ISSN: 2753-7919
British Journal of Healthcare and Medical Research; Vol. 13 No. 06 (2026) (211-215)
https://doi.org/10.14738/bjhr.1306.12839

A Current Epidemiological Perspective on Influenza Viruses and COVID-19

Giulio Tarro

President of T.&L. de Beaumont Bonelli Foundation for Cancer Research, Naples, Italy

Abstract: From the plague of past centuries to the tuberculosis of the nineteenth and early twentieth centuries, no less than in antiquity, disease has always been a quintessential literary theme. The combination of medicine and literature lends itself to numerous interpretations. Since 1977, the year it appeared in the prestigious Journal of the American Medical Association (JAMA), narrative medicine has highlighted how evidence-based medicine fails to take into account all those emotional aspects that characterize a person and influence the state of the disease. Starting with influenza virus epidemics, history teaches us that influenza originates in birds, generally aquatic, and then passes to humans via the "leap" into pigs. Promiscuous breeding, as is common in Asia, determines this passage and its subsequent spread. This is how the Spanish flu (1918, H1N1), the Asian flu (1957, H2N2), the Hong Kong flu (1968, H3N2), and so on, originated. Strains spread in some years may also present relationships with those of other years. Younger people have antibodies directed against the most important antigens of the strains they have come into contact with. As they age, a broader spectrum of immunity is observed, reflected in the polyvalent antibodies acquired through contact with numerous primary and secondary antigens present in the strains encountered over the course of subsequent years. Each subsequent contact with a type A influenza virus results not only in the production of strictly characteristic antibodies, but also in an increase in those directed against the strain responsible for the subject's first influenza infection (Davenport phenomenon or doctrine of "original antigenic sin"). Thus, immunization against a particular strain, prevalent at a given time, progressively hinders its further distribution and creates a selective advantage for some variant of the virus to multiply and spread. The new strains will be able to multiply in their hosts, regardless of whether they have had immunological experience with previous strains. As a result, shortly after the emergence of a new strain, the old forms will disappear and the new family will become dominant for a period that generally lasts 10–20 years. During this period, due to the appearance of minor antigenic variations, the family will split into various subtypes.

Keywords: Influenza Virus, COVID-19, Vaccines, FDA, SARS

INTRODUCTION

The emergence of a new epidemic virus strain can be considered a developmental process involving the strain's characteristics and the population's susceptibility. For a strain to be widely distributed, its antigenic characteristics must allow it to escape neutralization by the host's and surrounding population's antibodies. Thus, epidemic outbreaks can occur with those strains possessing dominant antigens that adapt to the population's antibody deficiency, or rather, its lack of antibodies. In conclusion, it seems that the influenza A virus displays a capacity and aptitude for survival that hinges on the emergence of new antigenic models, allowing the virus to easily blend into populations still partially immune to previous antigenic forms. From this perspective, the variations of influenza A viruses can

be conceived as a unitary process, within the framework of an evolutionary principle and development, called by Burnet "immunological drift. " It is very important to remember that the presence of antibodies against the most recent Asian strains of 1957 (A2) has been demonstrated precisely in the oldest segment of the population at the time: in the Asian flu, strains with dominant antigenic characteristics have evidently reappeared, different from those that had characterised the more or less previous years, but similar to those of the strains that had spread much earlier (Pandemic 1889-90) [1-4].

METHODS

During the avian influenza epidemic that struck ten Asian countries in 2006 (Hong Kong, China, Pakistan, Thailand, Cambodia, Indonesia, South Korea, Taiwan, Laos and Vietnam) with 80 million dead or sacrificed chickens and 42 human fatalities, the H5N1 virus was identified as the etiological agent, the same virus that in 1997 had caused an epidemic outbreak in Hong Kong with 18 infected humans and 6 deaths and the sacrifice of 1.5 million chickens.

In 2006, outbreaks of avian influenza (H7N2) were identified in the United States in Texas and Delaware. Delaware, along with the states of Maryland and Virginia, employed 14,000 people and 1,900 families, producing 8% of America's poultry meat, with a turnover of $1.5 billion. In 2003, American exports to Europe reached 8,800,000 eggs and 452,000 chicks, worth over €20 million.

While direct contact was required for SARS—in practical terms, the so-called Pflugge droplets—this flu was different; it spread through the air, even over long distances. It was completely unnecessary to create a panic attack, which often occurs through misinformation or a lack of understanding of the phenomenon. Therefore, there's no need to raise alarm because the death toll was significantly lower than that of other influenza viruses [5-7].

RESULTS

Given the emergency created by the "swine flu" epidemic in Mexico, it was right not to create alarmism, being victims of misinformation. The possibility of the virus reaching other parts of the world was present, as is the case with all influenza viruses.

This disease was caused by a new H1N1 “swine” influenza virus that then caused a global epidemic.

The spread of the virus in at least two WHO regions (Africa, the Americas, Europe, the Mediterranean, Southeast Asia, and the Western Pacific) has automatically triggered alert level 6, the definition of a pandemic. So, it was a necessary step, I'd say... but overdue!

Fortunately, there was no cause for concern because the virus was not aggressive; in fact, its mortality rate was lower than that of seasonal viruses.

There is a potential risk of genetic recombination with already circulating human influenza viruses, which could have resulted in a viral variant capable of aggressive and more harmful human-to-human transmission [8-10].

This flu spread through the air with so-called Pflugge droplets or by direct contact, through hands contaminated by secretions.

It is essential to follow basic principles of good hygiene (wearing a mask when near potentially flu-infected patients and washing your hands frequently).

The vaccine for the new A/H1N1 influenza virus, currently being distributed, was effective in preventing the disease in 70-80% of cases, 2-3 weeks after its intramuscular administration, the time required for the body to develop specific antibodies. A single dose appears to have been sufficient, without the need for a second vaccination 30 days after the first.

The massive promotional campaign for the vaccine is justified by the fact that by stopping the flu, the majority of the population will be protected because it reduces the spread of the virus, which, while not aggressive, is highly contagious. The prototype vaccines, prepared in advance, have not reported any adverse side effects, except for mild reactions already observed with similar seasonal flu vaccines [11-13].

DISCUSSION

The truth about SARS, why the virus is spreading, China's cover-up, how scared we should be, and other details are summarized. The main goal is to compare previous coronavirus epidemics with the one that has occurred since 2019 and to highlight the main preventions and treatments for the current problem, which is finally coming to an end.

Furthermore, while Pfizer and Moderna announced a 90% efficacy against transmission, Professor Peter Doshi of the University of Maryland in the British Medical Journal on January 4, 2021, as also reported by the New Your Times, found approximately 19% to 29% efficacy against person-to-person transmission. Therefore, well below the thresholds for approval of a vaccine, and even an emergency vaccine [14-16].

The Lancet recently reported that individuals who have recovered from natural SARS-CoV-2 infection should be considered exempt from mandatory vaccinations. Article 2 of Lorenzin Law 119 of 2017 specifies: "Immunization following natural illness, proven by notification from the attending physician, pursuant to Article 1 of the Decree of the Minister of Health of 15 December 1990, published in the Official Journal no. 6 of 8 January 1991, or by the results of serological testing, exempts from the requirement for the relevant vaccination." This supplement is not used for COVID, despite the fact that it is now known that natural immunity is 18 times higher and can identify variants [17-19].

A messenger RNA vaccine can alter cellular DNA by transcribing viral sequences integrated into the genome by a cellular “reverse transcriptase” or HIV reverse transcriptase, and these DNA sequences can be integrated into the cellular genome, and their expression has been induced by COVID-19 infection, suggesting a molecular mechanism for COVID-19 reverse integration in patients [20].

After the Wuhan outbreak in China and the subsequent global pandemic, the spread of the CoV-SARS-2 coronavirus has finally come to an end. The United Kingdom declared its end on July 19, 2021, having begun vaccinations primarily on December 8, 2020, targeting especially those over 80 and the frail. The entire world has fallen into line, particularly taking into account oral therapies and monoclonal antibodies, against a virus that, while remaining contagious, has reduced its virulence. The African continent has stood out for its endemicity linked to zoonoses of the betacoronavirus family. Finally, particular importance

is being placed on natural COVID-19 infection and the immune response, with vaccination being exempted due to the risk of blood clots caused by genetic mutation and antibody overload [21].

CONCLUSIONS

The virus's goal is clear: to coexist with our bodies. Indeed, COVID-19 is now endemic, and the greatest risk today is that of an infodemic—that is, an epidemic of information disseminated by doctors who have forgotten the Hippocratic Oath, by politicians interested in benefiting from the general fear, and by complacent journalists [22].

There was nothing scientific about the bulletins reported daily on the unified networks and which still crowd the radio and television networks. Deaths should have been confirmed by autopsies from the beginning to determine the cause of death, as well as other factors and age. Instead, we have simply exploited a health emergency to instill a sense of fear and terror in the population, who are now going out wearing masks even where they are no longer required. Meanwhile, they are already preparing us for a fourth or fifth dose of mRNA vaccines in the fall, the adverse effects of which are beginning to be highlighted from many quarters.

We've forgotten the journey Homo sapiens took over millennia, evolving amidst viruses and bacteria, from central Africa to the Mediterranean and then Eurasia. Smallpox and plague even influenced the emergence and formation of blood types. The importance of the relationship between humans and microorganisms such as viruses and bacteria in the history of evolution should not be underestimated. It's therefore not surprising that those who have had COVID-19 are much more immune-protected than those who have been vaccinated. Even in light of the fact that in the American registry system VAERS (Vaccine Adverse Event Reporting System), the percentage of all deaths reported after vaccination for COVID-19 vaccines in the USA for the period from December 2020 to June 2023 alone is double the total of all deaths since 1990 for all other vaccines [23].

ACKNOWLEDGMENTS

The author thanks for their support: Foundation T. & L. De Beaumont Bonelli for Cancer Research. Naples, Italy

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