



Until Advancing Age Gets Reversed With A Pinch Of Salt, Usage Duration Of Mask Trinity As Universal Precaution Against Discrimination

Peer review status:

No

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Article ID: WMC005670

Article Type: My opinion

Submitted on: 12-Nov-2020, 12:46:14 PM GMT **Published on:** 03-Dec-2020, 07:29:18 AM GMT

Article URL: http://www.webmedcentral.com/article_view/5670

Subject Categories: PUBLIC HEALTH

Keywords: Advancing Age, Salt, Masks, Universal Precautions, Discrimination, SARS-CoV-2, COVID-19

How to cite the article: Gupta D. Until Advancing Age Gets Reversed With A Pinch Of Salt, Usage Duration Of Mask Trinity As Universal Precaution Against Discrimination. WebmedCentral PUBLIC HEALTH 2020;11(12):WMC005670

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Source(s) of Funding:

NOT APPLICABLE

Competing Interests:

NOT APPLICABLE

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My opinion

I am raising the following questions: Can omnipotent cells in young age sera overcome aging to reverse the advancing age which has turned out to be a major risk factor for COVID-19 related morbidity and mortality? Can salt-impregnated masks inactivating pathogens make a case for salt itself as an administration vehicle to simplify mass vaccination programs against SARS-CoV-2? Can daily duration of mask use dilute SARS-CoV-2 repositivity in convalescent COVID-19 patients? Can mask use practiced as universal precaution reap benefits from mask trinity in the postulated tri-faceted role as protector-therapeutic-immunizer against SARS-CoV-2? Can mask use practiced as universal precaution take a stand against discrimination inflicted by COVID-19 pandemic secondary to morbid and fatal contagiousness of SARS-CoV-2?

Can Infusion Of Youth Counter Age-Associated COVID-19 Morbidity And Mortality?

My opinion is: If yet-not-known biochemical factors deteriorate with age, those yet-not-known factors producing omnipotent cells once harvested from young may be able to overcome the disadvantage of advancing age among the aged as related to their COVID-19 morbidity and mortality.

It has been observed that advancing age is associated with severe morbidity and mortality with COVID-19. Even though the effect of age on COVID-19 morbidity and mortality may not be as strong as initially thought [1], it seems like a certain fact that young are faring better in their fight against COVID-19 as compared to the aged. This begs the question whether youth has certain biochemical factors which are helping them to fight off SARS-CoV-2 better [2]. Even though it may be better to delineate these specific biochemical factors [3-4], the time constraints in the rapidly evolving

COVID-19 pandemic may warrant urgent exploration into the omnipotent cells as therapy to see if "youth" may be injected into at-risk aged overcoming their bodies'™ age-related wear and tear making them more susceptible to losing their fight against COVID-19 [5-6]. Omnipotent cells have been explored for numerous diseases and it is time to overdrive the cord blood donations in case the ongoing clinical trials succeed in finding the irrefutable evidence for omnipotent cells against SARS-CoV-2 and COVID-19 [7]. Until "youth" becomes medically amenable in finding its way back into our aging populations only if and only after irrefutable evidence has been generated in the ongoing clinical trials [8], we should be realistic in our research pursuits into youth as an antidote to SARS-CoV-2 while concurrently proactively protecting our aging populations.

Can There Be Sublingual Vaccine With A Pinch Of Salt For Mass Vaccination Against SARS-CoV-2?

My opinion is: If salt may be directly inactivating pathogens, vaccine "fortified" salt may be considered for futuristic exploration and investigation by futurist vaccinologists looking into novel ways for mass vaccination programs globally.

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COVID-19 pandemic has revived the age-old adage making a case for saline irrigation and gargles to counter sinusitis and sore throat [9-10]. Some say that salt may be just relieving the symptoms while others say that salt may be directly inactivating pathogens [11]. The bottom-line is that mucosal salt has some unconfirmed role against pathologies. Therefore, while enthusiasts are delving into proving a pharmacological role for a product having physiological ingredients, it may be interesting for vaccinologists [12-13] to ponder, explore, investigate and prove/disprove then validate/refute if pathogen-inactivating salt can serve as an administration vehicle for mass vaccination

against seasonal/epidemic/pandemic pathogens like influenza and SARS-CoV-2. If salt as a vaccine is futuristically demonstrated to be feasible and then irrefutably proven to be manageable, salt as a vaccine-administration vehicle may be able to keep the antigenic immunogenic pathological particles inactivated in vitro as packaged and delivered forms until they are ready to induce antigenicity and immunogenicity in vivo among populations potentially getting self-vaccinated with a pinch of salt sublingually. It can be decided in due course of time that although a pinch of salt sounds good to ears, it may be up to vaccinologists to discover if salt as vaccine-administration vehicle will have to be a tad/dash more or a smidgen/drop less. Summarily, extending explorations and investigations of salt as intranasal irrigations or as face-mask coatings against pathogens [9-11], vaccine as salt may be considered as futuristic exploration and investigation by futurist vaccinologists looking into novel ways for mass vaccination programs globally.

Can Daily Duration Of Mask Use Dilute SARS-CoV-2 Repositivity In Convalescent COVID-19 Patients?

My opinion is: Masks and their usage duration may have to be explored for their potential (if any) as ex vivo antibodies complementing in vivo antibodies and T-cells to counter and control SARS-CoV-2 even during and after convalescence from COVID-19.

Very common (>10%) SARS-CoV-2 repositivity among convalescent COVID-19 patients per Landi et al adds further to the SARS-CoV-2 repositivity incidence related biomedical literature as reported by Gao et al [14-15]. However, there are few questions. If positivity for SARS-CoV-2 per real-time reverse transcription-polymerase chain reaction (RT-PCR) tests categorized COVID-19 patients as contagious at their initial diagnosis, why are Landi et al questioning their patients' contagiousness after discovering repositivity on the same type of RT-PCR tests [14]? If severity of clinical COVID-19 symptoms and quantitative SARS-CoV-2 viral loads seem better determinants for SARS-CoV-2 infectiousness before quarantining patients, why were Landi et al exploring RT-PCR repositivity in the first place among asymptomatic convalescent COVID-19 patients [14]? While erring on the safer side with indoor mask use being practiced by all repositive

patients during their second quarantine periods, did Landi et al explore the incidence and daily duration of mask use (indoor or outdoor) among their repositive patients after their first quarantine periods had been discontinued and before their patients' second quarantine periods had been initiated [14]? If convalescent COVID-19 patients' mask use data is available, can Landi et al analyze if there is a difference between repositive and non-repositive patients in terms of their daily durations of mask use during their convalescent periods [14]? With the presumptions of being disease-free per two negative RT-PCR tests for SARS-CoV-2 at least 24 hours apart, discontinuations of first quarantine periods can lead convalescent COVID-19 patients to drop their guards in terms of practicing mask use (indoor or outdoor). Therefore, it will be interesting if Landi et al are able to explore the comparative differences (if any) in daily durations of mask use among repositive and non-repositive patients [14]. I have a hypothesis that the efficaciousness of masks' therapeutic role secondary to created hot and humid microenvironments may correlate to the daily duration of mask use which could have deterred the redetection of SARS-CoV-2 per RT-PCR tests among non-repositive convalescent COVID-19 patients [16-18]. My understanding is that universal mask use by population irrespective of their COVID-19 status may make detection and redetection of SARS-CoV-2 irrelevant unless individuals' intermingling social life, their line of work or their symptoms warrant RT-PCR tests for detecting and redetecting SARS-CoV-2 to make a case for stricter quarantining at home away from work while effective therapeutics can resolve their symptoms (if any). Essentially, masks may be the ex vivo antibodies complementing in vivo antibodies and T-cells to counter and control SARS-CoV-2 literally.

Can Barrington-Snow Compromise To Unify Under Mask Trinity As Herd Immunity?

My opinion is: Barrington-Snow Compromise may have to unify under mask trinity (protective-therapeutic-immunizer) for the sake of natural herd immunity until artificial herd immunity can be generated with laboratory-made vaccines.

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The questions raised by Great Barrington Declaration and John Snow Memorandum overlap even when their

proponents may not seem to [19]. It is my opinion that they can compromise once they realize masksâ€™ tri-faceted role against SARS-CoV-2. Masks protection role against exposure is unquestionable [20]. Masks creating therapeutic hot and humid micro-climates have been implored [18]. Masks being imperfect thus allowing smaller dose exposures repeatedly may be generating immunity with milder symptoms [21]. Essentially, when both sides of aisle negotiate, they may agree that when masks are being worn to prevent contagious SARS-CoV-2, potentially treat SARS-CoV-2 and unsuspectingly immunize against SARS-CoV-2, the populations can return to work with masksâ€™ role in herd immunity at work.

It pains me to ask:

1. Why donâ€™t opponents understand protective role of masks unless they are waiting for masks to turn perfect in an imperfect world?
2. Why donâ€™t skeptics explore therapeutic role of hot and humid in-mask microclimates when Department of Homeland Security, Science and Technology directorate has documented the role of hot and humid environments in accelerating the decay of airborne and surface SARS-CoV-2 [22]?
3. Why donâ€™t partisans accept slow and steady role of masks in creating herd immunity while awaiting laboratory-made vaccines unless they mistakenly believe that herd immunity requires large dose exposures to SARS-CoV-2 inducing full spectrum of COVID-19 symptoms leading to either protracted convalescent periods or multiple casualties?
4. Why donâ€™t investigators investigate whether hot and humid in-mask microclimates can alleviate COVID-19 symptoms like cough to further mitigate the spread of SARS-CoV-2?
5. Why donâ€™t laypersons recognize that by invariably making it difficult to talk, masks are containing the spread of SARS-CoV-2 by talkative populations?
6. Why donâ€™t scientists overcome their over-reliance on measurement of dwindling antibodies which as an indicator for poor long-term immunity against SARS-CoV-2 may discourage vaccine development unless they switch gear to measuring memory T-cell responses because if natural infection is not â€œmeasurablyâ€• inducing long-term immunity how the vaccine will produce â€œmeasurableâ€• immunity [23-24]?
7. Why donâ€™t epidemiologists advise COVID-19 contacts and patients against completely abandoning their mask use during quarantine and isolation periods because therapeutic role of in-mask microclimates (anti-viral and/or symptom control roles being duration-dependent potentially) may continue to work even during their lonesome quarantines and isolations?

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Summarily, Barrington-Snow Compromise may have to unify under mask trinity

(protective-therapeutic-immunizer) for the sake of natural herd immunity until artificial herd immunity can be generated with laboratory-made vaccines.

Are AIDS-Warriors Teaching COVID-19-Warriors "Universal Precautions Against Discrimination"?

My opinion is: Universal precautions (masks, shields and small talksâ€™ restrictions) may mitigate discrimination that may get incited among the ignorant commoners in response to testing, tracing, isolating and quarantining when knowledge about individualâ€™s infectivity an essentiality primarily for caregivers managing diseased and epidemiologists controlling pandemics.

Blood-borne HIV/AIDS-pandemic may enlighten about respiratory-borne SARS-CoV-2/COVID-19-pandemic. Firstly, diseasesâ€™ naivety catches host by surprise. Secondly, fast-evolving pathogens force hosts to catch-up while strategizing. Finally, pathogens and hosts must learn to cohabit ecosystems without eradicating each other [25].Â

So, can absence of vaccines despite preponderance of therapeutics against HIV make case for therapeuticsâ€™ primary role against SARS-CoV-2 irrespective of vaccines against SARS-CoV-2 getting developed and embraced? Is evolutionary hypervirulence induced by vaccinated masses more drastic compared to that induced by treated few [26]? Do universal precautions (gloves, condoms and transfusion productsâ€™ screenings) against HIV make case for universal precautions (masks, shields and small talksâ€™ restrictions) against SARS-CoV-2 [27]? Can universal precautions barricade inadvertently perpetuated discrimination among hosts when they miscalculate symptom-specific- (disease-stage-specific-), case- and infection- fatality rates [28]? Can passive barrier modalities induce hypo-virulence among pathogens which are able to persist when hosts do not actively resist?

Essentially, as monk-like abstinence from sex plus silence in conversation may not be practical among â€œsuper-spreaderâ€• commoners [29-30], universal precautions may mitigate discrimination that may get incited among the ignorant commoners in response to testing, tracing, isolating and quarantining when knowledge about individualâ€™s infectivity an essentiality primarily for caregivers managing diseased and epidemiologists controlling pandemics.

Seemingly, the end game may be the therapeutics reversing symptoms without inducing pathogens'™ hypervirulence while barrier modalities containing spread without disconcerting hosts'™ livelihood. Henceforth, research and development should focus on efficacious therapeutics plus comfortable barriers [31]. In the interim, virtual pleasure industry booming in response to AIDS-pandemic makes case for virtual socialization industry zooming in response to COVID-19-pandemic.

Conclusion

Essentially, the answer to my questions can be that it may not be possible to validate until we investigate and to my limited understanding, the above-mentioned avenues seem worth exploring to possibly (if validated) better evolve and adapt to the rapidly evolving COVID-19 pandemic.

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