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(data updated to 12 March 2020)

Dear colleagues, dear friends,

after an initial reluctance to write obvious and logical considerations based on the reality of the facts, of the data and statistics that any industry expert could find - and which will be cited here with the appropriate references so that anyone can check and verify - I decided to put in for inscribed these thoughts on the basis of the "principle of authority". My role as a doctor, as a hospital doctor in Intensive Care and the experiences gained in the field in over 15 years of experience (not least the Therapy Intensive Care in Geneva, the Intensive Care Unit of the largest University Hospital in Europe), in light of the general panic and current evolution regarding Coronavirus infection force me to have to intervene.

I know very well that I have already dealt with some of you on the subject and I am very comforted by the idea that the great part of you is aware of the same data (current and past) for which everyday life lives without understanding why there is this sidereal distance with the reality of the facts. Ideological is the one who thinks "my idea is right, it is the reality that is wrong" - and many of us see daily in our professional experience such offensive behavior of the most basic logic. Here one has the impression that - for reasons not always very clear and evident - ideology has taken over, completely detaching itself from reality of facts, from the truth of things.

If in a healthy and respectful world of Aristotelian Logic, the word of an expert would be enough, or how he should say "of one who has Authority", so that everyone can trust themselves according to when declared by the sector expert, in today's mentality the simple presence and Authority of the person is not enough, but you are asked to provide concrete data, figures and evidence that I will also provide, not so much to come to terms with a world that does not believe in the simple Principle of Authority, but because these figures, facts and evidences can allow everyone to make the right distinction with respect to those people who, despite having Authority, it appears that they are making serious valuation errors and are misleading an entire Company.

The main documents from which I draw inspiration for this reflection are available to all experts in the sector and are easily verifiable; there always remains that right attitude of prudence whereby - if things should change - the following assessments would also need to be reviewed. However, that experience remains which reminds us how with the numbers we already have in hand it appears extremely unlikely that the situation may change. If you want to verify in person, in addition to the links that will come from time to time highlighted, you can access the following pages:

- Italian Institute of Health: <http://www.iss.it/en/comunicati-stampa>

- World Disease Control Center (CDC): www.cdc.gov
- UpToDate (controlled access): www.uptodate.com
- New England Journal of Medicine: www.nejm.org

Further data also exist in the World Health Organization, on JAMA and by the Italian CNR; all accessible documents and above all all official documents, issued by those entities that currently have an officially recognized task of collecting and analyzing data.

1. Definitions:

The use of definitions is essential to understand each other, because often it is on the ambiguity of language that one is many misunderstandings and discussions are based; again: it is with a cleverly malicious use of language and of definitions, which carry on the revolutions. So it is important to use language as much as possible univocal and shared, in order to better understand each other.

- Flu: it is a very specific disease, caused by a specific virus, which belongs to the class

Orthomixoviridae¹. Like so many viruses, it is a virus that changes over time, and causes both syndromes para-flu that the real flu²

. Flu is a disease characterized by fever, upper respiratory symptoms (colds, sneezing, sinusitis, etc ...), respiratory symptoms lower airways (cough, phlegm, difficulty breathing of varying degrees), chills and widespread myalgias³.

All these symptoms - albeit to varying degrees in presentation and in severity – define the flu. The real influence. Which can - as we will see later - at high mortality rates even in the young and primarily healthy population⁴.

- Para-flu: it is a different disease from the clinical point of view compared to the flu, because it is not presents all the symptoms that are present in the flu, symptoms that generally have a less intense and more favorable course compared to Influenza⁵.

Para-flu can for example manifest with a little fever, cough and myalgias, or fever, cough and phlegm, or

1 American Academy of Pediatrics. Influenza. In: Red Book: 2018 Report of the Committee on Infectious Diseases, 31st ed, Kimberlin DW, Brady MT, Jackson MA, Long SS (Eds), American Academy of Pediatrics, Itasca, IL 2018. p.476

2 Centers for Disease Control and Prevention. Elevated influenza activity: Influenza B / Victoria and A (H1N1) pdm09 viruses are the predominant viruses.
https://emergency.cdc.gov/han/han00425.asp?deliveryName=USCDC_7_3-DM16978
 (Accessed on January 14, 2020)

3 [https://www.uptodate.com/contents/clinical-manifestations-of-seasonal-influenza-in-adults?](https://www.uptodate.com/contents/clinical-manifestations-of-seasonal-influenza-in-adults?topicref=influence%20search=&=7006&source=related_link)
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4 Shrestha SS, Swerdlow DL, Borse RH, et al. Estimating the burden of 2009 pandemic influenza A (H1N1) in the United States (April

2009-April 2010). Clin Infect Dis 2011; 52 Suppl 1: S75.

5 Russell E, Ison MG. Parainfluenza Virus in the Hospitalized Adult. Clin Infect Dis 2017; 65: 1570.

colds, sinusitis and myalgias, etc ... 6 Para-flu syndrome can be caused by numerous viruses; given that: a) the clinical symptoms are exactly superimposable and b) does not exist a specific therapy, generally defined today as "syndrome" (ie a set of symptoms which can be caused by different causes) and is treated with symptomatic drugs, while in cases more severe or for epidemiological purposes a nasal and pharyngeal smear / swab is performed which allows to clearly define the origin of the virus. In the nasal smear kit, generally yes search "battery" (ie all together): influenza A, B and C, Respiratory Syncytial Virus (VRS), Parainfluenza 1 and 2, Coronavirus (generally 3 or 4 specific strains), Adenovirus, Enterovirus, Rhinovirus, etc ... Last year, in our small Intensive Care Unit, just with these kits a Epidemiological purpose, we found 4 cases of Coronavirus in intubated patients, of whom di consequently the preventive isolation was removed and that they all came out of the Intensive Care alive.

- Infection: an individual defines himself as "infected" when he has the germ (bacterium, virus, fungus, etc ...); Yes defines such after research by bacteriological analysis or special smears. Being infected does not want to say to be sick, because the disease is defined by the presence of an infection by a certain germ that causes damage to the body, which reacts with specific signs and symptoms.

- Virulence: is the aggressiveness of a certain germ (virus, bacterium, fungus, etc ...), that is, the ability to generate a serious illness in the individual who hosts it⁷ ; a germ with high virulence will cause the most infected people will also be sick and will cause many sick people are the serious ones. On the contrary, germs with low virulence are characterized by a high rate of infection without disease and with clinically mild illnesses.

- Virologist: he is a NON-clinical specialist, particularly a student of viruses, but he is not in the field, he is not treats patients as infectious disease specialists do (for less severe cases) and I Resuscitators (for severe cases). The virologist studies viruses and virus-like agents, including but not limited to their taxonomy, disease provocation, their culture and theirs genetica⁸. Virologists are not clinicians⁹. In an easy-to-understand example for everyone, it's like a fish expert who can perfectly describe the characteristics of each fish species, but it is NOT a fish fish restaurateur, who is on the field and knows better than anyone how to cook and serve that fish.

6 Karron RA, Collins PL. Parainfluenza viruses. In: Fields Virology, 5th ed, Knipe D, Howley P (Eds), Lippincott Williams and W ilkins, Philadelphia 2006. p.1497

7 https://dizionari.corriere.it/dictionary_italiano/V/virulenza.shtml

8 Condit RC. Virology principles. In: Knipe dm, Howley PM, editors. Field Virology ', volume 1. Lippincott Williams & Wilkins, 2007; pp. 25-58

9 Journal of Virology, June 2009, Vol. 83, No. 11, p. 5296-5308 Dr. med. Samuele Ceruti v 1.4 - March 12, 2020 4/22

In Intensive Care, virologists are consultants, that is, they express their knowledge in about the characteristics of the virus, but it is then the clinical specialist - the Resuscitator / Intensivist – who decides how and how much to put into practice what the virologist recommends. Such management of Therapy Intensive has been known since at least the 1990s, and it has been shown to reduce overall mortality in intensive therapy

because the Resuscitator brings together all the information he needs as an art -including those of the virologist - but in specific proportion for each different clinical situation. Therefore a virologist can express himself on a virus, but not on the clinical characteristics that this virus involves, because it does not have the appropriate degrees and knowledge to do it. In addition, always remaining in a culinary metaphor, as well as if you went to ask a fish restaurant if prefer meat or fish, the answer would be obvious, it is just as obvious that a virologist (that is specialist of the virus and not of the holistic clinical management of the patient) emphasizes a lot features and therapy on the virus, without seeing the entirety of the problem and managing everything what is around, starting from the patient in his global vision up to the epidemiology and the problems of society. For the fish restaurateur, fish is everything and everything go around it. The reality, however, is more complex and articulated.

2. The scientific evidence:

Coronavirus has been known for several years¹⁰, roughly from the 1950s and was better studied in the 60s of the same century¹¹; it is a ubiquitous virus^{12,13}, which is searched everywhere found, and it is not a seasonal virus^{14,15,16}. Again: it's not a seasonal virus. It can infect or provoke disease throughout the year, even if it is with the cold season that its incidence increases: it ranges from 5%

of all para-flu syndromes during the warm season up to 25-35% during the winter season¹⁷.

The virus is known to mutate cyclically; more or less virulent strains existed in the history of the virus. The Coronavirus is usually not very virulent and generally at least 50% of the non-infected population presents no symptoms^{18, 19}; global mortality for the current Coronavirus - which is often asymptomatic^{20, 21,22} - settles around 1-2%; other studies confirm a global mortality for all Coronaviruses (excluding the latter

10 <https://www.uptodate.com/contents/Coronaviruses>

11 McIntosh K, Dees JH, Becker WB, et al. Recovery in tracheal organ cultures of novel viruses from patients with respiratory disease. Proc Natl Acad Sci U S A 1967; 57:933

12 Zeng ZQ, Chen DH, Tan WP, et al. Epidemiology and clinical characteristics of human Coronaviruses OC43, 229E, NL63, and HKU1: a study of hospitalized children with acute respiratory tract infection in Guangzhou, China. Eur J Clin Microbiol Infect Dis 2018; 37:363.

13 Hamre D, Procknow JJ. A new virus isolated from the human respiratory tract. Proc Soc Exp Biol Med 1966; 121:190

14 McIntosh K, Kapikian AZ, Turner HC, et al. Seroepidemiologic studies of Coronavirus infection in adults and children. Am J Epidemiol 1970; 91:585.

15 Vabret A, Dina J, Gouarin S, et al. Human (non-severe acute respiratory syndrome) Coronavirus infections in hospitalised children in France. *J Paediatr Child Health* 2008; 44:176.

16 Gaunt ER, Hardie A, Claas EC, et al. Epidemiology and clinical presentations of the four human Coronaviruses 229E, HKU1, NL63, and OC43 detected over 3 years using a novel multiplex real-time PCR method. *J Clin Microbiol* 2010; 48:2940.

17 Monto AS. Medical reviews. Coronaviruses. *Yale J Biol Med* 1974; 47:234

18 Prill MM, Iwane MK, Edwards KM, et al. Human Coronavirus in young children hospitalized for acute respiratory illness and asymptomatic controls. *Pediatr Infect Dis J* 2012; 31:235

19 Heimdal I, Moe N, Krokstad S, et al. Human Coronavirus in Hospitalized Children With Respiratory Tract Infections: A 9-Year Population-Based Study From Norway. *J Infect Dis* 2019; 219:1198

20 Rothe C, Schunk M, Sothmann P, et al. Transmission of 2019-nCoV Infection from an Asymptomatic Contact in Germany. *N Engl J Med* 2020

21 Bai Y, Yao L, Wei T, et al. Presumed Asymptomatic Carrier Transmission of COVID-19. *JAMA* 2020.

22 Kupferschmidt K. Study claiming new Coronavirus can be transmitted by people without symptoms was flawed. *Science*. February 3, 2020. <https://www.sciencemag.org/news/2020/02/paper-non-symptomatic-patient-transmitting-Coronavirus-wrong> (Accessed on February 04, 2020) Dr. med. Samuele Ceruti v 1.4 - 12 marzo 2020 5/22 attuale) attorno al 5-8%

current) around 5-8%^{23,24}, where it must be remembered that this percentage is increased by the fact that the virus which resulted in SARS (mortality around 10% of symptomatic patients) and MERS were two Coronavirus. Without these two cases, the overall mortality of Coronavirus is around 2-3%, entirely superimposable on current mortality data.

The cyclical seasonal variation of the 2019 Coronavirus (the so-called CoVID-19) did not generate a virus particularly virulent²⁵: most infections remain asymptomatic²⁶ and among those who get sick

about 80% have few or no symptoms, 14% have respiratory symptoms requiring hospital assessment

and possibly hospitalization, 5% require an ICU stay²⁷; global mortality stands around 2%, although probably given the high rate of asymptomatic carriers the true mortality is more low^{28, 29}, it is estimated about half (between 1-2%). So the data can be superimposed on previous years.



 23 Birch CJ, Clothier HJ, Seccull A, et al. Human Coronavirus OC43 causes influenza-like illness in residents and staff of aged-care facilities in Melbourne, Australia. *Epidemiol Infect* 2005; 133:273

24 Patrick DM, Petric M, Skowronski DM, et al. An Outbreak of Human Coronavirus OC43 Infection and Serological Cross -reactivity with SARS Coronavirus. *Can J Infect Dis Med Microbiol* 2006; 17:330 25 <https://www.uptodate.com/contents/Coronavirus -disease-2019-covid-19>

26 Wu Z, McGoogan JM. Characteristics of and Important Lessons From the Coronavirus Disease 2019 (COVID-19) Outbreak in China: Summary of a Report of 72 314 Cases From the Chinese Center for Disease Control and Prevention. *JAMA* 2020.

27 Kui L, Fang YY, Deng Y, et al. Clinical characteristics of novel Coronavirus cases in tertiary hospitals in Hubei Province. *Chin Med J (Engl)* 2020

28 Report of the WHO-China Joint Mission on Coronavirus Disease 2019 (COVID-2019). February 16-24, 2020. <http://www.who.int/docs/default-source/Coronaviruse/who-china-joint-mission-on-covid-19-final-report.pdf>

29 Bajema KL, Oster AM, McGovern OL, et al. Persons Evaluated for 2019 Novel Coronavirus - United States, January 2020. *MMWR Morb Mortal Wkly Rep* 2020; 69:166.

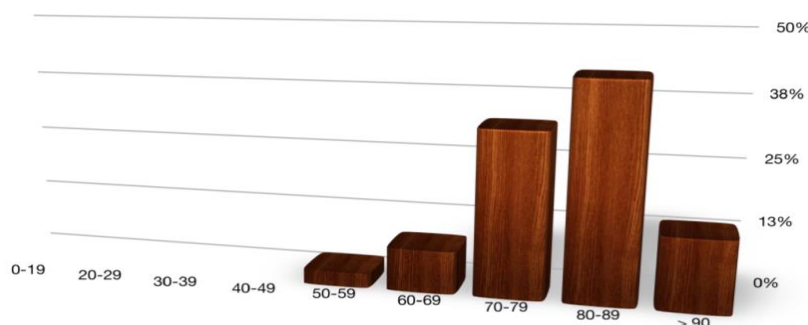
If you look at the distribution of mortality, you notice that this is lower than that of China³⁰ and not

bring people under 60 to death; it is known, also from the data issued by the Istituto Superiore di Sanità (ISS) that coronavirus deaths had at least 2-3 pre-existing cardiorespiratory co-pathologies³¹. TO demonstration that the aggressiveness of the virus is very low: it is not a virus, as many have written, that "spares children and young people", but of a virus that affects everyone, but given the low virulence, it is such as to do not cause illness or mortality in those who are otherwise healthy. It does not lead to death in young people. Example.

Let's imagine we are barrels, and that the more we are affected by chronic pathologies, the more we are full of water. Coronavirus leads to disease by adding just a finger of water to our barrel. What's up?

That who is an empty barrel (that is, is not affected by pre-existing chronic diseases) does not have any clinical consequence of the infection, while instead those barrels that are previously full (i.e. chronically ill) can decompensate with the presence of Coronavirus³²

Tasso di mortalità diviso per fasce d'età fra i morti per COVID-19



Reward is the key word: it means losing a delicate balance in the already altered physiology body. It can be decompensated at heart level³³, at respiratory level^{34,35}, at renal level, etc...-----

30 <http://www.iss.it/en/comunicati-stampa> N° 16/2020

31 <http://www.iss.it/en/comunicati-stampa> N° 15/2020 32 <http://www.iss.it/en/comunicati-stampa>

33 https://www.uptodate.com/contents/approach-to-diagnosis-and-evaluation-of-acute-decompensated-heart-failure-in-adults?search=cardiac%20decompensation&source=search_result&selectedTitle=1~150&usage_type=default&display_rank=1#H3761618367

34 Sethi S, Murphy TF. Infection in the pathogenesis and course of chronic obstructive pulmonary disease. N Engl J Med 2008; 359:2355.

35 Mohan A, Chandra S, Agarwal D, et al. Prevalence of viral infection detected by PCR and RT-PCR in patients with acute exacerbation of COPD: a systematic review. Respirology 2010; 15:536.

The coronavirus deaths happened because of the viral infection - like any other viral infection or

bacterial - has led to decompensation on cardio-respiratory level of people already sick and at risk of death in case of failure³⁶. The reason why patients with ischemic heart disease, hypertensive and diabetes mellitus are more at risk (among other things more than chronic respiratory diseases) and is linked to myocardial damage important (it is not clear to date whether it is a direct myocardial injury or the result of one massive inflammation) which is associated with damage to the pulmonary interstitium. The flu and the virus of flu (Orthomixoviridae) instead, in addition to bringing to death the already sick people through the same mechanism, presents a much greater virulence: cases of young adults, even healthy ones, who are known are well known they fall seriously ill with very severe viral pneumonia and a high mortality rate^{37,38,39}. ISTAT data on the flu mortality in 2019 was around 8,000 cases in Italy^{40,41}; It is true that ad personam il Coronavirus would seem more deadly (1-2% vs 0.003% of the flu as reported by the Control Center Atlanta World Disease⁴², remembering that flu can also have a more trend lethal^{43,44}), but the spread of the flu virus every year is such that in the end the social damage to the total death toll is significantly higher for influenza ^{45,46} than for other diseases⁴⁷.

36 Sapey E, Stockley RA. COPD exacerbations . 2: aetiology. Thorax 2006; 61:250

37 Thompson WW, Shay DK, Weintraub E, et al. Influenza-associated hospitalizations in the United States. JAMA 2004; 292:1333.

38 Su S, Chaves SS, Perez A, et al. Comparing clinical characteristics between hospitalized adults with laboratory -confirmed influenza A and B virus infection. Clin Infect Dis 2014; 59:252.

39 <https://gis.cdc.gov/GRASP/Fluview/PedFluDeath.html>

40 <http://www.assis.it/dati-istat-sui-decessi-da-influenza/>

41 https://www.istat.it/it/files//2011/02/Lista-indicatori_giu2019.pdf

42 <https://www.cdc.gov/flu/about/burden/2017-2018.htm#table1>

43 Presanis AM, Pebody RG, Paterson BJ, et al. Changes in severity of 2009 pandemic A/H1N1 influenza in England: a Bayesian evidence synthesis. BMJ 2011; 343:d5408

44 Morens DM, Taubenberger JK. Influenza Cataclysm, 1918. N Engl J Med 2018; 379:2285

45 <https://www.epicentro.iss.it/influenza/flunews#vir>

46 <https://www.cdc.gov/flu/about/season/flu-season.htm>

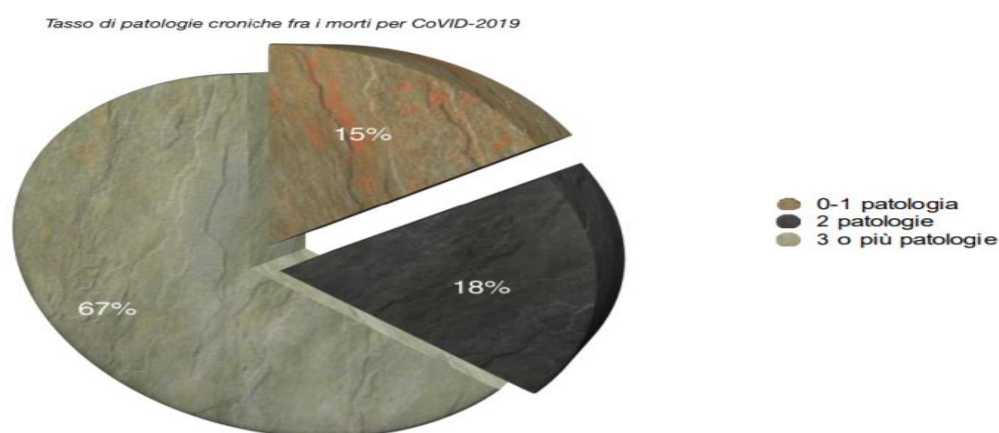
47 <https://www.cdc.gov/flu/about/burden/2018-2019.html>

48 [https://www.letemps.ch/suisse/didier-pittet-covid19-ny-aucune-raison-salarmer?](https://www.letemps.ch/suisse/didier-pittet-covid19-ny-aucune-raison-salarmer?utm_source=linkedin&utm_medium=share&utm_campaign=article)
[utm_source=linkedin&utm_medium=share&utm_campaign=article](https://www.letemps.ch/suisse/didier-pittet-covid19-ny-aucune-raison-salarmer?utm_source=linkedin&utm_medium=share&utm_campaign=article)

49 <http://www.iss.it/en/comunicati-stampa> N° 15/2020 50 World Health Organization (2015) - <http://www.who.int/bulletin/volumes/86/6/07-043471/en/>

Those data are also confirmed by epidemiological experts in the sector (such as Prof. Pittet, professor at HUG and expert dell'OMS⁴⁸).

If the data provided by the Istituto Superiore di Sanità⁴⁹ intersect with the data provided by the World Organization of Healthcare on the average survival of the population in Italy⁵⁰, the following can be noted: for the men the average life expectancy is 80.5 years compared to an average death age for CoVID-19 of 79.9 years; for women the average life expectancy is 84.8 years compared to an average death age for CoVID-19 of 83.4 years. This means that men who die of Coronavirus infection die when already in average tend to die (average life mortality of about 6 months is anticipated) the same also applies to the female population (about 1 year and 4 months). If we take the data seen before on the presence of at least 2-3 co-pathologies⁵¹, an extremely clear fact derives from this: those who die are elderly, those who have more die among the elderly cardio / respiratory co-pathologies⁵². But still: those who are healthy and those who are young do not die of Coronavirus.



Spettanza media di vita nella popolazione italiana senza CoVID-19 (grigio scuro) e con CoVID-19 (grigio chiaro),

Spettanza media di vita nella popolazione italiana senza CoVID-19 (grigio scuro) e con CoVID-19 (grigio chiaro),



51 <http://www.iss.it/en/comunicati-stampa> N° 15/2020

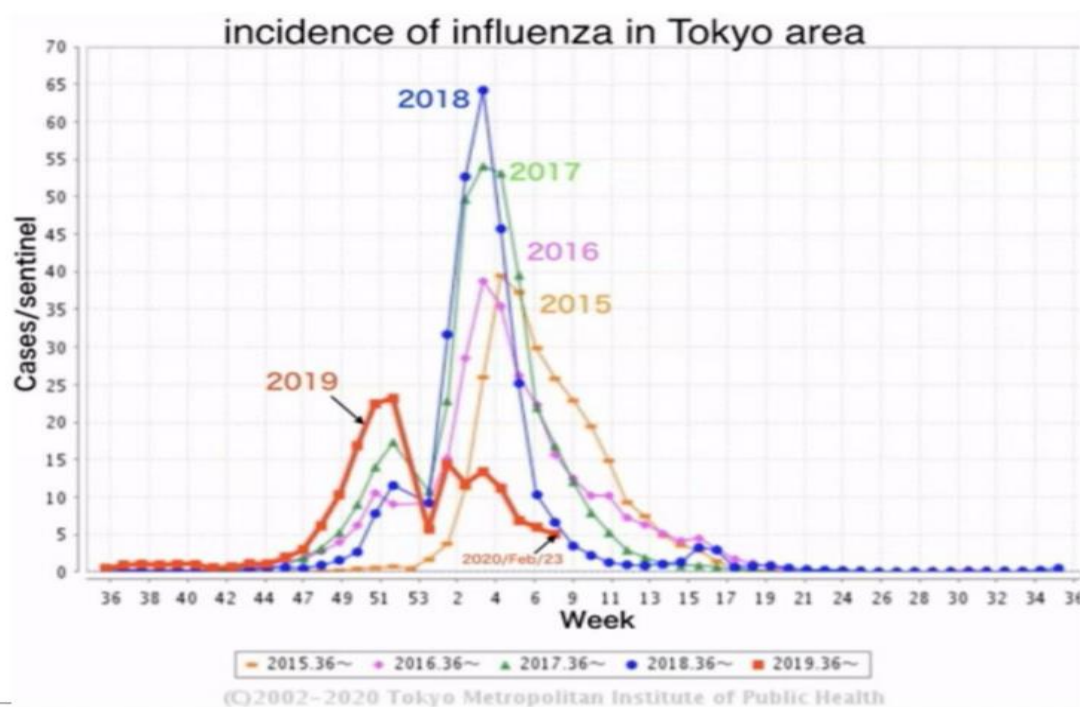
52 Ruan et al, Intensive Care Medicine 2020

3. The problem exists:

After all these data, I would like to underline an important point. The problem of Coronavirus infection it exists, but like every year. It infects people and brings to death the weakest and already sick people. Like all years. So, it is right that preventive measures should be put in place that they try to preserve these people, for example: wash your hands, use disposable tissues, respect the norms

rules of personal and collective hygiene (cleaning of premises, etc ...), if you are not feeling well and you are in contact with more fragile people, temporarily reduce contact with them (and not with people who are not fragile), etc ... Like every year.

Hence, it is true that elderly and already sick people must be concerned and careful because they are at risk of infection and disease, with a higher risk of death. Like all the years. Even last year, even that before, even the one before. Every year with the arrival of the cold season (which this year has been climatically delayed compared to last year) flu-like viruses and individuals come every year more fragile they get sick. Like all the years. Generally, the appropriate tests are not performed on the carpet etiological⁵³ (i.e. research of the cause) because with the exception of influenza A (where there is an antiviral specific), for the other cases there is no specific etiological therapy. So swabs generally do they perform purely epidemiological purposes, to estimate the rate of annual infections (among other things, we have seen that Coronavirus generally gets to account for up to 25-35% of viral respiratory infections in periods high disease rate) and for statistical reasons. All years. Like all the years.

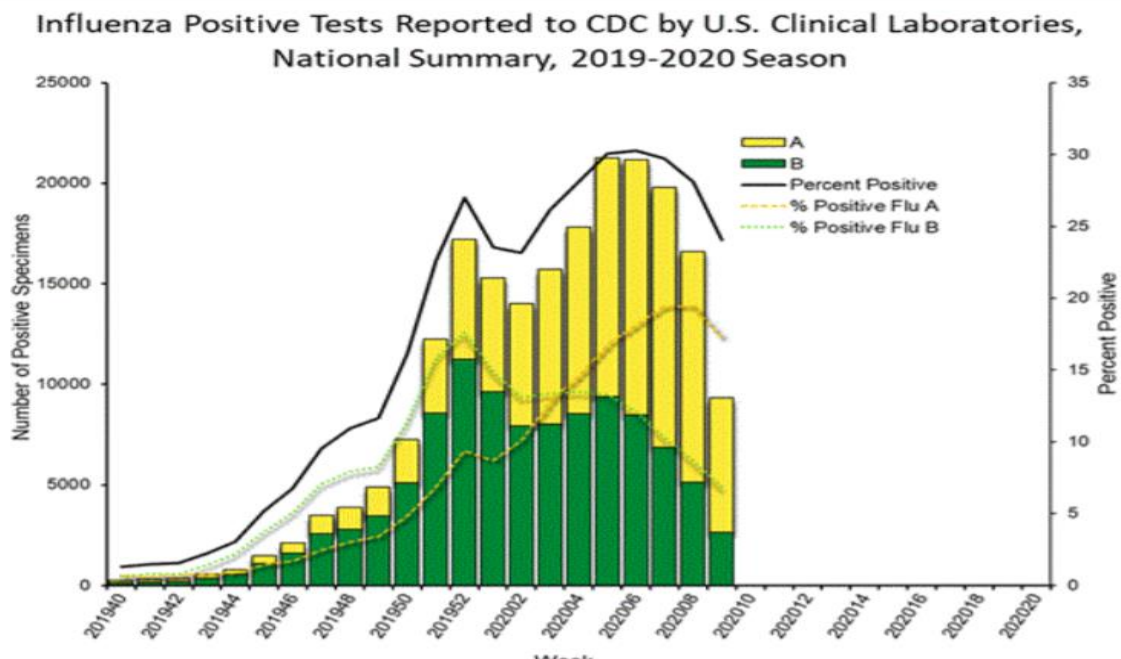


53 [https://www.uptodate.com/contents/avian-influenza-a-h7n9-epidemiology-clinical-manifestations -and- diagnosis?search=influenza%20mortality&topicRef=7006&source=related_link](https://www.uptodate.com/contents/avian-influenza-a-h7n9-epidemiology-clinical-manifestations-and-diagnosis?search=influenza%20mortality&topicRef=7006&source=related_link)

There is an extremely suggestive data - which still requires time to be definitively confirmed - to be analyzed. The flu cases were overlaid each year, week by week.

Generally there is an initial increase in disease around late November - early December, which then it "explodes" with January and February. This year - the data shown in the graph is Japanese, but it is

superimposable in China as in Western countries (diagnosed by the CDC in Atlanta) 54.55 - the second largest peak influence was not found, while this time the "CoVID19 peak" was found. Why?



It is important to stress how influence rates are determined; when a patient presents a respiratory syndrome (of different severity) suggestive of a non-bacterial infection, in the defined period by the public flu epidemic authority, there are two great possibilities based on the severity of the disease.

- In case of severe illness - requiring ICU admission - one is almost always performed I crawl a sample aimed at finding the cause, in particular of the influenza A towards which there is one

proven therapy (in case of severe disease). The search for other viruses that often "accompany"

influenza A is not always sought - even in the case of ICU hospitalization, because they are expensive tests that do not lead to a "change of progress", since there is no therapy specific ethology, but only supportive therapy. These tests are performed for any purpose Epidemiological.

54 <https://www.cdc.gov/flu/weekly/weeklyarchives2019-2020/data/senAllregt09.html>

55 <https://gis.cdc.gov/grasp/fluview/fluportaldashboard.html>

- When, however, non-bacterial respiratory disease is mild or moderate, it does not always come researched the flu cause - because it does not determine a change of therapy, but is only for epidemiological issues, with sustainable economic investments generally only from hospitals university - but a "probable diagnosis" or "presumed diagnosis" is given, regardless of etiological nature (adenovirus, coronavirus, picornavirus, paramixovirus, etc ...).

This year, with research and the possibility of identifying CoVID19 Coronavirus, the flu could be so reduced because - I repeat it is a hypothesis that will be confirmed with the passage of time in the next weeks - many cases that the previous years would have been defined as "flu" are re-pigeonholed into a more correct diagnosis of Coronavirus, exposing an alleged diagnosis and attributing better the etiology of this disease. Result: the peak of rapid influence increase disappears, the appears Coronavirus rapid increase peak. But - hence the definition "it's like every year" - the system it appears aggravated by an increase / peak of a different etiological nature, but quantitatively Stackable. It's not called influence - which makes many more but less social fear - it's called CoVID19, which currently it causes fewer deaths but more fear. Coronavirus virulence and mortality are not of concern (as a percentage and how much distribution by age, as we have seen previously); and we have seen mostly hit those patients who - in a completely non-specific way - could have died of another infection viral, bacterial, etc ... In addition, the average age of death is completely superimposable on the average survival (for male and female) that normally occurs⁵⁶. And normally you die just at that age, because statistically a certain number of pathologies accumulate for which with aging organs, it is the age that an infectious respiratory syndrome more easily leads to decompensation with poor ability to recovery. Like all the years. The problem must not be denied - because it would not correspond to reality; but it must be said and underlined that it is like all the years ⁵⁷.

4. Chapter "Intensive care"

Another fact that does not correspond to reality is that the Italian Healthcare System "is collapsing" or effective sentences similar. Circulating data (updated to 6 March 2020 - 366 cases in ICU in Lombardy compared to 900 posts read total) ⁵⁸ show that: a) with the arrival of flu syndromes all Intensive Care (like all years) have an increase in the occupancy rate of beds. All. For all respiratory infections. Therapies Intensive that were initially full (in the context of Coronavirus infection) are 4: four. IS make more noise - among other things - because they are led by notoriously important and "weight" industry experts internationally; with a wide and worldwide resonance. But full and intensive ICUs there were immediate overloads 4: four (civil protection data as of 8 March 2020⁵⁹).

In these ICUs, and then extended to other neighboring ICUs, there was a sudden and rapid increase (this is the period) of cases of respiratory failure from CoVID-19, in numbers such as to overcome the saturation of the system, taking into account that in Italy there is a rate of total beds

⁵⁶ World Health Organization (2015) - <http://www.who.int/bulletin/volumes/86/6/07-043471/en/>

⁵⁷ <https://www.linkedin.com/feed/update/urn:li:activity:6630761183215521792/>

⁵⁸ <https://github.com/pcm-dpc/COVID-19/blob/master/schede-riepilogative/regioni/dpc-covid19-ita-scheda-regioni-20200308.pdf>

of about 3 beds / 1,000 inhabitants (compared to Germany with 8 beds / 1,000 inhabitants, France 7 beds / 1,000 inhabitants, Switzerland 6.5 beds / 1,000 inhabitants), therefore the increase in cases that occurred quickly and suddenly, encountered an already saturated and bone-reduced situation -

regardless of CoVID-19. So the problem is not that of having a deadly disease by exterminating the population indiscriminately, leading to millions and millions of deaths (data not true), but that there is a rapid increase in ICU patients - in a numerically reduced and saturated system - with a mortality in numbers that is currently well below that of other diseases that constantly they scourge the population with dangerously higher numbers; therefore the answer is not understood in restrictions and panic that is generated and constantly fed. The social response is extremely exaggerated with respect to the problem, which is not denied, but which must be contextualized.

In Italy came the suggestion from some colleagues of known clinical experience to manage these respiratory failure immediately proceeding to Gold-Tracheal Intubation (IOT), by-passing the normal management through Non-Invasive Ventilation (VNI), for supposed reasons of improvement of the pathology - data still to be demonstrated⁶⁰ (technically we speak of "expert opinion"); NEJM and JAMA not they still demonstrated a real survival benefit from this multiple therapeutic approach aggressive. The ESICM (European Society of Intensive Medicine) supports and suggests this possibility⁶¹; there discussion is a bit technical, but for completeness it will be exposed. Given that these patients present a extremely high lung compliance despite interstitial lung injury (which he explains partial respiratory failure without compromising ventilation and increasing pCO₂), one non-invasive ventilation cannot afford ventilation at high PEEP values (diaphragmatic work would be such that it cannot be objectively and subjectively tolerated by the patient) and above all a Tidal Volume control because the patient is awake and compliant, therefore increasing the VNI time increases the risk of lung damage from ventilation. We therefore have to proceed with sedation, IOT, high PEEP values and low Tidal Volume (4-6 ml / Kg), any permissive hypercapnie with pH up to 7.3 (even if good compliance never seem to lead to this problem) and curarization, with titration of the PEEP according to PV-tool rather than with the use of pulmonary ultrasound (both in the choice for titration PEEP and / or pronation). It is undeniable that avoiding the VNI to proceed with the IOT increases dramatically the need for immediate ICU admission; therefore a medical decision was made that at the time it must be considered suggestive, but still at the expert opinion level, not supported by scientific data strong that this really benefits - resulting in an increased need for Intensive Care, necessity that with the "usual" management would have increased but not to the values indicated. To put it in simple way: medical recommendations were given for immediate management from Intensive therapy, which inevitably involves increasing ICU admissions without being able to stratify patients - as usually - according to the severity of disease, in the different wards, thus leading to an increase in cases of Intensive Care, in an already saturated system.

59 <https://github.com/pcm-dpc/COVID-19/blob/master/schede-riepilogative/regioni/dpc-covid19-ita-scheda-regioni-20200308.pdf>

60 https://www.nejm.org/doi/full/10.1056/NEJMoa2002032?query=featured_home

61 www.esicm.org/blog - interview with Dr. Lowell Ling

Yet. Health policy management when Intensive Care is full - an event that already is normally occurred several times in recent years, typically with the arrival of para-flu syndromes - is to proceed with the immediate transfer of transportable patients to other Intensive Therapies less severe. The truly serious sufferers, regardless of the cause (can be pneumonia from flu, typical bacterial pneumonia, Legionella pneumonia, etc ...), those to be understood under ECMO or that pronated, must remain in the specialized intensive care. For two reasons: a) why the staff that it is more formed guarantees a greater survival of the patient, b) because it moves the most serious patients its mortality increases. Those "less serious" (defined as such according to the criteria by the Therapy Societies Intensive - even if serious patients always appear to the eyes of non-experts) they must be moved to other Intensive Care - also to other cities - so as to relieve the overloaded Clinical Unit. Yeah it is always done everywhere, internationally as in Italy; also at the University Hospital of Geneva é happened often. It is therefore foolish and absurd to suggest that all hospitals are "collapsing" when these are some Intensive Therapies, with a management of the problem (which can be defined as "usual" in its exceptionality) already codified.

5. Epidemiological containment action:

If the premises for this "alarm" are not there because they are based on data superimposable on the years previous (see the previous points listed briefly and the links shown), it appears even more ridiculous handling of the problem. Both in management and especially on the "after", on the consequences that we must follow - if we want to be logical - the actions we take.

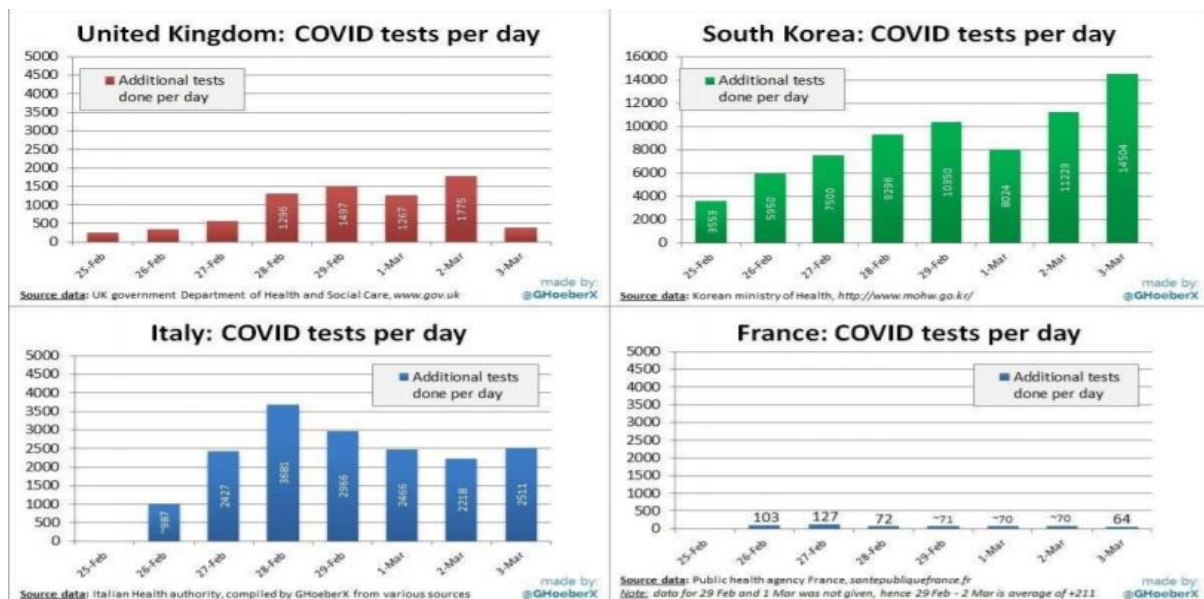
a. Intercontinental HUB.

China is not geographically close and the best way to reach it quickly is through the use of the plane. The most populated international airports and with which China has the greatest economic relations are Frankfurt (D), Munich (D), Heathrow (E), Paris (F), Schiphol (NL), Copenhagen (DK) and then come Italian airports⁶². Therefore, statistically, the largest number of infected people (which is not equal to being sick, as we have seen before) constantly travels to these cities and not to Italy⁶³. To think and to suggest that there is a direct metro line Wuan -> Lodi -> Codogno and that it is Italy currently the problem, while in the rest of Europe - which has the greatest commercial traffic and personal with China - nothing happens and everything comes from Italy - among other things, without anyone Italian housekeeper tries to defend his country, on the contrary, by continuing to have a attitude of confirmed guilt, does not correspond to reality. It is not likely.

The more time passes, the more one is also finding that some nations, such as France, are not by carrying out a minimally adequate number of swabs to monitor epidemiologically the infectious situation. The result is an apparent absence of the problem, when there is evidence showing as infection rates are likely to be extremely high (the possibility of approx. 450,000 infections in France alone) ⁶⁴.

62 Burghouwt et al., 2003; Burghouwt and de Wit, 2005

63 ⁶³ <http://www.ub.edu/graap/intercontinental.pdf>



b. Spread of the virus

Coronavirus, like all years and like all respiratory viruses, is present throughout Europe (beyond

to be present all over the world^{65, 66}). Other states have not adopted containment policies as well

as stringent as in Italy. Therefore - while in Italy it is thought that quota of territories can serve - i

different Mr. John from England, M. Le Corbusier from France and Herr Heinz from Germany can

come for a ride - for work or for personal reasons - being able to infect and / or be infected without any problem. Not that infection is a problem in itself (see before), but the idea of having "red areas"

when the passage is guaranteed at the entrance / exit, it is at least incomplete.

The current idea, then, of closing entire territories is even more ridiculous^{67, 68}. Let's take an example. There is one room full of ants; ants that you want to eliminate. In addition to the fact that the room is not

64 <https://www.maurizioblondet.it/il-viros-degli-altri/>

65 <http://www.salute.gov.it/portale/nuovocoronavirus/dettaglioContenutiNuovoCoronavirus.jsp?lingua=italiano&id=5338&area=nuovoCoronavirus&menu=vuoto>

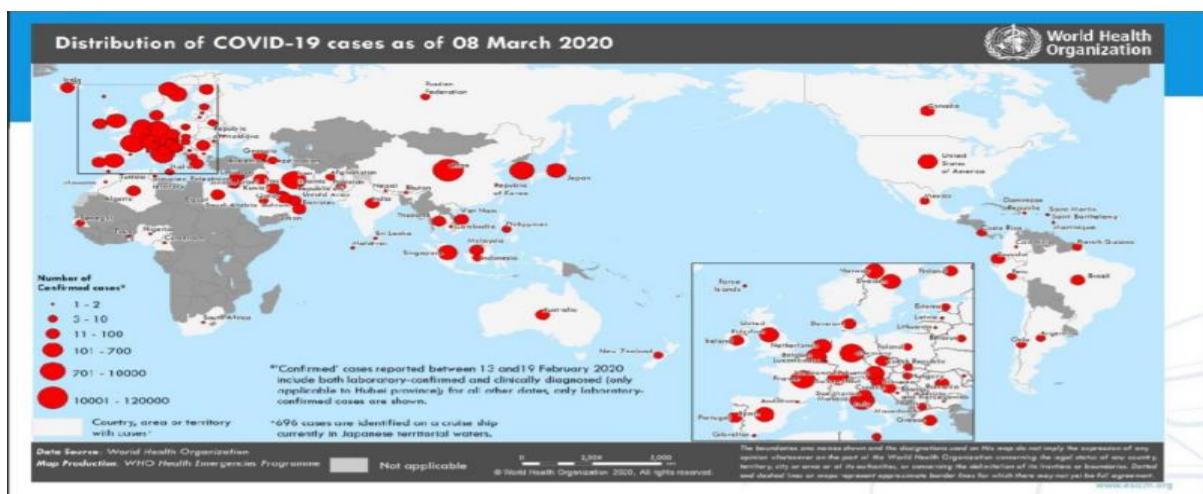
66

67 Rose G (1992). The strategy of preventive medicine. Oxford University Press, Oxford

68 68 Lewis et al. Mastering Public Health. A postgraduate guide to examinations and revalidation. Royal Society of Medicine press. 2014

completely closed (it is a passage room through which one must pass and it is also necessary to open the door) door from time to time for urgent and postponable issues), imagine that it will be closed.

Completely. Sooner or later the ants will die, right? Well. And then? At some point it will be necessary to reopen. Today, tomorrow or the day after tomorrow; on April 3 or May 24. But it will be necessary to reopen. And the ants they are out there, because the virus is not seasonal and is everywhere. Therefore an isolation makes no sense: o you carry on ad libitum (which is impossible) or at some point you have to realize that the virus - among other things, not serious, not fatal, etc ... - it is everywhere. An area is "reclaimed", if one succeeds, the virus can enter again undisturbed. Who thought of isolation (thinking well) clearly DOES NOT know the basics of Epidemiology^{69,70}



Chiudere l'Italia quando il virus è ovunque?

A further technical consideration. When there are epidemics, there are two great health strategies published to stem infectious diseases. They can be well exemplified by the flock metaphor.

- 1) The strategy of uprooting: consists in identifying the black sheep that could infect the others and isolate it so that the disease does not spread. Here the disease is prevented from spreading. This is the strategy used by China. In order to use it, you need some conditions: a strong authority, a system of sanctions, a capillary control, etc. China seems to have made it, but it is a dictatorial regime.

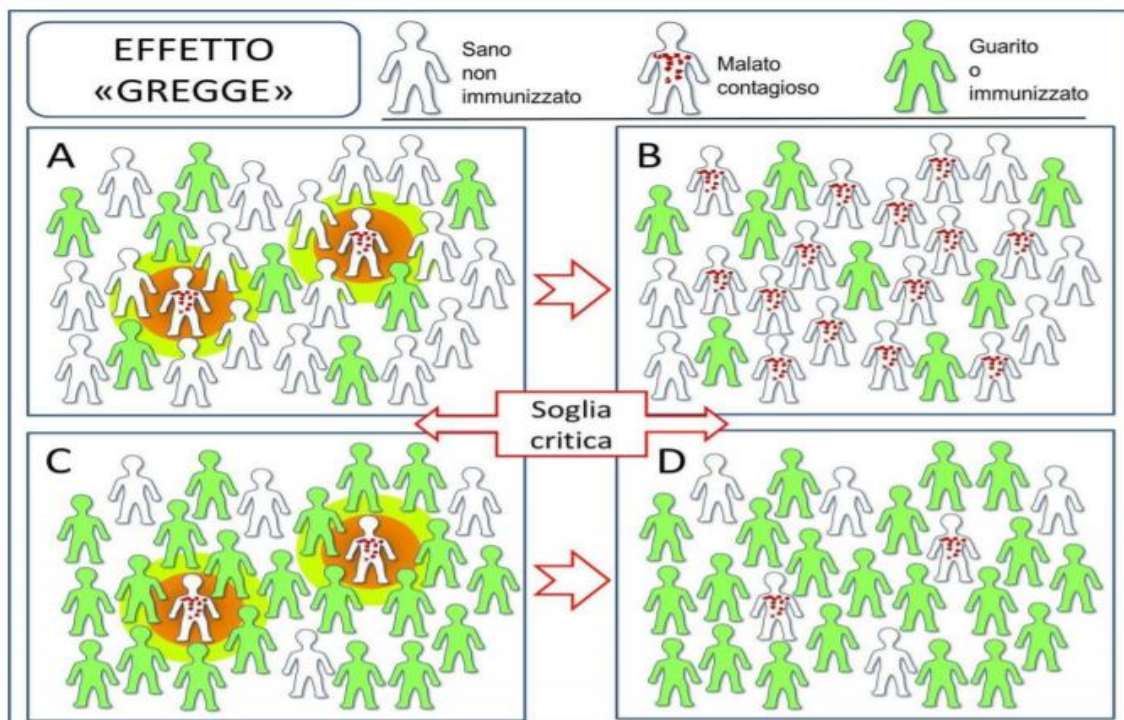
Italy is trying to use the same method, but with little chance. The strategy of uprooting it can work - in addition to the political requirements mentioned above - if you do not have around the "Italy" outbreak disease; the system is to "contain" the disease in an enclosed space until its infection is reduced to 0. In the light of the WHO graph above, it is impossible to bring the infections to 0 - among other things without leading to

69 <https://www.bmj.com/about-bmj/resources-readers/publications/epidemiology -uninitiated/11-outbreaks-disease>

70 https://samples.jblearning.com/0763728799/28799_CH02_023_060.pdf

post-infectious immunization the population - thinking that when the closed system reopens, the infection is around again, being able to re-enter the system that is reopened.

- Then there is the strategy of herd immunity; is to allow the disease to spread governing its propagation. Here the important things are two: be careful that the infection does not reach risk categories (hence the ban on contacts with people at risk) and make sure that do not go too fast to avoid sending the health system into distress, in this case Intensive care. Here we want the disease to spread, indeed, the more it spreads the better. But for two conditions: that it spreads among non - vulnerable people and that it spreads at a manageable pace for the sanitary system. Why do you want it to spread? Because the more people there are healed, the more the group becomes immune, that is, the disease no longer finds people to "stick" to; like this, after one first phase of social protection, the vulnerable are also protected. The purpose in this case is reach a high number of infected / healed so that there begins to be a protective effect thanks to the group; keep in mind that probably many of us have already done it without realizing it and I am already immune.



Switzerland has adopted this second strategy, because epidemiological and scientific data say that the disease is mild in non-risk categories, which if complications come these can be managed by hospitals and especially by Intensive Care (if they are not overloaded), and that to the point where

we are worldwide it is impossible to eradicate the virus totally, therefore we have to "tame it". The measures issued at the Swiss level therefore serve to slow down the infection (to prevent the health system go into distress) and protect vulnerable people. Well to reduce the share of social contacts without that personal freedom - like going out alone, even just for a walk - can be affected: if you drive alone, away from everyone, following the normal rules of personal hygiene, you won't, it does not infect anyone or get infected by anyone.

c. Feedback and consequences

Another least ridiculous fact is the continuation. Let's assume that there are parameters - then you can discuss whether they are adequate or not - which allow to understand if the measures taken are good or not.

What are the consequences? The possibilities (I repeat: net of evaluating which parameters to consider) are: the method works, the method does not work.

- The method works: what to do with coercive measures? If it works the logical consequence is that

we must continue like this.

- The method doesn't work: what do you do in these cases? 1. you abandon everything, 2. continue like this, 3. Yes exacerbate coercive measures. In the first case it is shown that it was all a farce (if I block everything with 200 infected and unlock everything with 4000 infected, then what I have undertaken before did not make sense); in the second case there is no logical consecutive (if it does not work, they cannot continue like this), or I tighten the measures.

The net result is: if it works this way (for how much then? See first ...), if it doesn't work unexpectedly measures. In no case is it expected to "let go". But when will it happen - out of understanding that the initial management of the problem is incorrect - it will be shown that all measures are not useful, because they are not.

d. Parameters

What parameters to use to monitor evolution? The number of infected? Beyond that this does not match to illness (see earlier), let's imagine the ridiculous starting from the impossible: in 3 weeks "finally" yes they reduce the infected to 1,000. Do we unblock coercive measures? Theoretically not, because with 1000 you can still spread the virus. In 4 weeks we have gone down to 500 infected. Do we unlock the measures? Theoretically no, because when there were 500 we ran for cover. We are 40 infected in 6 weeks, will we unlock?

Not even, these could be the source of a "new epidemic", etc ... down to 0 (assuming that it is possible arrive). If, however, under a certain "quota" (any), it is decided to remove the coercive measures, any number both (e.g. 500), this shows that what was done before made no sense.

The evolution of the disease and what has been undertaken will show the absurdity of what has been done. It is based on erroneous assumptions and we continue with equally erroneous and dangerous choices, socially, economically on very large scale. You do not have a completely "closed" system (it would be impossible) and even if this is could be obtained, at reopening the outside world would be in the same condition. Moreover, to remember, based on the fact that he falls seriously ill to death, only the elderly person and with comorbidities. The others may be asymptomatic or with few symptoms.

A very brief reflection therefore of how epidemiological measures are against Aristotelian logic and the more basic rules of epidemiology: the disease does not originate from Italy - but is passed on as such, even from those who would have every interest in defending the Nation - the monitoring system has none utility (the actual infection rate is largely

underestimated because many people are asymptomatic, see the continuous media tam-tam of those who say: "I'm infected, but I'm fine") and taking charge of the problem trying to close everything (which is impossible) without thinking about how to get out of the problem, shows that he wants to think well of a masterly naivety and ignorance, to think badly makes you think instead of a desire to want to make Italy sink socially, economically and morally.

6. Quid prodest?

This is the most speculative field, on which I have no objective data to present, even if I have ideas personal. Certainly, many government and non-governmental bodies profit from it, as recognized locally World, which can acquire "rights" and an Authority given to them by not knowing which Authority superior for which the WHO can lay down laws trans-nationally. So, governments can say, "don't shake hands ", tomorrow they will say " don't wear yellow "and the day after tomorrow they will say" when you turn off the music everyone has to sit down "... In this regard, the Council of Europe (!) has made numerous questions parliamentarians summoning and denouncing the WHO on suspicion "procured pandemic alarm", see attached video documentary⁷¹.

The "sense of panic" that is generated and which, among other things, arises from the acquisition of information mediated by third parties and not immediate. Our daily reality is not exposed to a danger of this genre is not seen and nothing is found. But the danger made perceived by those who "depend" on them means for acquiring information is such that one accepts not to dress in purple, not to go to visit the grandparents sick, of not being in more than 4 people outside (and who has a family of 5, 6, 7 people?), greet each other with the fascist greeting because the handshake is abolished. All above all based on objective data mentioned above, which do not justify such conduct at all. Indeed, they actually generate a dangerous previous, because nothing prevents you from taking the real data next winter - those that show how the flu causes more death - and they are used to condition people even more. Dangerous.

- Why close schools, when data show that children and young people do not die of disease?
- Why encourage staying at home - often with grandparents (who may be more at risk, even if like all the years) - when the data show the opposite?
- Why block everything when the mortality rates are the same as those of the population "not CoVID-19 "?
- Why block everything and everyone when who dies is who is already sick and softened by 2-3 chronic copatologies?
- Why give the idea that Italy is the country, when the virus is already everywhere?
- Why declare the "pandemic" (and then encourage the implementation of sanctions, including those of a character economic), that is to say that the virus is everywhere, but at the same time isolate an area?
- Why does a state react by isolating everyone, while other states do not use such restrictive policies?

⁷⁰ Youtube: Le pandemie prima del Coronavirus - https://www.youtube.com/watch?v=m6bEITVU_ic

7. No to disobedience:

To this I would like to reiterate an extremely important concept. All this information has no intent "revolutionary" or to want to stimulate the subversion of the normal order and the Authority in charge of control and management of public affairs, including healthcare. As long as the Hospital Management intends to take these measures, it is our job to fulfill what is required of us and do it in a way that collaborators follow the indications that are given. At the same time, data is required

they know each other so that - while remaining obedient - they can begin to understand and make it understood that measures taken are not based on objective data, pending that this situation may change.

Therefore, for those who consider this draft document useful, it is extremely important to talk about it and spread the links to original data so that we can counteract knowing the truth, the reality of things, without ideologies.

I give a concrete example. This weekend while I was on call as an emergency doctor pre-hospital, I am contacted by a person who asks me how to act for his 87-year-old dad, who has fever up to 39 ° C, with coughing and which currently (ipse dixit) "has difficulty breathing". The answer and the management it was more correct to send a crew on site, already equipped with PPE protections as required by the Law, take the parameters and in the face of the objectivity of a fever with desaturation proceed - as in usually, as every year, as every day, summer as winter - to administer oxygen, to administer intravenous paracetamol and to transfer the patient to the emergency room. Like all the years, because the problem is always there. With the addition of having to disguise "as for carnival" (and this goes said and reiterated, calming and reassuring everyone, because reality is objective and the data are clear) because, although it makes no sense and there is no need to proceed in this way, though aware of this, the Authority has thus established. In the meantime, you obey, looking in the appropriate ways and times to show the original sources, the data of the evolution of the disease, with the hope that the Authority – acknowledged of the objectivity of the data - proceed with the removal of these coercive measures of different degrees and nature.

8. A legitimate concern?

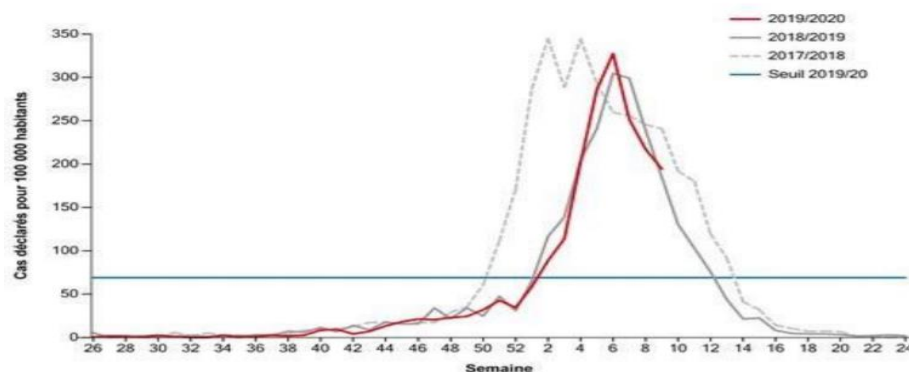
A fact that must make us think, but against which the solutions adopted are not useful anyway, is what the number of "immediate" patients appears to exceed the capacity of the health system of each nation. This appears in Italy in part due to the high population rate with a higher average age than the rest of the population of other nations⁷². The basic problem - assuming it exists - since as we have seen 5% of infected people require Intensive Care (between 5-10% in Italy) and there are no deaths among people not hospitalized in Intensive Care (deaths that are patients with an average age of life around 80 years, affected by multiple pathologies, etc ...), it has no logical link with the measures taken.

Some justify these measures with the idea "to slow down the spread of the virus, so that the health system can take care of the sick in an appropriate manner over two to three months

71 [https://www.iss.it/en/comunicati-stampa N° 17/2020](https://www.iss.it/en/comunicati-stampa/N°17/2020)

72 <https://www.tio.ch/ticino/attualita/1423734/cantone-ticinese-contagio-sanita-contagi>

"73 but a) the measures taken have not been taken were undertaken with this idea (the idea would be to "reduce the infection below a 1: 2 ratio to eradicate the virus "- the eradication strategy already discussed, whose important limitations we have mentioned in a situation of almost total diffusion) and b) they also do not correspond to the greater data epidemiological we have in progress (I refer to the study published in the New England Journal of Medicine⁷⁴ regarding Wuan data - which among other things appear to be more severe than those in Italy), in particular in about the outcome of the disease⁷⁵. It is also interesting to note how the use of quarantine measures aimed at containment of the disease, on the flu - which has a transmission modality similar to CoVID19, not yes has been shown to be helpful in reducing the disease peak^{76,77}.



Let's see the data. The patients were stratified into two groups: those clinically severe already at the time of presentation in the Emergency Room (n. 173) and non-severe ones (n. 926); meanwhile we see that clinically only 1/10 of patients show severe symptoms from the beginning, while most have no signs of disease severity. Let's see the evolution. Among patients initially assessed as "non-severe" the rate of ICU admission is 2.4% (ie 22 patients out of 926), while among severe patients it is 19.1% (in numbers absolute, it is 33 patients out of 173), with a median hospitalization of about 11 days between the first and 13 days between seconds. Among those who present with severe symptoms from the beginning, mortality is 8%, while among those with mild symptoms (926 in the first group), mortality is 0.8%. That is who is very badly dies, who is not very bad dies little. And among the dead there are the characteristics mentioned in the first points (elderly, with co-pathologies, etc ...), also confirmed by the NEJM population. Overall mortality, putting the two groups together: 1.4%. But who is more serious at the beginning dies more.

73 https://www.nejm.org/doi/full/10.1056/NEJMoa2002032?query=featured_home

74 https://www.nejm.org/na101/home/literatum/publisher/mms/journals/content/nejm/0/nejm.ahead-of-print/nejmoa2002032/20200306/images/img_medium/nejmoa2002032_t3.jpeg

75 <https://medium.com/@quinterojs/covid-19-infection-growth-rates-lagged-mortality-rates-and-other-interesting-statistics-ff39f5408a21>

76 Thierry Fumeaux - expert opinion (Candidat EMBA IMD, Président SSMI, spécialiste Médecine Interne/Médecine Intensive - Prof titulaire, Médecine Genève)

Variable	All Patients (N=1099)	Disease Severity		Presence of Composite Primary End Point	
		Nonsevere (N=926)	Severe (N=173)	Yes (N=67)	No (N=1032)
Complications					
Septic shock — no. (%)	12 (1.1)	1 (0.1)	11 (6.4)	9 (13.4)	3 (0.3)
Acute respiratory distress syndrome — no. (%)	37 (3.4)	10 (1.1)	27 (15.6)	27 (40.3)	10 (1.0)
Acute kidney injury — no. (%)	6 (0.5)	1 (0.1)	5 (2.9)	4 (6.0)	2 (0.2)
Disseminated intravascular coagulation — no. (%)	1 (0.1)	0	1 (0.6)	1 (1.5)	0
Rhabdomyolysis — no. (%)	2 (0.2)	2 (0.2)	0	0	2 (0.2)
Physician-diagnosed pneumonia — no./total no. (%)	972/1067 (91.1)	800/894 (89.5)	172/173 (99.4)	63/66 (95.5)	909/1001 (90.8)
Median time until development of pneumonia (IQR) — days*					
After initial Covid-19 diagnosis	0.0 (0.0–1.0)	0.0 (0.0–1.0)	0.0 (0.0–2.0)	0.0 (0.0–3.5)	0.0 (0.0–1.0)
After onset of Covid-19 symptoms	3.0 (1.0–6.0)	3.0 (1.0–6.0)	5.0 (2.0–7.0)	4.0 (0.0–7.0)	3.0 (1.0–6.0)
Treatments					
Intravenous antibiotics — no. (%)	637 (58.0)	498 (53.8)	139 (80.3)	60 (89.6)	577 (55.9)
Oseltamivir — no. (%)	393 (35.8)	313 (33.8)	80 (46.2)	36 (53.7)	357 (34.6)
Antifungal medication — no. (%)	31 (2.8)	18 (1.9)	13 (7.5)	8 (11.9)	23 (2.2)
Systemic glucocorticoids — no. (%)	204 (18.6)	127 (13.7)	77 (44.5)	35 (52.2)	169 (16.4)
Oxygen therapy — no. (%)	454 (41.3)	331 (35.7)	123 (71.1)	59 (88.1)	395 (38.3)
Mechanical ventilation — no. (%)					
Invasive	67 (6.1)	0	67 (38.7)	40 (59.7)	27 (2.6)
Noninvasive	25 (2.3)	0	25 (14.5)	25 (37.3)	0
Use of extracorporeal membrane oxygenation — no. (%)	5 (0.5)	0	5 (2.9)	5 (7.5)	0
Use of continuous renal-replacement therapy — no. (%)	9 (0.8)	0	9 (5.2)	8 (11.9)	1 (0.1)
Use of intravenous immune globulin — no. (%)	144 (13.1)	86 (9.3)	58 (33.5)	27 (40.3)	117 (11.3)
Admission to intensive care unit — no. (%)	55 (5.0)	22 (2.4)	33 (19.1)	55 (82.1)	0
Median length of hospital stay (IQR) — days†	12.0 (10.0–14.0)	11.0 (10.0–13.0)	13.0 (11.5–17.0)	14.5 (11.0–19.0)	12.0 (10.0–13.0)
Clinical outcomes at data cutoff — no. (%)					
Discharge from hospital	55 (5.0)	50 (5.4)	5 (2.9)	1 (1.5)	54 (5.2)
Death	15 (1.4)	1 (0.1)	14 (8.1)	15 (22.4)	0
Recovery	9 (0.8)	7 (0.8)	2 (1.2)	0	9 (0.9)
Hospitalization	1029 (93.6)	875 (94.5)	154 (89.0)	51 (76.1)	978 (94.8)

* For the development of pneumonia, data were missing for 347 patients (31.6%) regarding the time since the initial diagnosis and for 161 patients (14.6%) regarding the time since symptom onset.

† Data regarding the median length of hospital stay were missing for 136 patients (12.4%).

Therefore we have 9/10 of the population presenting mild symptoms, of which about 2.4% go to therapy Intensive (22/1099, about 2%), while among 173 already serious patients, 19.1% immediately enter Therapy Intensive (33/1099, about 3%). Total 5% of those who are such that they are actually taken to the hospital (not 5% of the infected): 55 patients out of 1099 patients analyzed, around 500 patients out of 9000 infected; this in a megacity like Wuhan that has 11 million inhabitants. They are not exceptional figures to indicate one "Extension over time" of hospitalizations nor the taking of coercive measures such as those undertaken - among other things useless and harmful on a moral, economic and social level.

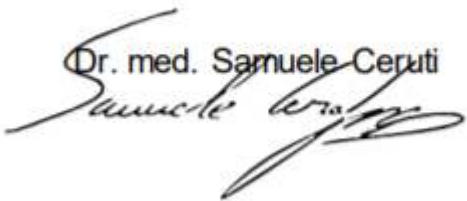
9. Conclusion:

Our task is that, where there is a pre-established personal and professional authority, of oblige all those for whom you have direct and indirect responsibility – always expecting what Authorities superior to us decide - but at the same time spreading the original data, real and the sources that anyone can draw from to realize that a) the main problem is not as it is you paint it, the data goes in another direction, b) the solutions undertaken will never be effective, according to I more basic principles of logic and epidemiology.

It seems that in 2020 the world discovered that with cold there are para-flu syndromes, by let them die and above all the older and already sick population die. Like all the years. To us the task of staying with "down to earth", of continuing our work as constantly done all the years, every day, with normal precautions as every year, obeying what we are asked for but offering everyone reading the references on the main data, in particular:

- Italian Institute of Health: <http://www.iss.it/en/comunicati-stampa>
- World Disease Control Center (CDC): www.cdc.gov
- UpToDate (controlled access): www.uptodate.com

Available for any comparison or clarification.

Dr. med. Samuele Ceruti

om

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