



NEWSLETTER JANUARY-FEBRUARY 2022

A warm welcome to the Millhouse community and other readers,

Most will be glad that the 2021 frustrations of lockdown, with forced waiting in supermarket lines, inability to dine out, restricted classroom learning and the curtailing of local travel have ended, but others will be exasperated they cannot freely resume international travel.

In 2022 what is certain is that COVID-19 is here to stay. Whatever variant appears, we must learn to live with the virus and accept that over time most will become infected. We need to be proactive, using vaccination to forewarn the body of the virus, to adopt positive lifestyle change (de-stress, relaxing sleep, healthy diet, low-no alcohol, beneficial nutrients) that strengthens the immune system, and to treat COVID infection early to minimise the severity of disease.

Vaccination provides good protection, reducing COVID transmission, disease severity and possible death. The United Kingdom (UK) Health Agency in December reported that vaccination gives "*protection that wanes against symptomatic disease with increasing time after dose 2, and by 10 weeks after the booster dose, with a 15 to 25% reduction in vaccine effectiveness after 10 weeks. This waning is faster for Omicron than for Delta infections.*" (p4, Briefing 33) On January 4 [Professor Sir Andrew Pollard](#), chairman of the UK Joint Committee on Vaccination and Immunisation said, "*that giving boosters to people every six months is not sustainable... we need to target the vulnerable in future, rather than giving boosters to all over-12s.*"

Know your risk. I have reminded readers in previous newsletters that the most vulnerable to COVID are the elderly, frail, grossly overweight, diabetic, sufferers of significant chronic illness and those on immunosuppressant medication. For those people, it is most important to continue to avoid crowded indoor public areas, and to be vigilant in washing hands and wearing masks, as well as forbidding friends and family with cold and flu symptoms to enter your house.

We are fortunate in New Zealand that our reasonably effective quarantine measures kept COVID at bay for many months, but DELTA finally entered and now the more infectious, though less deadly OMICRON has breached the walls. This summer, relax, live outdoors and allow the sun's ultraviolet rays to fortify your protective vitamin D stores. Winter 2022 will be the time of greatest COVID infection, so be prepared and plan now.

In this newsletter I again review four COVID countries, and discuss the new variant OMICRON and what treatment can be used if you do become infected.



MILLHOUSE NEWS

VIDEO CONSULTATIONS are important for the Millhouse Team as we begin to manage COVID infection in the community. For most the illness is mild, but others will experience a severe flu-like illness, with a few requiring hospital care.

With increasing COVID community infection, our **NURSE TEAM** will be primarily responsible to assist the many who become infected with COVID. Through video and phone conversations, our nurses will assess status, monitor progress, and liaise with your family doctor, community support agencies and (if needed) the hospital specialist.

COVID SWABS continue to be taken at **130 MILLHOUSE**. If you have any COVID symptoms, please have a test ASAP. Ring for an appointment. Reception will give you a booking time and you can park in the 130M carpark but remember to stay in your car when you arrive. Ring Reception again and a nurse will come and take the swab while you remain in your vehicle.

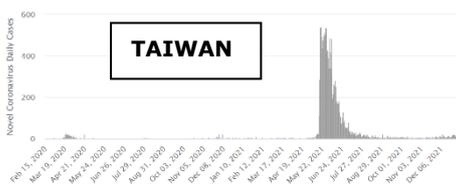
COVID VACCINATION continues to be available at **130 MILLHOUSE** with age 5 – 12 child immunisation available now. Please ring Reception for an appointment.

DR THERESE has returned to working her normal consulting hours.

FOUR-COUNTRY COVID REVIEW

Since the last newsletter on 9th November, **Taiwan** with a population of 9.8 million, has managed exemplary COVID control (see graph) with only 684 cases and 3 deaths. The Taiwanese are 69% totally vaccinated but demonstrate a [high level of civic responsibility](#) and cooperation in contact tracing, quarantine measures and the use of face masks. **New Zealand** however, with half the population, has had near 7000 new cases (evident in the middle graph) and 20 more deaths. 5% of all cases required hospitalisation and 0.35% have died – 1 death in every 300 known cases. However, epidemiology modelling suggests [the true incidence of infection](#) could be up to 3x higher, and if so, the mortality rate may be closer to 1 in 1000 cases. For 95% of people COVID infection is not a serious illness. NZ has achieved 76% vaccination of the total population (equivalent to 92% of the eligible population over 12years).

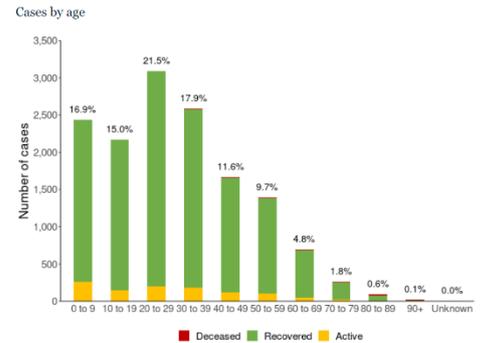
9 January 2022	Total cases	Cases/million	Total Deaths	Deaths/million
TAIWAN	17,302	724	850	36
NEW ZEALAND	14,525	2,904	51	10
SWEDEN	1,416,650	138,959	15,331	1,504
USA	60,513,640	181,208	858,519	2,571





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Those primarily infected in NZ are under 40 (see graph opposite), with Māori (36%) and Pacifica (24%) more highly represented and fewer infections for European & others (25%) and Asian (11%). The third graph shows **Sweden** with a population twice that of NZ. In the first and second COVID waves there were no restrictions but to curb the third wave limitations were introduced and later relaxed, when case numbers dropped during summer. However, during the current fourth wave, with another 252 deaths since early November, [restraints were reimposed](#) for restaurants, gyms, museums, and sporting events as well as enforcing working from home. The Swedes are 71% vaccinated.



OMICRON THE LATEST VARIANT

In last September's newsletter I mentioned how COVID enters the lining of the respiratory tract and begins viral replication that can peak anywhere between 1-100 billion, and it not surprising with so many viral particles that mutation variants occur. OMICRON was first detected in a South African (SA) blood sample taken on 8th November 2021 and within weeks this new variant had spread around the world. This virus has a much greater mutation difference than other variants suggesting it [evolved more slowly](#), allowing additional genetic change to take place without killing the host. Such slow change is often observed in the immunocompromised possibly from the HIV community which comprise 20% of the SA population.

OMICRON is less deadly but more contagious, invading the upper airways and conducting lung tubes, but it does not penetrate the lung tissue like DELTA. [A recent Danish study](#) reported it was 2.7-3.7 times more infectious than DELTA and can evade immune detection; however, those who were fully vaxxed or had received booster vaccination were less susceptible to the infection compared with the unvaccinated. The most [common symptoms for OMICRON](#) are a runny nose, headache, fatigue (either mild or severe), sneezing, and sore throat, like the common cold and flu and is [best detected with saliva testing](#) rather than nasal swabbing.

DR SHANKARA CHETTY

Recently I listened to [Dr Shankara Chetty](#), seen here outside the tent he erected at his home to treat COVID patients, discussing his experience treating thousands of COVID patients in rural South Africa, without experiencing one death and no hospitalisations. Chetty recognized that COVID began with respiratory illness, like the common cold and flu (viral replication phase) but that around DAY 7 some patients suddenly become acutely short of breath, with dry mouth, wheeze, and low levels of oxygen. He assumed this was like a Type I hypersensitivity, an acute allergic-reaction to the viral protein fragments which provoked the immune system to release chemical mediators - histamine, leukotrienes and inflammatory cytokines - inducing acute lung inflammation and tissue death.



His treatment to inhibit the viral replication was hydroxychloroquine (not recommended in NZ) and to prevent the *hypersensitivity-inflammatory* reaction occurring he added an antihistamine (Promethazine-Allersoothe), antileukotriene (Montelukast-Singulair), anti-inflammatory (Naprosyn) and aspirin to prevent clotting. For treatment in the *hypersensitivity-inflammatory phase* high-dose corticosteroids (oral prednisone & a steroid inhaler) were used, with nebulized adrenaline if needed. Using oxygen levels, blood inflammatory markers and IGE he identified persons at greatest risk.

For those with gastrointestinal symptoms an H2-antihistamine (Famotidine) was added. He also suggested that COVID vaccination spike protein reactions and LONG COVID inflammation can be treated in a similar manner. In his paper ['Elucidating the Pathogenesis and Treatment of Covid'](#), Chetty writes that "no treatments in current use... have shown such rapid response and predictable outcome in severely ill patients negating the need for oxygen and hospitalisation."

TREATING COVID

Remember for most, COVID infection is a mild illness only requiring symptomatic relief. I have listed in the table opposite my recommendations for treating those who are clinically distressed. Currently there is no medication available to stop viral replication. However a new generation antiviral drug from Pfizer, [Ritonavir](#) (Paxlovid-protease inhibitor), appears to be effective if used within the first 3 days of symptoms beginning. We will continue the COVID discussions in the next newsletter.

Yours in good health
Dr Richard J Coleman

SUGGESTED ADULT COVID TREATMENT PLAN

FOR SYMPTOMS get a COVID test ASAP

CONTINUE TO TAKE Vitamin D 50,000iu weekly, Vitamin C 1-2gm 4-6 hrly, Zinc 50mg daily, Quercetin 500mg x2 daily, N-Acetyl Cysteine 600mg x2 daily & Melatonin at night.

VIRAL PHASE

- Symptomatic relief with Ibuprofen or Celecoxib
- Use one of the Mouth & Nasal washes 3-4x daily to reduce the viral load in the upper respiratory tract when symptoms appear.
 - 0.5% iodine solution - Betadine gargle
 - Hydrogen peroxide mouth wash - buy 6% solution - dilute 6parts water = 1%
 - Chlorhexidine mouth wash gargle
 - Colloidal silver mouth wash gargle
 - Rock Salt 2-3tsp & Baking soda 1tsp in glass water gargle
- Aspirin 300mg for fever, pain & anticoagulation

INFLAMMATORY ALLERGIC PHASE

The following may be prescribed

- Promethazine (H1-antihistamine) 25mg up x3 daily
- Montelukast (antileukotriene) 10mg daily
- Corticosteroids
 - Budesonide (Steroclear) 100 Nasal Spray
 - Budesonide (Pulmicort) 400 Turbihaler
 - Oral Prednisone varying dose according to severity of illness
- Famotidine (H2-antihistamine) for gut symptoms
- Continue Aspirin 300mg daily

Monitoring will include

- Daily oxygen monitoring
- Daily liaising with Nurse +/- Doctor
- Referral to Middlemore Hospital if needed

REST and isolate from others at home.