COVID diagnostic test: worst test ever devised?

Sep10 by Jon Rappoport

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September 10, 2020

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The need for the COVID test is being hyped to the skies. More tests automatically create more case numbers. This allows heads of state and national governments to whipsaw the public:

"We were re-opening the economy, but now, with the escalating case numbers, we'll have to impose lockdowns again..."

This wreaks more havoc and economic destruction, which is the true goal of the COVID operation. Its cruelty is boundless.

In this article, I present quotes from official sources about their own diagnostic test for the coronavirus, the PCR.

Spoiler alert: the admitted holes and shortcomings of the test are devastating.

From "CDC 2019-Novel Coronavirus (2019-nCoV) Real-

Time RT-PCR Diagnostic Panel" [1]:

"Detection of viral RNA may not indicate the presence of infectious virus or that 2019-nCoV is the causative agent for clinical symptoms."

Translation: A positive test doesn't guarantee that the COVID virus is causing infection at all. And, ahem, reading between the lines, maybe the COVID virus might not be in the patient's body at all, either.

From the World Health Organization (WHO): "Coronavirus disease (COVID-19) technical guidance: Laboratory testing for 2019-nCoV in humans" [2]:

"Several assays that detect the 2019-nCoV have been and are currently under development, both in-house and commercially. Some assays may detect only the novel virus [COVID] and some may also detect other strains (e.g. SARS-CoV) that are genetically similar."

Translation: Some PCR tests register positive for types of coronavirus that have nothing to do with COVID—including plain old coronas that cause nothing more than a cold.

The WHO document adds this little piece: "Protocol use limitations: Optional clinical specimens for testing has [have] not yet been validated."

Translation: We're not sure which tissue samples to take

from the patient, in order for the test to have any validity.

From the FDA: “LabCorp COVID-19RT-PCR test EUA Summary: ACCELERATED EMERGENCY USE AUTHORIZATION (EUA) SUMMARYCOVID-19 RT-PCR TEST (LABORATORY CORPORATION OF AMERICA)” [3]:

“…The SARS-CoV-2RNA [COVID virus] is generally detectable in respiratory specimens during the acute phase of infection. Positive results are indicative of the presence of SARS-CoV-2 RNA; clinical correlation with patient history and other diagnostic information is necessary to determine patient infection status…THE AGENT DETECTED MAY NOT BE THE DEFINITE CAUSE OF DISEASE (CAPS are mine). Laboratories within the United States and its territories are required to report all positive results to the appropriate public health authorities.”

Translation: On the one hand, we claim the test can “generally” detect the presence of the COVID virus in a patient. But we admit that “the agent detected” on the test, by which we mean COVID virus, “may not be the definite cause of disease.” We also admit that, unless the patient has an acute infection, we can’t find COVID. Therefore, the idea of “asymptomatic patients” confirmed by the test is nonsense. And even though a positive test for COVID may not indicate the actual cause of disease, all positive tests must be reported—and they will be counted as “COVID cases.” Regardless.

From a manufacturer of PCR test kit elements, Creative Diagnostics, “SARS-CoV-2 Coronavirus Multiplex RT-qPCR Kit” [4]:

“Regulatory status: For research use only, not for use in diagnostic procedures.”

Translation: Don’t use the test result alone to diagnose infection or disease. Oops.

“non-specific interference of Influenza A Virus (H1N1), Influenza B Virus (Yamagata), Respiratory Syncytial Virus (type B), Respiratory Adenovirus (type 3, type 7), Parainfluenza Virus (type 2), Mycoplasma Pneumoniae, Chlamydia Pneumoniae, etc.”

Translation: Although this company states the test can detect COVID, it also states the test can read FALSELY positive if the patient has one of a number of other irrelevant viruses in his body. What is the test proving, then? Who knows? Flip a coin.

“Application Qualitative”

Translation: This clearly means the test is not suited to detect how much virus is in the patient’s body. I’ll cover how important this admission is in a minute.

“The detection result of this product is only for clinical reference, and it should not be used as the only evidence for clinical diagnosis and treatment. The clinical

management of patients should be considered in combination with their symptoms/signs, history, other laboratory tests and treatment responses. The detection results should not be directly used as the evidence for clinical diagnosis, and are only for the reference of clinicians."

Translation: Don't use the test as the exclusive basis for diagnosing a person with COVID. And yet, this is exactly what health authorities are doing all over the world. All positive tests must be reported to government agencies, and they are counted as COVID cases.

Those quotes, from official government and testing sources, torpedo the whole "scientific" basis of the test.

And now, I'll add another lethal blow: the test has never been validated properly as an instrument to detect disease. Even if we blindly assumed it can detect the presence of the COVID virus in a patient, it doesn't show HOW MUCH virus is in the body. And that is key, because in order to even begin talking about actual illness in the real world, not in a lab, the patient would need to have millions and millions of the virus actively replicating in his body.

Proponents of the test assert that it CAN measure how much virus is in the body. To which I reply: prove it.

Prove it in a way it should have been proved decades ago

—but never was.

Take five hundred people and remove tissue samples from them. The people who take the samples do NOT do the test. The testers will never know who the patients are and what condition they're in.

The testers run their PCR on the tissue samples. In each case, they say which virus they found and HOW MUCH of it they found.

"All right, in patients 24, 46, 65, 76, 87, and 93 we found a great deal of virus."

Now we un-blind those patients. They should all be sick, because they have so much virus replicating in their bodies. Are they sick? Are they running marathons? Let's find out.

This OBVIOUS vetting of the test has never been done. That is an enormous scandal. Where are the controlled test results in 500 patients, a thousand patients? Nowhere.

The PCR is an unproven fraud.

"But...but...what about all the sick and dying people...why are they sick?"

I've written thousands of words answering that question, in past articles. A NUMBER of conditions—none involving COVID, and most involving old traditional diseases—are

making people sick.

There are other large-scale studies of the PCR test that have never been done. I've covered them in detail, in prior articles. To summarize: a study using a thousand patients, in which their tissue samples are sent to 30 different labs for analysis and verdicts, to see whether the results are uniform from lab to lab; and a study of 1000 patients, in which the results are compared with the results of analysis by electron microcopy. These large studies—never done.

In other words, the PCR test has never been adequately tested; it has never been properly validated as a diagnostic tool.

Here, from Canadian researcher David Crowe's bombshell paper, FLAWS IN CORONAVIRUS PANDEMIC THEORY, is a key quote about the PCR test [5]:

"A review of 33 RT-PCR tests for COVID-19 approved under US FDA Emergency Use Authorizations showed a wide range of differences in what the tests were looking for and how they decided whether they had found it. The tests look for a variety of different segments ('genes') of the presumed COVID-19 genome, that only amounts to about 1% or less of the total genome, which is about 30,000 bases. Perhaps the worst feature of the tests is how they decide whether the sample is positive if more than one ['gene'] segment is being looked for. Some tests

look for only one, so it must be present for a positive. But tests that look for two segments are split between those that require both to be present and those that require either one for a positive. Some tests look for three segments but only require any two to be present, while one test insisted on all three. Tests that allow a segment to be undetected raise the question of how it can be said that a virus was detected when an important part of it was missing."

If the PCR is a uniform standardized test, a rabbit is a spaceship.

Speaking of lack of uniformity in test results, here is a quote from Stephen Bustin, who is considered one of the foremost experts on PCR in the world. The excerpt is from his 2017 article, "Talking the talk, but not walking the walk: RT-qPCR as a paradigm for the lack of reproducibility in molecular research" [6]:

"Awareness of variability problems associated with PCR has been long-standing, with the first report describing inconsistencies with replicate and serial specimens evaluated within and between laboratories as early as 1992. The lack of a theoretical understanding of the dynamic processes involved in PCR, especially with respect to the amplification of nonreproducible and/or unexpected amplification products, was also highlighted decades ago. These observations and the resulting implications are largely disregarded."

Here is the story of an epic failure of the PCR, right out in the open, for all to see. The reference is the NY Times, January 22, 2007, "Faith in Quick Tests Leads to Epidemic That Wasn't." [7]

"Dr. Brooke Herndon, an internist at Dartmouth-Hitchcock Medical Center, could not stop coughing...By late April, other health care workers at the hospital were coughing..."

"For months, nearly everyone involved thought the medical center had had a huge whooping cough outbreak, with extensive ramifications. Nearly 1,000 health care workers at the hospital in Lebanon, N.H., were given a preliminary test and furloughed from work until their results were in; 142 people, including Dr. Herndon, were told they appeared to have the disease; and thousands were given antibiotics and a vaccine for protection. Hospital beds were taken out of commission, including some in intensive care."

"Then, about eight months later, health care workers were dumbfounded to receive an e-mail message from the hospital administration informing them that the whole thing was a false alarm."

"Now, as they look back on the episode, epidemiologists and infectious disease specialists say the problem was that they placed too much faith in a quick and highly sensitive molecular test [PCR] that led them astray."

“There are no national data on pseudo-epidemics caused by an overreliance on such molecular tests, said Dr. Trish M. Perl, an epidemiologist at Johns Hopkins and past president of the Society of Health Care Epidemiologists of America. But, she said, pseudo-epidemics happen all the time. The Dartmouth case may have been one of the largest, but it was by no means an exception, she said.”

“Many of the new molecular [PCR] tests are quick but technically demanding, and each laboratory may do them in its own way. These tests, called ‘home brews,’ are not commercially available, and there are no good estimates of their error rates. But their very sensitivity makes false positives likely, and when hundreds or thousands of people are tested, as occurred at Dartmouth, false positives can make it seem like there is an epidemic.”

“’You’re in a little bit of no man’s land,’ with the new molecular [PCR] tests, said Dr. Mark Perkins, an infectious disease specialist and chief scientific officer at the Foundation for Innovative New Diagnostics, a nonprofit foundation supported by the Bill and Melinda Gates Foundation. ‘All bets are off on exact performance’.”

“With pertussis, she [Dr. Kretsinger, CDC] said, ‘there are probably 100 different P.C.R. protocols and methods being used throughout the country,’ and it is unclear how often any of them are accurate. ‘We have had a number of outbreaks where we believe that despite the presence

of P.C.R.-positive results, the disease was not pertussis,' Dr. Kretsinger added."

"Dr. Cathy A. Petti, an infectious disease specialist at the University of Utah, said the story had one clear lesson."

"'The big message is that every lab is vulnerable to having false positives,' Dr. Petti said. 'No single test result is absolute and that is even more important with a test result based on P.C.R'."

There is more to report about the PCR test, and I have, but I'll make this final point for now: I've presented, over the last several months, compelling evidence that no one proved the existence of the COVID virus, by proper scientific procedures, in the first place. So the PCR test would be looking for...what? A virus that isn't there?

And on the back of this test, governments are wrecking economies all over the world, and untold numbers of human lives.

SOURCES:

[1] https://www.fda.gov/media/134922/download

[2] https://web.archive.org/web/*/http://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/laboratory-guidance

note: said document above (archived at web.archive.org) was on the following page...

https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/laboratory-guidance

...however, that page now redirects to...

https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance-publications

...and that new page does not have said document

see also,...

blog.microbiologics.com/2019-novel-coronavirus-what-microbiologists-need-to-know/

[3] https://www.fda.gov/media/136151/download

[4] https://www.creative-diagnostics.com/sars-cov-2-coronavirus-multiplex-rt-qpcr-kit-277854-457.htm

[5] https://theinfectiousmyth.com/book/CoronavirusPanic.pdf

[6] https://onlinelibrary.wiley.com/doi/pdf/10.1111/eci.12801

[7] nytimes.com/2007/01/22/health/22whoop.html

(To read about Jon's mega-collection, ***The Matrix Revealed****, click here.)*

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The author of three explosive collections, THE MATRIX REVEALED, EXIT FROM THE MATRIX, and POWER OUTSIDE THE MATRIX, Jon was a candidate for a US Congressional seat in the 29th District of California. He maintains a consulting practice for private clients, the purpose of which is the expansion of personal creative power. Nominated for a Pulitzer Prize, he has worked as an investigative reporter for 30 years, writing articles on politics, medicine, and health for CBS Healthwatch, LA Weekly, Spin Magazine, Stern, and other newspapers and magazines in the US and Europe. Jon has delivered lectures and seminars on global politics, health, logic, and creative power to audiences around the world. You can sign up for his **free** NoMoreFakeNews emails **here** or his **free** OutsideTheRealityMachine emails **here**.