

SARS-CoV-2 COVID-19: What You Need To Know



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1. WHAT IS COVID-19?

COVID-19 (coronavirus disease 2019) is an acute respiratory illness caused by SARS-CoV-2, a coronavirus strain among seven coronaviruses known to infect humans.¹ Other coronavirus infections include those due to seasonal (common cold) coronaviruses (229E, NL63, OC43 and HKU1), which cause up to a third of community-acquired upper respiratory tract infections,² as well as MERS-CoV and SARS-CoV-1. Approximately 33%³ of SARS-CoV-2 infections are asymptomatic (never develop symptoms). However, when symptoms do occur, they happen 2–14 days after infection and range from mild to severe fever or chills, difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, nasal congestion or runny nose, nausea or vomiting, or diarrhea.⁴ Most people's symptoms are short-lived, but some do have prolonged symptoms.⁵ Overall, more than 99.6% of people infected with SARS-CoV-2 recover.⁶ The strongest risk factors for fatal COVID-19 are obesity, anxiety disorders, and diabetes.⁷



$$\text{Infection-Fatality Rate} = \frac{\# \text{ COVID-19 Deaths}}{\# \text{ SARS-CoV-2 Infections}}$$

An IFR of 0.35% is supported by an analysis published in *Clinical Infectious Diseases* that estimated that there were 44.8 million symptomatic COVID-19 illnesses in February–September 2020 in the U.S.⁹ Since 33% of all SARS-CoV-2 infections are asymptomatic,³ there were an estimated 66.9 million (44.8 million/[100%-33%]) total number of SARS-CoV-2 infections in that time period. There were also 213,000 COVID-19 deaths in February–September 2020,¹⁰ resulting in a COVID-19 IFR of 0.32% (213,000/66.9 million).

When the pandemic began in early 2020, it was proposed that COVID-19 may be of comparable lethality to influenza in 1918.¹¹ However, the IFR of the 1918 flu (2.25%) was about six times greater than the IFR of COVID-19 (0.35%).^{12,13} See Figure 2.



2. WHAT IS THE INFECTION-FATALITY RATE OF COVID-19?

The infection-fatality rate (IFR) of COVID-19 is calculated by dividing the number of people who die from COVID-19 by the total number of people infected, including both symptomatic and asymptomatic cases.

A Stanford University systematic review that included 69 antibody studies estimated that the COVID-19 IFR in the United States ranges from 0.3% to 0.4%.⁸ Data analysis herein uses the midpoint of that range, 0.35%. See Figure 1.



3. WHAT IS THE IFR OF COVID-19 IN DIFFERENT AGE GROUPS?

About 75% of COVID-19 deaths occur in individuals aged 65 years or older,^{14,15} whereas about 0.1% of COVID-19 deaths occur in individuals aged 17 years or younger^{14,16} (Table 1^{6,9,14-30}). In addition, severe COVID-19 is particularly lethal in nursing homes.^{8,31} For example, in 2020, 59% of all COVID-19 deaths in the state of Massachusetts occurred in long-term care (LTC) facilities.³² The national COVID-19 IFR is 0.2% among individuals who do not live in long-term care institutions.⁶

SARS-CoV-2 Infection Outcomes^{3,8,9}

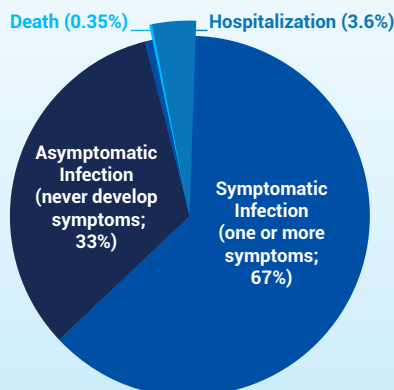


Figure 1: Among individuals infected with SARS-CoV-2, 33% of cases are asymptomatic (never develop symptoms) and 67% are symptomatic (one or more symptoms). Of these infections, 3.6% of cases are hospitalized and 0.35% are fatal.

Infection-Fatality Rate of 1918 Flu and COVID-19^{8,12,13}

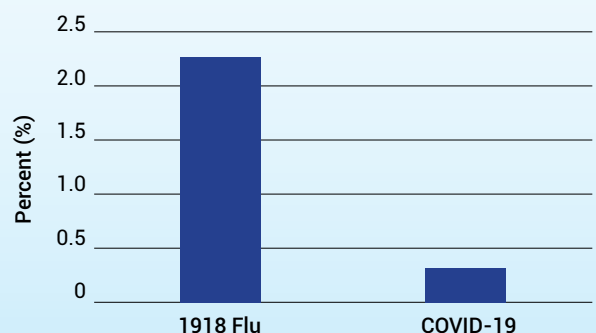



Figure 2: The infection-fatality rate (IFR) of the 1918 flu (2.25%) was about six times greater than the IFR of COVID-19 (0.35%). The IFR is the chance of dying if infected.

Table 1 shows that a COVID-19 infection in an individual 65 years or older dwelling in an LTC facility is over 30 times more likely to be fatal (37%/1.1%) than in an individual 65 years or older not dwelling in an LTC facility. Furthermore, most people who die in nursing homes die within six months of placement; therefore, many COVID-19 nursing home deaths may have occurred in people with a life expectancy of only a few months.³³

| Age Group | % of Infections | % of Deaths | Infection-Fatality Rate (%) |
|----------------------|-----------------------|-----------------------|-----------------------------|
| 0–17 years | 13.2 ⁹ | 0.1 ^{14,16} | 0.003 |
| 18–49 years | 56.4 ⁹ | 6.6 ^{14,17} | 0.04 |
| 50–64 years | 20.1 ⁹ | 18.7 ^{14,18} | 0.3 |
| 65+ years | 10.3 ⁹ | 74.6 ^{14,15} | 2.5 |
| 65+ years not in LTC | 9.9 ²⁰ | 32.3 ²⁸ | 1.1 |
| 65+ years in LTC | 0.4 ^{21,22} | 42.3 ²⁹ | 37 |
| 75+ years | 4.3 ²³ | 51.4 ^{14,19} | 4.2 |
| 75+ years not in LTC | 4.0 ²⁴ | 13.2 ³⁰ | 1.2 |
| 75+ years in LTC | 0.3 ²⁵ | 38.2 ²⁹ | 44.6 |
| All ages | 100 | 100 | 0.35 |
| All ages not in LTC | 99.5% ²⁶ | 56.9 ²⁶ | 0.2 ⁶ |
| All ages in LTC | 0.5% ^{21,27} | 43.1 ²⁶ | 30.2 |

Table 1: Age-specific COVID-19 infection-fatality rate in the United States.
LTC = long-term care facility.



COVID-19 cases in people 65 years or older who reside in long-term care facilities (nursing homes) are over 30 times more likely to be fatal than COVID-19 cases in people 65 years or older who do not reside in long-term care facilities.


4. WHAT IS THE DIFFERENCE BETWEEN BEING EXPOSED AND BEING INFECTED WITH SARS-COV-2?

Although the IFR measures the chance of dying assuming infection with SARS-CoV-2, the IFR does not include the chance of being exposed or the chance of being infected. Research shows that not everyone who is exposed to SARS-CoV-2 is necessarily infected with it, as T cells may protect against, or modify, infection.^{34–36} A *BMJ* article investigating whether people have pre-existing immunity to SARS-CoV-2

states that “at least six studies have reported T cell reactivity against SARS-CoV-2 in 20% to 50% of people with no known exposure to the virus.³⁴ In addition, a study published in *Nature Immunology* states: “T cells control viral infections and provide immunological memory that enables long-lasting protection... Cross-reactivity of T cells for different virus species or even among different pathogens is a well-known phenomenon postulated to enable heterologous immunity to a pathogen after exposure to a nonidentical pathogen.”³⁶ The study found, “Cross-reactive SARS-CoV-2 peptides revealed pre-existing T cell responses in 81% of unexposed individuals and validated similarity with common cold coronaviruses.”³⁶

5. CAN PREVIOUS INFECTION BE PROTECTIVE AGAINST REINFECTION?

The Johnson & Johnson vaccine clinical trial observed that an unvaccinated person previously infected with SARS-CoV-2 has a 99.9% chance of being protected from a repeat infection.³⁷



Per clinical trial data, an unvaccinated person previously infected with SARS-CoV-2 has a 99.9% chance of being protected from a repeat infection.

6. WHAT TREATMENT OR PREVENTION OPTIONS ARE AVAILABLE FOR COVID-19?

Treatments for COVID-19 have improved significantly since the pandemic began in early 2020, resulting in improved survival rates in hospitalized cases.^{38,39} Many studies have observed the effectiveness of various treatments, the most studied being ivermectin, vitamin D, hydroxychloroquine (HCQ), and monoclonal antibodies.^{40,41} Studies have also observed that ivermectin, vitamin D, and hydroxychloroquine may be beneficial for prophylaxis (i.e., pre-exposure or post-exposure prevention of symptomatic COVID-19 infections).^{42–46}

Mass vaccination with COVID-19 vaccines was introduced in December 2020. The vaccines have been shown to significantly prevent symptomatic COVID-19 cases that are not hospitalized or fatal. However, studies have shown that the vaccine may not prevent the spread of COVID-19, may not have a measurable impact on COVID-19 mortality, and may lead to more severe adverse events than it prevents.⁴⁷

All references are available at physiciansforinformedconsent.org/COVID-19.

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- Since 10.3% of SARS-CoV-2 infections in the U.S. were 65 or older and 0.4% of SARS-CoV-2 infections in the U.S. were 65 or older in LTCs,²² 9.9% (10.3% - 0.4%) of SARS-CoV-2 infections in the U.S. were 65 or older and not in LTCs.
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- Of the 2.16 million residents of nursing homes and residential care communities in 2016, 1.88 million were 65 or older.²¹ Those 1.88 million residents comprised 3.82% of the population 65 or older in 2016; therefore, we estimated that 3.82% of all SARS-CoV-2 infections in that age group occurred in LTCs. The total number of infections in LTCs is 0.4% (3.82%*10.3%) of all infections in the U.S.
- Since the population 75 or older is 41.9% of the population 65 or older, we estimated that 41.9% of all SARS-CoV-2 infections 65 or older were 75 or older. The total number of infections is 4.3% (41.9%*10.3%) of all infections in the U.S.
- Since 4.3% of SARS-CoV-2 infections in the U.S. were 75 or older²³ and 0.3% of SARS-CoV-2 infections in the U.S. were 75 or older in LTCs,²⁵ 4% (4.3% - 0.3%) of SARS-CoV-2 infections in the U.S. were 75 or older and not in LTCs.
- Of the 2.16 million residents of nursing homes and residential care

- communities in 2016, 1.55 million were 75 or older.²¹ Those 1.55 million residents comprised 7.5% of the population 75 or older in 2016; therefore, we estimated that 7.5% of all SARS-CoV-2 infections in that age group occurred in LTCs. The total number of infections in LTCs is 0.3% (7.5%*4.3%) of all infections in the U.S.
26. Since 0.5% of all infections in the U.S. occurred in LTCs,²⁷ 99.5% (100% - 0.5%) of all infections occurred outside LTCs. Let X equal the % of all infections in the U.S. that occurred outside LTCs. Since the IFR excluding LTCs is 0.2%⁶ and that IFR is also equal to (0.35%*X)/99.5%, X = 56.9%.
 27. Of the 2.16 million residents of nursing homes and residential care communities in 2016, 276,000 were <65 and 1.88 million were 65 or older.²¹ The 276,000 is 0.44% of the population 50-64 years old in 2016; therefore, we estimated that 0.44% of all SARS-CoV-2 infections in that age group occurred in LTCs. The 1.88 million is 3.82% of the population 65 or older in 2016; therefore, we estimated that 3.82% of all SARS-CoV-2 infections in that age group occurred in LTCs. The total number of infections in LTCs is 0.5% (0.44%*20.1% + 3.82%*10.3%) of all infections in the U.S.
 28. Since 74.6% of COVID-19 deaths in the U.S. were 65 or older and 42.3% of COVID-19 deaths in the U.S. were 65 or older in LTCs,²⁹ 32.3% (74.6% - 42.3%) of COVID-19 deaths in the U.S. were 65 or older and not in LTCs.
 29. Label the LTC population 50-64 years old as population A, the LTC population 65-74 years old as population B, and the LTC population 75 or older as population C. Table 1 shows the IFR of the population 50-64 years old regardless of LTC status (IFR_a) was 0.3%. The IFR of the population 65-74 years of age regardless of LTC status (IFR_b) is the difference in deaths between the 65 or older group and 75 or older group divided by the difference in infections of those groups: 1.4% (0.35%*[74.6%-51.4%]/[10.3%-4.3%]). Table 1 shows the IFR in the population 75 years or older regardless of LTC status (IFR_c) was 4.2%. Table 1 also shows that the total number of LTC COVID-19 deaths is 43.1% of all COVID-19 deaths. Let I_a, I_b, and I_c be the % of all infections comprised by LTC infections in each age group. I_a = 0.09% (0.44%*20.1%);²⁷ I_b = 0.1% (0.4% - 0.3%, Table 1); and I_c = 0.3% (Table 1). Let D_a, D_b, and D_c be the % of all COVID-19 deaths comprised by each group. D_a, D_b, and D_c can be solved using the following system of equations:

$$D_a + D_b + D_c = 43.1\%$$

$$IFR_b / IFR_a = (D_b / I_b) / (D_a / I_a)$$

$$IFR_c / IFR_a = (D_c / I_c) / (D_a / I_a)$$
 Solving the system of equations above for D_a, D_b, and D_c results in D_a = 0.8%, D_b = 4.1%, and D_c = 38.2%.
 30. Since 51.4% of COVID-19 deaths in the U.S. were 75 or older and 38.2% of COVID-19 deaths in the U.S. were 75 or older in LTCs,²⁹ 13.2% (51.4% - 38.2%) of COVID-19 deaths in the U.S. were 75 or older and not in LTCs.
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