The Insanity of the PCR Testing Saga

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STORY AT-A-GLANCE -

- Curative offers a PCR test using spit rather than swabs from the back of your nasal cavity. Initially only authorized for use on symptomatic patients, the company has requested the U.S. Food and Drug Administration expand its authorization for use on asymptomatic individuals
- According to company data, the spit test accurately identifies about 90% of positive cases when compared against a nasopharyngeal PCR test set to 35 CT
- According to the FDA, that comparative CT is too low, and will produce too many false negatives. This, despite the scientific consensus, which states anything over 35 CTs is scientifically unjustifiable as it produces enormous amounts of false positives
- According to an April 2020 study, a CT of 17 must be used to obtain 100% confirmed real positives. Above 17 cycles, accuracy drops dramatically. At 33 cycles, the false positive rate is 80%. Beyond 34 cycles, the false positive rate reaches 100%
- Because the PCR test cannot discern between live virus and dead, noninfectious viral debris, the timing of the test is important. Recent research shows the median time from symptom onset to viral clearance confirmed by viral culture is seven days, whereas the PCR test continues to detect nonviable (noninfectious) SARS-CoV-2 for a median of 34 days

For several months, experts have highlighted the true cause behind the COVID-19 pandemic, namely the incorrect use of PCR tests set at a ridiculously high cycle count (CT), which falsely labels healthy people as "COVID-19 cases." In reality, the PCR test is not a proper diagnostic test, although it has been promoted as such.

An important question that demands an answer is whether the experts at our federal health agencies and the World Health Organization were really too ignorant to understand the implications of using this test at excessive CT, or whether it was done on purpose to create the illusion of a dangerous, out-of-control pandemic.

Regardless, those in charge need to be held accountable, which is precisely what the **German Corona Extra-Parliamentary Inquiry Committee** (Außerparlamentarischer Corona Untersuchungsausschuss,[1] or ACU),[2,3] intends to do.

They're in the process of launching an international class-action lawsuit against those responsible for using fraudulent testing to engineer the appearance of a dangerous pandemic in order to implement economically devastating lockdowns around the world. I wrote about this in "**Coronavirus Fraud Scandal — The Biggest Fight Has Just Begun**" and "**German Lawyers Initiate Class-Action Coronavirus Litigation**."

FDA Demands Higher False Positives

An interesting case detailed in a January 21, 2021, Buzzfeed article[4] that raises those same questions in regard to the U.S. Food and Drug Administration is its recent spat with Curative, a California testing company that got its start in January 2020. It has since risen to become one of the largest COVID-19 test providers in the U.S.

Curative's most popular PCR test differs from other providers in that it uses spit swabbed from the patient's tongue, cheek and mouth rather than from the back of the nasal cavity.

In April 2020, the FDA issued an accelerated emergency use authorization[5] for the Curative spit test, but only for patients who had been symptomatic within the two weeks prior to taking the test, as the data available at that time showed it failed to catch asymptomatic "cases."

However, the test was subsequently used off-label on individuals without symptoms anyway, and the company has been urging the FDA to expand its authorization to include asymptomatic individuals based on newer data.

In December 2020, Curative submitted that data,[6] showing its oral spit test accurately identified about 90% of positive cases when compared against a nasopharyngeal PCR test set to 35 CT.[7]

The FDA objected, saying that Curative was comparing its test against a PCR that had a CT that was too low, and would therefore produce too many false negatives.[8] According to the FDA, the bar Curative had chosen was "not appropriate and arbitrary," Buzzfeed reports.[9]

This is a curious statement coming from the FDA, considering the scientific consensus on PCR tests is that anything over 35 CTs is scientifically unjustifiable.[10,11,12]

From the start, the FDA and the U.S. Centers for Disease Control and Prevention recommended running PCR tests at a CT of 40.[13] This was already high enough to produce an inordinate number of false positives, thereby labeling healthy people as "COVID-19 cases," but when it comes to Curative's spit test, the FDA is demanding they compare it against PCR processed at a CT of 45, which is even more likely to produce false positives.

> **"Medically speaking, a "case" refers to a sick person. It never ever referred to someone who had no symptoms of illness."**

The FDA's concern is that Curative's test is missing infections and giving infectious people a clean bill of health. However, in reality, it's far more likely that the test is accurately weeding out people who indeed are not infectious at all and rightly should be given a clean bill of health. It seems the FDA is merely pushing for a process that will ensure a higher "caseload" to keep the illusion of widespread infection going.

When Are You Actually Infectious?

A persistent sticking point with the PCR test is that it picks up dead viral debris, and by excessively magnifying those particles with CTs in the 40s, noninfectious individuals are

labeled as infectious and told to self-isolate. In short, media and public health officials have conflated "cases" — positive tests — with the actual illness.

Medically speaking, a "case" refers to a sick person. It never ever referred to someone who had no symptoms of illness. Now all of a sudden, this well-established medical term, "case," has been arbitrarily redefined to mean someone who tested positive for the presence of noninfectious viral RNA.

The research is unequivocal when it comes to who's infectious and who's not. You cannot infect another person unless you carry live virus, and you typically will not develop symptoms unless your viral load is high enough.

As it pertains to PCR testing, when excessively high CTs are used, even a minute viral load that is too low to cause symptoms can register as positive. And, since the test cannot distinguish between live virus and dead viral debris, you may not even be carrying live virus at all.

These significant drawbacks are why PCR testing really only should be done on symptomatic patients, and why a positive test should be weighed as just one factor of diagnosis. Symptoms must also be taken into account. If you have no symptoms, your chances of being infectious and spreading the infection to others is basically nil, as data[14] from 9,899,828 individuals have shown.

Of these, not a single person who had been in close contact with an asymptomatic individual ended up testing positive. This study even confirmed that even in cases where asymptomatic individuals had had an active infection, and had been carriers of live virus, the viral load had been too low for transmission. As noted by the authors:[15]

> *"Compared with symptomatic patients, asymptomatic infected persons generally have low quantity of viral loads and a short duration of viral shedding, which decrease the transmission risk of SARS-CoV-2.*
>
> *In the present study, virus culture was carried out on samples from asymptomatic positive cases, and found no viable SARS-CoV-2 virus. All close contacts of the asymptomatic positive cases tested negative, indicating that*

> *the asymptomatic positive cases detected in this study were unlikely to be infectious.*"

PCR Picks Up Dead Virus for Weeks After Infection Has Cleared

Because the PCR test cannot discern between live virus and dead, noninfectious viral debris, the timing of the test ends up being important. One example of this was presented in a letter to the editor of The New England Journal of Medicine,[16] in which the author describes an investigation done on hospitalized COVID-19 patients in Seoul, South Korea.

Whereas the median time from symptom onset to viral clearance confirmed by cultured samples was just seven days, with the longest time frame being 12 days, the PCR test continued to pick up SARS-CoV-2 for a median of 34 days. The shortest time between symptom onset to a negative PCR test was 24 days.

In other words, there was no detectable live virus in patients after about seven days from onset of symptoms (at most 12 days). The PCR test, however, continued to register them as "positive" for SARS-CoV-2 for about 34 days. The reason this matters is because if you have no live virus in your body, you are not infectious and pose no risk to others.

This then means that testing patients beyond, say, Day 12 to be safe, after symptom onset is pointless, as any positive result is likely to be false. But there's more. As noted in that New England Journal of Medicine article:[17]

> *"Viable virus was identified until 3 days after the resolution in fever … Viral culture was positive only in samples with a cycle-threshold value of 28.4 or less. The incidence of culture positivity decreased with an increasing time from symptom onset and with an increasing cycle-threshold value.*"

This suggests symptomology is a really important piece of the puzzle. If no viable virus is detectable beyond Day 3 after your fever ends, it's probably unnecessary to retest

beyond that point. A positive result beyond Day 3 after your fever breaks is, again, likely to be a false positive, as you have to have live virus in order to be infectious.

Even more important, these results reconfirm that CTs above 30 are inadvisable as they're highly likely to be wrong. Here, they found the CT had to be below 28.4 in order for the positive test to correspond with live virus. As noted by the authors:[18]

> *"Our findings may be useful in guiding isolation periods for patients with Covid-19 and in estimating the risk of secondary transmission among close contacts in contract tracing."*

Testing for Dead Viruses Will Ensure Everlasting Lockdowns

To circle back to the Curative PCR test, the company argues that the test is accurate when it comes to detecting active infection, and as CEO Fred Turner told Buzzfeed:[19]

> *"If you're screening for a return to work and you're picking up everyone who had COVID two months ago, no one's going to return to work. If you want to detect active COVID, what the 'early' study shows is that Curative is highly effective at doing that."*

Again, this has to do with the fact that the Curative spit test has a sensitivity resembling that of a nasopharyngeal PCR set at a CT of 30. The lower CT count narrows the pool of positive results to include primarily those with higher viral loads and those who are more likely to actually carry live virus. This is a good thing. What the FDA wants Curative to do is to widen that net so that more noninfectious individuals can be labeled as a "case."

In an email to Buzzfeed, Dr. Michael Mina, an epidemiologist at Harvard T.H. Chan School of Public Health, stated that using a CT of 45 is "absolutely insane," because at that magnification, you may be looking at a single RNA molecule, whereas "when people are sick and are contagious, they literally can have 1,000,000,000,000x that number."[20]

Mina added that such a sensitive PCR test "would potentially detect someone 35 days post-infection who is fully recovered and cause that person to have to enter isolation.

That's crazy and it's not science-based, it's not medicine-based and it's not public health-oriented."[21]

While the FDA has issued a warning not to use the Curative spit test on asymptomatic people, Florida has dismissed the warning and will continue to use the test on symptomatic and asymptomatic individuals alike. Only Miami-Dade County is reconsidering how it is using the test, although a definitive decision has yet to be announced.[22]

The Lower the CT, the Greater the Accuracy

While the FDA claims high sensitivity (meaning higher CT) is required to ensure we don't end up with asymptomatic spreaders in our communities, as reviewed above, this risk is exceedingly small. We really need to stop panicking about the possibility of healthy people killing others. It's not a sane trend, as detailed in "**The World Is Suffering from Mass Delusional Psychosis**."

According to an April 2020 study[23] in the European Journal of Clinical Microbiology & Infectious Diseases, to get 100% confirmed real positives, the PCR test must be run at just 17 cycles. Above 17 cycles, accuracy drops dramatically.

By the time you get to 33 cycles, the accuracy rate is a mere 20%, meaning 80% are false positives. Beyond 34 cycles, your chance of a positive PCR test being a true positive shrinks to zero.

Similarly, a December 3, 2020, systematic review[24] published in the journal of Clinical Infectious Diseases, which assessed the findings of 29 different studies, found that "CT values were significantly lower … in specimens producing live virus culture." In other words, the higher the CT, the lower the chance of a positive test actually being due to the presence of live (and infectious) virus.

"Two studies reported the odds of live virus culture reduced by approximately 33% for every one unit increase in CT," the authors noted. Importantly, five of the studies

included were unable to identify any live viruses in cases where a positive PCR test had used a CT above 24.

In cases where a CT above 35 was used, the patient had to be symptomatic in order to obtain a live virus culture. This again confirms that PCR with a CT over 35 really shouldn't be used on asymptomatic people, as any positive result is likely to be meaningless and simply force them into isolation for no reason.

PCR Testing Based on Erroneous Paper

In closing, the whole premise of PCR testing to diagnose COVID-19 is in serious question, as the practice appears to be based on an erroneous paper that didn't even undergo peer-review before being implemented worldwide.

November 30, 2020, a team of 22 international scientists published a review[25] challenging the scientific paper[26] on PCR testing for SARS-CoV-2 written by Christian Drosten, Ph.D., and Victor Corman (the so-called "Corman-Drosten paper").

According to Reiner Fuellmich,[27] founding member of the German Corona Extra-Parliamentary Inquiry Committee mentioned at the beginning of this article, Drosten is a key culprit in the COVID-19 pandemic hoax.

The scientists demand the Corman-Drosten paper be retracted due to "fatal errors,"[28] one of which is the fact that it was written, and the test itself developed, before any viral isolate was available. The test is simply based on a partial genetic sequence published online by Chinese scientists in January 2020. In an Undercover DC interview, Kevin Corbett, Ph.D., one of the 22 scientists who are now demanding the paper's retraction, stated:[29]

> *"Every scientific rationale for the development of that test has been totally destroyed by this paper … When Drosten developed the test, China hadn't given them a viral isolate. They developed the test from a sequence in a gene bank. Do you see? China gave them a genetic sequence with no corresponding viral isolate.*

> *They had a code, but no body for the code. No viral morphology … the bits of the virus sequence that weren't there they made up. They synthetically created them to fill in the blanks …*
>
> *There are 10 fatal errors in this Drosten test paper ... But here is the bottom line: There was no viral isolate to validate what they were doing. The PCR products of the amplification didn't correspond to any viral isolate at that time. I call it 'donut ring science.' There is nothing at the center of it. It's all about code, genetics, nothing to do with reality …*
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> *There have since been papers saying they've produced viral isolates. But there are no controls for them. The CDC produced a paper in July … where they said: 'Here's the viral isolate.' Do you know what they did? They swabbed one person. One person, who'd been to China and had cold symptoms. One person. And they assumed he had [COVID-19] to begin with. So, it's all full of holes, the whole thing."*

The critique against PCR testing is further strengthened by the November 20, 2020, study[30] in Nature Communications, which found no viable virus in any PCR-positive cases. I referenced this study earlier, noting that not a single person who had been in close contact with an asymptomatic individual ended up testing positive.

But that's not all. After evaluating PCR testing data from 9,899,828 people, and conducting additional live cultures to check for active infections in those who tested positive, using a CT of 37 or lower, they were unable to detect live virus in any of them, which is a rather astonishing finding.

On the whole, it seems clear that mass testing using PCR is inappropriate, and does very little if anything to keep the population safe. Its primary result is simply the perpetuation of the false idea that healthy, noninfectious people can pose a mortal threat to others, and that we must avoid social interactions. It's a delusional idea that is wreaking havoc on the global psyche, and it's time to put an end to this unhealthy, unscientific way of life.

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