

The Sick Cycle Carousel

Round and around we go on the pathogen merry-go-round.



MIKE STONE

JUN 9, 2023



Share

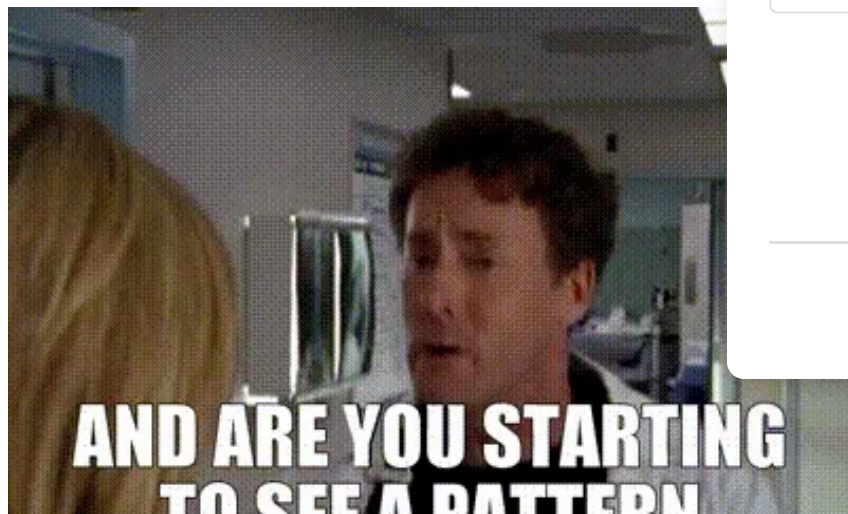


Stop me if you've heard this one before. People are suffering from the same set of non-specific symptoms that they encounter each and every year, and it is declared that a [influenza](#) outbreak is upon us. A few months pass, and despite the vaccines and treatments, the symptoms persist. However, the flu season ends, and so it is time to usher in a new culprit to blame for this continued disease. Enter a “novel virus” that has never been seen before that steps right in to take the place of the previously guilty party.

However, the protective measures, vaccines, and treatments fail to eliminate these same non-specific symptoms brought about by the novel “virus.” This requires the influenza “virus” to re-emerge after a long slumber in order to take the burden off of and absorb some of the blame for the “novel virus.” This allows for the appearance of effectiveness in the enacted measures used to combat the “novel virus” so that the fearful public do not lose faith. Yet flying in the face of all wisdom, these non-specific symptoms continue to persist, despite the season and despite the various tactics used to “contain” these “viruses.”

Thus, another culprit, going by “respiratory syncytial virus” (RSV), enters the stage in order to take the spotlight away from the failures to eliminate the non-specific symptoms of disease brought about by the previous two “viruses.” This, again, creates the illusion that the previous measures were effective at reducing the two “viruses” when those cases drop while “RSV” cases rise. As luck would have it, several vaccine contenders emerge just in the nick of time for this “respiratory syncytial virus,” a “virus” that had been in existence for decades without ever having one.

However, against the odds, these non-specific symptoms continue. Three “viruses” running around causing the exact same symptoms. The effectiveness of the measures to contain them begin to be questioned. A new contender, called the “human metapneumovirus,” makes its presence known. It should shoulder the burden of these persistent non-specific symptoms. As the three culprits go down while a rise is noted in “HMPV infections,” the countermeasures to look effective at reducing the number of cases. The three “viruses” associated with the exact same non-specific symptoms.



Discover more from 1

Exposing the lies of Germ Thec
sour
Over 3,000

Type your email...

Subs

Continue re

Sig



Of course, we are told that there are many other “viruses,” bacteria, and even fungi currently running around rampant and causing these same symptoms of disease (remember [tomato flu?](#)). Despite the various treatments, vaccines, and medical interventions available, and despite spending more money on combating these “pathogens” than ever before, these same symptoms of disease persist. In fact, judging by the headlines, there are more pathogens appearing regularly in order to wreak havoc on our health than ever before:

Virologist explains why so many viruses such as Covid and bird flu are emerging

“Instead, we’ve been regularly hearing about outbreaks of newly emerging or re-emerging viruses.

“So, is the incidence of virus outbreaks increasing? Or, have we just become better at detecting outbreaks thanks to improved technology developed during the COVID pandemic? **The answer may be a bit of both**”.

Putting things into perspective, Dr. Broadbent said there are “**an estimated 1.67 million viruses yet to be identified that currently infect mammals and birds. Of these, it is thought that up to 827,000 have the potential to infect humans**”.

[https://www.irishmirror.ie/news/irish-news/health-news/virologist-explains-many-virusessuch-covid-29468789?](https://www.irishmirror.ie/news/irish-news/health-news/virologist-explains-many-virusessuch-covid-29468789?int_source=amp_continue_reading&int_medium=amp&int_campaign=continue_reading_button#amp-readmore-target)

[int_source=amp_continue_reading&int_medium=amp&int_campaign=continue_reading_button#amp-readmore-target](https://www.irishmirror.ie/news/irish-news/health-news/virologist-explains-many-virusessuch-covid-29468789?int_source=amp_continue_reading&int_medium=amp&int_campaign=continue_reading_button#amp-readmore-target)

If we are to believe the headlines and the doctors and virologists behind them, beyond climate change ([yep...](#)), this surge in infectious disease is due to our improved abilities to detect “viruses.” However, there is an estimated 1.67 million unidentified “viruses,” of which at least 827,000 of them may be able to “infect” us, that can pop up at a moment’s notice in order to slide in as the cause for the same symptoms of disease. Thus, we are left with more cases of old “viruses” due to our ability to “detect” them, as well as the threat of

“viruses” that are currently in the process of being identified. All of which is the result of

new viruses waiting in the wings to take their place. All the while, the same symptoms of disease persist in the face of the massive efforts to contain them. Let's see if we can make some sense of this madness by taking a quick look at what appears to be the latest “viral” contender for the prestigious “Respiratory Virus of the Year” award. We can then examine how this revolving door of “viral” causes for the exact same symptoms of disease can keep on spinning through diagnostic tricks as long as people continue to believe in them.

HMPV SYMPTOMS

RUNNY NOSE • SORE THROAT • FEVER • COUGH
NASAL CONGESTION • SHORTNESS OF BREATH

“HMPV” is the newest addition to the “viral” ride that is being used to blame for the exact same respiratory symptoms that are regularly seen with the common cold, influenza, “Covid-19,” and “RSV.” While it was “discovered” by a team of Dutch researchers in 2001, “HMPV” has remained in relative obscurity to the public at large. In order to discover this “virus,” the researchers analyzed the nasopharyngeal swabs collected over a 20 year period of an unrelated group of 28 children suffering from “RSV-like” symptoms of disease. They ruled out “RSV” as the cause of the disease these children suffered from based upon results from the always reliable (note sarcasm) [PCR testing](#). The researchers then claimed to have found unidentified “viruses” within these NP swabs when they cultured samples in both Vero and A549 cells. However, “viral” growth was slow until trypsin, a protein digester, was added to the culture. The cytopathogenic effect (CPE), a sign of cell death that was observed in the [cell culture](#), was then said to resemble that seen in “RSV” cultures. Despite

the similarities between “HMPV” and “RSV,” somehow through the power of pseudoscientific imagination, a new “virus” was born.

A Zoonotic Origins of Human Metapneumovirus: A Journey from Birds to Humans

“In 2001, a Dutch group performed virus isolations from clinical samples from 28 epidemiologically unrelated children that had been collected over a time span of 20 years [14]. These children, spanning 0–5 years of age, all shared common characteristics of suffering from a respiratory tract infection (RTI) suggestive of RSV infection for which the most common causes of RTI were ruled out by PCR testing. The distinctive growth phenotype of HMPV in cell culture provided the initial data suggesting that a novel respiratory virus had been isolated. Virus growth in tertiary monkey kidney (tMK) cells was very slow and was only observed in Vero and A549 cells upon the addition of exogenous trypsin to the cell culture medium [14]. The observed cytopathic effects (CPE), which appeared 10–14 days post-inoculation, were analogous to those of RSV infection, displaying large syncytia formation with sudden internal disruption of the multinucleated cells leading to detachment.”

<https://www.mdpi.com/1999-4915/14/4/677>

Through the beauty of cell culture, PCR, and a dash of pseudoscientific magic, researchers are allowed to go back and use swabs from over a 20 year period in order to “find” new “viruses” for the exact same symptoms of disease. Essentially, they conjured up a new label to be applied when one of the others won't do. What this ultimately led to is a “new virus” that is identical to “RSV,” and just like many other respiratory “viruses,” it doesn't even need to be tested for in order for a diagnosis to be made:

Diagnosing hMPV

“Most health care providers will diagnose you with a cold based on your symptoms and the time of year. With this diagnosis, your health care team won't try to find out which virus caused your symptoms because knowing won't change the treatment you receive.

In some cases, particularly at the height of the flu season, your provider may test you for influenza.”

<https://foundation.chestnet.org/lung-health-a-z/human-metapneumovirus-hmpv/?Item=Diagnosis>

There are a few reasons why these common cold “viruses” are not tested for regularly. For one, it is stated that lab tests do not exist for the common cold, only for the flu:

Labs and Tests

“A physical exam is the primary way healthcare providers diagnose colds and the flu, but they sometimes confirm that diagnosis using other methods like labs and tests.

No lab tests exist to diagnose colds—a quick physical exam or self-check is usually all that’s needed—but there are several available to test for flu, including rapid tests that can be done in a clinic or at home.”

<https://www.verywellhealth.com/cold-flu-diagnosis-4689129>

Even if doctors were to test for the common cold, it is stated that the patient will normally feel better within a week, and thus, test results are useless:

Clinical course and diagnosis

“Symptoms caused by colds typically last for 1 to 2 weeks, and most patients will feel better after the first week. **Tests are of no use in diagnosing the common cold.**”

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2231439/>

As the treatment will always remain the same, it is claimed that they do not need to test for the specific causal “virus.” They can just assume which one is the cause, or leave it blank altogether. In other words, if doctors see non-specific symptoms that they determine are a cold rather than seasonal allergies, they will say “it’s just a virus that needs to run its course.” Thus, we will see random labels such as “viral syndrome,” “upper respiratory infection” or “acute viral rhinitis.” These are all fancy doctor terms used to say that it’s just a cold without stating what the “virus” is that is actually supposed to be the cause:

Your kid is really sick, but the doctor says it's 'just a virus'

“If you do take your child to the doctor for a virus of the “just a” variety, she may be diagnosed with a “viral syndrome,” “upper respiratory infection” or “acute viral rhinitis.” These are doctor terms for “a cold.” (When you go to the trouble of bringing your child in, we don’t want to seem like we are downplaying your concerns, so we use a complicated medical term instead of “a cold.”)

After making this diagnosis, the doctor will probably provide reassurance and recommend “symptomatic care.” This means fluids, rest, humidifiers — things you were probably doing already. I promise, it’s not that we don’t understand how miserable “just a” viruses can be. Trust me, we’ve all picked up more than our share from snotty little kids (including our own). It’s also not that we don’t care. **It’s just that we have nothing else to offer.**

But don’t worry. **It’s just a virus.** He’ll be fine.”

https://www.washingtonpost.com/national/health-science/your-kid-is-really-sick-but-the-doc-says-its-just-a-virus/2015/03/16/e89ff86a-c347-11e4-ad5c-3b8ce89f1b89_story.html



- The common cold (also known as nasopharyngitis, rhinopharyngitis, acute coryza, or a cold) is a viral infectious disease of the upper respiratory system which affects primarily the nose.
- Symptoms include a cough, sore throat, runny nose, and fever which usually resolve in seven to ten days, with some symptoms lasting up to three weeks.
- Well over 200 viruses are implicated in the cause of the common cold; the rhinoviruses are the most

common.

Another reason doctors do not regularly perform any specific testing to determine what “virus” a person is infected with is due to the plethora of “viruses” that they would have to test for that are claimed to cause the same symptoms of disease. [According to the CDC](#), there are well over 200 different respiratory “viruses” associated with the exact same symptoms of disease. These 200+ different “viruses” are said to be mostly “[rhinoviruses](#)” and “[enteroviruses](#)” that “infect” the majority of people without any signs of disease whatsoever:

Rhinovirus and Enterovirus

“About 50% of common colds are caused by some kind of rhinovirus. There are more than 100 rhinoviruses and 100 enteroviruses that can infect people.

Non-polio enteroviruses and rhinoviruses are very common viruses. **Most infected people have no symptoms** or only mild symptoms, but some infections can be serious, especially among infants and people with weakened immune systems.

Examples of enteroviruses include [Enterovirus-D68 \(EV-D68\)](#); [Hand, foot, and mouth disease](#); [Viral meningitis](#); and Viral conjunctivitis.”

<https://www.dhs.wisconsin.gov/disease/rhino-entero.htm>

Of course, there are a variety of other assumed “viral” causes of these identical symptoms as well, many of which we have seen in recent headlines such as “[adenoviruses](#),” “[coronaviruses](#),” “parainfluenza viruses,” “influenza viruses,” “respiratory syncytial viruses,” “rotaviruses,” “[noroviruses](#),” and “human metapneumoviruses.” They have a veritable pick of the litter to choose from in order to identify a culprit that can be used to frighten the masses with. Testing for a specific “virus” boils down to the location and whether or not they have the capabilities to carry out the tests.

However, when testing is actually done in order to determine which specific “viruses” are

prevalent, usually for research purposes, we find that there are issues that keep this data from being reliable beyond the problems related to fraudulent PCR testing. For starters, most commercial panels cannot distinguish between “rhinoviruses” and “enteroviruses.” Perhaps this could be the reason why these “viruses” are considered to be the most prevalent, accounting for over 50% of the cases. If the tests can not determine one “virus” from another, how would researchers ever be able to declare which one of the two “viral” families is actually causing the majority of the cases? What if it is a completely separate “virus” that mimics both during testing? Without being able to distinguish between two “viral” families that contain over 100 related “viruses” in each of their respective families, the results are essentially meaningless.

Second, the tests used by hospital labs usually only include a limited list of pathogens such as “influenza, RSV, and adenovirus.” This means that hospital labs are only testing for random “viruses” that they are told may be prevalent while ignoring the remaining 200+ “known viruses” that are hiding out there in the ether somewhere. Thus, certain “viruses” are given preferential treatment over others in order to generate case numbers via the fraudulent tests.

Third, in a year-long study that tested 108 adults and children weekly for “adenovirus, human bocavirus, coronaviruses HKU1, NL63, OC43, and 229E, enterovirus, influenza A (including subtype identification for H1, H3, and A/H1N1pdm09), influenza B, human metapneumovirus, parainfluenza viruses 1–4, respiratory syncytial virus, and rhinovirus,” half of those who tested positive were entirely asymptomatic (i.e. healthy). In nearly half of those with respiratory symptoms, there was no “virus” found whatsoever. In other words, the researchers found “viruses” in those who were healthy, and they could not find the “viruses” in many of those who were unhealthy when using PCR tests designed to look for specific “viral” causes. This means that the positive result did not reflect the health status of the patient. Despite the lack of any “virus,” it was still assumed that a “virus” must be present within the symptomatic cases that tested negative:

Making Sense of Respiratory Viral Panel Results

What Viruses Do PCR-based Panels Detect?

“While there is some variation among panels, most multiplex PCR-based respiratory

viral [panels test for](#) influenza, respiratory syncytial virus (RSV), adenovirus, parainfluenza virus, adenovirus, coronavirus (not that coronavirus—see below), rhinovirus, enterovirus, and human metapneumovirus; some also include [bocavirus](#) and offer subtyping of influenza, parainfluenza, RSV, and coronavirus. (Of note, most panels cannot distinguish between rhinovirus and enterovirus.)

The “respiratory viral panel” (RVP) offered by a given hospital or clinic lab may refer to one of a number of different tests. The focus of this article is on commercial multiplex systems, in which a company produces both a testing platform and the associated consumables (cartridges to which the patient sample, usually a nasopharyngeal swab, is added), but some labs offer PCR-based tests that they have developed and validated in-house, known as [laboratory-developed tests](#) (LDTs). The LDT tests or test panels offered by a hospital laboratory are unlikely to be as extensive or comprehensive as the panels provided with commercial platforms and usually include a more limited list of pathogens – for example, influenza, RSV, and adenovirus.”

“Not all positive results indicate current active infection. Indeed, a study of 108 adults and children who underwent [weekly RVP testing](#) for a year found that approximately half of all viral detection episodes were asymptomatic.”

“RVPs do not test for every viral cause of respiratory tract infections, despite their extensive testing breadth; in nearly half of the symptomatic respiratory illness episodes reported in the year-long study described above, [no virus was detected](#). Furthermore, false-negative results are possible with any test, and are more likely for RVPs if [suboptimal sampling procedures](#) are performed. If a patient has a negative RVP in the setting of what clearly appears to be viral respiratory infection, **there’s probably a virus in there somewhere.**”

<https://asm.org/Articles/2020/March/Making-Sense-of-Respiratory-Viral-Panel-Results>

As the testing is essentially meaningless, doctors and researchers will normally slap an “acute viral rhinitis” label as the cause. If, for some reason, they do want to seek a certain “virus,” targeted PCR and/or a “viral” culture may be performed in order to try and pin it on a specific culprit. These different labels can then be utilized to make it appear as if the treatments are effective at reducing the different “viruses” circulating while the same symptoms of disease persist amongst the population due to a “different pathogen.”



Medical

NREVSS

means

National Respiratory and Enteric
Virus Surveillance System

by [acronymsandslang.com](https://www.acronymsandslang.com)

Even though the test results are fraudulent, in order to perpetuate this “viral” fear, random testing is done through the *The National Respiratory and Enteric Virus Surveillance System (NREVSS)*, a reporting system made up of university and community hospitals, selected state and county public health departments, and commercial entities. They report on data generated by random antigen, PCR, and cell culture tests which goes straight to the CDC in order to create their guesstimates, graphs and reports for their *Morbidity and Mortality Weekly Report*. This information, in turn, is picked up on by mainstream media outlets for fear-promoting headlines:

The National Respiratory and Enteric Virus Surveillance System (NREVSS)

“The National Respiratory and Enteric Virus Surveillance System (NREVSS) is a laboratory-based system that monitors temporal and geographic circulation patterns (patterns occurring in time and place) of respiratory syncytial virus (RSV), human parainfluenza viruses (HPIV), human metapneumovirus (HMPV), respiratory adenoviruses, human coronavirus, rotavirus, and norovirus. In this surveillance system, **participating U.S. laboratories voluntarily report weekly to CDC the total number of weekly aggregate tests performed to detect these viruses, and the weekly aggregate**

positive tests. They also report the specimen type, location, and week of collection. NREVSS allows for timely analysis of data to monitor viral seasons and circulation patterns.

NREVSS was created in the 1980s to monitor seasonal trends in influenza and respiratory syncytial virus (RSV). In 2007, data collection for rhinovirus, enterovirus, and human metapneumovirus began. Influenza specimen information, also reported to NREVSS, is integrated with CDC Influenza Surveillance. **On a weekly basis, participating U.S. laboratories from university and community hospitals, selected state and county public health departments, and commercial entities, voluntarily report the total number of tests performed, the method used for detection, and the number of those tests with positive results. Reports include virus antigen detections, isolations by culture, and polymerase chain reaction (PCR) results on a weekly basis.**

CDC makes NREVSS data available through the graphs on this website to public health professionals, health care providers, and the public. **CDC also publishes periodic summaries and alerts based on NREVSS data** in CDC's Morbidity and Mortality Weekly Report and in peer-reviewed journals.

We anticipate that NREVSS will continue to play an important role in describing the temporal and geographic circulation patterns of respiratory and enteric viruses—including deviations in the typical annual circulation patterns and identifying viral outbreaks. **NREVSS has proven to be a relatively simple and practical surveillance system that will continue to be an important part of CDC's efforts to treat, prevent, and control respiratory and enteric viral diseases."**

<https://www.cdc.gov/surveillance/nrevss/index.html>

However, there are some pretty glaring problems with this system used to create the guesstimates for the CDC. For starters, according to the CDC, the testing capabilities of each participating lab varies as well as the intentions for testing certain pathogens. Thus, it is a limited system built with inherent bias:

"NREVSS aggregate, weekly tests are reported specifically for each pathogen. NREVSS participating laboratories' testing capabilities vary annually, and testing intentions vary for each pathogen. A range of 50–178 laboratories met the pathogen-specific

criteria for inclusion criteria during a given surveillance year.”

<https://www.cdc.gov/mmwr/volumes/70/wr/mm7029a1.htm>

According to *healthdata.gov*, there are other issues with this data as well. While reiterating that testing practices and the number of participating laboratories can change from year to year, it is pointed out that the results can be changed at any point for two years after the data has been reported. It is noted that the NREVSS does not collect patient-data or demographic information and that multiple samples may be collected from a single patient. This means that NREVSS results do not reflect the number of patients tested nor does it reflect hospitalizations or deaths related to any particular “virus.” Also, it is said that without direct knowledge of the population base, NREVSS cannot be used to determine the prevalence or incidence of “infection.” In other words, the results are unreliable and worthless in spite of the fact that it is entirely reliant upon fraudulent antigen, PCR, and cell culture data. However, this does not stop the data from being used to claim an increase in cases of a specific “virus” that is preferentially chosen to be in the spotlight:

(NREVSS)

“Clinical laboratories do not report demographic data through NREVSS. **Testing practices and the number of participating laboratories may change from year to year. Results can be changed two years after the initial reporting week.** However, discrepancies may be noted and updated at the discretion of the data stewards and key stakeholders. Data are collected from collaborating university and community hospital laboratories, select states and county public health laboratories, and commercial laboratories. This information is submitted and updated on a weekly basis. While NREVSS strives to present the most precise national, regional and state respiratory viral trends with the least amount of burden possible for participating laboratories, there are a number of inherent limitations to this surveillance system. **NREVSS does not collect patient-data or demographic information. Multiple samples may be collected from a single patient, so NREVSS results do not necessarily reflect the number of patients tested nor does it reflect hospitalizations or deaths related to a particular virus.** Participating laboratories vary in size, testing capabilities, and areas served. Some institutions may receive and test samples from sites across a given state or even from

multiple states. Without direct knowledge of the population base, NREVSS cannot be used to determine the prevalence or incidence of infection.”

https://healthdata.gov/widgets/7zqg-bp9w?mobile_redirect=true

© MARK ANDERSON, WWW.ANDERSTOONS.COM



**“It’s just some viral marketing;
you’ll be fine.”**

With the ability to generate new “viruses” for the same symptoms on demand from a pool of unidentified “viruses,” assume “viral” causes without any testing whatsoever, and create

guesstimates based upon fraudulent targeted testing for preferential “pathogens” whilst ignoring the vast majority of the other potential causes, there is an unlimited ability to keep this perpetual state of fear in the invisible boogymen rolling. All that is needed is for people to accept the new name, the "accuracy" in the lab results, and the resulting CDC data in order to cover up the fact that these symptoms still persist under different names at the same levels, or even worse, than they had been before. As long as we are focused on the microbial invader, we will never get to the root causes of why these symptoms of disease continue to persist despite increasing efforts to combat them. Until we collectively decide that the ride is over, this sick cycle carousel will keep on spinning.



Here are two related articles on the tricks used to keep this sick cycle carousel spinning.

Differential Diagnosis?

MIKE STONE · NOVEMBER 25, 2022

MERCYONE.

Source: CDC

COVID-19 vs. Cold vs. Flu

COVID-19	SYMPTOMS.....	COLD	SYMPTOMS	FLU	SYMPTOMS.....
	<ul style="list-style-type: none"> ● Fever or chills ● Cough ● Shortness of breath or difficulty breathing ● New loss of taste or smell ● Sore throat ● Congestion or runny nose 		<ul style="list-style-type: none"> ● Cough ● Sore throat ● Runny nose ● Body aches ● Headaches ● Sneezing 		<ul style="list-style-type: none"> ● Fever or chills ● Cough ● Sore throat ● Runny or stuffy nose ● Muscle or body aches ● Headaches ● Fatigue (tiredness) ● Vomiting and diarrhea

differential diagnosis : the distinguishing of a disease or condition from others presenting with similar signs and symptoms <https://www.merriam-webster.com/dictionary/differential%20diagnosis> I imagine most of us have “fond” memories of going to the doctor when feeling unwell and getting subsequently poked and prodded in order to determine a “cause” for t...

[Read full story →](#)

The Magic Trick

MIKE STONE · JAN 20



I was recently in a discussion on Twitter with a user who was utterly convinced in the power of vaccination to end “viral” diseases. This person believed that smallpox had been successfully wiped off the face of the Earth through the injection of toxins directly into the bloodstream and that the defeat of polio was well within our grasp through these same methods. It did not matter one iota to this individual that the evidence supporting the belief that vaccines led to a decrease, and in some cases “elimination,” of a particular disease was entirely fraudulent. No matter how hard I tried to pull the curtain back in order to reveal the magic tricks that had successfully led to the diehard indoctrination, this person resisted and fought feverishly to maintain the illusion. The cognitive dissonance was unfortunately too strong to overcome.

[Read full story →](#)

[Christine Massey's "germ" FOI Newsletter](#) provided another round of eye-opening

[Read more of Christine Massey's FOI Newsletter](#)