“An Evidence-Based Re-Examination of Rhode Island’s Covid-19 Response”

The Warwick Public Library—Central Library, 600 Sandy Lane, Warwick, RI 02889
Saturday, May 13, 2023, from 1:00 to 4:30 P.M. (Light Refreshments, 1:00-1:30 P.M.; Program, 1:30-4:00 P.M.)

The event will be divided into two intimately-related themes:

—A re-evaluation of the covid-19 response in Rhode Island juxtaposed to available scientific data

—The socioeconomic impact of the Rhode Island covid-19 pandemic response based on testimonials from representative healthcare providers, a parent, a teacher, an entrepreneur, a lawyer, a state politician, and an independent journalist

RIDOH’s Dr. James McDonald, 12/2/21, holding his masked Dr. Fauci doll, & a mask

RIDOH’s Dr. James McDonald, 12/2/21, holding his Omicron Teddy Bear

Andrew Bostom, MD, MS: Background

- **40+ year career as an allied health professional (physical therapist & exercise physiologist), then a physician (since 1990), both a clinician (cardiac rehab/CVD prevention), & an academic, incl 24-years as Brown Medical School faculty**
- **Trained epidemiologist & clinical trialist, who for 10-years ran one of the largest clinical trials ever based in RI, involving kidney transplant recipients from academic centers across the U.S., & also in Canada & Brazil**


department of
Medicine Newsletter
BROWN
Alpert Medical School
Spring 2008 • Volume 9 Issue 1 • Published Quarterly

Andrew Bostom, MD, MS receives $19.6 million federal grant

Multi-site trial aims to reduce cardiovascular disease in kidney transplant recipients


Cochrane Library
Trusted evidence.
Informed decisions.
Better health.

Cochrane Database of Systematic Reviews | Review - Intervention

Interventions for lowering plasma homocysteine levels in kidney transplant recipients

Amy Kang, Sagar U Nigwekar, Vlado Perkovic, Satyarth Kulshrestha, Sophia Zoungas, Sankar D Navaneethan, Alan Cass, Martin P Gallagher, Toshiharu Ninomiya, Giovanni FM Strippoli, Meg J Jardine Authors' declarations of interest

Version published: 04 May 2015 Version history

https://doi.org/10.1002/14651858.CD007910.pub2

The literature search yielded a total of 359 records (Figure 1). Of these, 44 were reviewed in full text. One study (13 reports) was identified that met our inclusion criteria (FAVORIT Study 2006).

THE PREPRINT SERVER FOR HEALTH SCIENCES

medRxiv preprint doi:
https://doi.org/10.1101/2021.01.26.21250557; this version posted January 29, 2021.

Covid-19 positive test cycle threshold trends predict covid-19 mortality in Rhode Island

Andrew G. Bostom, M.D.,M.S.,[1] Todd Kenyon, Ph.D.,[2] Charles B. Eaton, M.D., M.S.[1]

[1] The Brown University Center For Primary Care and Prevention
Department of Family Medicine
Memorial Hospital of Rhode Island
111 Brewster Street
Pawtucket, Rhode Island 02860

[2]Nobadeer Capital Management, LLC
337 Water Street
Warren, Rhode Island 02885

Abstract

The cycle thresholds (Cts) at which reverse transcriptase polymerase chain reaction (rtPCR) tests for covid-19 become positive are intimately associated with both viral load, and covid-19 infectiousness (i.e., ability to culture live virus). Clinical data indicate lower Cts—and hence larger viral loads—independently predict greater covid-19 mortality when patients are hospitalized for symptomatic covid-19 pneumonia. We merged public covid-19 mortality data from the Rhode Island Department of Health with a de-identified dataset of n=5036 positive rtPCR test Cts from the Rhode Island Department of Health State Laboratory to explore the potential relationship between positive covid-19 test Ct distribution trends, and covid-19 mortality in the state of Rhode Island, from March through early to mid-June, 2020. Mean daily covid-19 positive test Ct data were compiled, and 7-day rolling average covid-19 mortality was offset by 21-days, given the lag between infection and death. We divided the Ct data into three strata, >32, 28-32, and <28, which were operationally defined as "not infectious," "maybe infectious," and "infectious," respectively. Between late March and June, mean daily Ct values rose linearly (R-squared=0.789) so that by early June, as the covid-19 pandemic ebbed in severity, all means reached the noninfectious (Ct >32) range. Most notably, this May-June trend for Cts was accompanied by a marked, steady decline in Rhode Island's daily covid-19 mortality. Our results suggest that monitoring, and public reporting of mean population covid-19 test Cts over time is warranted to gauge the vacillations of covid-19 outbreak severity, including covid-19 mortality trends.

"The cycle thresholds (Cts) at which reverse transcriptase polymerase chain reaction (rtPCR) tests for covid-19 become positive are intimately associated with both viral load, and covid-19 infectiousness (i.e., ability to culture live virus). An rtPCR covid-19 assay system developed at the Harvard University/ Massachusetts Institute of Technology Broad Institute, currently determining covid-19 "positivity" at 108 northeastern universities—**including Rhode Island's major colleges**—described this *exponential* relationship: '…***the Ct values correlated strongly with the logarithm of (covid-19) RNA concentration (R-squared > 0.99), with the observed range from Ct =12 cycles to Ct = 38 cycles corresponding to viral loads ranging from ~1.9 billion copies/mL to 8 copies/mL, respectively.'*** "

The “Pillars” of Covid-19 Public Health Lysenkoism in Rhode Island

- **The Covid-19 Hospitalization Models of April 16, 2020**

  —Ignoring both the very short-term/real-time failure of the models, & the implications of that failure (i.e., *ignoring the Swedish counter example, vis-à-vis lockdowns, school closures, mask mandates, etc.*)

- **Ignoring Covid-19’s Extreme Risk Stratification By Age & Comorbidity**

  —Understanding Covid-19’s Infection Fatality Rate

- **From Mask Mandates to Covid-19 Vaccine Mandates**

  —Ignoring the Uniformly NEGATIVE Randomized Controlled Trial (RCT) Data on Community Masking for Prevention of Respiratory Virus Infections (both before, & since the covid-19 pandemic)

  —Ignoring Naturally-Acquired Immunity to SARS-CoV-2

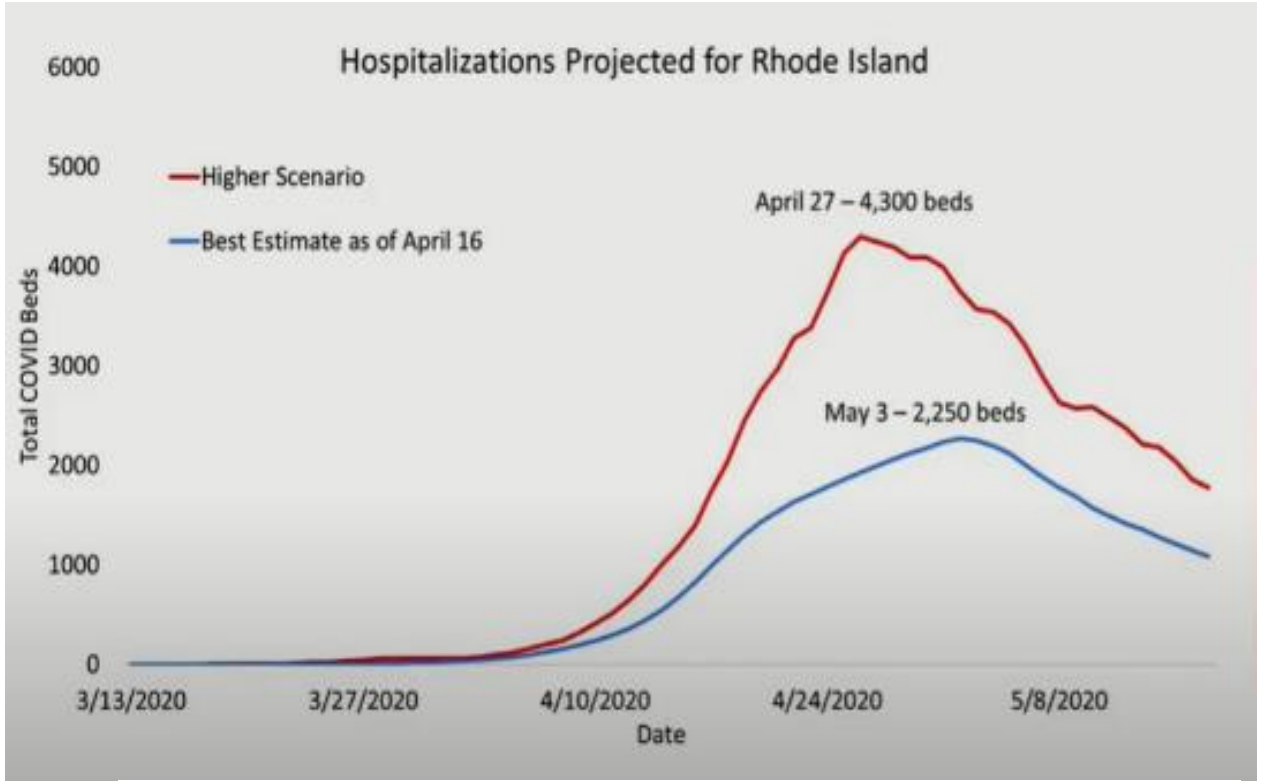
  —Ignoring Covid-19 Vaccine Risk/Benefit Assessment

  (Using the limited RCT data available, & ignoring the copious vaccine injury, [VAERS, etc.]data available)

- **Ignoring D.A. Henderson & Embracing Lysenko (Closing comments)**

Then Governor Gina Raimondo presser on Rhode Island covid-19 hospitalization “models,” 4/16/20, broadcast live on C-SPAN

"Modeled" vs. Actual Rhode Island Covid-19 Hospitalizations, 4/27/20 & 5/3/20, were *> 6- to 12-fold higher only ~2-weeks after the predictions were made, on 4/16/20!*



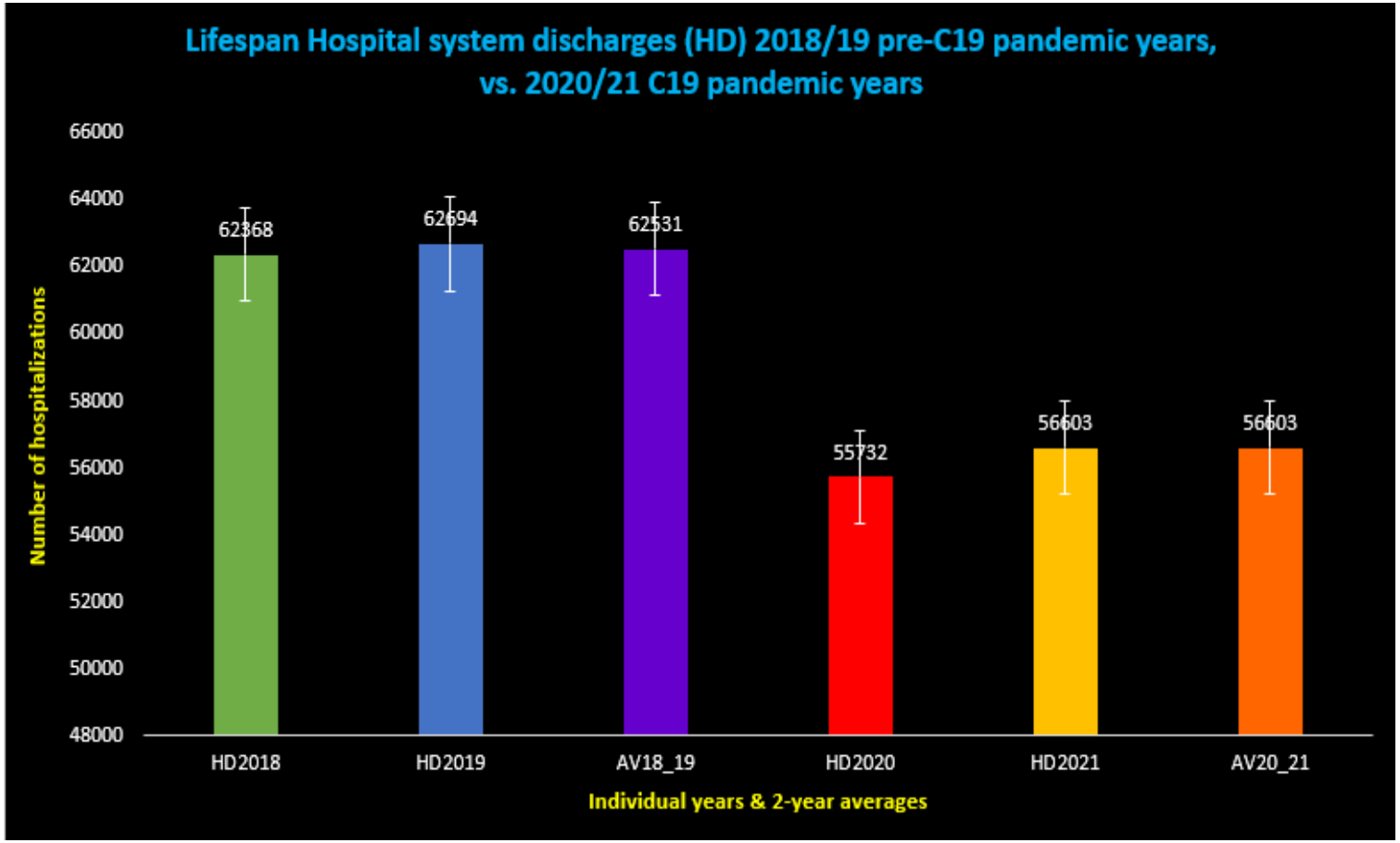
Type of Covid-19 Hospitalizations	Date	Number of Covid-19 Hospitalizations
Poor Social Distancing Model	**4/27/20**	**4,300**
Actual	**4/27/20**	**356**
Good Social Distancing Model	**5/3/20**	**2,250**
Actual	**5/3/20**	**350**

Then Governor Raimondo:
"It's been a collaborative effort with the (Rhode Island) Department of Health [**RIDOH], our own experts, Brown University, and Brown University's Policy Lab**. By the way, **I wanna give a huge shout out of thanks to Brown University**. I called you over a month ago, and **you gave us your very best statisticians and public health experts, and epidemiologists**. Thank you for being a great partner…***The blue line you could think of as our best guess of what we think the next few weeks will look like in Rhode Island. The blue line assumes all of the current restrictions—the stay at home order, the mask wearing, social distancing—are in place, and we are doing a pretty good job of adhering to them***. (Not a perfect job, but a good job of adhering to them.) In that scenario, we thank our peak will be around May 3, 2020, that means last week of April, first week of May, approximately, and at that time, **we will need about 2,250**…(O)n your screen, you should be seeing a red line. That red line represents what we think will happen if we stop taking social distancing seriously. And in that scenario, the peak comes sooner, probably April 27th, and obviously the peak is much higher. In that scenario, the red line that you're seeing, **we'll need closer to 4,300 hospital beds**."

(*Note: Actual absolute peak was n=373, on 4/28/20)

Lifespan Hospital Discharges, Comparing Pre-Covid-19 Pandemic Years 2018-19, & Covid-19 Pandemic Years 2020-21

- **62,531 avg for 2018-19, Pre-covid-19 pandemic years**
- **56,603 avg for 2021 covid-19 pandemic year, i.e., *-9.5% LOWER***



Reference:
https://www.lifespan.org/about-lifespan/lifespan-reports

Sweden NEVER "Locked Down," Never Imposed Mask Mandates, etc., & Kept In-Class, Primary School Education Schools Open, Throughout

National Demographer Orjan Hemstrom on Sweden's 2020 Total Mortality:

"We are back to the mortality of 2012…excess mortality is the same as it was a decade ago" 1918 flu pandemic far worse than covid-19

Statistics Sweden Demographer Orjan Hemstrom Reviews Swedish Total Mortality Trends, 1900-2020

From SVT (Swedish National Television), "The price of the Corona battle," Part 8 of 19, Sunday, February 28, 2021
https://www.svtplay.se/video/30291114/vetenskapens-varld/vetenskapens-varld-sasong-34-coronakampens-pris?start=auto&info=visa

SARS-CoV-2/Covid-19 Infection Fatality Rates (IFR)*: Critical Impact of Age

*(*covid-19 deaths/ total infected by SARS-CoV-2 antibody seroprevalence data)*

Age group (years)	IFR
≥70, overall (incl nursing homes)	4.5%
≥70, community dwelling When >85=5% When >85=10% When >85=20%	2.9% 1.2% 1.8% 3.9%
0-69, overall	0.1%
60-69	0.5%
50-59	0.1%
40-49	0.04%
30-39	0.01%
20-29	0.002%
0-19	0.0003%

- **≥ 70, overall, confers 45X the risk of 0-69, overall**
- **≥ 70, overall confers 15,000X the risk of 0-19**

Reminders:

→→ 94% of the world's population is <70

→→ 86% of the world's population is <60

References:

Axfors C, **Ioannidis JPA**. Infection fatality rate of COVID-19 in community-dwelling elderly populations. Eur J Epidemiol. 2022 Mar;37(3):235-249. doi: 10.1007/s10654-022-00853-w. Epub 2022 Mar 20. PMID: 35306604; PMCID: PMC8934243

Pezzullo AM, Axfors C, Contopoulos-Ioannidis DG, Apostolatos A, **Ioannidis JPA**. Age-stratified infection fatality rate of COVID-19 in the non-elderly population. Environ Res. 2023 Jan 1;216(Pt 3):114655. doi: 10.1016/j.envres.2022.114655. Epub 2022 Oct 28. PMID: 36341800; PMCID: PMC9613797.

Mortality From, or With Covid-19?
Death Certificate Reviews and Autopsy Findings

Death certificate review in North Rhine-Westphalia (northwestern), Germany, following Germany's 1st major covid-19 outbreak, in 2020:

—33% of deaths in SARS-CoV-2+ persons were unrelated to covid-19, "due to complete recovery from covid-19 between illness & death," & other obvious, chronic/acute causes of death (incl kidney disease, cardiovascular disease, & cancer)

My own assessment of Florida's covid-19 death certificate review of its first ~14K covid-19 deaths:

—After culling out deaths where covid-19 was not even listed as the final cause of death, those occurring in hospice care, those which classified Covid-19, *alone*, as *both* the immediate & underlying cause of death despite acknowledging contributing co-morbidities, or "conditions," up to **45% of these initial Florida "covid-19 deaths" did not necessarily merit that classification**

Autopsy findings, integrated with prior comorbidity evaluation, from mean age 87-year-old Italian long term care facility residents, during May to June, 2020, 72% of whom were SARS-CoV-2+

Strength of causation between COVID-19 infection and death	
Strength of causation of covid-19 infection	percent
High	12%
Intermediate	10%
Low	59%
None	19%

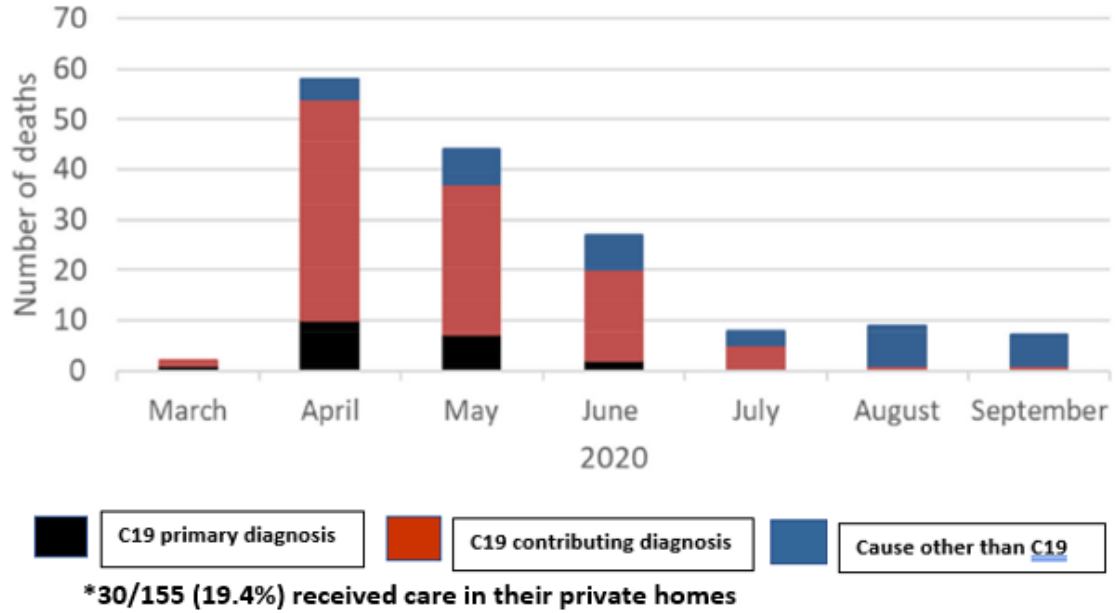
References:
Richter et al. "Analysis of Fatality Impact and Seroprevalence Surveys in a Community Sustaining a SARS-CoV-2 Superspreading Event" medRxiv 2022.01.26.22269805; https://doi.org/10.1101/2022.01.26.22269805;
https://www.andrewbostom.org/2020/10/covid-19-death-distortion-in-florida-over-40-of-states-covid-19-deaths-may-not-merit-that-classification/;
Zanon et al. "Spread of COVID-19 Infection in Long-Term Care Facilities of Trieste (Italy) during the Pre-Vaccination Era, Integrating Findings of 41 Forensic Autopsies with Geriatric Comorbidity Index as a Valid Option for the Assessment of Strength of Causation." *Vaccines*. 2022; 10(5):774. https://doi.org/10.3390/vaccines10050774

Covid-19 Mortality Among Those at Highest Risk: From, or With Covid-19?
Swedish Care Home Facility Deaths, March to September, 2020

Medical record review of 155 SARS-CoV-2 + Swedish care home facility deaths, 88 women/67 men, median age 88, with "considerable" to "severe" frailty, Mar to Sept, 2020:

—**Only 13% (20/155) were primary cause covid-19 deaths**, 22.5% (35/155) were non-covid-19 deaths, & ***"in 2/3 of individuals the cause of death was less obvious. Symptoms of COVID-19 were vague & there were other possible causes for death like ischemic cardiac disease, chronic pulmonary disease or dementia."***

Assessed primary cause of death over time in n=155 SARS-CoV-2 positive Swedish home health care facility patients,* median age 88 years old, March to September, 2020



***30/155 (19.4%) received care in their private homes**

Reference:

Nilsson L et al. COVID-19 as the sole cause of death is uncommon in frail home healthcare individuals: a population-based study. BMC Geriatr. 2021 Apr 20;21(1):262. doi: 10.1186/s12877-021-02176-z.

Patients with fatal or serious covid-19 disease were disproportionately elderly, & heavily burdened with multiple, chronic comorbidities: Data from ~541K U.S. covid-19 hospitalizations

Table 1. Characteristics of Adults Hospitalized With COVID-19 in Premier Healthcare Database Special COVID-19 Release (PHD-SR), March 2020–March 2021

Characteristic[a]	All Hospitalized Patients in PHD-SR, No. (%)	Hospitalized Patients With COVID-19, No. (%)			
		Full Sample	ICU[b] admission	IMV[b]	Died[b]
Total	4,899,447 (100.0)	540,667 (100.0)	249,522 (100.0)	76,680 (100.0)	80,174 (100.0)
No. of conditions					
≥1[c]	4,438,183 (90.6)	513,292 (94.9)	242,372 (97.1)	75,514 (98.5)	79,434 (99.1)
0	461,264 (9.4)	27,375 (5.1)	7,150 (2.9)	1,166 (1.5)	740 (0.9)
1	402,499 (8.2)	39,776 (7.4)	14,272 (5.7)	2,785 (3.6)	2,087 (2.6)
2–5	1,796,770 (36.7)	212,429 (39.3)	94,405 (37.8)	27,405 (35.7)	25,893 (32.3)
6–10	1,565,845 (32.0)	167,706 (31.0)	84,745 (34.0)	28,774 (37.5)	31,310 (39.1)
>10	673,069 (13.7)	93,381 (17.3)	48,950 (19.6)	16,550 (21.6)	20,144 (25.1)
Sex					
Female	2,860,589 (58.4)	261,078 (48.3)	110,017 (44.1)	30,062 (39.2)	32,939 (41.1)
Male	2,037,012 (41.6)	279,317 (51.7)	139,416 (55.9)	46,587 (60.8)	47,211 (58.9)
Unknown	1,846 (0.0)	272 (0.1)	89 (0.0)	31 (0.0)	24 (0.0)
Age, y					
Median (IQR), y	68 (57–78)	66 (53–77)	67 (55–77)	67 (57–75)	74 (65–83)
18–39	1,304,324 (26.6)	59,697 (11.0)	19,120 (7.7)	4,192 (5.5)	1,299 (1.6)
40–49	428,000 (8.7)	51,591 (9.5)	22,605 (9.1)	5,913 (7.7)	2,710 (3.4)
50–64	1,085,170 (22.1)	144,306 (26.7)	68,791 (27.6)	22,791 (29.7)	14,867 (18.5)
65–74	923,004 (18.8)	121,832 (22.5)	62,056 (24.9)	23,055 (30.1)	21,421 (26.7)
75–84	735,429 (15.0)	103,012 (19.1)	50,891 (20.4)	16,041 (20.9)	23,308 (29.1)
≥85	423,520 (8.6)	60,229 (11.1)	26,059 (10.4)	4,688 (6.1)	16,569 (20.7)

64.2% of those who died, 59.1% requiring mechanical ventilation, & 53.6 requiring ICU admission had ≥ 6 chronic comorbidities

76.5% of those who died, 57.1% requiring mechanical ventilation, & 55.7 requiring ICU admission were ≥ 65 years old

Reference:
Kompaniyets L, Pennington AF, Goodman AB, Rosenblum HG, Belay B, Ko JY, Chevinsky JR, Schieber LZ, Summers AD, Lavery AM, Preston LE, Danielson ML, Cui Z, Namulanda G, Yusuf H, Mac Kenzie WR, Wong KK, Baggs J, Boehmer TK, Gundlapalli AV. Underlying Medical Conditions and Severe Illness Among 540,667 Adults Hospitalized With COVID-19, March 2020-March 2021. Prev Chronic Dis. 2021 Jul 1;18:E66. doi: 10.5888/pcd18.210123. PMID: 34197283; PMCID: PMC8269743

Rhode Island Covid-19 Mortality: Critical Impact of Age

- **78% of deaths have occurred among those ≥ 70**
- **55% of deaths have occurred among those ≥ 80 (which is above the state's avg. life expectancy at birth of 79.8)**
- **53% of deaths have occurred in nursing home or elder-assisted living facility residents (which further emphasizes the impact of comorbidity)**
- **NO DEATHS have occurred in those ≤ 18 during > 3-years (*;**,***), while there were *269 non-covid-19 pediatric deaths* in Rhode Island from 1/1/2020-4/22/23**
  - *** Despite then RIDOH official Dr. James McDonald initially perjuring himself on the issue of pediatric covid-19 deaths during Southwell v. McKee**
  - **** Compare this to 3 pediatric deaths in a single 2009-2010 H1N1 swine flu pandemic year in RI**
  - ***** CDC SARS-CoV-2 antibody (nc) seroprevalence data indicates 96-100% of RI children have been infected!**

References:
RIDOH Covid-19 Data Hub: https://docs.google.com/spreadsheets/d/1c2QrNMz8pIbYEKzMJL7Uh2dtThOJa2j1sSMwiDo5Gz4/edit#gid=1592746937
RI avg life expectancy: https://247wallst.com/state/heres-how-life-expectancy-in-rhode-island-compares-to-the-nation/
CDC all-cause RI pediatric mortality: https://www.cdc.gov/nchs/nvss/vsrr/covid_weekly/index.htm
For Dr. McDonald's initial perjury see: https://www.andrewbostom.org/wp-content/uploads/2021/10/brief-in-support-of-motion-for-preliminary-injunction_10_25-21.pdf
On 3 RI pediatric deaths from H1N1, 2009-10: (p.15) https://health.ri.gov/publications/surveillance/2011/Influenza.pdf
CDC SARS-CoV-2 antibody seroprevalence data for RI children as of 12/22: https://covid.cdc.gov/covid-data-tracker/#pediatric-seroprevalence

“Statistical and Numerical Errors Made by the US Centers for Disease Control and Prevention (CDC) During the COVID-19 Pandemic (March 7, 2023).”*

“***94% of the errors we identified that pertained to children alone exaggerated their COVID-19 risks. All 13 errors involving COVID-19 mortality risks were exaggerations of pediatric deaths.*** This is a group that has a COVID-19 infection fatality ratio of at least 1000-fold [at least] less than older groups, and **the CDC’s errors have likely led the public to believe children’s risks are higher than they truly are in non-erroneous data**.”

Lead author data analyst Kelly Krohnert provided this salient example:

“For months, the CDC reported that an estimated 4.0% of Covid deaths were among children, ***when the actual percentage based on their initial estimates was 0.04%***.” (i.e., 100-fold in excess of actual)

References

***Krohnert, Kelley and Haslam, Alyson and Hoeg, Tracy Beth and Prasad, Vinay. “Statistical and Numerical Errors Made by the US Centers for Disease Control and Prevention During the COVID-19 Pandemic (March 7, 2023).” https://ssrn.com/abstract=4381627 or http://dx.doi.org/10.2139/ssrn.4381627**

Kelly Krohnert: https://twitter.com/KelleyKga/status/1638919628494626816?t=V_fnR2ytndg7giyR5-NMrQ&s=09

Low Burden of Covid-19 Hospitalizations in Rhode Island Children

Overall Context: March-April, 2023 *~20-25%%* of Rhode Island "Covid-19 Hospitalizations," Adult & Children Combined, Were "Primary *or* 'Suspected' Primary Covid-19 Hospitalizations

U.S. Pediatric Hospitalizations Were Fraught With Overclassification When Even More Virulent Strains Were Prevalent (in 2020, to early 2021)
— 40-45% of "covid-19" pediatric hospitalizations were incidental (i.e., "+ tests" but admitted for another cause)

Since RI "Adjusted" Covid-19 Hospitalizations to Identify Specific "Primary *or* 'Suspected' Primary Covid-19 Hospitalizations," in February, 2022:
—There were 15 "primary/suspected primary" pediatric covid-19 hospitalizations from 2/13/22-6/4/22, i.e., < 1/week
—The ginned up so-called "pediatric tripledemic" of October through December, 2022 was shown to be a dishonest sham (next slide), to which covid-19 barely contributed

The Swedish Pediatric/Primary School Counter-Example, Even During Most Virulent "First Wave," i.e., Spring, 2020, When Primary Schools Remained Open, With In-Class Education, & No Masks:
—15 children (out of 1,951,905) were hospitalized, 4 of whom had serious, chronic comorbidities
— ZERO deaths in children

References
Kushner LE, et al. "For COVID" or "With COVID": Classification of SARS-CoV-2 Hospitalizations in Children. *Hosp Pediatr.* 2021; doi: 10.1542/hpeds.2021-006001.; Webb NE and Osburn TS. Characteristics of Hospitalized Children Positive for SARS-CoV-2: Experience of a Large Center. *Hosp Pediatr.* 2021; doi: 10.1542/hpeds.2021-005919.; https://ridoh-covid-19-response-hospital-data-rihealth.hub.arcgis.com/; https://www.andrewbostom.org/wp-content/uploads/2022/08/APRA-request-Only-15-Peds-Hosps-Feb-13-to-June-4.pdf ; https://www.andrewbostom.org/2022/12/rsv-accounted-for-90-of-rhode-island-pediatric-tripledemic-hospitalizations-in-october-and-november/; Ludvigsson JF, Engerström L, Nordenhäll C, Larsson E. Open Schools, Covid-19, and Child and Teacher Morbidity in Sweden. N Engl J Med. 2021 Feb 18;384(7):669-671. doi: 10.1056/NEJMc2026670. Epub 2021 Jan 6. PMID: 33406327; PMCID: PMC7821981.

The Factitious (October Through December, 2022) Rhode Island "Pediatric Tripledemic" of Covid-19, Influenza, & RSV

SINCE 1891

THE BROWN DAILY HERALD

METRO

'Tripledemic' of respiratory viruses burdens Rhode Island health care system

Respiratory Syncytial Virus joins COVID-19, influenza to contribute to hospital bed shortage in RI

By Emma Madgic
Senior Staff Writer
December 7, 2022 | 1:05am EST

'Tripledemic' of respiratory viruses burdens Rhode Island health care system. "Respiratory syncytial virus (RSV) joins COVID-19, influenza to contribute to hospital bed shortage in RI"

- **That was the "messaging" from RI Public Health savants Drs. Philip Chan & Amy Nunn**

Number of Rhode Island children 17 years old or younger hospitalized for RSV, COVID-19, or Influenza, as a primary cause, October, November, & December 2022.

Respiratory virus	Hospitalizations Oct	Hospitalizations Nov	Hospitalizations, Dec	Hospitalizations Oct/Nov/Dec Pooled
RSV*	*122*	*150*	*32*	*304*
COVID-19**	4	2	8	14
Influenza**	1	21	*45*	*67*

*Acute bronchiolitis due to RSV (ICD-10 CM: J21.0), *only*, Hasbro Children's Hospital

**Data supplied by the Rhode Island Department of Health, which monitors covid-19 and influenza hospitalizations

It was an *RSV driven outbreak, i.e., 79% (304/385) were RSV cases,* 17% (67/385) were influenza cases, & < 4% were cases of covid-19!

Student Covid-19 Hospitalizations on Major Public New England Campuses: UMASS-Amherst, UCONN-Storrs, URI-Kingston

Collective Hospitalizations Throughout Pandemic

University	Enrollment	Covid-19 Hospitalizations (n)
UMASS	~32,000	1*
UCONN	~27,200	0
URI	~17,500	Won't reveal!

* "Released & recovering well" (9/8-14/21)

References

https://www.umass.edu/coronavirus/dashboard-archive-2021-22 ;
https://www.andrewbostom.org/2022/12/breaking-uconn-storrs-foi-request-confirms-that-zero-students-have-been-hospitalized-because-of-covid-19-lower-respiratory-tract-infection-throughout-pandemic/ ;
https://www.andrewbostom.org/2023/01/ri-state-minority-leader-michael-chippendale-excoriates-uri-for-its-wholly-inadequate-response-to-a-simple-data-request-for-a-deidentified-tally-of-the-number-of-student-covid-19-lower-respiratory/

Healthy Bryant University basketball player Kvonn Cramer was ICU hospitalized & ventilated *for influenza* this past December, 2022

"He was on a ventilator when he staved off an aggressive case of the flu that had doctors thinking his life was in danger."

https://www.wpri.com/sports/college-hoops-column/wpri-college-hoops-column-martin-cements-legacy-at-brown/

Cramer won just by stepping on court

Bryant forward recovers from illness to play in win over NJIT

Bill Koch
Providence Journal
USA TODAY NETWORK

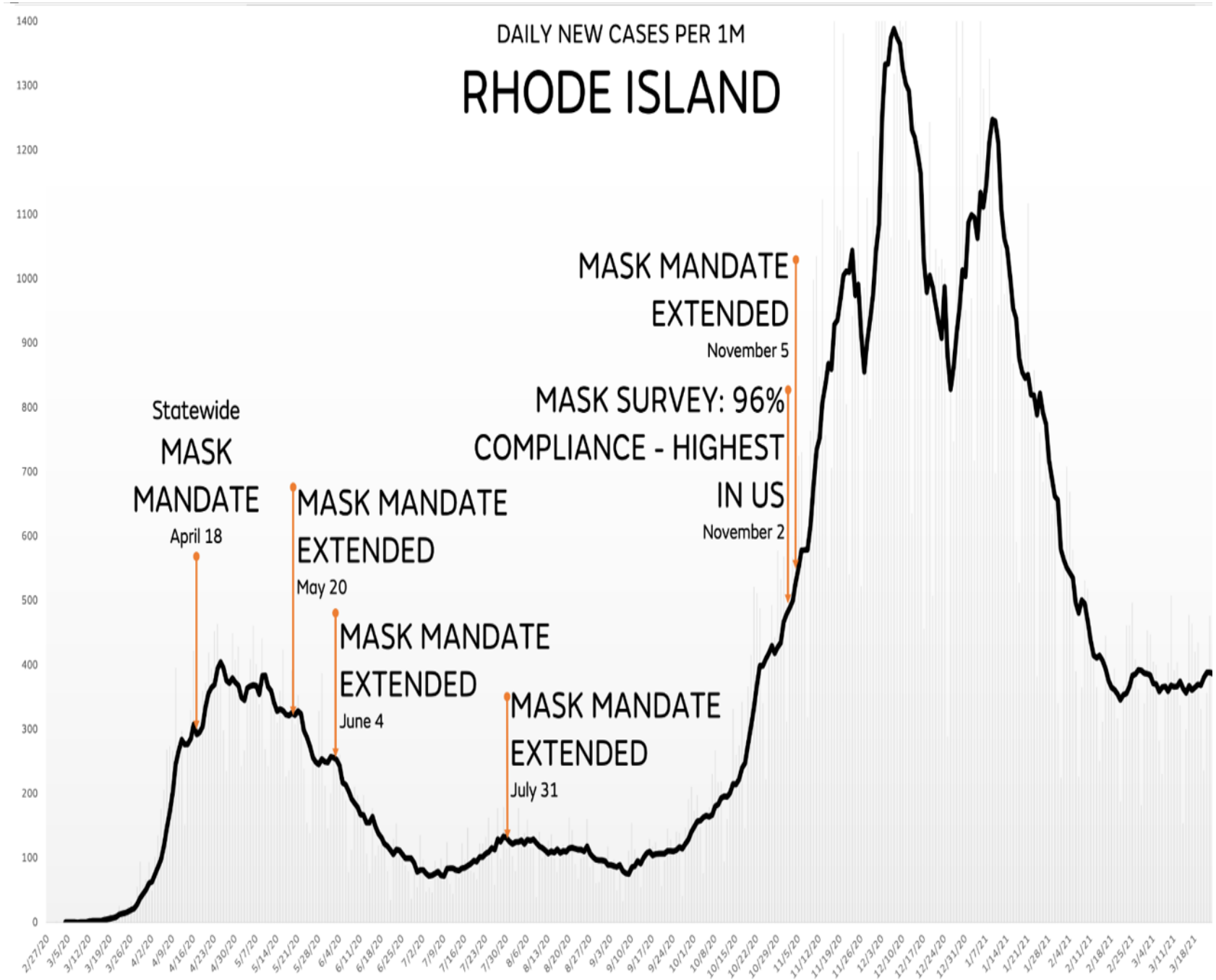
SMITHFIELD — There are moments in every basketball season — and in life, of course — far more important than any game.

Thursday night brought one of them. Kvonn Cramer checked in for Bryant with 14:08 to play in the first half against NJIT. The warm hand offered by the crowd at Chace Center was an acknowledgment of an inspiring off-court victory secured by the third-year forward from Delaware.

Cramer was lying in a Cincinnati intensive care unit just seven short weeks ago. This 22-year-old young man with no corresponding health issues watched a bout with the flu develop into something far worse. That he

See BRYANT, Page 7B

After dealing with a medical issue that landed him in a Cincinnati ICU, Kvonn Cramer made his return to the Bryant Bulldogs Thursday night in Smithfield.



Observational data confirming "*masks don't work,*" from 2020/21, & 1918

← ← 2020/21 Rhode Island data
https://tinyurl.com/bdcnh55p; https://tinyurl.com/yc2ye7x6

1918 Northern California data

↓

W.H. Kellogg, MD, infectious diseases expert, & then executive officer of the California State Board of Health, made this remorseful, brutally honest 1920 observation on the failure of masking to contain rampant influenza spread during the devastating 1918 pandemic (***Am J Public Health** [N Y]*. 1920;10(1):34-42. p. 35):

"The failure of the mask was a source of disappointment, for the first experiment in San Francisco was watched with interest with the expectation that if it proved feasible to enforce the regulation the desired result would be achieved. The reverse proved true. *The masks, contrary to expectation, were worn cheerfully and universally, and also, contrary to expectation of what should follow under such circumstances, no effect on the epidemic curve was to be seen. Something was plainly wrong with our hypotheses*." (*plus ça change*...)

Cochrane Meta-analysis (+2): Randomized, Controlled Trials of Masking (Med-surgical Masks & N95 Masks) Confirm NO BENEFIT for the Prevention of Influenza, or Covid-19

Cochrane—Medical/surgical masks compared to no masks

"***Wearing masks in the community probably makes little or no difference to the outcome of influenza-like illness (ILI)/COVID-19 like illness compared to not wearing masks*** (risk ratio (RR) 0.95, 95% confidence interval (CI) 0.84 to 1.09; **9 trials, 276,917 participants**; moderate-certainty evidence. ***Wearing masks in the community probably makes little or no difference to the outcome of laboratory-confirmed influenza/SARS-CoV-2 compared to not wearing masks*** (RR 1.01, 95% CI 0.72 to 1.42; **6 trials, 13,919 participants**; moderate-certainty evidence). **Harms were rarely measured and poorly reported (very low-certainty evidence)**."

Cochrane—N95=P2 respirators compared to medical-surgical masks

"***The use of a N95/P2 respirators compared to medical/surgical masks probably makes little or no difference for the objective and more precise outcome of laboratory-confirmed influenza infection*** (RR 1.10, 95% CI 0.90 to 1.34; **5 trials**, 8407 participants; moderate-certainty evidence). **Restricting pooling to healthcare workers made no difference to the overall findings. Harms were poorly measured and reported, but discomfort wearing medical/surgical masks or N95/P2 respirators was mentioned in several studies (very low-certainty evidence)**."

Reference

Jefferson et al. Physical interventions to interrupt or reduce the spread of respiratory viruses. Cochrane Database of Systematic Reviews 2023, Issue 1. Art. No.: CD006207. DOI: 10.1002/14651858.CD006207.pub6

Fit tested N95s vs. medical masks in ~1000 HCWs for SARS-CoV-2 Prevention:

RCT among health care workers comparing fit-tested N95 masks (**n=507**), to medical masks (**n=497**) published 11/29/22 in the pre-eminent internal medicine journal *Annals of Internal Medicine*, found **SARS-CoV-2 infection rates did not differ between the groups**. Confirmed (by RT-PCR) SARS-CoV-2 infections occurred in 52/497 (10.46%) of those assigned to medical masks, vs. 47/507 (9.27%) assigned to fit-tested N95 masks (hazard ratio 1.14 [95% CI, 0.77-1.69).

Enormous (~40K) community RCT of cloth masks in Guinea-Bissau

No benefit in entirety which incl subgroup of 10-18 yo children (~10K)*; suggestion of both slightly increased all-cause deaths (52 vs. 37) & hospitalizations (8 vs. 3) in the mask intervention grp

*(*During Southwell v. McKee, Dr. McDonald claimed it would be "unethical" to conduct an RCT of masking in children...[but ethical to just mask them, in the absence of supportive data from an RCT!])*

References

Loeb M et al. Medical Masks Versus N95 Respirators for Preventing COVID-19 Among Health Care Workers : A Randomized Trial. Ann Intern Med. 2022 Dec;175(12):1629-1638. doi: 10.7326/M22-1966. Epub 2022 Nov 29;

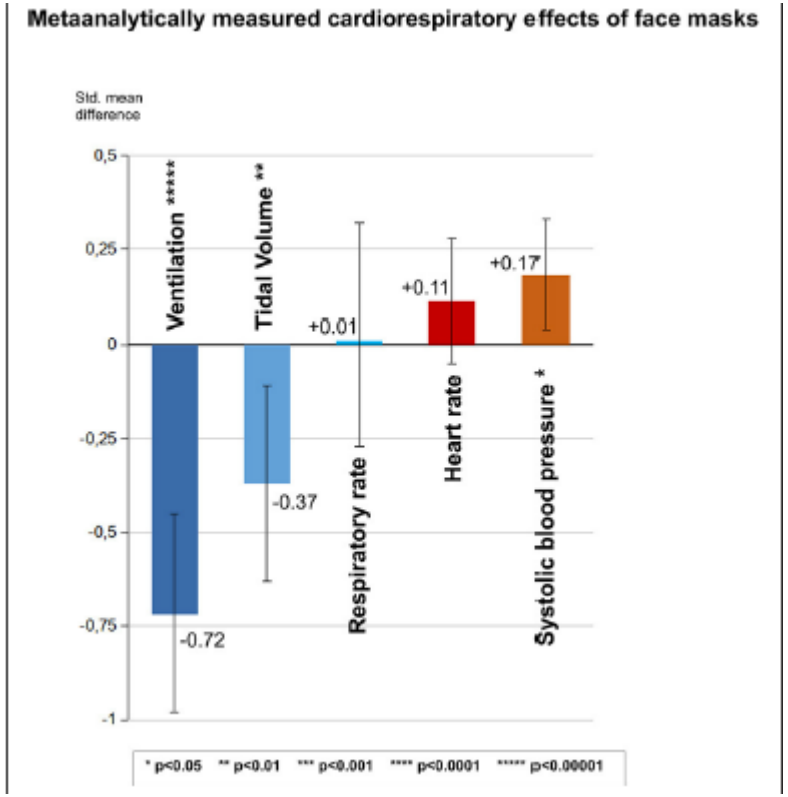
Nanque LM et al. Effect of Distributing Locally Produced Cloth Facemasks on COVID-19-Like Illness and All-Cause Mortality – a Cluster-Randomised Controlled Trial in Urban Guinea-Bissau. SSRN; 2023. DOI: 10.2139/ssrn.4307646.

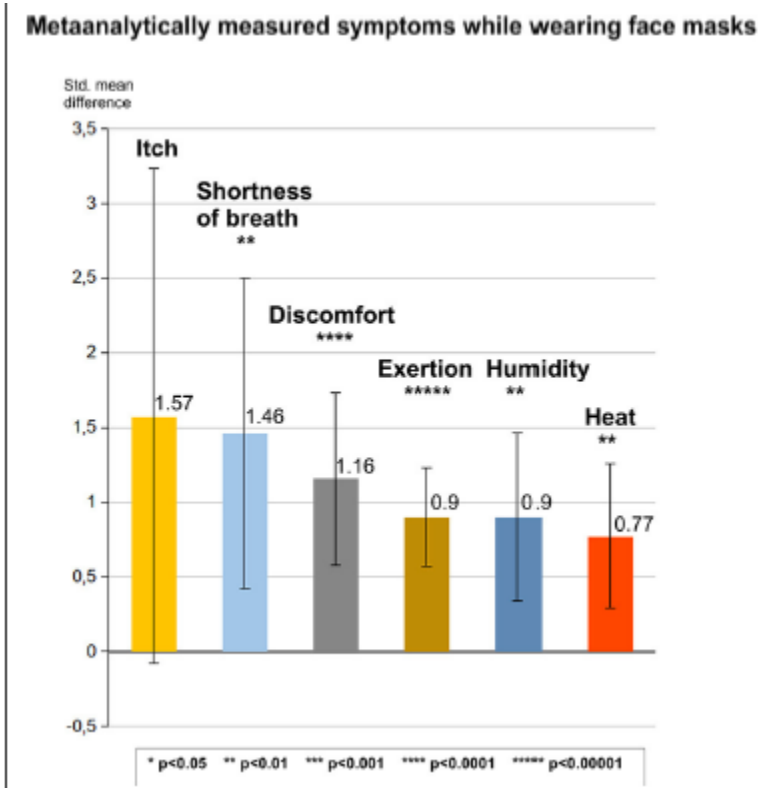
Notwithstanding these *actual* RCT data showing <u>*NO*</u> "benefit"...

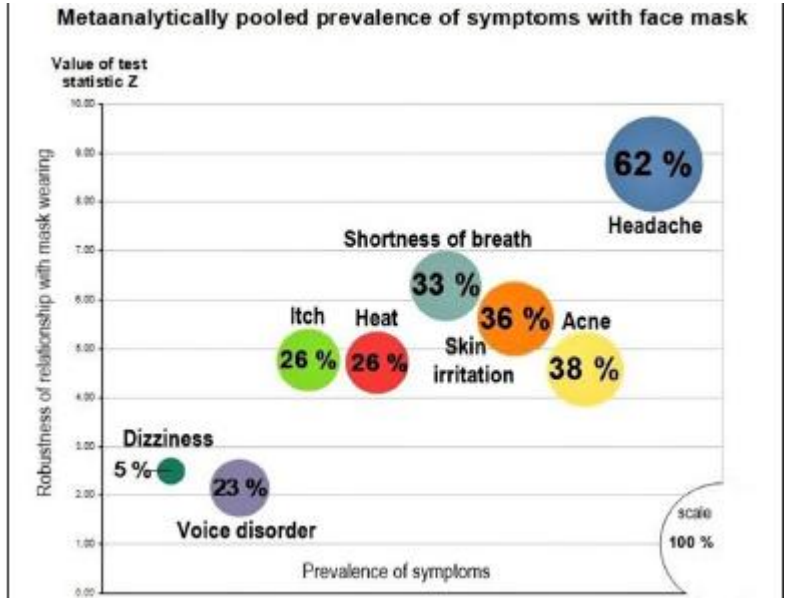
Complemented by RIDOH's own Dr. Scott endlessly regurgitating her false mantra, *"Masks work!"*

Meta-analysis of the adverse effects of masking:
"ample evidence for multiple adverse physio-metabolic & clinical outcomes of medical face masks"

"In the absence of strong empirical evidence of mask effectiveness, mask wearing should NOT be mandated let alone enforced by law"



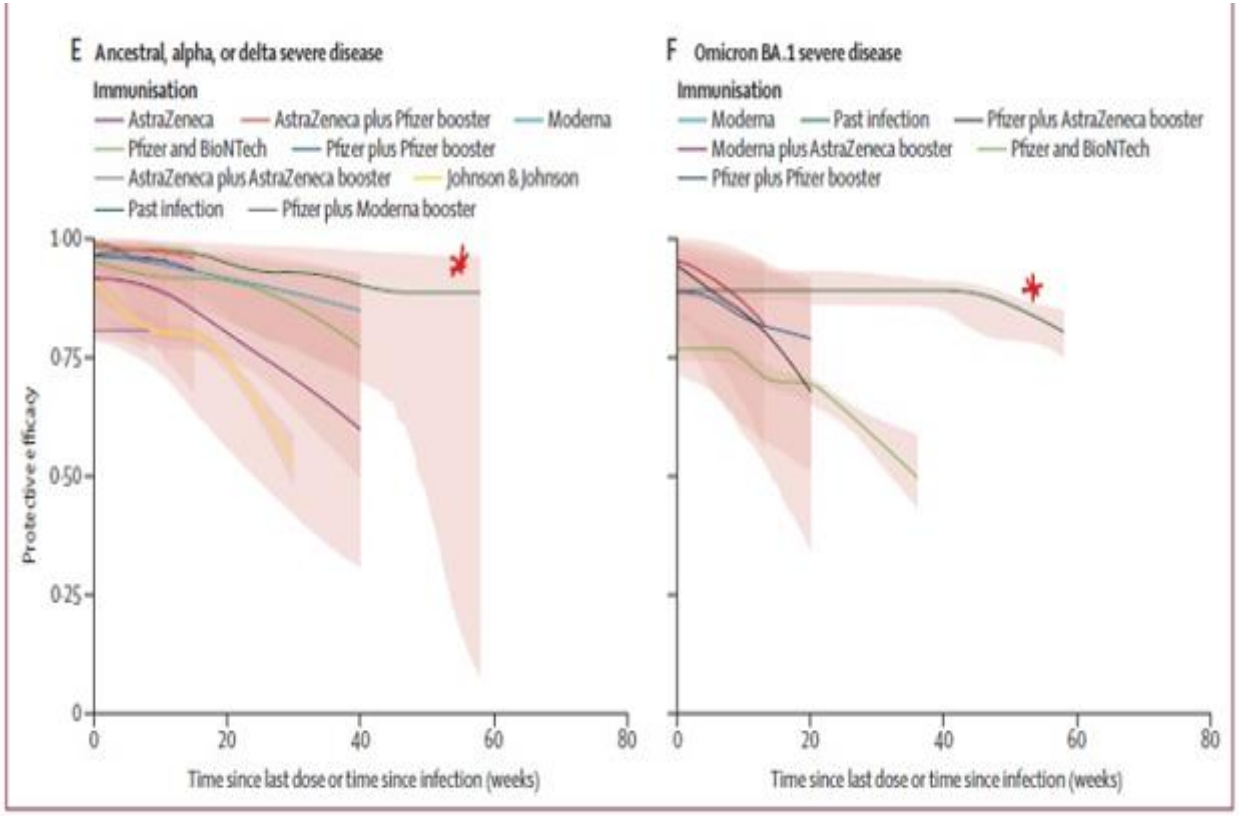




Kisielinski K et al. "Physio-metabolic and clinical consequences of wearing face masks—Systematic review with meta-analysis and comprehensive evaluation" *Front. Public Health*, 05 April 2023, Volume 11 – 2023, https://doi.org/10.3389/fpubh.2023.1125150

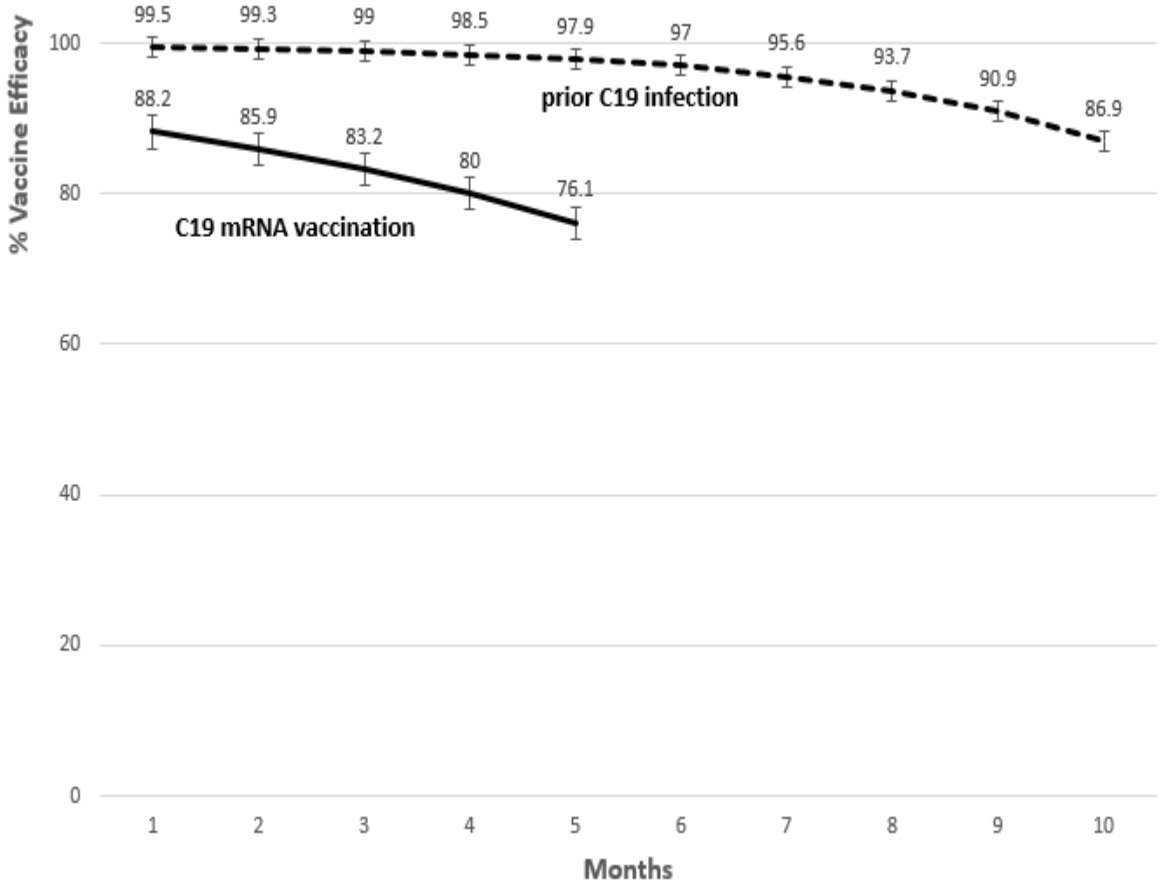
Naturally-Acquired Immunity to SARS-CoV-2 is More Robust & Enduring Than Covid-19 Vaccine-Acquired Immunity, in Both Adults & Children

12 pooled studies from adults in *The Lancet,* severe covid-19 disease* data
(*covid-19 hospitalization & death)



COVID-19 Forecasting Team. Past SARS-CoV-2 infection protection against re-infection: a systematic review and meta-analysis. Lancet. 2023 Mar 11;401(10379):833-842.

Study of ~900K N Carolina children aged 5-11 yo, covid-19 hospitalization data



Suppl to: Lin D-Y, Gu Y, Xu Y, et al. Effects of vaccination and previous infection on omicron infections in children. N Engl J Med. DOI: 10.1056/NEJMc2209371, plot of data from Tables S5 & S6

Generic Failures of the Covid-19 Vaccine Trials: No Evaluation of SARS-CoV-2 Transmission*, & *Underpowered for Clinical Outcomes, i.e., Covid-19 Hospitalizations & Deaths*

"80 years of vaccine development for inhaled viral infections, failed to develop one sterilizing vaccine capable of inducing herd immunity*...[N]o vaccine induces stronger immunity than that following the disease, yet it took a recent *Lancet* meta-analysis to confirm that post Covid-19 trumps vaccine immunity."

—Emeritus Professor Robert Clancy, Foundation Professor of Pathology in the Medical School, University of Newcastle. He is a clinical immunologist.

From: Robert Clancy, "Strange times: Covid, immunology and medicine," *The Spectator* (Australia), March 11, 2023 https://www.spectator.com.au/2023/03/strange-times/

*certainly by the summer of 2021, self-evident clinical/observational data emerged, such as the Barnstable County, MA covid-19 delta variant outbreak in primarily (74%) fully vaccinated persons, to demonstrate the covid-19 vaccines did ***NOT*** prevent SARS-CoV-2 transmission

(**reported by CDC itself in MMWR**: https://www.cdc.gov/mmwr/volumes/70/wr/mm7031e2.htm)

Benn et al., i***Science*** 26, 106733 May 19, 2023. https://doi.org/10.1016/ j.isci.2023.106733 (online 5/9/23)

***"In the RCTs with the longest possible blinded follow-up," mRNA vaccines*→ no ↓ in total mortality (31 deaths vaxxed/30 deaths unvaxxed), possible slight ↑ in CVD mortality (16 deaths vaxxed/11 deaths unvaxxed), & possible small ↓ in covid mortality (2 deaths vaxxed/5 deaths unvaxxed)**

Table 1. Overall and non-COVID-19 mortality in the RCTs of mRNA vaccines

	Vaccine group (deaths/N)	Placebo group (deaths/N)	Relative risk (95% CI)
Combined for Pfizer and Moderna vs. placebo[d]			
Overall mortality	31/37110	30/37083	1.03 (0.63–1.71)
COVID-19 mortality	2/37110	5/37083	0.40 (0.08–2.06)
Cardiovascular mortality	16/37110	11/37083	1.45 (0.67–3.13)
Other non-COVID-19 mortality	11/37110	12/37083	0.92 (0.40–2.08)
Accidents	2/37110	2/37083	1.00 (0.14–7.09)
Non-accident, non-COVID-19 mortality	27/37110	23/37083	1.17 (0.67–2.05)

For each covid-19 death prevented by mRNA vaccination (NNV=12,346), there will be 1.65 CVD (cardiovascular disease) deaths caused (NNV=7,463)

Polio and Polio Vaccination, Vs. Covid-19 and Covid-19 Vaccination, in Young Children

Dr. Anthony Fauci, & local savant, Dr. Ashish Jha (Dean of Brown University SPH & most recent "Covid Czar"), each had the temerity to equate polio & covid-19 vaccination in children, even hectoring parents as "anti-vaccine deniers" for not accepting their specious comparisons

Polio vs. Covid-19 Mortality in Children

—US polio mortality in children, 1915-1954, averaged 5.7%

—The U.S. pediatric covid-19 IFR is ≤ 0.0003%

—In RI, during the 1st 10 months of 1953 (thru 10/31), there were 289 polio cases & 15 polio deaths, a 5.2% mortality

—Despite thousands of pediatric "covid-19 cases" (& 95-100% of the pediatric population infected), there have been ZERO pediatric covid-19 deaths in 3-years in RI

Polio vs. Covid-19 RCT Data

—The 1954 polio RCT (& field trial) enrolled 1.8 million children, and polio vaccination prevented 374 cases of crippling polio (vs. placebo).

—The 2021 Pfizer mRNA RCT in 5-11-year-olds enrolled ~2300, & covid 19 mRNA vaccination "prevented" 13 cases of mild C19 (i.e., sniffles)

- **There were ZERO covid-19 hospitalizations in EITHER the placebo or active C19 vaccine groups**
- **None of the subgroup of children with prior infection history (natch immunity) even developed sniffles regardless of active C19 or placebo vaccination**

These blogs contain the primary sources: https://www.andrewbostom.org/2021/12/comparing-pediatric-polio-vaccination-to-pediatric-covid-19-vaccination-is-lysenkoist-absurdity/; https://www.andrewbostom.org/2021/12/pediatric-polio-in-rhode-island-reported-by-the-newport-daily-news-december-16-1953-289-cases-treated-15-deaths-reported-through-october-31-1953-a-5-2-fatality-rate/

Formal Risk-Benefit Analyses of Covid-19 mRNA Vaccines Based Upon RCT & Observational Data

Adult Risk/Benefit Data:

"In the **Moderna trial**, the **excess risk of serious Adverse Events of Special Interest*** (AESIs; 15.1 per 10,000 participants) **was (8.7/10,000) *higher* than the risk reduction for COVID-19 hospitalization relative to the placebo group** (6.4 per 10,000 participants). In the **Pfizer trial**, **the excess risk of serious AESIs (10.1 per 10,000) was (7.8/10,000) *higher* than the risk reduction for COVID-19 hospitalization** relative to the placebo group (2.3 per 10,000 participants).

***esp. myopericarditis, coagulation disorders, cholecystitis**

Fraiman J et al. "Serious adverse events of special interest following mRNA COVID-19 vaccination in randomized trials in adults." ***Vaccine***. 2022 Sep 22;40(40):5798-5805.

Risk/Benefit Data for 18-29 Year Olds*:

"To prevent one COVID-19 hospitalization over a 6-month period, we estimate that **31 207–42 836** young adults aged 18–29 years must receive a third mRNA vaccine. Booster mandates in young adults are expected to cause a net harm: **per COVID-19 hospitalization prevented, we anticipate at least 18.5 serious adverse events from mRNA vaccines, including 1.5–4.6 booster-associated myopericarditis cases in males (typically requiring hospitalization). We also anticipate 1430–4626 cases of grade ≥3 reactogenicity interfering with daily activities (although typically not requiring hospitalisation)**."

"**It is even harder to justify a two-dose primary vaccine mandate in late 2022 than when such policies began in mid-2021****. This rationale is weak at best and wrong at worst. Consistent with our argument above, the now high prevalence of prior infection, data regarding the lack of sustained transmission reduction by current vaccines and the age at peak risk for myo/pericarditis being young adults aged 16–17 years"

Bardosh K et al. COVID-19 vaccine boosters for young adults: a risk benefit assessment and ethical analysis of mandate policies at universities. ***J Med Ethics***. 2022 Dec 5:medethics-2022-108449.

In ≤18-year-olds, Fraiman estimated for each covid-19 hospitalization prevented by mRNA vaccination, there would be 700 cases of vaccine-associated myocarditis; for each ICU hospitalization prevented, that # rises to 2000!

***** The monovalent 2-dose regimen had its EUA termionated in April is no longer available!!***

Covid-19 Vaccine Data From the U.S. Vaccine Adverse Events Reporting System (VAERS), & Medicaid/Medicare (CMS)

National Myopericarditis & Pulmonary Embolus Data

- **≥ 80% of VAERS reports of C19 mRNA vaccine-assoc myopericarditis (1626/1991; 81.6%) through the 1st ~9mos of vaccine release (Dec 2020-Aug 2021) were validated by CDC**

(Currently there are ~3800 C19 mRNA vaccine-assoc myopericarditis cases in the VAERS system)

- **Among healthy adolescent males, 12-to 17-years-old, C19 mRNA vaccination conferred a ~2 to 3-fold ↑ed risk of myopericarditis, relative to C19 hospitalizations prevented, in those with no prior history of C19 infection; in those with a history of prior C19 infection the relative risk of myopericarditis was 70 to 71-fold ↑ed**
- **Medicare/Medicaid data from ~31 million ≥65-year-olds revealed 1 .54X ↑ed risk for pulmonary embolus assoc with the BNT162b C19 mRNA vaccine**

Oster ME et al. "Myocarditis Cases Reported After mRNA-Based COVID-19 Vaccination in the US From December 2020 to August 2021" JAMA. 2022 Jan 25;327(4):331-340.

Krug A et al. "BNT162b2 Vaccine-Associated Myo/Pericarditis in Adolescents: A Stratified Risk-Benefit Analysis" Eur J Clin Invest. 2022 May;52(5):e13759.

Wong HL et al. "Surveillance of COVID-19 vaccine safety among elderly persons aged 65 years and older" *Vaccine*. 2023 Jan 9;41(2):532-539.

General Rhode Island VAERS Data

A Sept 2021 ***RI Med J*** report described how a RIDOH "vaccine surveillance team" meets regularly (i.e., each week) to review CDC VAERS data from RI residents categorizing the severity, & updating the frequency, of adverse events associated with C19 vaccination. These efforts are geared, allegedly, toward identifying, "cases of significant interest, & [to] respond to media & data requests in a timely manner." **This has NOT occurred. Below are the *only* data produced & made public.**

Table 2. Outcomes from VAERS reports in Rhode Island [1/8/2021–7/16/2021]

Outcomes	Count	Percent
Non-serious		
Recovered at the time of adverse event	579	39.15%
Treated at Vaccine Site	174	11.76%
Office/clinical visit	321	21.70%
Serious		
Hospitalization	89	6.02%
Persistent or significant incapacity	25	1.69%
Congenital anomaly or birth defect	0	0%
Death	16	1.08%
Other		
Emergency room/urgent care visit	233	15.75%
Vaccine Administration Error	112	7.57%

Karayeva E et al. "Monitoring Vaccine Adverse Event Reporting System (VAERS) Reports Related to COVID-19 Vaccination Efforts in Rhode Island" *R I Med J* (2013). 2021 Sep 1;104(7):64-66.

Highlighting Rhode Island Covid-19 Vaccine-Associated Myopericarditis Cases (which included a Brown University student), & a Prominent Pulmonary Embolus Case

RI post-mRNA C19 vaccine myopericarditis cases in healthy young men (<40 years old) during 2021

- **Initial report of 5 hospitalized cases (incl a Brown University student*)**
- **Subsequent report included those 5, & 9 more = fourteen hospitalized cases**
- **Three to six-month follow-up of 9/14 cases → 8/9 with residual myocardial necrosis/scar on (magnetic resonance) imaging (LGE)**

Patel YR et al. "Cardiovascular magnetic resonance findings in young adult patients with acute myocarditis following mRNA COVID-19 vaccination: a case series" *J Cardiovasc Magn Reson*. 2021 Sep 9;23(1):101.

*Bostom AG "Brown University's Silence on Post-Vaccine Myocarditis" *Brownstone Inst* July 9, 2022 https://brownstone.org/articles/brown-universitys-silence-on-post-vaccine-myocarditis/

Patel YR et al. "Cardiac MRI Findings in Male Patients with Acute Myocarditis in the Presence or Absence of COVID-19 Vaccination" *Radiol Cardiothorac Imaging*. 2022 Jun 9;4(3):e220008.

Patel YR et al. "Follow-Up Cardiovascular Magnetic Resonance Findings in Patients With COVID-19 Vaccination-Associated Acute Myocarditis" *JACC Cardiovasc Imaging* 2022 Nov;15(11):2007-2010.

Rhode Island Radio Hall of Famer, Ron St. Pierre revealed on WPRO, 7/30/21, that he had suffered a life-threatening (?saddle) pulmonary embolus after his C19 mRNA vaccination. Both his primary care MD, & a consulting hematologist, agreed the vaccine was the most likely cause based on Mr. St. Pierre's medical history, & the case was recorded in VAERS. Audio here: https://www.bitchute.com/video/fma5BLZqi48M/

Details for VAERS ID: 1302479-1

Event Information			
Patient Age	64.00	Sex	Male
State / Territory	Rhode Island	Date Report Completed	2021-05-10
Date Vaccinated	2021-03-27	Date Report Received	2021-05-10
Date of Onset	2021-04-17	Date Died	
Days to onset	21		
Vaccine Administered By	Pharmacy *	Vaccine Purchased By	Not Applicable *
Mfr/Imm Project Number	NONE	Report Form Version	2
Recovered	No	Serious	Yes

* VAERS 2.0 Report Form Only
** VAERS-1 Report Form Only
"Not Applicable" will appear when information is not available on this report form version.

Event Categories	
Death	No
Life Threatening	Yes
Permanent Disability	No
Congenital Anomaly / Birth Defect *	No
Hospitalized	Yes
Days in Hospital	5
Existing Hospitalization Prolonged	No
Emergency Room / Office Visit **	N/A
Emergency Room *	Yes
Office Visit *	Yes

* VAERS 2.0 Report Form Only
** VAERS-1 Report Form Only
"N/A" will appear when information is not available on this report form version.

Vaccine Type	Vaccine	Manufacturer	Lot	Dose	Route	Site
COVID19 VACCINE	COVID19 (COVID19 (PFIZER-BIONTECH))	PFIZER\BIONTECH	EP6955	2	IM	LA

Symptom
BLOOD TEST
COMPUTERISED TOMOGRAM THORAX ABNORMAL
PULMONARY THROMBOSIS
THROMBOSIS
ULTRASOUND DOPPLER ABNORMAL

Adverse Event Description
Blood Clots in left leg and both sides of lungs

Lab Data	Current Illness	Adverse Events After Prior Vaccinations
CTs, ultrasounds and blood tests		

Swiss Public Health & Vaccine Agencies, 4/3/23: "will NOT formulate a recommendation for vaccination against Covid-19 in spring/summer 2023 due to the expected low virus circulation & the high level (>98%) of immunity in the population"

"Corona Immunity seroprevalence data shows that in March and June/July > 98% of the population in Switzerland had antibodies against SARS-CoV-2"

Machine Translated by Google

Schweizerische Eidgenossenschaft
Confédération suisse
Confederazione Svizzera
Confederaziun svizra

Federal Department of Home Affairs FDHA
Federal Office of Public Health FOPH

Federal Commission for
Vaccination questions EKIF

Vaccination recommendation for the Covid-19 vaccination (valid from April 3rd, 2023)

Status 04/03/2023

Federal Office of Public Health (BAG) and Federal Commission for Vaccination (EKIF)

This document describes the recommendation for a Covid-19 vaccination for the period Spring/Summer 2023:

In principle, the FOPH and EKIF will **not formulate a recommendation for vaccination against Covid-19** in spring/summer 2023 due to the expected low virus circulation and the high level of immunity in the population .

In individual cases, people who are particularly at risk can be vaccinated against Covid-19 at the discretion of the doctor treating them.

Only in the event of an emerging SARS-CoV-2 wave would people at high risk (BGP) whose last vaccination dose was more than 6 months ago be recommended to be vaccinated against Covid-19. In this case, the recommendation would be updated accordingly by BAG and EKIF.

https://www.bag.admin.ch/dam/bag/de/dokumente/mt/k-und-i/aktuelle-ausbrueche-pandemien/2019-nCoV/covid-19-impfempfehlung-herbst-2022.pdf.download.pdf/Covid-19-Impfempfehlung_BAG_EKIF_DE.pdf

The Path Foreword: More Lysenkoism (Lysenko/Birx), or...

- Trofim Lysenko believed that acquired traits are inherited, claimed that heredity can be changed by "educating" plants, & denied the existence of genes. Lysenko was supported by Stalin & Communist Party elites

Borinskaya SA et al. "Lysenkoism Against Genetics: The Meeting of the Lenin All-Union Academy of Agricultural Sciences of August 1948, Its Background, Causes, and Aftermath." *Genetics*. 2019 May;212(1):1-12

"Professor T.D. Lysenko, vice chairman of The Academy of Sciences of the Soviet Union, and holder of the Order of Lenin, is far ahead of any scientist in the field of genetics. ***He is, in fact, the only scientist who ever grew wax tomatoes from an ordinary vine****...This unusual product was revealed at the Moscow Scientific Congress…One report says that Lysenko's tomatoes were right on the vine. In any case, some scientist managed to stick one in his pocket and give it further examination.* ***The tomato was made of wax****.* ***But Dr. Lysenko is no joke to Soviet scientists****. One leading Russian scientist who happened to dispute his views, Professor Nikolai Vavilov, died in a concentration camp 6-years ago under circumstances that were never explained. Obviously other scientists unwilling to share the fate of Vavilov agree with Lysenko."*

Hugh E. Wells. "**How Soviet Shackles Its Scientists**" *The Philadelphia Inquirer* September 26, 1948; p. 152

Governor Ron Desantis, spring, 2020:
"[Dr.] Deborah [Birx], just tell me. When in American history has this (lockdowns) been done and what were the results because I kind of feel like we're flying blind here and we may be doing things that are gonna be damaging."

Dr. Birx:
"You know, it's kind of our own science experiment that we're doing in real time."

...a Return to Experiential, Evidence-Based Medicine (Henderson)?

D. A Henderson, MD, MPH, Dean of the Johns Hopkins University School of Public Health, and a leading figure in the WHO's successful smallpox eradication program, on respiratory virus, esp. influenza, pandemic planning, circa 2006.

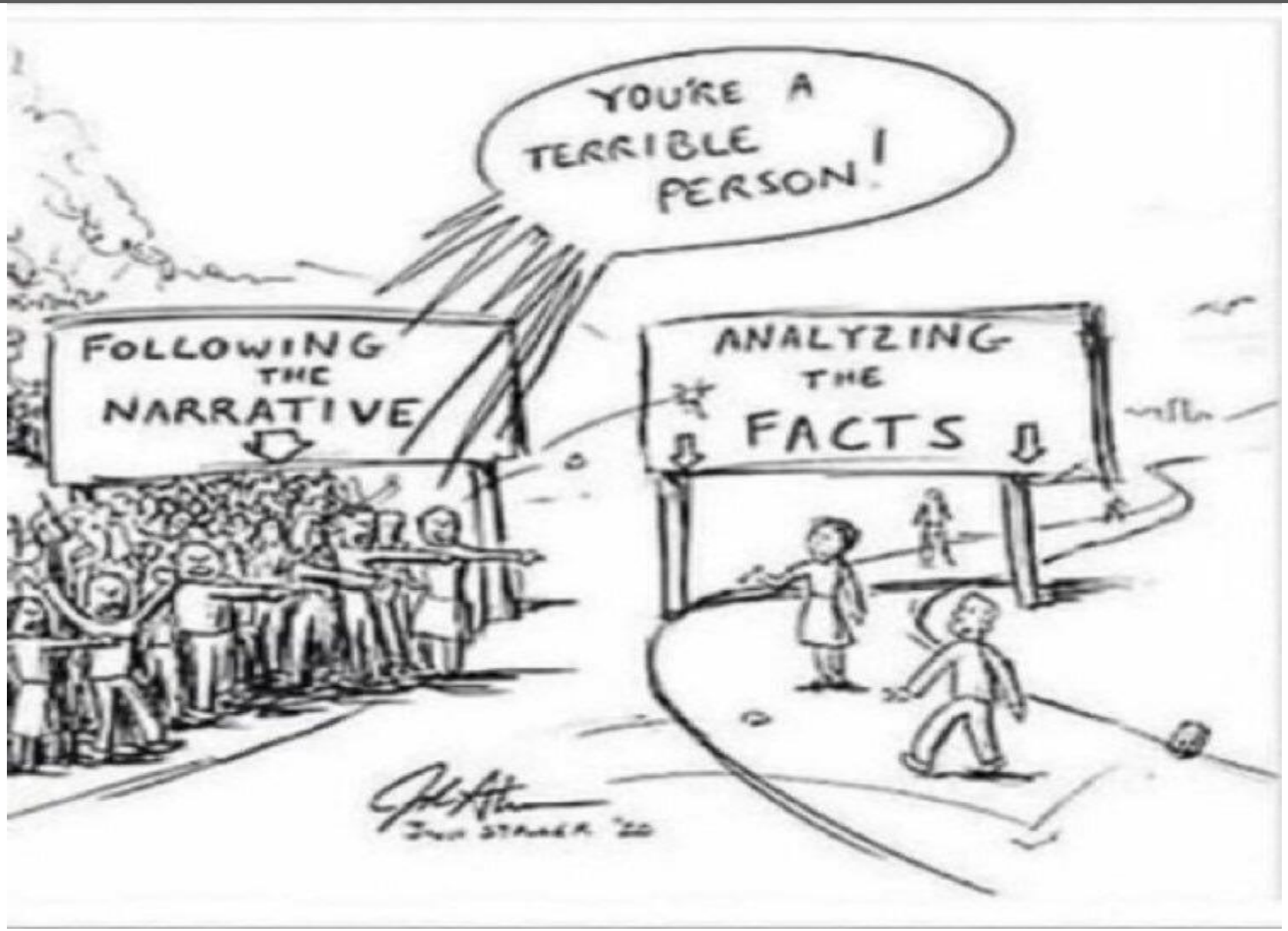
Perhaps Henderson's very calm, sober perspective was shaped by dealing with a much more catastrophic illness—smallpox—which had a 20–60% fatality rate (persisting at 15-30% in its last endemic century), whose survivors were often maimed by the disease. This scourge, and the havoc it wrought, destroyed entire civilizations, and killed some 300 million in the 20th century, alone.

"There are **no historical observations or scientific studies that support the confinement by quarantine of groups** of possibly infected people for extended periods in order to slow the spread of influenza... **The negative consequences of large-scale quarantine are so extreme (forced confinement of sick people with the well; restriction of movement of large populations)... that this mitigation measure should be eliminated from serious consideration...** During seasonal influenza epidemics, public events with an expected large attendance have sometimes been cancelled or postponed, the rationale being to decrease the number of contacts with those who might be contagious. **There are, however, no certain indications that these actions have had any definitive effect on the severity or duration of an epidemic**... Schools are often closed for 1–2 weeks early in the development of seasonal community outbreaks of influenza primarily because of high absentee rates, especially in elementary schools, and because of illness among teachers. This would seem reasonable on practical grounds. **However, to close schools for longer periods is not only impracticable but carries the possibility of a serious adverse outcome...**

...a Return to Experiential, Evidence-Based Medicine (Henderson)? [cont'd]

...In Asia during the SARS period, many people in the affected communities wore surgical masks when in public. **But studies have shown that the ordinary surgical mask does little to prevent inhalation of small droplets bearing influenza virus. The pores in the mask become blocked by moisture from breathing, and the air stream simply diverts around the mask. There are few data available to support the efficacy of N95 or surgical masks outside a healthcare setting. N95 masks need to be fit-tested to be efficacious and are uncomfortable to wear for more than an hour or two**... **The problems in implementing such measures are formidable, and secondary effects of absenteeism and community disruption as well as possible adverse consequences, such as loss of public trust in government and stigmatization of quarantined people and groups, are likely to be considerable**…***Experience has shown that communities faced with epidemics or other adverse events respond best and with the least anxiety when the normal social functioning of the community is least disrupted***. Strong political and public health leadership to provide reassurance and to ensure that needed medical care services are provided are critical elements. If either is seen to be less than optimal, **a manageable epidemic could move toward catastrophe**."

From Henderson's senior author paper: "Disease mitigation measures in the control of pandemic influenza." Biosecur Bioterror. 2006;4(4):366-75. doi: 10.1089/bsp.2006.4.366. PMID: 17238820.


YOU'RE A TERRIBLE PERSON!
FOLLOWING THE NARRATIVE
ANALYZING THE FACTS

End of Presentation

department of
Medicine Newsletter
BROWN
Alpert Medical School
Spring 2008 • Volume 9 Issue 1 • Published Quarterly

Andrew Bostom, MD, MS receives $19.6 million federal grant

Multi-site trial aims to reduce cardiovascular disease in kidney transplant recipients

Andrew G. Bostom, M.D., M.S., a specialist in the division of kidney disease and hypertension at Rhode Island Hospital, has received $19.6 million from the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) to fund another five years of his landmark study, which looks at ways to reduce heart attack and stroke in kidney transplant patients.

The Folic Acid for Vascular Outcome Reduction in Transplantation (FAVORIT) trial is critical because patients with chronic kidney disease, including those who have received kidney transplants, are at high risk for cardiovascular disease (CVD)—the nation's leading cause of death.

The multi-site FAVORIT trial, which began in 2002, is a double-blind, randomized controlled clinical trial designed to evaluate whether lowering an amino acid known as total homocysteine using vitamin supplements like folic acid can reduce CVD in kidney transplant recipients.

Elevated homocysteine—which is more prelavent in patients with chronic kidney disease—can increase the risk of coronary heart disease, stroke and peripheral vascular disease, while folic acid and other B vitamins help break it down.

Bostom, who is also an associate professor of medicine at The Warren Alpert Medical School of Brown University, initiated the trial five years ago and will continue to direct the clinical coordinating center at Rhode Island Hospital. Federal funding will be distributed to each of the 30 major kidney transplant centers in the United States, Canada and Brazil participating in this trial.

> "With a better understanding of why these patients are at significant risk for cardiovascular disease, we can develop more effective ways to prevent and treat it, enabling us to improve the overall health, as well as the quality of life, of people with chronic kidney disease"

Participants in the FAVORIT trial are clinically stable kidney transplant recipients who have had their new kidney for at least six months and who also have elevated total homocysteine. Patients are randomized to a multivitamin containing high doses of folic acid and vitamins B6 and B12 or a vitamin with no folic acid and the estimated average daily requirements of vitamins B6 and B12. To date, 42 percent of the randomized patients had a history of diabetes and 21 percent had

Cochrane Library
Trusted evidence.
Informed decisions.
Better health.

Cochrane Database of Systematic Reviews | Review - Intervention

Interventions for lowering plasma homocysteine levels in kidney transplant recipients

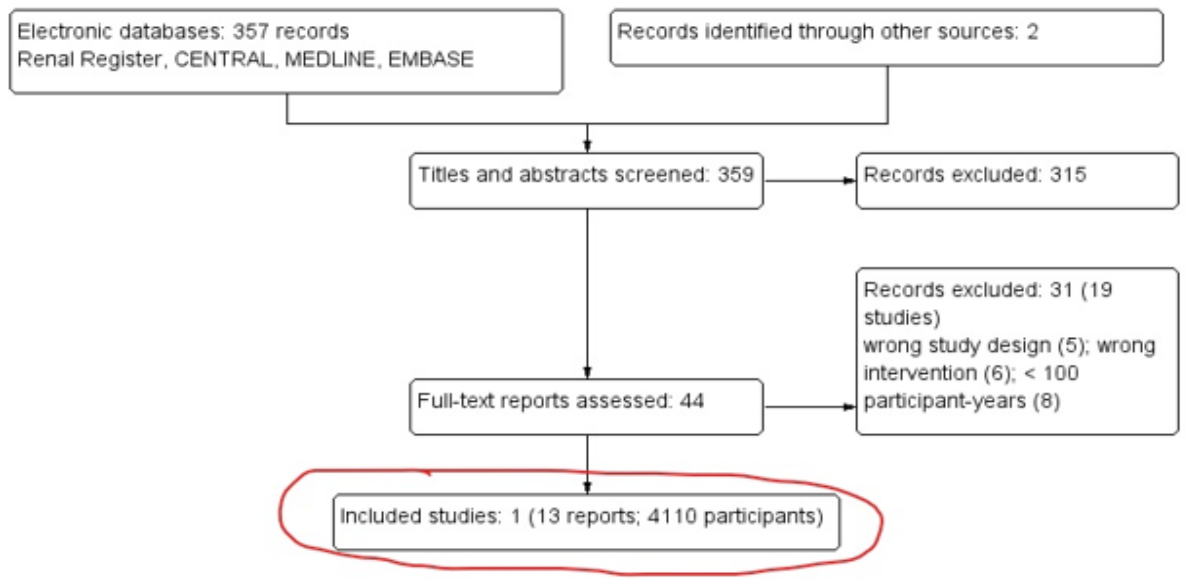
Amy Kang, Sagar U Nigwekar, Vlado Perkovic, Satyarth Kulshrestha, Sophia Zoungas, Sankar D Navaneethan, Alan Cass, Martin P Gallagher, Toshiharu Ninomiya, Giovanni FM Strippoli, Meg J Jardine Authors' declarations of interest

Version published: 04 May 2015 Version history

https://doi.org/10.1002/14651858.CD007910.pub2

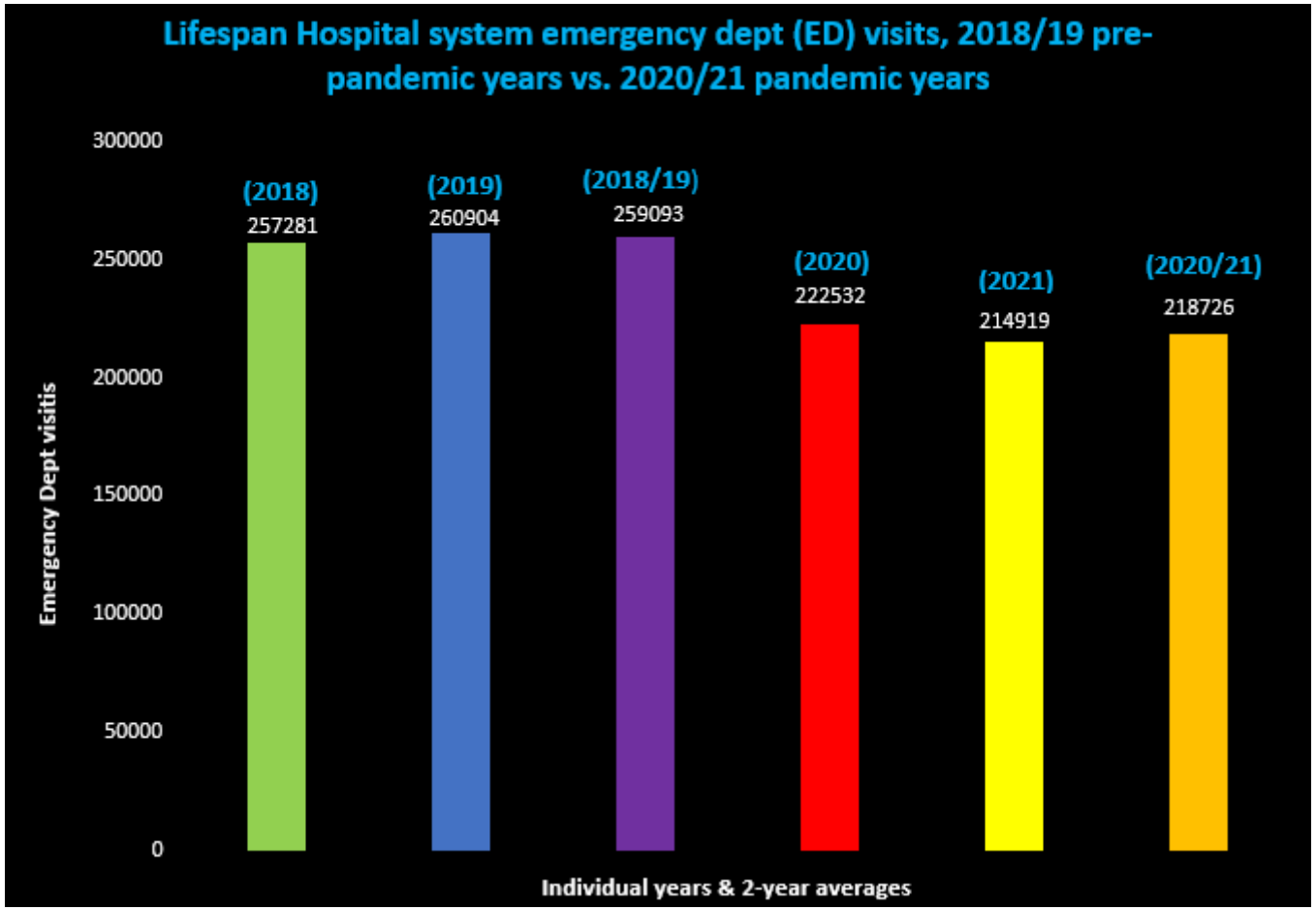
The literature search yielded a total of 359 records (Figure 1). Of these, 44 were reviewed in full text. One study (13 reports) was identified that met our inclusion criteria (FAVORIT Study 2006).

Figure 1 **Open in figure viewer**



Lifespan Emergency Dept Visits, Comparing Pre-Covid-19 Pandemic Years 2018-19, & Covid-19 Pandemic Years 2020-21

- **259,093 avg for 2018-19, Pre-covid-19 pandemic years**
- **218,726 avg for 2021 covid-19 pandemic year, i.e., *-15.6% LOWER***



Reference:
https://www.lifespan.org/about-lifespan/lifespan-reports

Covid-19 Policy Educational (i.e., Reading) Outcomes in Schoolchildren: U.S. vs. Sweden

Test Scores Show Historic COVID Setbacks for Kids Across US

New national test results show that the pandemic spared no part of the country as it caused historic learning setbacks for America's children.

By Associated Press | Oct. 24, 2022, at 5:37 p.m.

"Across the country, math scores saw their largest decreases ever. Reading scores dropped to 1992 levels. Nearly four in 10 eighth graders failed to grasp basic math concepts. Not a single state saw a notable improvement in their average test scores, with some simply treading water at best. Those are the findings from the National Assessment of Educational Progress — known as the 'nation's report card' — which tested hundreds of thousands of fourth and eighth graders across the country this year. It was the first time the test had been given since 2019, and it's seen as the first nationally representative study of the pandemic's impact on learning."

International Journal of Educational Research
Volume 114, 2022, 102011

No learning loss in Sweden during the pandemic: Evidence from primary school reading assessments

Anna Eva Hallin [a], Henrik Danielsson [b], Thomas Nordström [c], Linda Fälth [d]

Highlights

- No COVID-19 related learning loss in reading in Swedish primary school students.
- The proportion of students with weak reading skills did not increase during the pandemic.
- Students from disadvantaged socio-economic backgrounds were not especially affected.

U.S. Pediatric Influenza vs. Covid-19 Mortality

Disease/Period	Age range (years)	Deaths
Covid-19, 2020	0-17	199/129*
Covid-19, 2021	0-17	609/395*
Pandemic H1N1 Flu, 2009-10	0-17	1282
Seasonal Flu, 2012-13	0-17	1161
Seasonal Flu, 2014-15	0-17	803
Seasonal Flu, 2017-18	0-17	643
Seasonal Flu, 2018-19	0-17	477
Seasonal Flu, 2019-20	0-17	434

[Through 4/5/23**;** *Adjusted for CDC 35% over counting of covid-19 pediatric deaths by death certificate review https://www.cdc.gov/mmwr/volumes/70/wr/mm7014e2.htm?s_cid=mm7014e2_x, i.e., "COVID-19 with no plausible chain of event", =35.2%.;

Covid-19: https://www.cdc.gov/nchs/nvss/vsrr/covid_weekly/index.htm;
Past seasonal flu burdens: https://www.cdc.gov/flu/about/burden/past-seasons.html;

"Estimating the Burden of 2009 Pandemic Influenza A (H1N1) in the United States (April 2009–April 2010)"
https://academic.oup.com/cid/article/52/suppl_1/S75/499147]

Deleterious effects of masking in children

–The discomfort of a mask distracts some children from learning, & can cause social isolation as described during the 2003 SARS-CoV-1 epidemic in a Hong Kong study of preschool children.

–A 2019 controlled randomized, crossover study of N95 masking in children reported that within 5-minutes, masking significantly raised blood CO2 concentrations vs. a controlled 5-minute period when unmasked

–A 2022 controlled study of 72 children, aged 6–14 years old using the Cambridge Face Memory Test, a validated measure of face perception performance, revealed *"substantial quantitative and qualitative alterations in the processing of masked faces in school-age children,"* which *"could have significant effects on children's social interactions with their peers and their ability to form relationships with educators."*

Rao N. "Sars, preschool routines and children's behaviour: Observations from preschools in Hong Kong" *Int J Early Child*. 2006;38(2):11-22.

Goh DYT et al. "A randomised clinical trial to evaluate the safety, fit, comfort of a novel N95 mask in children" *Sci Rep.* 2019 Dec 12;9(1):18952.

Stajduhar A et al. Face masks disrupt holistic processing and face perception in school-age children. *Cogn Res Princ Implic*. 2022 Feb 7;7(1):9.

Early Brown University Nursing Home Patient* Data (2/15/21-3/31/21) Among those Receiving Covid-19 mRNA Vaccines, Before "Vaccine Waning" [*Highest Covid-19 Risk Group]

- **1240/18,242 =6.8% with ANY incident SARS-CoV-2 infections among the vaccinated, & 270/3,990 also=6.8% incident SARSCOV2 infections among the unvaccinated *by including* infections which accrue days 0-14 in each group**
- **Vaccinated with at least one dose=335/18,242=0.0184 → (1.84%) with SYMPTOMATIC incident SARS-CoV-2 infections among the vaccinated, & 90/3,990=0.0223 = (2.23%), a mere 0.39% absolute reduction, & a Number Needed to Vaccinate of 256 to prevent 1 SYMPTOMATIC SARS-CoV-2 infection**

"Incident SARS-CoV-2 Infection among mRNA-Vaccinated and Unvaccinated Nursing Home Residents"
July 29, 2021 ***N Engl J Med*** 2021; 385:474-476 DOI: 10.1056/NEJMc2104849

Norwegian Expert Panel Examination of Initial Covid-19 mRNA Vaccine-Associated Nursing Home Deaths (Mean Age 87.7 Years)

- **10% (10) of initial Norwegian nursing home post-covid mRNA vaccine-related deaths (n=100) were deemed "probably" caused by vaccination, with 26% (26) deemed "possibly" caused by vaccination, as determined by an expert panel of geriatricians, & infectious diseases MDs**

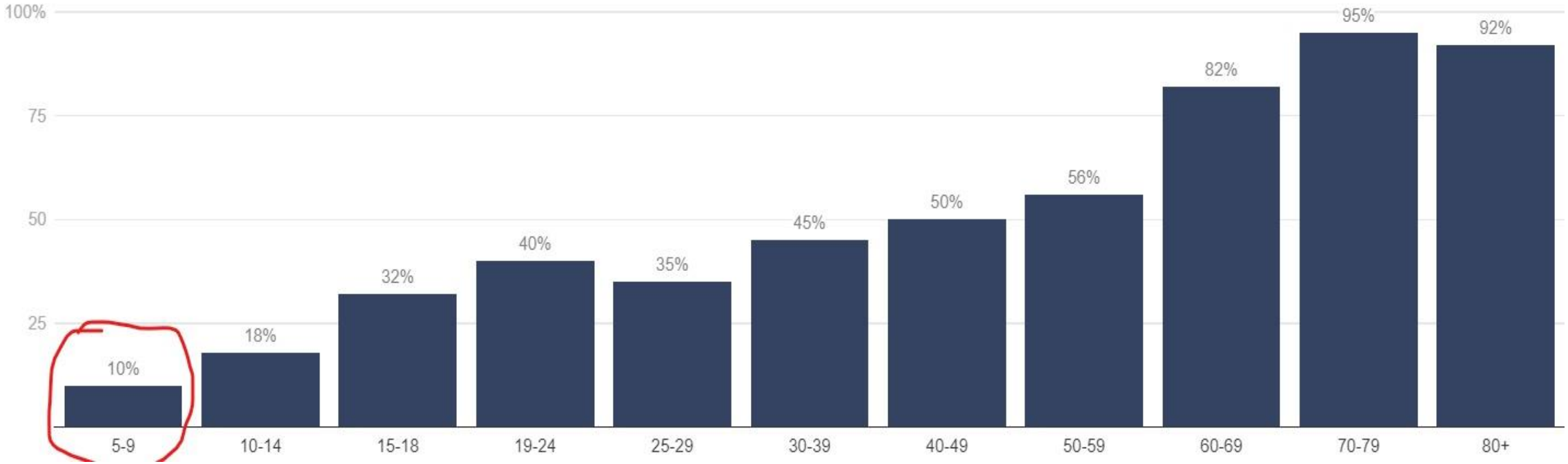
Published in ***The Journal of the Norwegian Medical Association:***
Wyller TB et al. "Nursing home deaths after COVID-19 vaccination". *Tidsskr Nor Laegeforen.* 2021 May 19;141. English, Norwegian.

Only 10% of RI Parents Have Opted to “Fully” Covid-19 Vaccinate Their 5- to 9-Year-Old Children

Percentage of Rhode Island Residents Vaccinated by Age

Percentage of Rhode Island residents who received a booster dose are those with at least one dose beyond the primary vaccination series. This includes people who have compromised (weakened) immune systems who received a third dose, as well as those in the general population who received a booster dose. Percentage of people who completed the primary vaccine series reflects RI residents who have received all doses of a primary vaccine series, which includes the single-dose Johnson and Johnson vaccine. Percentage of people at least partially vaccinated reflects the number of RI residents who have received at least one vaccine and includes the single-dose Johnson and Johnson vaccine.

% of Population Who Received a Booster Dose | % of Population Who Completed Primary Vaccine Series | % of Population At Least Partially Vaccinated



Four Independent Sources of Confirmatory/Matching Data for Brown University Student Case of mRNA-Associated Myopericarditis, March 2021

SOURCE	Age*	Sex	Home State of Residence	Diagnosis	Admitting Hospital	Date/ Month Admitted	Echo data	Troponin
Cardiologist on-call audio	"Brown Undergrad" *	M	"Down south"	MP	TMH	3/21	N/A	"very high"
RIDOH hospitalizations	20yo	M	FL	MP	TMH	3/21	N/A	N/A
VAERS	20yo	M	N/A	MP	N/A	3/20/21	Echo: 51% LVEF	"troponin was elevated"
Ref. 1	20yo	M	N/A	MP	N/A	N/A	Echo: 51% LVEF	58 ng/ml (0.006 to 0.060= normal range)

Abbreviations: yo= years old; M= male; FL=Florida; N/A= not available; MP=myopericarditis; TMH=The Miriam Hospital; Echo=Transthoracic Echocardiograpy; LVEF=Left ventricular ejection fraction

Cardiologist on-call audio: https://rumble.com/v1cr4u1-audio-of-a-ri-cardiologist-confirming-a-brown-u-student-covid-19-vax-relate.html; RIDOH hospitalization datasets: https://health.ri.gov/data/hospitalization/discharge/; VAERS database: https://wonder.cdc.gov/vaers.html; VAERS ID 1347752-1 https://www.andrewbostom.org/wp-content/uploads/2022/06/VAERS-ID-1347752-1.pdf; Reference 1: "Case 5" in, Patel YR, Louis DW, Atalay M, Agarwal S, Shah NR. Cardiovascular magnetic resonance findings in young adult patients with acute myocarditis following mRNA COVID-19 vaccination: a case series. J Cardiovasc Magn Reson. 2021 Sep 9;23(1):101. doi: 10.1186/s12968-021-00795-4. PMID: 34496880; PMCID: PMC8425992. https://jcmr-online.biomedcentral.com/articles/10.1186/s12968-021-00795-4

Healthy, athletic 14-year-old girl suffers sudden cardiac death post mRNA vaccination in conjunction with systemic post-vaccination myopericarditis, pneumonia, hepatitis, nephritis, gastroenteritis, cystitis, & myositis.

"A diagnosis of vaccine-related multiple-organ inflammation was made based on the absence of bacterial or viral infection, lack of a past medical history suggestive of autoimmune disease, no allergic reaction, and no drug exposure other than the vaccine... the cause of death was vaccine-related myopericarditis, which led to severe arrhythmias and progressive heart failure"

Contents lists available at ScienceDirect

Legal Medicine

journal homepage: www.elsevier.com/locate/legalmed

Case Report

A case of fatal multi-organ inflammation following COVID-19 vaccination

Hideyuki Nushida [a,*], Asuka Ito [a], Hiromitsu Kurata [a,b], Hitomi Umemoto [a,c], Itsuo Tokunaga [a], Hirofumi Iseki [a,b], Akiyoshi Nishimura [a]

[a] Department of Forensic Medicine, Institute of Biomedical Sciences, Tokushima University Graduate School, Tokushima, Japan
[b] Department of Physical Medicine, Nakazu-Yagi Hospital, Tokushima, Japan
[c] Division of Anatomical Education Support, Tokushima University Graduate School, Tokushima, Japan

ARTICLE INFO

Keywords:
Systemic inflammation
Myopericarditis
COVID-19
Vaccines
Sudden death
Autopsy

ABSTRACT

A 14-year-old Japanese girl died unexpectedly 2 days after receiving the third dose of the BNT1262b2 mRNA COVID-19 vaccine. Autopsy findings showed congestive edema of the lungs, T-cell lymphocytic and macrophage infiltration in the lungs, pericardium, and myocardium of the left atria and left ventricle, liver, kidneys, stomach, duodenum, bladder, and diaphragm. Since there was no preceding infection, allergy, or drug toxicity exposure, the patient was diagnosed with post-vaccination pneumonia, myopericarditis, hepatitis, nephritis, gastroenteritis, cystitis, and myositis. Although neither type of inflammation is fatal by itself, arrhythmia is reported to be the most common cause of death in patients with atrial myopericarditis. In the present case, arrhythmia of atrial origin was assumed as the cause of cardiac failure and death. In sudden post-vaccination deaths, aggressive autopsy systemic search and histological examination involving extensive sectioning of the heart, including the atrium, are indispensable.

Nushida H et al. "A case of fatal multi-organ inflammation following COVID-19 vaccination" *Leg Med* (Tokyo). 2023 Mar 20;63:102244. doi: 10.1016/j.legalmed.2023.102244.

Did a 37-year-old Rhode Island female suffer sudden cardiac death due to an mRNA vaccine-associated "lymphocytic myocarditis," diagnosed at autopsy?

APRA requested autopsy summary revealed no significant pathology, other than a "*lymphocytic myocarditis involving the cardiac conduction system*"

Autopsy report and matching VAERS report for a 37- year-old decent with lymphocytic myocarditis and drowning

RHODE ISLAND DEPARTMENT OF HEALTH

Office of State Medical Examiners
48 Orms Street
Providence, RI 02904-2222
401.222.5500
401.222.5505 fax
TTY 711
www.health.ri.gov

AUTOPSY REPORT

NAME: [redacted]
PLACE OF DEATH: [redacted] RI 029[redacted]

CASE#: [redacted]
AGE: 37-year-old
GENDER: Female

DATE/TIME OF DEATH: [redacted]2021
DATE/TIME OF AUTOPSY: [redacted]2021

Decedent: [redacted] *Case Number:* [redacted]

CASE SUMMARY AND OPINION: This 37-year-old [redacted] female, [redacted], was found submerged in a bathtub full of water, in a supine position, with her neck extended. Personal items on and surrounding the bathtub appeared undisturbed. Police investigation [redacted] Lividity was partially blanching on the posterior aspect of the body at the scene, and fixed on the posterior aspect of the body at the time of autopsy. A temporary bathroom floor tile pattern of postmortem lividity was present at the scene during handling of the body by the scene investigators/body transport personnel. The body was mildly to moderately decomposed at the time of autopsy. At autopsy, a small hemorrhage of the left frontoparietal scalp was identified, suggestive of a possible fall; no intracranial injuries were identified. There was evidence of underwater submersion, to include fluid in the sphenoid sinus and moisture induced wrinkling of the skin of the bilateral hands and left foot. The cause of death is deemed drowning.

Examination of the heart by a cardiovascular pathologist shows focal lymphocytic myocarditis involving the cardiac conduction system; it is believed that the decedent was at risk for a sudden cardiac arrhythmia/event, and that it is likely that such an event preceded/contributed to the drowning of the decedent. Comprehensive toxicology testing was positive for alcohol (may in part or whole represent a postmortem artifact of decomposition). The manner of death is [redacted].

CAUSE OF DEATH: Drowning. Contributing factor: lymphocytic myocarditis.

(Matching) VAERS Report, which first prompted me to request the autopsy

Details for VAERS ID: 2375029-1

Event Information			
Patient Age	37.00	Sex	Female
State / Territory	Rhode Island	Date Report Completed	2022-07-21
Date Vaccinated	2021-05-13	Date Report Received	2022-07-21
Date of Onset	2021-05-25	Date Died	2021-05-25
Days to onset	12		
Vaccine Administered By	Other	Vaccine Purchased By	Not Applicable *
Mfr/Imm Project Number	NONE	Report Form Version	2
Recovered	Missing	Serious	Yes

* VAERS 2.0 Report Form Only
** VAERS-1 Report Form Only
"Not Applicable" will appear when information is not available on this report form version.

Event Categories	
Death	Yes
Life Threatening	No
Permanent Disability	No
Congenital Anomaly / Birth Defect *	No
Hospitalized	No
Days in Hospital	None
Existing Hospitalization Prolonged	No
Emergency Room / Office Visit **	N/A
Emergency Room *	No
Office Visit *	No

* VAERS 2.0 Report Form Only
** VAERS-1 Report Form Only
"N/A" will appear when information is not available on this report form version.

Vaccine Type	Vaccine	Manufacturer	Lot	Dose	Route	Site
COVID19 VACCINE	COVID19 (COVID19 (MODERNA))	MODERNA	004C21A	2	IM	

Symptom
AUTOPSY
CARDITIS
DEATH
DROWNING
MYOCARDITIS
THROMBOSIS

Adverse Event Description
PATIENT WAS FOUND DROWN IN BATHTUB AT HOME. REASON FOR DEATH: LYMOCYTIC MYOCARDITIS

Lab Data	Current Illness	Adverse Events After Prior Vaccinations
ON AUTHOPSY REPORT: HEART INFALMATION AND BLOOD CLOTS		

Medications At Time Of Vaccination	History/Allergies

Countermeasures Injury Compensation Program (*CICP*), presently the only viable option for covid-19 vaccine injury compensation, epitomizes the hollow, uncompensated failure of heart of U.S. "efforts."

- **Through March 1, 2023, 11,425 Covid-19 vaccine injury claims have been filed. 18 claims for covid-19 associated myocarditis/pericarditis are "pending," (out of >100 filed), & 2 have been compensated thus far**, for minimal $$ awards: $1083 & $1033 (see below)**.**

- **Indeed, CICP has compensated only 33 total claims, since 2010, including a single (smallpox) vaccine injury myopericarditis claim, awarded $323,036**

There is NO “Post-Covid-19 condition (PCC)” in mildly afflicted adolescents & young adults

Data from 509 Norwegian adolescents and young adults:

— (1) “the prevalence of PCC 6 months after acute COVID-19 was approximately 50%, but was equally high in a control group of comparable SARS-CoV-2–negative individuals”;

— (2) “acute COVID-19 was *not* an independent risk factor for PCC”;

— (3) “the severity of clinical symptoms at baseline, *irrespective of SARS-CoV-2 status*, was the main risk factor of persistent symptoms 6 months later.”

CONCLUSION:

“persistent symptoms & disability that characterize PCC are associated with factors other than SARS-CoV-2 infection, *including psychosocial factors*“

Selvakumar J et al. “Prevalence and Characteristics Associated With Post-COVID-19 Condition Among Nonhospitalized Adolescents and Young Adults” ***JAMA Netw Open***. 2023 Mar 1;6(3):e235763.

Three Personal Experiences With Rhode Island MSM Covid-19 "Journalism"

—Spiked 30 min interview with WPRI's Erica Ricci (Apr 12, 2021) on severe adverse reactions to the covid-19 vaccines (namely, the J& J adenovirus vector vaccine → intracranial thrombosis/hemorrhage; the Pfizer & Moderna mRNA vaccines → myopericarditis)

—Spiked reference to me (specifically) on order of the Projo editor to Jim Hummel regarding the issue of masking during H.S. sporting activities in the spring of 2021. Hummel had used my series of background interviews extensively for both reference materials, & direct quotes. Hummel was forced to edit what he had initially written by removing any mention of me from his article, if he wanted it published. Conceding to the editor, Hummel published his article, purged of any reference to me.

—Projo's Mark Reynold's early Oct 2021"coverage" of my certification as an expert witness during the Southwell v. McKee case *ignored* my 24-year academic career at Brown University Medical School as a nationally & internationally recognized clinical trialist & epidemiologist, but did observe, *"Some television viewers might recognize Dr. Andrew Bostom for his television appearances on Fox News & C-SPAN, where he has made appearances (repeated, sic) as an author with much to say about Islamic jihad"*