemicals, surgical experiments, interrogation and torture experiments, tests which involved mind-altering substances, and a wide variety of other experiments. Many of these tests were performed on children,[1] the sick, and mentally disabled individuals, often under the guise of "medical treatment". In many of the studies, a large portion of the subjects were poor, racial minorities, or prisoners.

Many of these experiments violated US law. Some others were sponsored by government agencies or rogue elements thereof, including the Centers for Disease Control, the United States military, and the Central Intelligence Agency, or they were sponsored by private corporations which were involved in military activities.[2][3][4] The human research programs were usually highly secretive and performed without the knowledge or authorization of Congress, and in many cases information about them was not released until many years after the studies had been performed.

The ethical, professional, and legal implications of this in the United States medical and scientific community were quite significant, and led to many institutions and policies that attempted to ensure that future human subject research in the United States would be ethical and legal. Public outrage in the late 20th century over the discovery of government experiments on human subjects led to numerous congressional investigations and hearings, including the Church Committee and Rockefeller Commission, both of 1975, and the 1994 Advisory Committee on Human Radiation Experiments, among others.

In 1987 the United States Supreme Court ruled in *United States v. Stanley*, 483 U.S. 669, that a U.S. serviceman who was given LSD without his consent, as part of military experiments, could not sue the U.S. Army for damages. Stanley was later awarded over $400,000 in 1996, two years after Congress passed a private claims bill in reaction to the case.[187] Dissenting the original verdict in *U.S. v. Stanley*, Justice Sandra Day O'Connor stated:

> No judicially crafted rule should insulate from liability the involuntary and unknowing human experimentation alleged to have occurred in this case. Indeed, as Justice Brennan observes, the United States played an instrumental role in the criminal prosecution of Nazi scientists who experimented with human subjects during the Second World War, and the standards that the Nuremberg Military Tribunals developed to judge the behavior of the defendants stated that the 'voluntary consent of the human subject is absolutely essential ... to satisfy moral, ethical, and legal concepts.' If this principle is violated, the very least that society can do is to see that the victims are compensated, as best they can be, by the perpetrators.

https://en.wikipedia.org/wiki/Unethical_human_experimentation_in_the_United_States

Violation of The International Covenant on Civil and Political Rights (ICCPR) Treaty on Human Experimentation.

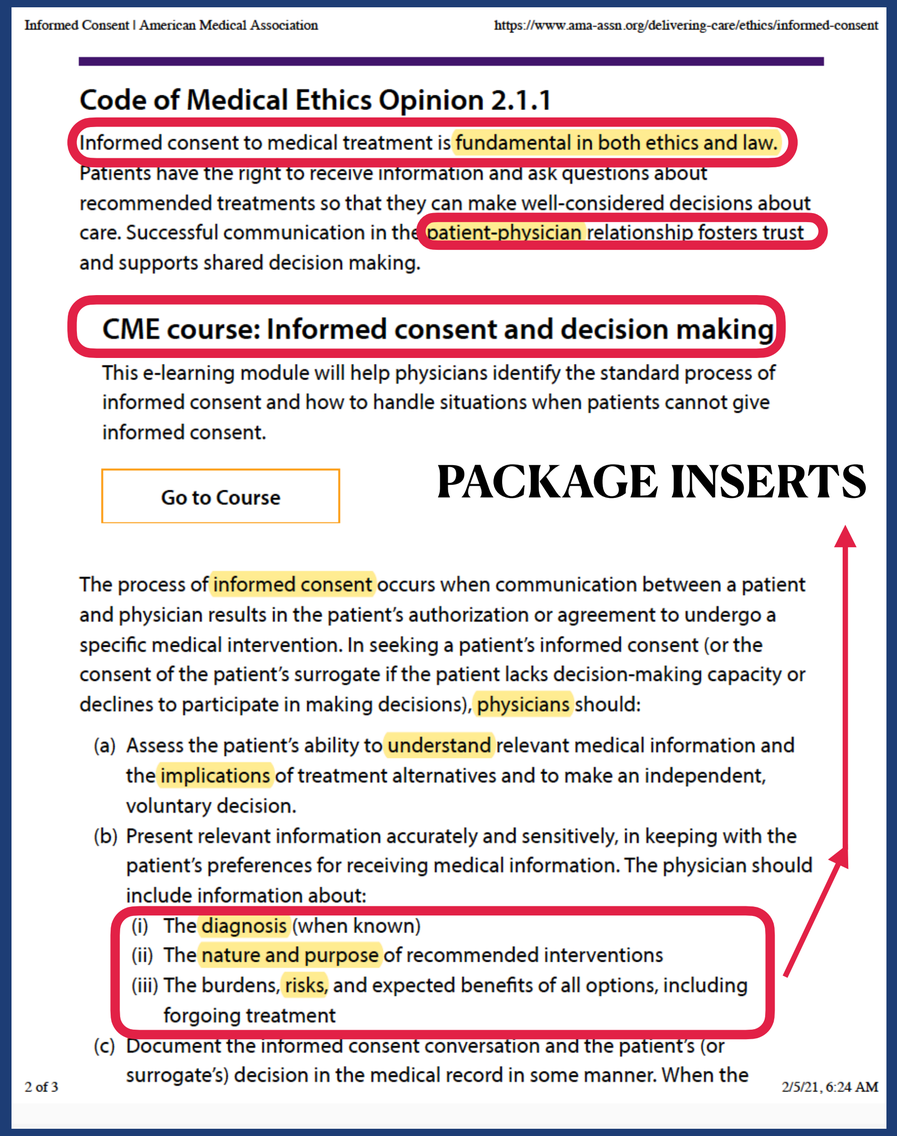
International Covenant on Civil and Political Rights

Adopted and opened for signature, ratification and accession by General Assembly resolution 2200A (XXI) of 16 December 1966, entry into force 23 March 1976, in accordance with Article 49

Article 7

No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his free consent to medical or scientific experimentation.

Physician Violation The American Medical Association (AMA) Code of Medical Ethics



Informed Consent | American Medical Association https://www.ama-assn.org/delivering-care/ethics/informed-consent

Code of Medical Ethics Opinion 2.1.1

Informed consent to medical treatment is fundamental in both ethics and law. Patients have the right to receive information and ask questions about recommended treatments so that they can make well-considered decisions about care. Successful communication in the patient-physician relationship fosters trust and supports shared decision making.

CME course: Informed consent and decision making

This e-learning module will help physicians identify the standard process of informed consent and how to handle situations when patients cannot give informed consent.

Go to Course

PACKAGE INSERTS

The process of informed consent occurs when communication between a patient and physician results in the patient's authorization or agreement to undergo a specific medical intervention. In seeking a patient's informed consent (or the consent of the patient's surrogate if the patient lacks decision-making capacity or declines to participate in making decisions), physicians should:

(a) Assess the patient's ability to understand relevant medical information and the implications of treatment alternatives and to make an independent, voluntary decision.

(b) Present relevant information accurately and sensitively, in keeping with the patient's preferences for receiving medical information. The physician should include information about:

(i) The diagnosis (when known)
(ii) The nature and purpose of recommended interventions
(iii) The burdens, risks, and expected benefits of all options, including forgoing treatment

(c) Document the informed consent conversation and the patient's (or surrogate's) decision in the medical record in some manner. When the

2 of 3 2/5/21, 6:24 AM

Patient Informed Consent is Fundamental to both Medicine and Law.

Informed Consent is between the patient and physician.

Informed Consent requires patients being made aware of the purpose, risks & benefits of a test or treatment.

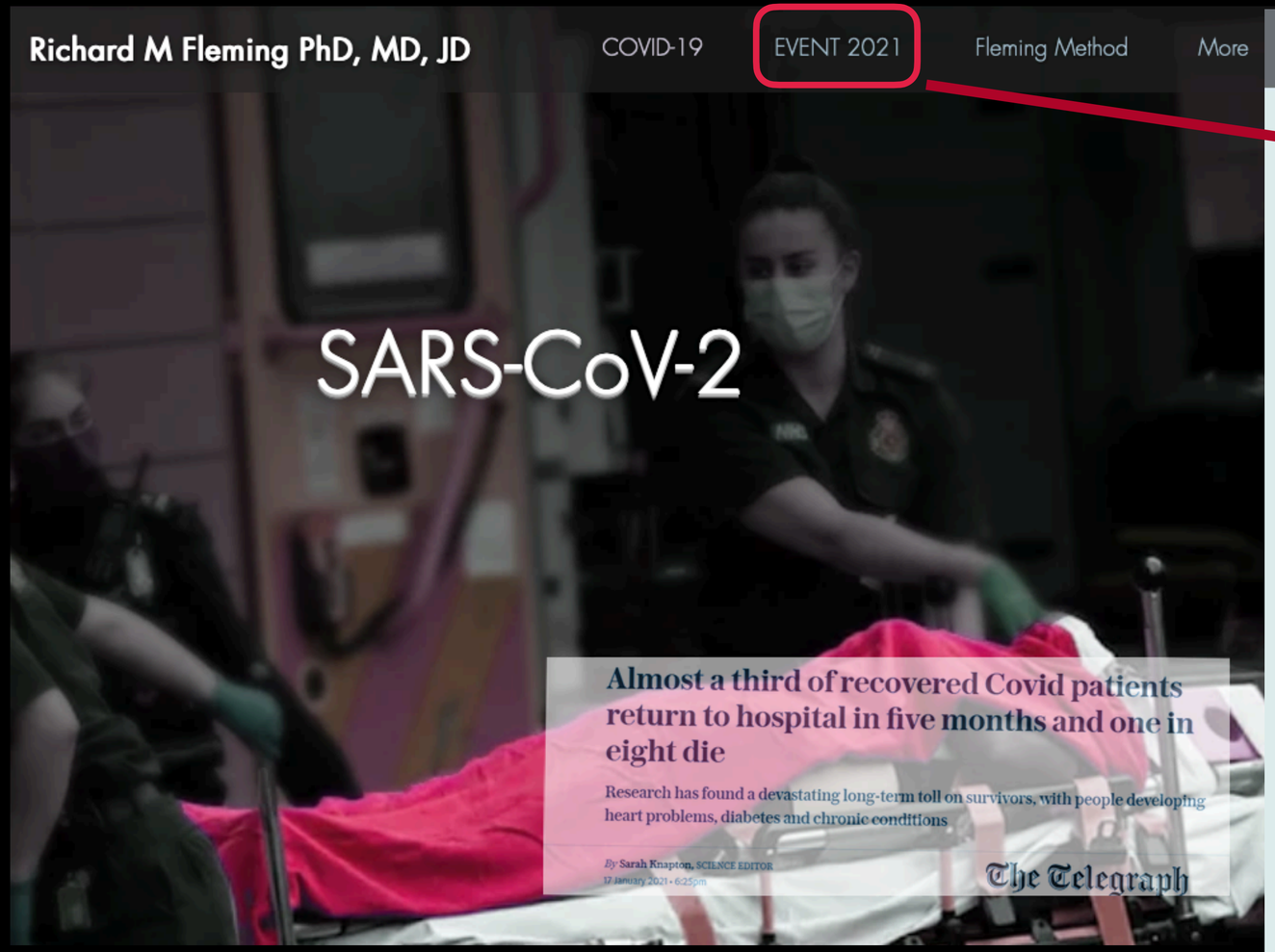
This Time

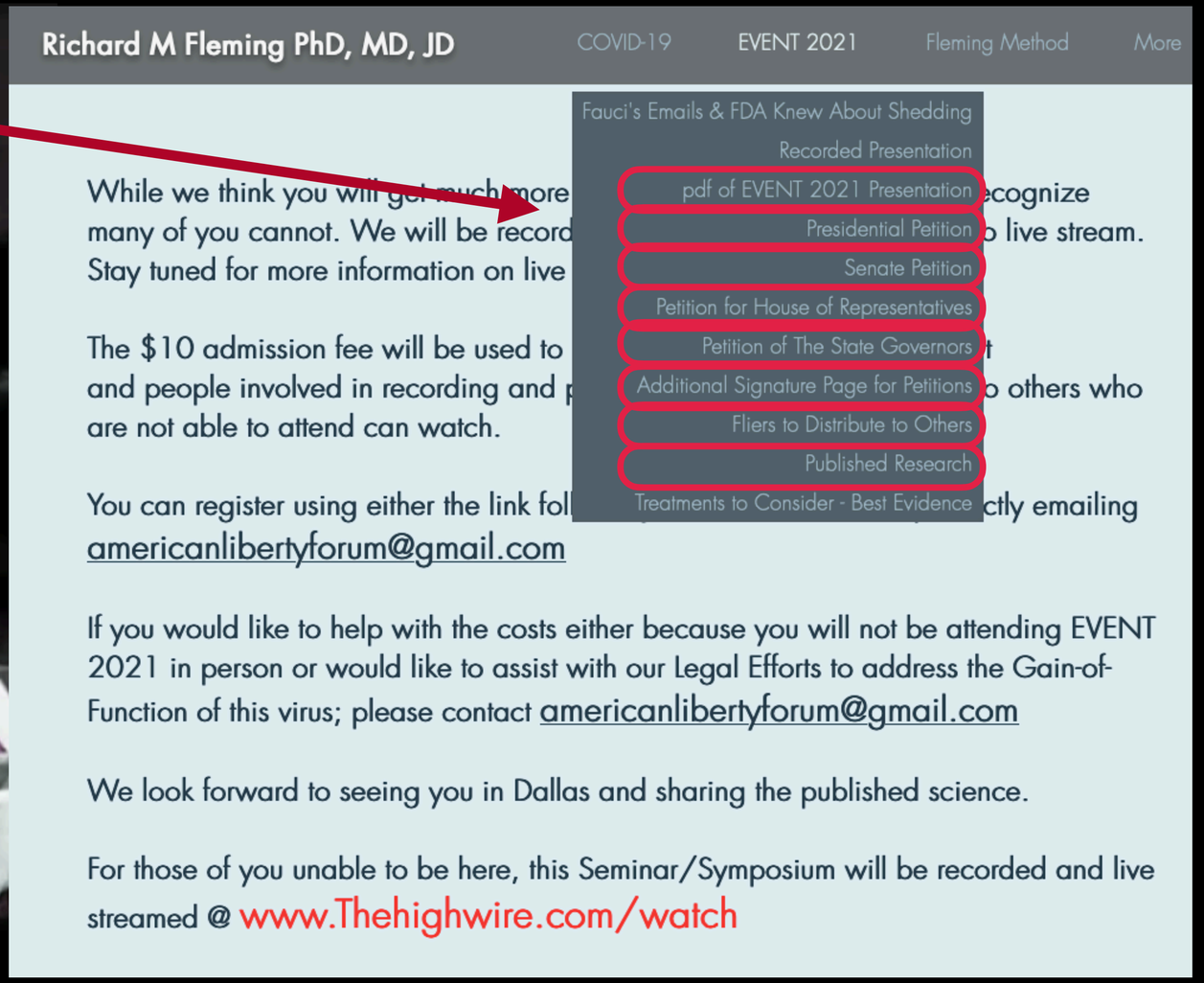
This time there will be no hiding of evidence from the jury (the people) &

There will be no pulling the wool over the jury's (people's) eyes.

Action Items on www.FlemingMethod.com

Download and Act Upon.





From There You Can Download & Share

Notice to Cease and Desist

This document serves as an order to CEASE AND DESIST harassment, which is an UNLAWFUL ACTION as outlined below. Whoever chooses to knowingly and willingly engage in unlawful behavior is committing a CRIMINAL OFFENSE and is subject to any punishments afforded by well established law.

Unlawful Mask Mandates and Vaccine Verification

While some states may mandate the wearing of masks or vaccine verification, there is no law in place requiring them. Denying entry or access to services for those without a face covering or requiring proof of SARS-CoV-2 vaccination is in direct violation of state law and is discriminatory, unlawful and unconstitutional.

Individuals without a face covering or vaccine verification cannot be considered a direct threat, unless they have been deemed to be contagious by a treating physician with full access to their medical history, and are therefore legally entitled to full access at all places of public accommodation. A person that complies with all lawful conditions at places of public accommodation cannot be considered as trespassing.

Behavior meant to create a hostile or unsafe environment toward those without a face covering or vaccine verification is regarded as harassment, which is a criminal offense.

Harassment is a gross misdemeanor punishable by up to a year of jail time.

--------- This document is supported by Richard M Fleming, PhD, MD, JD ---------

For more information on SARS-CoV-2 & COVID-19 go to:
www.FlemingMethod.com

Harassment

The following types of actions toward individuals without a face covering or vaccine verification are regarded as harassment:

(1) Subjecting someone to physical restraint such as blocking their entry or restraining their free movement.

(2) Deprivation of rights under color of law (18 U.S.C. § 242).

(3) Being unlawfully detained by police when there is no evidence of trespass. Such action by law enforcement is considered a **false report** and restraining these individuals against their will is **false imprisonment**. Every public officer who shall knowingly and willingly make any false or misleading statement in any official report or statement, under circumstances not otherwise prohibited by law, shall be guilty of a **gross misdemeanor**.

(4) Threatening someone so as to create concern for his or her physical or mental health safety, such as calling or purporting to call law enforcement under the guise of a trespass violation is **assault**.

Sheriff

The Office of the Sheriff is the chief law-enforcement agency in the County with duty to keep peace and uphold the LAW in accordance with Federal and State Constitutions. In the execution of their duties, the Sheriff may arrest and commit to prison all persons who break the peace, attempt to break the law, and all persons guilty of these public offenses.

A public offense is any conduct that is in violation of the United States Constitution, the State Constitution, and well-established law, and is punishable to the fullest extent the law will allow.

Harassment, false reporting, false imprisonment, and assault are violations of law established under Federal and State Constitutions.

--------- This document is supported by Richard M Fleming, PhD, MD, JD ---------

For more information on SARS-CoV-2 & COVID-19 go to:
www.FlemingMethod.com

Civil Rights Act 1964 Titles I & II

Public accommodations are prohibited from unlawful discrimination and must allow free and equal access to all goods, services, facilities, privileges and accommodations as the general public.

Title U.S.C. 42 § 2000

(a) All persons shall be entitled to the full and equal enjoyment of the goods, services, facilities, privileges, advantages, and accommodations of any place of public accommodation, as defined in this section, without discrimination or segregation on the ground of race, color, religion, or national origin.

(b) Establishments affecting interstate commerce or supported in their activities by State action as places of public accommodation; lodgings; facilities principally engaged in selling food for consumption on the premises; gasoline stations; places of exhibition or entertainment; other covered establishments.

A Private Business is a Public Accommodation that is open to the general public & engaged in commerce. A private business cannot lawfully deny you service if they are open to the general public while they are engaging in commerce.

They are breaking well-established law if they discriminate against you. The only places that are not a public accommodation are churches, temples, synagogues, private membership association, or a 501(C)(3) nonprofit.

A grocery store is a private entity that provides goods and services to the general public and is therefore lawfully defined in Federal and State laws as a place of “Public Accommodation”. The legal, federal definition of a public accommodation: Public accommodation means a private entity that owns, leases (or leases to), or operates a place of public accommodation.

--------- This document is supported by Richard M Fleming, PhD, MD, JD ---------

For more information on SARS-CoV-2 & COVID-19 go to:
www.FlemingMethod.com

You Can Download, Sign and Send to Your Governor

By affixing our signatures below, we respectfully petition both Governor Abbott of the State of Texas, and the Texas State Legislature to take the following actions on behalf of the Citizens of the State of Texas pursuant to the 10th Amendment of the U.S. Constitution as ratified on 15 December 1791.

Whereas: The Spike Protein of SARS-CoV-2 virus is the direct result of Gain-of-Function (GoF) research on Corona Viruses; and

Whereas: this Gain-of-Function research was funded by Texan and U.S. taxpayers via Federal Agencies, including but not limited to, the NIH, NIAID, DOD, HHS, NSF, and the USAID; and

Whereas: these Federal Agencies have paid monies to multiple Universities, Public and Private Corporations for Gain-of-Function research, in addition to and including but not limited to, Peter Daszak of EcoHealth, who subsequently funneled these monies including but not limited to, Professor Ralph Baric at the University of North Carolina – Chapel Hill, and Professor Shi Zhengli at the Wuhan Institute of Virology; and

Whereas: this has resulted in a pandemic that has cost more American lives than any war in U.S. history including WWII, The Civil War, or all other U.S. Wars combined; and

Whereas: The EUA documents filed by Pfizer, Moderna, and Janssen all demonstrate that the use of these Experimental Drug/Vaccines that include either the mRNA or dsDNA of the Spike Protein produced by this Gain-of-Function Research, do NOT statistically reduce the incidence of COVID-19; and

Whereas: by definition this Spike Protein is pursuant to the terms and conditions of the Biological Weapons Convention Treaty (BWCT) is a violation of the Biological Weapons Convention Treaty; and

Whereas: the failure to require and provide written Informed Consent to individuals being given an Experimental Drug, which these Vaccines are by definition; is a violation of (1) The 1947 Nuremberg Code, (2) The International Covenant on Civil and Political Rights (ICCPR) Treaty, (3) The 1964 Declaration of Helsinki, and (4) The American Medical Association (AMA) Code of Ethics.

We respectfully and formally request: That Governor Abbott and the Texas legislature pass legislation and/or executive action that protect consumers from businesses denying entry to consumers who don't have vaccine or mask pursuant to the 10th Amendment to the U.S. Constitution.

We respectfully and formally request: That Governor Abbott and the legislature provide an exemption from any vaccine documents including vaccine passports for consumers and citizens of the State of Texas pursuant to the 10th Amendment to the U.S. Constitution.

We respectfully and formally request: That Governor Abbott and the legislature pass legislation protecting consumers from any and types of discrimination if a consumer decides not to wear a mask or take a vaccine. In other words, no business, company, or entity can force its employees or consumers to take a vaccine or wear a mask pursuant to the 10th Amendment to the U.S. Constitution.

Signatories

Richard M Fleming, PhD, MD, JD — 5 June 2021

_____ Date: _____

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You Can Download, Sign and Send to President Biden & The Congress of the USA

By affixing our signatures below, we respectfully petition both **The President of the United States, Joseph Robinette Biden, Jr. and the Congress of the United States** to take the following actions on behalf of the Citizens of the United States of American pursuant to Article I and Article II of the U.S. Constitution as ratified on 21 June 1788, and in accordance with the Amendments to the U.S. Constitution.

Whereas: The Spike Protein of SARS-CoV-2 virus is the direct result of Gain-of-Function (GoF) research on Corona Viruses; and

Whereas: this Gain-of-Function research was funded by U.S. taxpayers via Federal Agencies, including but not limited to, the NIH, NIAID, DOD, HHS, NSF, and the USAID; and

Whereas: these Federal Agencies have paid monies to multiple Universities, Public and Private Corporations for Gain-of-Function research, in addition to and including but not limited to, Peter Daszak of EcoHealth, who subsequently funneled these monies including but not limited to, Professor Ralph Baric at the University of North Carolina – Chapel Hill, and Professor Shi Zhengli at the Wuhan Institute of Virology; and

Whereas: the Constitution of the United States of America does not empower the Senate or the Executive Branch of the U.S. Federal Government with the power or authority to regulate medical care; and

Whereas: physicians have been prevented from practicing medical care of patients as they and their patients deem medically appropriate, following actions taken by the Federal Government including but not limited to Administrative agencies including the NIH, NIAID, CDC, PHS, FDA, and HHS; and

Whereas: this has resulted in a pandemic that has cost more American lives than any war in U.S. history including WWII, The Civil War, or all other U.S. Wars combined; and

Whereas: The EUA documents filed by Pfizer, Moderna, and Janssen all demonstrate that the use of these Experimental Drug/Vaccines that include either the mRNA or dsDNA of the Spike Protein produced by this Gain-of-Function Research, do NOT statistically reduce the incidence of COVID-19, or deaths from COVID-19, and

Whereas: by definition this Spike Protein is pursuant to the terms and conditions of the Biological Weapons Convention Treaty (BWCT) a direct violation of the Biological Weapons Convention Treaty; and

Whereas: the failure to provide the required written Informed Consent to individuals being given these Experimental Drug Vaccine (Biological Agents), make the injection of these Experimental Drug Vaccines (Biological Agents) by definition; a violation of (1) The 1947 Nuremberg Code, (2) The International Covenant on Civil and Political Rights (ICCPR) Treaty, (3) The 1964 Declaration of Helsinki, and (4) The American Medical Association (AMA) Code of Ethics.

We hereby respectfully and formally request: That the President and Congress of the United States of American begin the immediate investigation of those involved in Gain-of-Function research, and that the investigation specifically include the investigation of those individuals and agencies responsible for the investment and development of the SARS-CoV-2 virus. That these individuals be held legally and criminally accountable for their actions in violation with including but not limited to U.S. Statutory violations as well as violations of the BWC Treaty, the ICCPR Treaty, and The Declaration of Helsinki.

We hereby respectfully and formally request: Legislative and Executive action to ban the funding and development of such Gain-of-Function research, and the immediate cessation of such research currently being conducted and a return of such funding to the agencies or individuals that dispensed said funding.

We hereby respectfully and formally request: Legislative and Executive action to ban any Federal interference with the practice of medicine and to refrain from any further interference with the practice of medicine.

We hereby respectfully and formally request: Legislative and Executive action to ban any mask or drug vaccine (biologics) mandates or requirements of U.S. citizens including but not limited to travel, entry into places of business, or other activities consistent with the practices and principles of the U.S. Constitution and Amendments to the Constitution.

Signatories----State----Date

Richard M Fleming, PhD, MD, JD

TEXAS 5 June 2021

NAME YOUR STATE _____ Date: DATE

_____ Date: _____

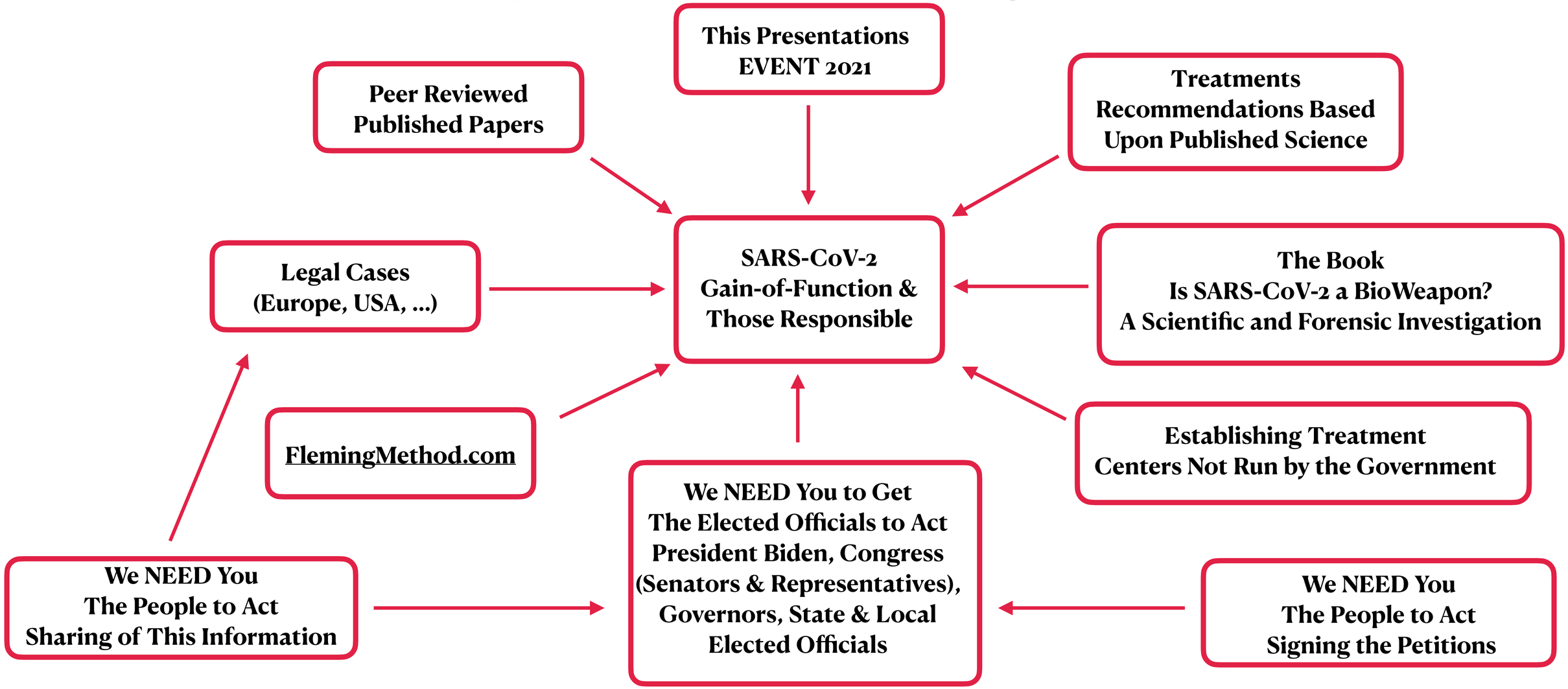
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Empower

We Need Your Help. I Need Your Help. Frankly

The Country & The World Needs Your Help.
Perhaps More Importantly Your Children, Grandchildren, Friends & Neighbors Need Your Help.
As Well As The People Who Are Scared & Looking to Others for Answers.



Help Us Prove Hermann Wilhelm Göring Wrong!

Because the Alternative is to Prove He was Right.



What We Do Together Will Determine What Happens Next



Section 04

04 Hope From The Best Available Research Results.

The Prevention

Treatment of SARS-CoV-2 Infection

Treatment of COVID-19 ITR Disease

Treatment of Those Who Are Experiencing

Adverse Effects Following Vaccination with Biologics.

HOPE : Best Available Evidence Treatments



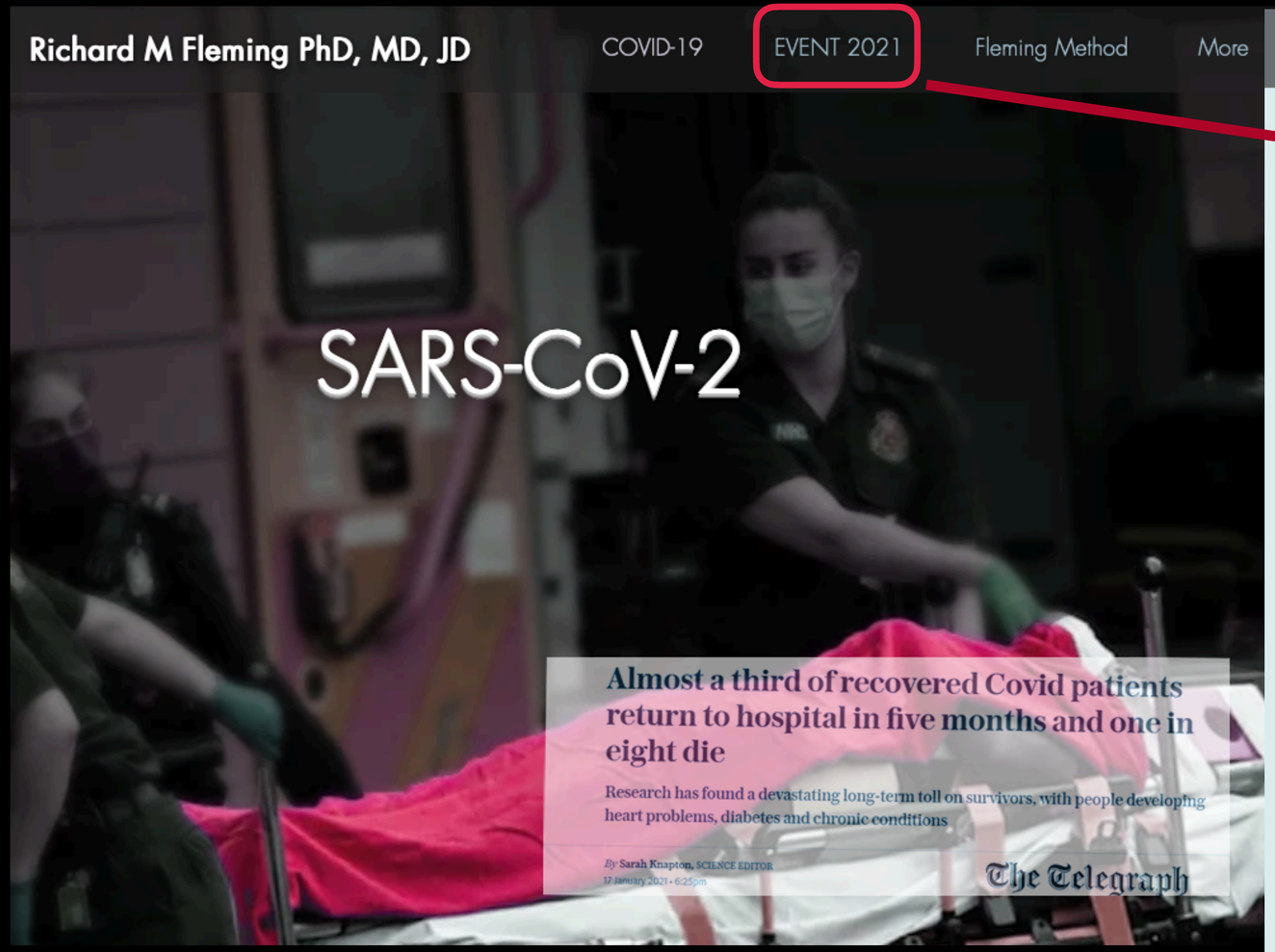


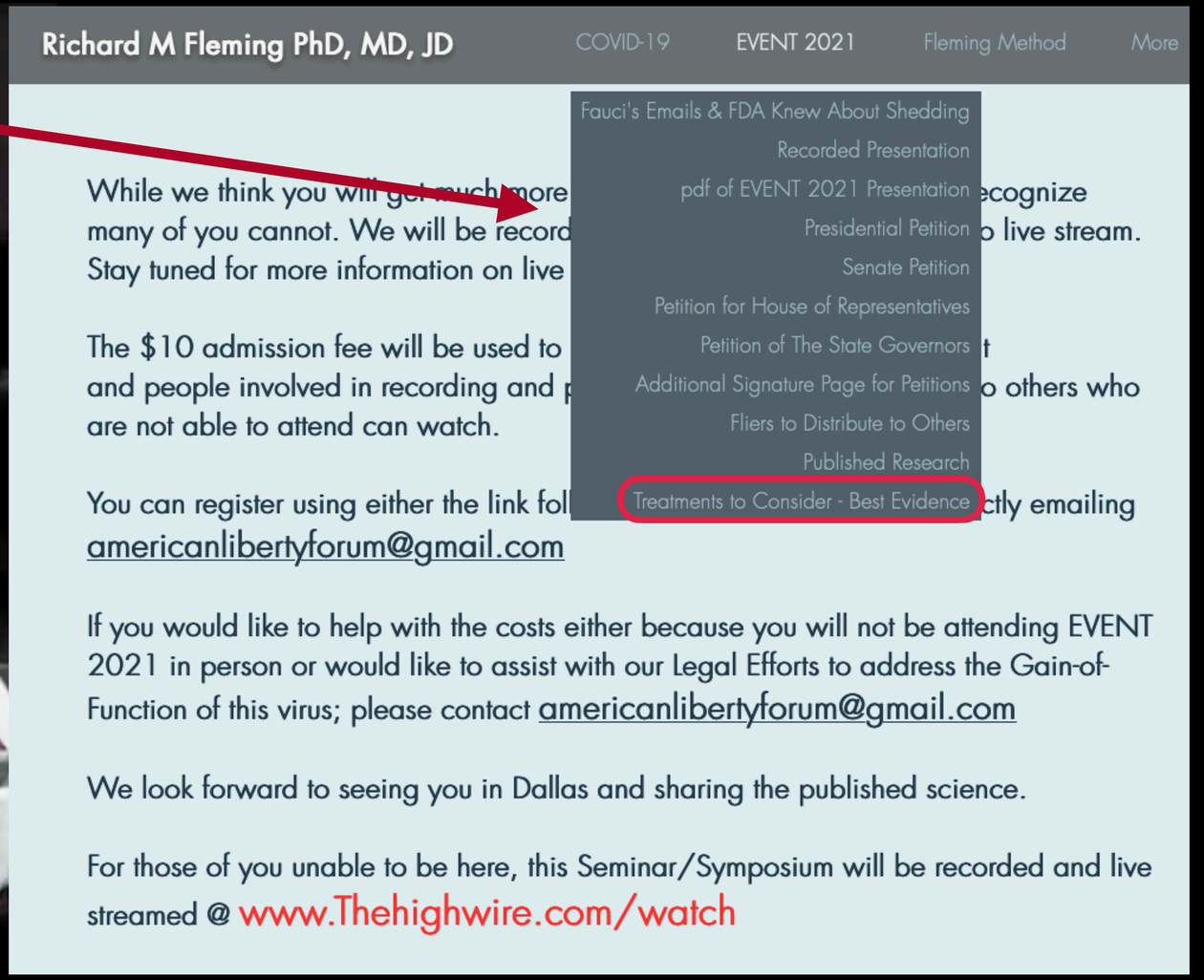




Treatments to Consider www.FlemingMethod.com

Download and Act Upon.





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5 June 2021

Treatments to Consider Based Upon the Best Available Evidence Research Results.

PROPOSED TREATMENT APPROACHES FOR PROPHYLAXIS, SARS-COV-2, COVID-19, AND POST-VACCINATION; **FOR YOU TO DISCUSS WITH YOUR PHYSICIAN**. THIS IS NOT A SERVICE, THE SALE, BUYING, OR MARKETING OF A PRODUCT, OR THE PRACTICING OF MEDICINE.

This document has been assembled following repeated requests for such information. Given the discordant dissemination of information and misinformation, it is clear that clinicians are receiving little guidance in the treatment of individuals infected with SARS-CoV-2; who have developed the InflammoThrombotic Response (ITR) disease of COVID-19; or who have undergone injection of a vaccine containing genetic material encoding the gain-of-function spike protein.

Consequently, pursuant to those requests, and the need to provide some level of guidance, I have assembled based upon the best available evidence research results, the following proposed treatment options to be considered by your doctor to address these various health problems and concerns[1].

Also included are potential options for treatment of Individuals infected with SARS-CoV-2 or have been injected with SARS-CoV-2 Vaccines, based upon mechanisms of action and the best available evidence research results.

These best available evidence research results and understood mechanisms of action are to be followed only under the care and supervision of your physician.

Nothing within this material should be considered as my providing you with medical care, a service, sale or advertisement of a product or medical advice.

I have no relationship to any of the companies that make any of these drug products.

Any care or treatment provided to you is the responsibility of your personal physician, as well as yourself, and should follow informed consent. There is no expressed U.S. Constitutional authority under Article I or II, for the Federal Government to direct, govern, or otherwise be involved in your personal Health Care. https://constitutioncenter.org/interactive-constitution/full-text

[1] This does not represent a "service."

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The fundamental expressed concerns people appear to have as a result of becoming infected with SARS-CoV-2 or having been vaccinated include:

(1) The possible insertion of the genetic code sequence(s) found within the Drug Vaccines through Reverse Transcription (RT) into human DNA, potentially made possible as a result of either the RT capacities present within the SARS-CoV-2 virus itself (spike protein, nucleocapsid, envelope, or other genetic sequences); the Long Interspersed Nuclear Elements (LINE-1) found within approximately 18% of the human genome; or RT facilitated in CD-4 cells and platelets as previously demonstrated with Human Immunodeficiency Viruses (HIV); raise increased concerns about the potential of genetic material being inserted into the human genome, or replacing components of the human genome; particularly when coupled with Clustered Regularly Interspaced Short Palindromic Repeats (CRISPR).

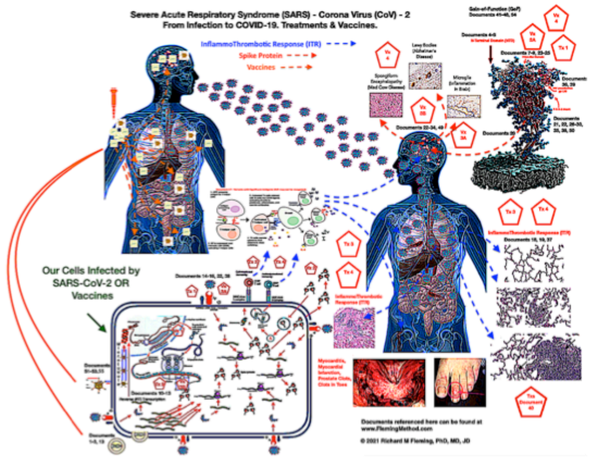
(2) The circulation of the spike protein within the body, from the virus or drug vaccine with induced production of SARS-CoV-2 spike proteins, as well as other genetic material; needs to be neutralized to reduce the dissemination of this genetic material as well as prion-like domains found near the receptor binding domain (RBD) of the spike protein; either within the individual infected or injected, to minimize the InflammoThrombotic Response (ITR) resulting in the disease COVID-19; the potential development of amyloidal and prion diseases, occurring within the brain resulting from the prion-like domain at the Receptor Binding Site (RBS) of the spike protein as seen in animal models; and to minimize the shedding of this genetic and protein material that could be transmitted to others, resulting in further disease.

(3) The need to reduce, inhibit or prevent the viral or other non-native individual genetic material from being re-expressed at a later time – as seen with many viral diseases – through transcription and translation of viral or genetic material inserted into the human DNA through the above noted RT process, and

(4) The immediate and long treatment of potentially damaged human DNA, including but not limited to the potential short and long-term neurologic, cardiac, and prion-like diseases and sequela.

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OVERVIEW OF THE SARS-CoV-2 PROCESS IN INFECTED AND VACCINATED PEOPLE INCLUDING THE INFLAMMOTHROMBOTIC RESPONSE (ITR) DISEASE COVID-19. https://www.flemingmethod.com/documentation



CURRENTLY SUGGESTED TREATMENTS BASED UPON BEST AVAILABLE EVIDENCE RESEARCH RESULTS PROPHYLAXIS FOR PEOPLE CONCERNED ABOUT SARS-CoV-2

As someone who has practiced clinically I am not a believer in the use of medications for prophylaxis when there is no disease yet to be treated. Just as treating an abnormal blood test without the presence of a disease to be treated makes it impossible to measure a treatment benefit – given no disease to measure – or treatment failure; the only potential measureable outcome is that of potential risks or complications resulting from the treatment. E.g. prophylaxis of cancer by having chemotherapy when there is no measureable evidence of cancer.

That being said, the following steps based upon best available evidence research results have been shown to reduce the development and progression of InflammoThrombotic Response (ITR) Diseases; including but not limited to aging, coronary artery disease, cancer, strokes, hypertension, diabetes, and obesity.

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Modification of diet and lifestyle, to reduce risk factors for these chronic inflammatory diseases, as I and others have previously published and discussed [https://www.youtube.com/watch?v=OE6cnZFOBJ8] have been shown to reduce the risk of associated comorbidities associated with SARS-CoV-2 & COVID-19.

In addition, it has been the standard of care, that patients with respiratory problems, particularly those with compromised airway flow and reductions in acceptable oxygen levels within the arteries (viz. oxygen saturation), have received bronchodilator treatments and steroids when deemed medically appropriate.

Many researchers and clinicians would additionally advocate for sufficient dietary supplementation of vitamins and minerals to maximize overall immune response – particularly under "stressful" conditions.

Examples of these best available evidence research results include:

RESPIRATORY SUPPORT

1) Ipratropium bromide (Atrovent) inhaler treatment every 4-hours.

   Inhalers 2-puffs every 4 hours. Nebulizer 500 mcg every 4 hours (adults). Dose to be reduced accordingly for children.

THROMBOSIS REDUCTION

1) Either heparin 5000 units subcutaneously every 12 hours OR
2) Aspirin 325 mg tablets (once or twice daily as tolerated), OR
3) Equivalent given specifics of person.

IMMUNE SUPPORT

1) Folate (B9) 3 mg by mouth daily
2) Magnesium 400 mg by mouth daily
3) Calcium Carbonate 400 mg by mouth daily
4) Cobalamin (B12) 3 mg by mouth daily
5) Pyridoxine (B6) 30 mg by mouth daily
6) Dehydroepiandrosterone (DHEA) 50 mg by mouth twice daily
7) Ascorbic acid (C) 2000 mg by mouth daily
8) Zinc 10 mg by mouth daily, and
9) 1,25-dihydroxycholecalciferol (D3) 1500 IU by mouth daily.

Based upon best available evidence research results, viruses have been treated by focusing on viral attachment and replication. Given the InflammoThrombotic Response (ITR) to SARS-CoV-2, and the best available evidence research results, patients infected with the virus with adverse outcomes are developing ITRs. Currently suggested treatments based upon best available evidence research results include the following.

Inform

Is SARS-CoV-2 & COVID-19 Treatable?

Yes Treatment of SARS-CoV-2 & COVID-19 are Treatable by Using a Combination of Medicines to address

(1) Virus attachment & Entry into the cell.
(2) Virus replication once inside the cell.
(3) Reducing Inflammation & Blood Clotting associated with the T-Cell (Innate) response to the virus.
(4) Reducing Inflammation & Blood Clotting associated with the B-cell (Delayed Humoral) response to the virus.

It is also important to use Medicines that improve airflow in and out of the lungs, as well as Medications to reduce blood clotting, and assist controlled immune response.



- CONTINUED -

CURRENTLY SUGGESTED TREATMENTS BASED UPON BEST AVAILABLE EVIDENCE RESEARCH RESULTS FOR PEOPLE INFECTED BY SARS-CoV-2 WHO ARE NOT HOSPITALIZED

When Treatment was Started within 3-4 Days of Symptoms.

(1) 100% Effective
- Primaquine 200 mg by mouth on day 1.
- Clindamycin 150 mg by mouth every 6-hours for 7-days.
- Hydroxychloroquine 200 mg by mouth every 8-hours for 10-days.

(2) 97.9% Effective
- Hydroxychloroquine 200 mg by mouth every 8-hours for 10-days.
- Clindamycin 150 mg by mouth every 6-hours for 7-days.

(3) 74.2% Effective
- Hydroxychloroquine 200 mg by mouth every 8-hours for 10-days.
- Azithromycin 500 mg by mouth on day 1, then 250 mg by mouth on days 2 through 5.

(4) 69.1% Effective
- Hydroxychloroquine 200 mg by mouth every 8-hours for 10-days.
- Doxycycline 100 mg by mouth every 12-hours for 10-days.

CURRENTLY SUGGESTED TREATMENTS BASED UPON BEST AVAILABLE EVIDENCE RESEARCH RESULTS FOR PEOPLE INFECTED BY SARS-CoV-2 WHO ARE HOSPITALIZED WITH COVID-19 (ITR to Virus)

(1) With prior Aminoquinoline Treatment begin
- Methylprednisolone 125 mg IV every 6-hours for 3 days;
- then 125 mg IV every 12-hours for 2 days;
- then 125 mg IV daily for 2 days;
- then 60 mg IV daily for 2 days [with each infusion given over 30-minutes];
- then Solumedrol dose pack to taper off steroids).

(2) With prior Aminoquinoline Treatment begin
- Tocilizumab 8-mg/kg [IBW; not to exceed 800 mg] not to exceed 800 mg intravenously infused over 1-hour.
- May be repeated every 8-hours for a maximum of 4-doses; and
- Interferon α-2β (5-million units per nebulizer every 12-hours for 7-days).

(3) Without prior Aminoquinoline Treatment
- Primaquine 200 mg by mouth day 1;
- Clindamycin 150 mg by mouth every 6-hours for 7-days; and
- Tocilizumab and Interferon-α2β - using the same doses shown in (2) above.

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CURRENTLY SUGGESTED TREATMENTS BASED UPON BEST AVAILABLE EVIDENCE RESEARCH RESULTS FROM PHYSICIANS REPORTING CLINICALLY SUCCESSFUL TREATMENTS

Clinicians Reporting Treatment Success.

- Dr. Vladimir Zelenko (Family Practice in New York) - treatment with hydroxychloroquine, azithromycin and zinc had an 84% reduction in hospitalization. [doi: 10.20944/preprints202007.0025.v1]
- Dr. Peter A. McCullough (Baylor Dallas) - nine studies reveal patients treated with hydroxychloroquine and other drugs like doxycycline had a greater than 60% reduction in death. [https://www.researchgate.net/publication/348946216]
- AAPS - Early Treatment Saves Lives [https://aapsonline.org/early-treatment-saves-lives/]
- Dr. Harvey Risch (Yale) - Hydroxychloroquine (HCQ) produced a 34% reduction in risk of death, while HCQ and azithromycin produced a 29% reduction in risk of death in hospitalized patients with COVID-19. [https://doi.org/10.1016/j.ijid.2020.06.099]
- Dr. Richard Bartlett (Budesonide Nasal Steroids) - reports 100% success rate when started early.
- Dr Eleftheria Atalla (Brown University, R.I.) - treatment of critically ill seniors in Long Term Care Facilities with anticoagulants who had elevated markers of inflammation were 84% less likely to die. [Pathogens 2021, 10, 8. https://dx.doi.org/10.3390/pathogens10010008]

CURRENT POTENTIAL TREATMENTS CONSIDERATIONS BASED UPON BEST AVAILABLE EVIDENCE RESEARCH RESULTS - FOCUSING ON SPECIFIC COMPONENTS - FOR PEOPLE WHO HAVE BEEN VACCINATED

Based upon the best available evidence currently being collected, the fundamental goals for treating potential complications from drug vaccine delivery of genetic material, includes first blocking the Nuclear Protein Complex (NPC), to minimize continued entry and re-entry of this genetic material into the cellular nuclear region where reverse transcription (RT) could occur; protecting the native human DNA.

The next step is to remove any circulation spike proteins, minimizing the potential harm they might cause including InflammoThrombotic Response (ITR) disease and Prion diseases. The next logical step would be to interfere with any reuptake of spike protein by host cells that could serve as potential new sources of prions, mRNA or DNA, with potential RT, or any other potential sources of SARS-CoV-2 genetic material or any other genetic or non-genetic material circulating from the injected drug vaccines.

The fourth goal is to minimize any potential damage caused by the prion-like domains (PLDs) including reducing the potential longer term neurologic, cardiac, and other organ tissue damage.

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This sequence of steps will hopefully reduce the genetic load introduced into the body by these drug vaccines. By interfering with the entry and re-entry of this genetic material through the NPC through this series of steps, this will hopefully provide adequate time for sufficient glycosylase enzyme removal of genetic bases or nucleotide excision - repair mechanisms - of any damaged DNA; through continued encouragement of transcription of the viral – and other – genetic material, increasing the potential for these DNA repairs to occur.

In essence, by reducing the active viral or spike protein load through these steps, the increased transcription required for maintenance of the genetic code or protein products, will increase the potential for DNA excision repair and exhaust or at a minimum fatigue the viral genetic load.

Step 1: Stop the Reverse Transcriptase (RT) - Block the Nuclear Protein Complex (NPC)

(A) **Ivermectin** 0.2-0.4 mg/kg body weight by mouth (PO) every two weeks.

Step 2: Remove Spike Protein in circulation that could cause ITR or prion-like initiated amyloid or equivalent plaquing.

(A) **Casirivimab** 1200 mg & **Imdevimab** 1200 mg provided intravenously together as a single infusion over a minimum of 60-minutes.

Step 3A: Reduce further uptake of Spike protein by cells throughout the body including transmission across the Blood Brain Barrier (BBB).

(A) **Primaquine** 200 mg orally given once – Targets ACE2 receptor.

(B) **Clindamycin** 150 mg orally every 6-hours for 7-days – Targets transmembrane protease serine 2 (TMPRSS2) receptor.

(C) **Hydroxychloroquine** 200 mg orally twice a week – Targets ACE2 receptor.

Step 3B: Reduce further translation of mRNA to spike protein.

(A) The **Primaquine** from 3A also inhibits viral protein translation (production of spike protein from mRNA).

(B) The **Clindamycin** from 3A also inhibits viral protein translation; reduces ITR by reducing tissue necrosis factor – alpha (TNF-α) and interleukin-1 beta (IL-1β).

(C) The **Hydroxychloroquine** from 3A enhances zinc entry through the zinc ionophore; enhances the production of type 1 interferons, interferes with ribosomal translation of the spike protein, reduces interleukin-6 (IL-6) levels;

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increases cellular pH thereby decreasing viral antigen (mRNA or spike protein) major histocompatability complex (MHC) presentation of the spike protein to B-cells reducing antibody formation and ITR.

(D) **Zinc** 10 mg orally (po) daily. While this may also interfere with the ACE2 receptor, it also interferes with RNA dependent RNA polymerase (RdRP).

(E) **Ascorbic Acid** (Vitamin C) 2000 mg orally (po) daily to reduce ITR.

(F) **1,25-dihydroxycholecalciferol** (Vitamin D3) 1500 IU orally (po) daily to reduce ITR.

Step 4: Address potential amyloid production and neurologic sequlae resulting from prion-like domains on spike protein.

(A) Treat ApoE through **dietary** and **lifestyle** factors; **HMG CoA-reductase inhibitors** or **Probucol** [An ATP-binding transporter A1 (ABCA1)].
(B) **Niacin** (Vitamin B3) 15 mg twice daily.

FURTHER INFORMATION WILL BE MADE AVAILABLE BASED UPON BEST AVAILABLE EVIDENCE RESEARCH RESULTS.

Richard M Fleming, PhD, MD, JD

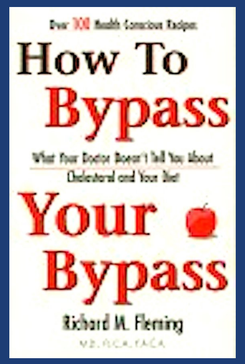
Sites in Europe will soon begin providing these treatments & using FMTVDM to measure results.

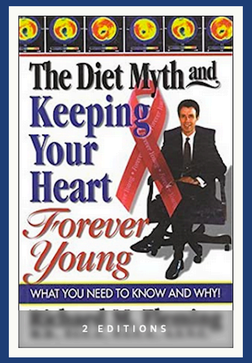
We Cannot Blame Others If We Fail To Act!

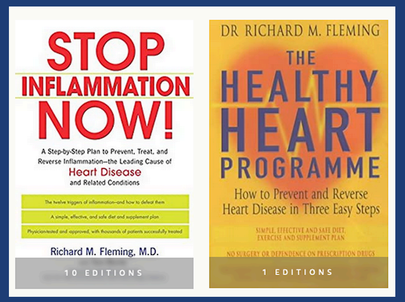


Books With More Information For Medical Professionals & The General Public.

- https://www.amazon.com/Dr-Richard-M-Fleming/e/B08NGY2YZK?ref=sr_ntt_srch_lnk_1&qid=1609337190&sr=1-1

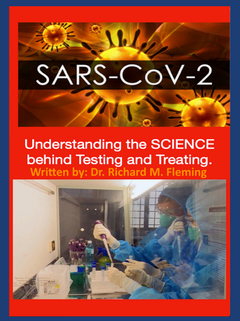


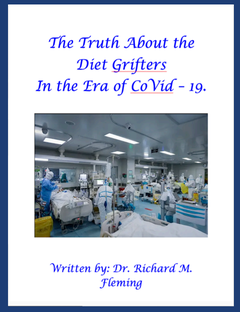


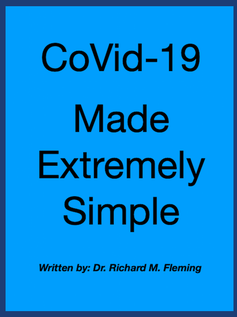










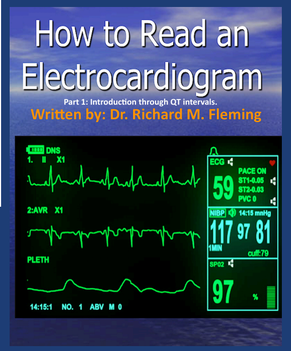


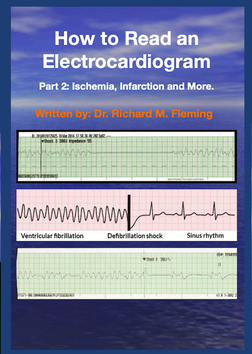


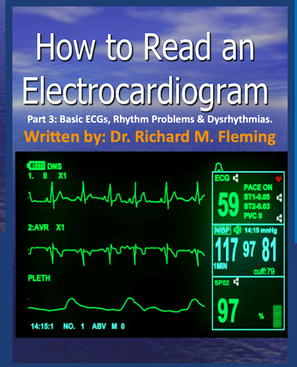


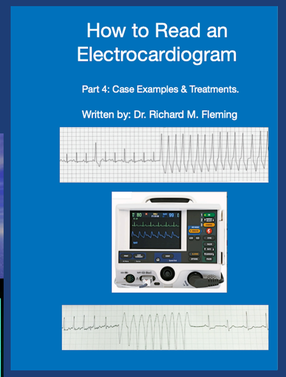


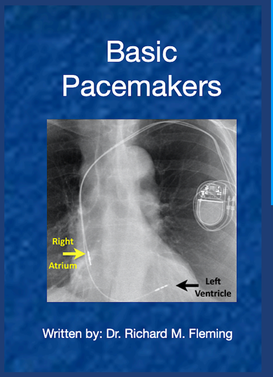


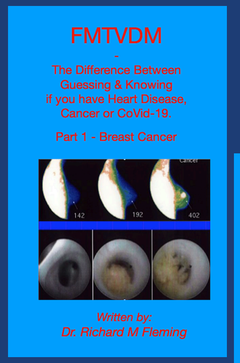


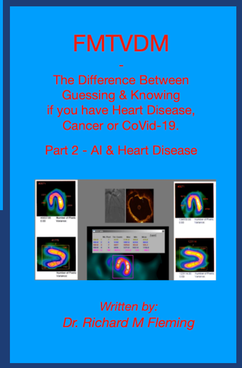








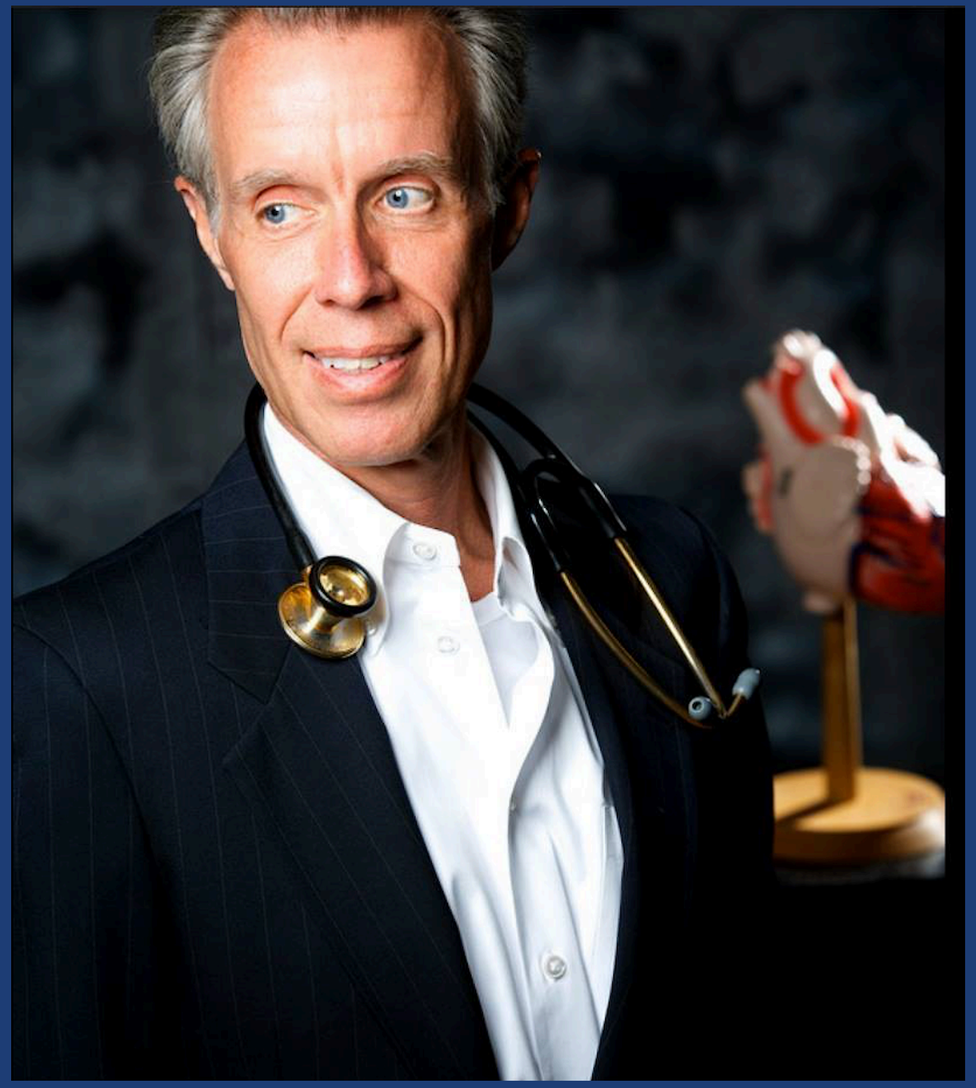




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