

The COVID-19 RT-PCR Test: How To Mislead All Humanity Into Accepting Societal Lock-Downs



by Tyler Durden

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Authored by Dr. Pascal Sacré via GlobalResearch.ca,

It is time for everyone to come out of this negative trance, this collective hysteria, because famine, poverty, massive unemployment will kill, mow down many more people than SARS-CoV-2!



Introduction: using a technique to lock down society

All current propaganda on the COVID-19 pandemic is based on an assumption that is considered obvious, true and no longer questioned:

Positive RT-PCR test means being sick with COVID. This assumption is misleading.

Very few people, including doctors, understand how a PCR test works.

RT-PCR means **Real Time-Polymerase Chain Reaction**.

In French, it means: *Réaction de Polymérisation en Chaîne en Temps Réel*.

In medicine, we use this tool mainly to diagnose a viral infection.

Starting from a clinical situation with the presence or absence of particular symptoms in a

patient, we consider different diagnoses based on tests.

In the case of certain infections, particularly viral infections, we use the RT-PCR technique to confirm a diagnostic hypothesis suggested by a clinical picture.

We do not routinely perform RT-PCR on any patient who is overheated, coughing or has an inflammatory syndrome!

It is a laboratory, molecular biology technique of gene amplification because it looks for gene traces (DNA or RNA) by amplifying them.

In addition to medicine, other fields of application are genetics, research, industry and forensics.

The technique is carried out in a **specialized laboratory**, it cannot be done in any laboratory, even a hospital. This entails a certain cost, and a delay sometimes of several days between the sample and the result.

Today, since the emergence of the new disease called **COVID-19 (COrona VIRus Disease-2019)**, the RT-PCR diagnostic technique is used to define positive cases, confirmed as SARS-CoV-2 (coronavirus responsible for the new acute respiratory distress syndrome called COVID-19).

These positive cases are assimilated to COVID-19 cases, **some of whom** are hospitalized or even admitted to intensive care units.

Official postulate of our managers: positive RT-PCR cases = COVID-19 patients.

This is the starting postulate, the premise of all official propaganda, which justifies all restrictive government measures: isolation, confinement, quarantine, mandatory masks, color codes by country and travel bans, tracking, social distances in companies, stores and even, even more importantly, in schools.

This misuse of RT-PCR technique is used as a **relentless and intentional strategy by some governments**, supported by scientific safety councils and by the dominant media, **to justify excessive measures** such as the violation of a large number of constitutional rights, the destruction of the economy with the bankruptcy of entire active sectors of society, the degradation of living conditions for a large number of ordinary citizens, under the pretext of a pandemic **based on a number of positive RT-PCR tests, and not on a real number of patients.**

Technical aspects: to better understand and not be manipulated

The PCR technique was developed by chemist **Kary B. Mullis** in 1986. Kary Mullis was awarded the Nobel Prize in Chemistry in 1993.

Although this is disputed, Kary Mullis himself is said to have criticized the interest of **PCR as a diagnostic tool for an infection, especially a viral one.**

He stated that if PCR was a good tool for research, it was a very bad tool in medicine, in the clinic.

Mullis was referring to the AIDS virus (HIV retrovirus or HIV), before the COVID-19 pandemic, but this opinion on the limitation of the technique in viral infections, by its creator, cannot be dismissed out of hand; it must be taken into account!

PCR was perfected in 1992.

As the analysis can be performed in real time, continuously, it becomes **RT (Real-Time) - PCR**, even more efficient.

It can be done from any molecule, including those of the living, the nucleic acids that make up the genes:

- DNA (deoxyribonucleic acid)
- RNA (Ribonucleic Acid)

Viruses are not considered as “living” beings, they are packets of information (DNA or RNA) forming a genome.

It is by an amplification technique (multiplication) that the molecule sought is highlighted and this point is very important.

RT-PCR is an amplification technique.

If there is DNA or RNA of the desired element in a sample, it is not identifiable as such.

This DNA or RNA must be **amplified (multiplied) a certain number of times**, sometimes a very large number of times, before it can be detected. From a minute trace, up to billions of copies of a specific sample can be obtained, but this does not mean that there is all that amount in the organism being tested.

In the case of COVID-19, the element sought by RT-PCR is SARS-CoV-2, an RNA virus.

There are **DNA viruses** such as Herpes and Varicella viruses.

The most well known **RNA viruses**, in addition to coronaviruses, are Influenza, Measles, EBOLA, ZIKA viruses.

In the case of SARS-CoV-2, RNA virus, an additional specific step is required, a transcription of RNA into DNA by means of an enzyme, Reverse Transcriptase.

This step precedes the amplification phase.

It is not the **whole** virus that is identified, but sequences of its viral genome.

This does not mean that this gene sequence, a fragment of the virus, is not specific to the virus being sought, but it is an important nuance nonetheless:

RT-PCR does not reveal any virus, but only parts, specific gene sequences of the virus.

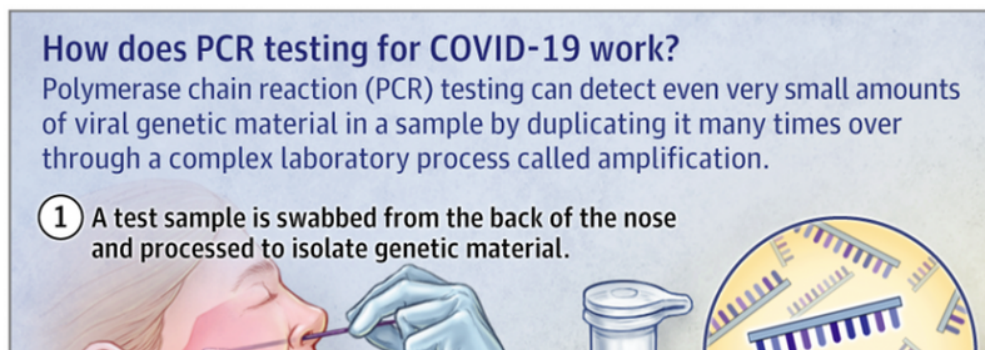
At the beginning of the year, the SARS-CoV-2 genome was sequenced.

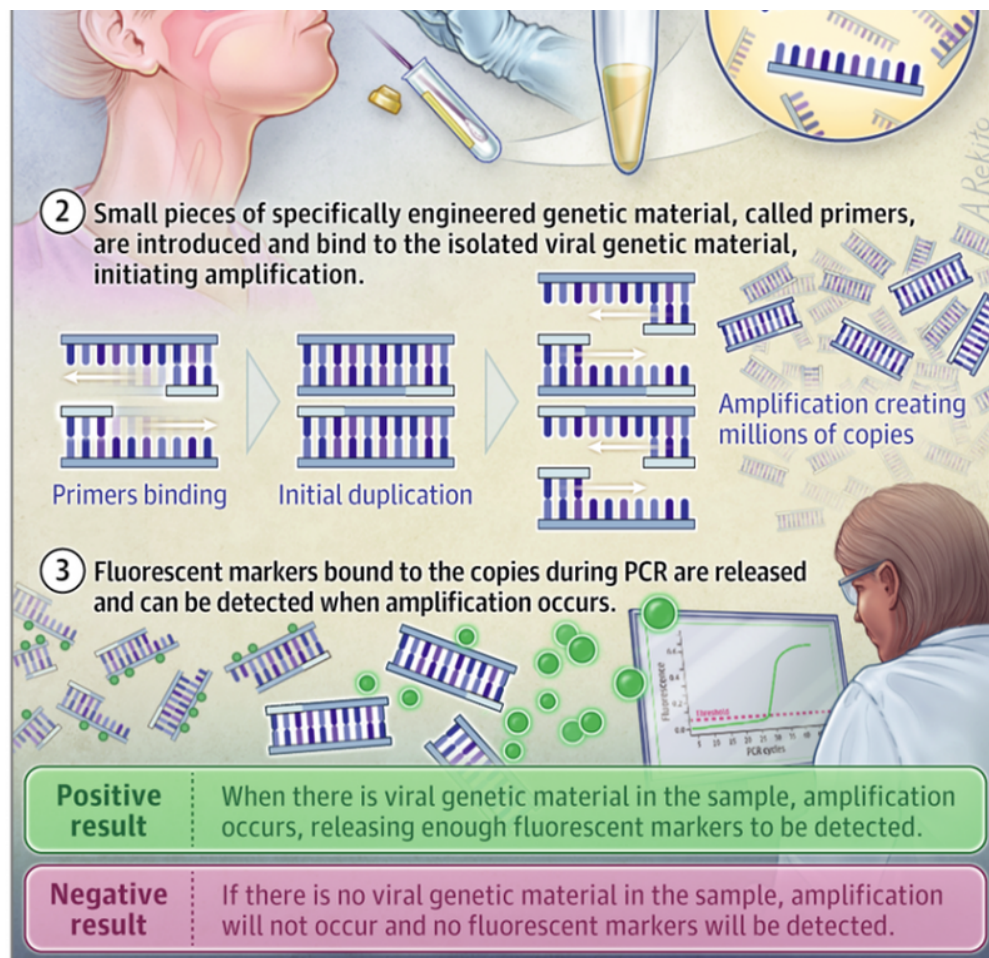
It consists of about 30,000 base pairs. The nucleic acid (DNA-RNA), the component of the genes, is a sequence of bases. In comparison, the human genome has more than 3 billion base pairs.

Teams are continuously monitoring the evolution of the SARS-CoV-2 viral genome as it evolves, through the mutations it undergoes. Today, there are many variants.

By taking a few specific genes from the SARS-CoV-2 genome, it is possible to initiate RT-PCR on a sample from the respiratory tract.

For COVID-19 disease, which has a nasopharyngeal (nose) and oropharyngeal (mouth) entry point, the sample should be taken from the upper respiratory tract as deeply as possible in order to avoid contamination by saliva in particular.





All the people tested said that it is very painful.

The Gold Standard (preferred site for sampling) is the **nasopharyngeal (nasal) approach**, the most painful route.

If there is a contraindication to the nasal approach, or preferably to the individual being tested, depending on the official organs, the oropharyngeal approach (through the mouth) is also acceptable. The test may trigger a nausea/vomiting reflex in the individual being tested.

Normally, for the result of an RT-PCR test to be considered reliable, **amplification from 3 different genes (primers) of the virus under investigation is required.**

“The primers are single-stranded DNA sequences specific to the virus. They guarantee the specificity of the amplification reaction. »

“The first test developed at La Charité in Berlin by Dr. Victor Corman and his associates in January 2020 allows to highlight the RNA sequences present in 3 genes of the virus called E, RdRp and N. To know if the sequences of these genes are present in the RNA samples collected, it is necessary to amplify the sequences of these 3 genes in order to obtain a signal sufficient for their detection and quantification. ».

The essential notion of Cycle Time or Cycle Threshold or Ct positivity threshold [16].

An RT-PCR test is negative (no traces of the desired element) or positive (presence of traces of the desired element).

However, even if the desired element is present in a minute, negligible quantity, the principle

of RT-PCR is to be able to finally highlight it by continuing the amplification cycles as much as necessary.

RT-PCR can push up to 60 amplification cycles, or even more!

Here is how it works:

- Cycle 1: target x 2 (2 copies)
- Cycle 2: target x 4 (4 copies)
- Cycle 3: target x 8 (8 copies)
- Cycle 4: target x 16 (16 copies)
- Cycle 5; target x 32 (32 copies)
- Etc exponentially up to 40 to 60 cycles!

When we say that the Ct (Cycle Time or Cycle Threshold or RT-PCR positivity threshold) is equal to 40, it means that the laboratory has used **40 amplification cycles**, i.e. obtained **240** copies.

This is what underlies the **sensitivity** of the RT-PCR assay.

While it is true that in medicine we like to have high specificity and sensitivity of the tests to avoid false positives and false negatives, in the case of COVID-19 disease, this hypersensitivity of the RT-PCR test caused by the number of amplification cycles used has backfired.

This over-sensitivity of the RT-PCR test is deleterious and misleading!

It detaches us from the medical reality which must remain based on the real clinical state of the person: is the person ill, does he or she have symptoms?

That is the most important thing!

As I said at the beginning of the article, in medicine we always start from the person: we examine him/her, we collect his/her symptoms (complaints-anamnesis) and objective clinical signs (examination) and on the basis of a clinical reflection in which scientific knowledge and experience intervene, we make diagnostic hypotheses.

Only then do we prescribe the most appropriate tests, based on this clinical reflection.

We constantly compare the test results with the patient's **clinical condition** (symptoms and signs), which **takes precedence over everything else** when it comes to our decisions and treatments.

Today, our governments, supported by their scientific safety advice, are making us do the opposite and put the test first, followed by a clinical reflection necessarily influenced by this prior test, whose weaknesses we have just seen, particularly its hypersensitivity.

None of my clinical colleagues can contradict me.

Apart from very special cases such as genetic screening for certain categories of populations (age groups, sex) and certain cancers or family genetic diseases, we always work in this direction: from the person (symptoms, signs) to the appropriate tests, never the other way around.

This is the conclusion of an article in the Swiss Medical Journal (RMS) published in 2007, written by doctors Katia Jaton and Gilbert Greub microbiologists from the University of Lausanne :

[PCR in microbiology: from DNA amplification to result interpretation:](#)

“To interpret the result of a PCR, it is essential that clinicians and microbiologists share their experiences, so that the analytical and clinical levels of interpretation can be combined.”

It would be indefensible to give everyone an electrocardiogram to screen everyone who might have a heart attack one day.

On the other hand, in certain clinical contexts or on the basis of specific evocative symptoms, there, yes, an electrocardiogram can be beneficial.

Back to **RT-PCR** and **Ct** (Cycle Time or Cycle Threshold).

In the case of an infectious disease, especially a viral one, the notion of **contagiousness** is another important element.

Since some scientific circles consider that an asymptomatic person can transmit the virus, they believe it is important to test for the presence of virus, even if the person is asymptomatic, thus extending the indication of RT-PCR to everyone.

Are RT-PCR tests good tests for contagiousness?

This question brings us back to the notion of viral load and therefore **Ct**.

The relationship between contagiousness and viral load is disputed by some people and no formal proof, to date, allows us to make a decision.

However, common sense gives obvious credence to the notion that the more virus a person has inside him or her, especially in the upper airways (oropharynx and nasopharynx), with symptoms such as coughing and sneezing, **the higher the risk of contagiousness**, proportional to the viral load and the importance of the person's symptoms.

This is called **common sense**, and although modern medicine has benefited greatly from the contribution of science through statistics and Evidence-Based Medicine (EBM), it is still based primarily on common sense, experience and empiricism.

Medicine is the **art of healing**.

No test measures the amount of virus in the sample!

RT-PCR is qualitative: positive (presence of the virus) or negative (absence of the virus).

This notion of quantity, therefore of viral load, can be estimated indirectly by the number of amplification cycles (Ct) used to highlight the virus sought.

- The lower the Ct used to detect the virus fragment, the higher the viral load is considered to be (high).
- The higher the Ct used to detect the virus fragment, the lower the viral load is considered to be (low).

Thus, the French National Reference Centre (CNR), in the acute phase of the pandemic, estimated that the peak of viral shedding occurred at the onset of symptoms, with an amount of virus corresponding to **approximately 108 (100 million) copies of SARS-CoV-2 viral RNA** on average (French COVID-19 cohort data) with a variable duration of shedding in the upper airways (from 5 days to more than 5 weeks) [19].

This number of 108 (100 million) copies/ μ l corresponds to a very low Ct.

A Ct of 32 corresponds to 10-15 copies/ μ l.

A Ct of 35 corresponds to about 1 copy/ μ l.

Above Ct 35, it becomes impossible to isolate a complete virus sequence and culture it!

In France and in most countries, Ct levels above 35, even 40, are still used even today!

The French Society of Microbiology (SFM) issued an opinion on September 25, 2020 in which it does not recommend quantitative results, and it recommends to make positive up to a Ct of 37 for a single gene [20]!

With 1 copy/ μ l of a sample (Ct 35), without cough, without symptoms, one can understand why all these doctors and scientists say that a **positive RT-PCR test means nothing**, nothing at all in terms of medicine and clinic!

Positive RT-PCR tests, without any mention of Ct or its relation to the presence or absence of symptoms, are used as is by our governments as the exclusive argument to apply and justify their policy of severity, austerity, isolation and aggression of our freedoms, with the impossibility to travel, to meet, to live normally!

There is no medical justification for these decisions, for these governmental choices!

In an article published on the website of the New York Times (NYT) on Saturday, August 29, American experts from Harvard University are surprised that RT-PCR tests as practiced can serve as tests of contagiousness, even more so as evidence of pandemic progression in the case of SARS-CoV-2 infection [21].

According to them, the threshold (Ct) considered results in positive diagnoses in people who do not represent any risk of transmitting the virus!

The binary "yes/no" answer is not enough, according to this epidemiologist from the Harvard University School of Public Health.

*"It's the **amount of virus** that should dictate the course of action for each patient tested. »*

The amount of virus (viral load); but also and above all the clinical state, symptomatic or not of the person!

This calls into question the use of the binary result of this RT-PCR test to **determine whether a person is contagious and must follow strict isolation measures**.

These questions are being raised by many physicians around the world, not only in the United States but also in France, Belgium ([Belgium Health Experts Demand Investigation Of WHO For Faking Coronavirus Pandemic](#)), France, Germany, Italy, the United Kingdom, the United States and the United Kingdom. in Germany, Spain...

According to them:

"We are going to put tens of thousands of people in confinement, in isolation, for nothing. » [22]. 22] And inflict suffering, anguish, economic and psychological dramas by the thousands!

Most RT-PCR tests set the Ct at 40, according to the NYT. Some set it at 37.

"Tests with such high thresholds (Ct) may not only detect live virus but also gene fragments, remnants of an old infection that do not represent any particular danger," the experts said.

A virologist at the University of California admits that an RT-PCR test with a Ct greater than 35 is too sensitive. "A more reasonable

threshold would be between 30 and 35,” she adds.

Almost no laboratory specifies the Ct (number of amplification cycles performed) or the number of copies of viral RNA per sample µl.

Here is an example of a laboratory result (approved by Sciensano, the Belgian national reference center) in an RT-PCR negative patient:

Analyse	Résultat
Biologie moléculaire	
Respiratoire - Aspiration nasopharyngée	
RT-qPCR SARS-CoV-2	Non détecté ⁽¹⁾
<small>(1) Nouvelle méthode à partir du 30/07/2020</small>	
Remarques	
<p>(1) RECHERCHE DU SARS-CoV-2 PAR AMPLIFICATION GENIQUE</p> <p>Si résultat POSITIF: Présence du virus SARS-CoV-2 détectée dans le prélèvement; patient potentiellement contagieux.</p> <p>Si NON DETECTABLE: absence du virus dans le prélèvement.</p> <p>Causes éventuelles de faux-négatifs :</p> <ol style="list-style-type: none"> 1. La sécrétion variable du virus au niveau le nasopharynx au long de la journée peut entrainer des résultats faussement négatifs. En cas de forte suspicion clinique une confirmation sur un nouvel échantillon peut être réalisée. 2. Le virus peut devenir indétectable une à deux semaines après le début des symptômes 3. L'échantillon de prédilection est le frottis nasopharyngé profond. <p>Laboratoire reconnu par Sciensano (Institut de Santé Publique Belge) pour la réalisation d'analyses PCR SARS CoV-2.</p>	

No mention of Ct.

In the NYT, experts compiled three datasets with officials from the states of Massachusetts, New York and Nevada that mention them.

Conclusion?

“Up to 90% of the people who tested positive did not carry a virus.”

»

The Wadsworth Center, a New York State laboratory, analyzed the results of its July tests at the request of the NYT: 794 positive tests with a Ct of 40.

“With a Ct threshold of 35, approximately half of these PCR tests would no longer be considered positive,” said the NYT.

“And about 70% would no longer be considered positive with a Ct of 30!”

In Massachusetts, **between 85 and 90%** of people who tested positive in July with a Ct of 40 would have been considered **negative with a Ct of 30**, adds the NYT. **And yet, all these people had to isolate themselves, with all the dramatic psychological and economic consequences, while they were not sick and probably not contagious at all.**

In France, the Centre National de Référence (CNR), the French Society of Microbiology (SFM) continue to push Ct to 37 and recommend to laboratories to use only one gene of the virus as a primer.

I remind you that from Ct 32 onwards, it becomes very difficult to culture the virus or to extract a complete sequence, which shows the completely artificial nature of this positivity of the test, with such high Ct levels, above 30.

Similar results were reported by researchers from the UK Public Health Agency in an article published on August 13 in [Eurosurveillance](#): *“The probability of culturing the virus drops to 8% in samples with Ct levels above 35.”*

In addition, currently, the National Reference Center in France only evaluates the sensitivity of commercially available reagent kits, not their specificity: serious doubts persist about the

possibility of cross-reactivity with viruses other than SARS-CoV-2, such as other benign cold coronaviruses.

It is potentially the same situation in other countries, including Belgium.

Similarly, mutations in the virus may have invalidated certain primers (genes) used to detect SARS-CoV-2: the manufacturers give no guarantees on this, and if the AFP fast-checking journalists tell you otherwise, test their good faith by asking for these guarantees, these proofs.

If they have nothing to hide and if what I say is false, this guarantee will be provided to you and will prove their good faith.

1. We must demand that the RT-PCR results be returned mentioning the **Ct used** because beyond Ct 30, a positive RT-PCR test means nothing.
2. We must listen to the scientists and doctors, specialists, virologists who recommend the use of **adapted Ct, lower, at 30**. An alternative is to obtain the number of copies of viral RNA/ μ l or /ml sample.
3. We need to **go back to the patient, to the person, to his or her clinical condition (presence or absence of symptoms) and from there** to judge the appropriateness of testing and the best way to interpret the result.

Until there is a better rationale for PCR screening, with a known and appropriate Ct threshold, an asymptomatic person should not be tested in any way.

Even a symptomatic person should not automatically be tested, as long as they can place themselves in isolation for 7 days.

Let's stop this debauchery of RT-PCR testing at too high Ct levels and return to clinical, quality medicine.

Once we understand how RT-PCR testing works, it becomes impossible to let the current government routine screening strategy, inexplicably supported by the virologists in the safety councils, continue.

My hope is that, **finally, properly informed, more and more people will demand that this strategy be stopped**, because it is all of us, enlightened, guided by real benevolence and common sense, who must decide our collective and individual destinies.

No one else should do it for us, especially when we realize that those who decide are no longer reasonable or rational.

Summary of important points :

- The RT-PCR test is a laboratory diagnostic technique that is not well suited to clinical medicine.
- It is a binary, qualitative diagnostic technique that confirms (positive test) or not (negative test) the presence of an element in the medium being analyzed. In the case of SARS-CoV-2, the element is a fragment of the viral genome, not the virus itself.
- In medicine, even in an epidemic or pandemic situation, it is dangerous to place tests, examinations, techniques above clinical evaluation (symptoms, signs). It is the opposite that guarantees quality medicine.
- The main limitation (weakness) of the RT-PCR test, in the current pandemic situation, is its extreme sensitivity (false positive) if a suitable threshold of positivity (Ct) is not chosen. Today, experts recommend using a maximum Ct threshold of 30.
- This Ct threshold must be informed with the positive RT-PCR result so that the physician knows how to interpret this positive result, especially in an asymptomatic

person, in order to avoid unnecessary isolation, quarantine, psychological trauma.

- In addition to mentioning the Ct used, laboratories must continue to ensure the specificity of their detection kits for SARS-CoV-2, taking into account its most recent mutations, and must continue to use three genes from the viral genome being studied as primers or, if not, mention it.

Overall Conclusion

Is the obstinacy of governments to use the current disastrous strategy, systematic screening by RT-PCR, due to ignorance?

Is it due to stupidity?

To a kind of cognitive trap trapping their ego?

In any case, we should be able to question them, and if among the readers of this article there are still honest journalists, or naive politicians, or people who have the possibility to question our rulers, then do so, using these clear and scientific arguments.

It is all the more incomprehensible that our rulers have surrounded themselves with some of the most experienced specialists in these matters.

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If I have been able to gather this information myself, shared, I remind you, by competent people above all suspicion of conspiracy, such as H el ene Banoun, Pierre Sonigo, Jean-Fran ois Toussaint, Christophe De Brouwer, whose intelligence, intellectual honesty and legitimacy cannot be questioned, then the Belgian, French and Quebec scientific advisors, etc., know all this as well.

So?

What's going on?

Why continue in this distorted direction, obstinately making mistakes?

It is not insignificant to reimpose confinements, curfews, quarantines, reduced social bubbles, to shake up again our shaky economies, to plunge entire families into precariousness, to sow so much fear and anxiety generating a real state of post-traumatic stress worldwide, to reduce access to care for other pathologies that nevertheless reduce life expectancy much more than COVID-19!

Is there intent to harm?

Is there an intention to use the alibi of a pandemic to move humanity towards an outcome it would otherwise never have accepted? In any case, not like that!

Would this hypothesis, which modern censors will hasten to label "conspiracy", be the most valid explanation for all this?

Indeed, if we draw a straight line from the present events, if they are maintained, we could

find ourselves once again confined with hundreds, thousands of human beings forced to remain inactive, which, for the professions of catering, entertainment, sales, fairgrounds, itinerants, canvassers, risks being catastrophic with bankruptcies, unemployment, depression, suicides by the hundreds of thousands.

The impact on education, on our children, on teaching, on medicine with long planned care, operations, treatments to be cancelled, postponed, will be profound and destructive.

“We risk a looming food crisis if action is not taken quickly.”

It is time for everyone to come out of this negative trance, this collective hysteria, because famine, poverty, massive unemployment will kill, mow down many more people than SARS-CoV-2!

Does all this make sense in the face of a disease that is declining, over-diagnosed and misinterpreted by this misuse of overly sensitively calibrated PCR tests?

For many, the continuous wearing of the mask seems to have become a new norm.

Even if it is constantly downplayed by some health professionals and fact-checking journalists, other doctors warn of the harmful consequences, both medical and psychological, of this hygienic obsession which, maintained permanently, is in fact an abnormality!

What a hindrance to social relations, which are the true foundation of a physically and psychologically healthy humanity!

Some dare to find all this normal, or a lesser price to pay in the face of the pandemic of positive PCR tests.

Isolation, distancing, masking of the face, impoverishment of emotional communication, fear of touching and kissing even within families, communities, between relatives...

Spontaneous gestures of daily life hindered and replaced by mechanical and controlled gestures ...

Terrified children, kept in permanent fear and guilt...

All this will have a deep, lasting and negative impact on human organisms, in their physical, mental, emotional and representation of the world and society.

This is not normal!

We cannot let our rulers, for whatever reason, organize our collective suicide any longer.

Translated from French by Global Research. Original source: Mondialisation.ca

Dr Pascal Sacré is a physician specialized in critical care, author and renowned public health analyst, Charleroi, Belgium. He is a Research Associate of the Centre for Research on Globalization (CRG)

* * *

Professionals whose references and comments are the basis of this article in its scientific aspect (especially and mainly on RT-PCR):

1) Hélène Banoun

https://www.researchgate.net/profile/Helene_Banoun

PhD, Pharmacist biologist

Former INSERM Research Officer

Former intern at the Paris Hospitals

2) Pierre Sonigo

Virologist

Research Director INSERM, worked at the Pasteur Institute

Heads the Virus Genetics Laboratory in Cochin, Paris.

Participated in 1985 in the sequencing of the AIDS virus.

3) Christophe De Brouwer

PhD in Public Health Science


Honorary Professor at the School of Public Health at ULB, Belgium

4) Jean-François Toussaint

Doctor, Professor of Physiology at the University of Paris–Descartes

Director of IRMES, Institute for BioMedical Research and Sports Epidemiology

Former member of the High Council of Public Health

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