

## What's New Under the Sun?

### Understanding Established from the Shoulders of Giants Necessary to See the RNA Virus Assimilation of the Human World

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#### Want What Works

A personal paradigmatic shift would adapt the “Three W’s” to head off exposure to respiratory germs.

Family, friends, neighbors and co-workers should look out for each other, so no one needs to move to isolation, quarantine, intensive hospital care or rehabilitation.

1. **Wear** facial barriers to eliminate germ exposure.
2. **Watch** distance and time to eliminate germ exposure.
3. **Wash** hands and face to eliminate germ exposure.

#### My Perspective

My perspective is derived from a lifetime of experience, exposure, study, research and clinical medical practice.

My thusly informed analysis and the associated continuous reassessment of assumptions, presuppositions, principles and evidence seem to have a modicum of relevance.

For both the unwitting public and professionals, the evolving realities, unfolding patterns and multi-level societal transformations, in play, are crushing many notional constructs, e.g., foodborne (Wuhan wet market) and direct contact transmission (Human Immunodeficiency Viruses and Hepatitis C) and conspiracy theories (malevolent or slapdash CRISPr and cDNA recombinant genetic engineering gone amuck).

These faulty paradigmatic constructs fail to hold beneath the forceful pressure of the SARS-CoV-2 (**Severe Acute Respiratory Syndrome Coronavirus 2**) powering the **COVID-19** (Coronavirus Infectious Disease 2019) **Pandemic** juggernaut.

#### *Caveat Emptor*

The reiterative improvements of my evolving perspective produce a foundation vastly different from that employed by the political mandarin, ivory tower pedantry and conventional-BigTech media darlings when it comes to asymmetrical expertise of **multi-modal cycles of zoonotic transmission**

rooted in **respiratory** person-to-person initiation of wider and wider cycles of infection.

### **Evolving Realities**

*Keep in mind, your infection is only a breath away.*

Considerable analytical thought is required for an integrated critical understanding of the dialectical interplay of 21st century socio-cultural reality into which SARS-CoV-2 has been thrust.

Such a **respiratory** RNA virus as SARS-CoV-2 can establish a toehold for new colonies via its novel acquisition of new “targets” for invasion among the global jet-set, their sphere of influence and casual contacts.

Thereafter, SARS-CoV-2, and similar zoonotic microbes, take advantage of widely successful non-lethal and silent assimilation of its new hosts and niches from which it moves unchecked with growing waves of global mobility.

*Human physiology is dependent on respiration and gives SARS-CoV-2 incredible evolutionary advantage over mammals.*

They readily find receptive species with biosimilar membranes (homologous), embedding the Angiotensin Converting Enzyme-2 (ACE-2) and protease, and monocyte-based immunoglobulin-receptor dependent whole-body trafficking.

*Movement to the human world outside of an isolated cave niche in which the virus uses bats for its primary reservoir is a game-changer.*

Mobility of the viruses within the bat population is generally limited to its migratory flight path.

*Only occasionally did respiratory or fecal oral mechanisms enable spread to other species.*

The development of the human as a **mobile respiratory RNA virus reservoir** confers exponential advantages, leading to present disease BigData dynamic and statistical patterns.

In regard to the constructal forces operating on multiple levels, this infectious disease does not burn out. There is an unfolding of evolutionary processes. Transmission, reactivation and reinfection are characteristic, NOT entropic decay of time-limited disease cycles ending in death.

*For this opportunistic and adaptive pathogen, the pandemic does not end with vaccination, herd immunity or “culling” the weak and vulnerable.*

In fact, with COVID-19, a pattern of channeled spread and genomic mixing and mutational reformation of variant sub-populations has emerged.

New advantages are therefore conferred within the human population and also homologous mammalian reservoirs because of receptive biology of mucosal surfaces.

With each breath the concentration of pathogenic RNA viruses build within a room just like in the

confines of the bat's cave.

The utility of effective and well-managed isolation and quarantine becomes immediately obvious.

Because of the **respiratory mode of exposure**, it is essential to establish that viral shedding from mucosal cells is not active and that adaptive immunity is not immature, compromised or overwhelmed by the virus or secondary infections.

*Unlike the migrating bat, modern transportation and human biology has made opportunities infinitely greater for SARS-CoV-2.*

Basic respiratory and digestive anatomy and physiology as well as the molecular processes noted generate evolutionary opportunities for SARS-CoV-2 in diverse species, facilitating sustainable viral symbiosis and multi-organ assimilation.

*Good hand-washing, facial hygiene, liberal boundaries and effective barriers to the microbes combine to eliminate the seeding of a new infection.*

Six feet is basically arm-length. Picture an adult with the arm extended (about three feet) and someone else standing with their arm extended (about three feet).

Six feet is ample distance to prevent direct person-to-person exposure, NOT exposure to a bioaerosol of virus projected into personal space by breathing, talking, singing, yelling, sneezing, coughing, spitting, burping and so on.

Likewise, any barrier must be impenetrable to the virus but facilitate easy inhalation and exhalation so as to avoid respiratory fatigue or discontinuation of use of a facial barrier.

*Keep in mind, if you “zip your lips” only the nostrils and mucosal surfaces of the opened eyes are available as landing places for any microbial invasion.*

Since about 85 percent of SARS-CoV-2 confirmed cases are among those reported to wear “masks,” it is obvious that their masks do NOT adequately protect the eyes, nostrils or mouth from the virus landing and the infectious cycle from reaching a detectable level. One must also consider that these findings do not reflect an entirely accurate history of personal mask usage.

**Wearing a constantly handled flimsy mask below the nose or on the chin creates no protective barrier against infection.**

**It is likewise important to consider the reduced rates of infection of those wearing glasses or protective eyewear.**

*Multi-organ assimilation and environmental survivability are now obviously tenable for various RNA viruses like SARS-CoV-2.*

They often achieve easy access to the respiratory and digestive system and produce few if any symptoms that are detected as a sign or symptom of infection.

When a person touches a virus-contaminated surface, they then can bring it into the vulnerable

openings of the face and initiate an ocular or oropharyngeal inoculation of SARS-CoV-2.

*It is now well-established that the virus can survive for some time on surfaces.*

Studies have also demonstrated that SARS-CoV-2 RNA is being detected in sewage effluent and shows up in shellfish and other foodstuffs.

In community settings, isolation and quarantine are essential.

*When super-spreaders and ill individuals are free to circulate, the scope of viral contamination grows.*

Contaminated surfaces become **fomites** for manual-oral exposure to the virus.

Manual-oral inoculation turns the unsuspecting into new SARS-CoV-2 incubators.

Many have no or few signs and symptoms of a respiratory infection, even though they tested positive for SARS-CoV-2. They can become unwitting respiratory transmitters as their mucosal SARS-CoV-2-hosted colony reaches maturity. Because their prodromal and brief acute infection is extraordinarily mild such individuals may not even recognize that they were infected. Moreover, subsequent periods of coronavirus cellular assimilation and mucosal transformation of host tissues are mislabeled as the convalescent phase of a SARS-CoV-2 infection. Some, however, remain contagious. Viral shedding can linger for weeks and even become a chronic health problem.

*If the host dies, SARS-CoV-2 loses its reproductive advantage. A dead host does not breathe or move about the world.*

Living and breathing SARS-CoV-2 hosts that move about interacting with other people and animals create new opportunities for more cycles of person-to-person respiratory infection and re-infection. The same holds true for animals with homologous ACE-2.

Similarly, healthcare institutions “set up” contaminated **nosocomial** surfaces that are also mobile. Such contamination assures new advantages for various evolving zoonoses. Many unconnected sets of persons generate new clusters of infections across all demographic and psychographic borders.

*Consider the role played by holiday travel in late 2019 and early 2020.*

Thereby, simple limited SARS-CoV-2 outbreaks among travelers returning to Seattle, New York, San Francisco, Minnesota exploded.

*The reality of respiratory transmission went unappreciated.*

Like with outbreaks of respiratory RNA diseases over many centuries, the outbreak natural history of COVID-19 confirmed cases reached endemic, epidemic and quickly achieved persistent pandemic proportions.

*Why are humans so resistant to changing their perspective and practices?*

Many continue to ignore the reality and dangers of respiratory disease transmission.

All too often many also erroneously believe that they and their loved ones are not and never shall be among those especially vulnerable to the complex complications of RNA viral diseases.

*This notional construct is analogous to the preschooler who has not advanced to a level of concrete reasoning nor accepted the Reality Principle.*

The viral fire does burn; albeit its damage starts very slowly and then suddenly can be transformed into a multi-organ conflagration.

Explosive growth, then, easily starts outstripping historical patterns, seen only with close contact or isolated food-borne transmission.

Ecological adaptation facilitated acquisition of new homologous hosts in remote locations as a result of multimodal consumer travel or exploitation of commercial, military and diplomatic logistics.

*Technology has given what most considered vulnerable and isolated pathogens vast new advantages for adapting outside isolation.*

The safe stability provided by an intracellular reservoir in an advanced mammalian host and respiratory mode of transmission from person-to-person opens a Pandora's box.

These advantages bring forward considerable advantages to viral populations, as a result of infections of human, livestock and other species.

Such ecosystem shifting zoonotic disease developments have devastating biopsychosocial, economic and geopolitical consequences.

Within the globally mobile networks spread is seen with homologous molecular biology among multiple species. Therefore, diverse ecosystems are open territory.

*Mobile, habitually careless, arrogant and ignorant human populations establish disease through novel interplay of viable food-borne, direct contact and respiratory modes of transmission.*

The time has come for a paradigmatic shift, upon which to build a solid foundation, for the elementary establishment of simple, sensible and practical policies, protocols and habits that are truly useful during all times and seasons.

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### **Carl R. Hansen, Jr. M.D. Biographical Summary**

Carl R. Hansen, Jr., M.D., is a preeminent medical expert, specializing in the field of child, adolescent and adult developmental neuropsychiatry. His insights, systematic formulations and recommendations were developed over the last 48 years.

Dr. Hansen has diligently worked to advance the study, clinical practice and basic research as related to complex medical and developmental neuropsychiatric conditions.

Dr. Hansen has extensive experience with rare and traumatic conditions. His work has included groundbreaking work with heritable and neuroimmunological conditions that are often triggered or worsened by infections.

His molecular genetic studies and expertise gave him a deep understanding of RNA viral pathology, including the type of complex problems, now observed with SARS-CoV-2 COVID-19 acute infections, complications and chronic diseases.

Dr. Hansen is a 1979 graduate of the University of Minnesota Medical School where he also received advanced study in Physiology, focused on spinal cord and cerebellar disease and neuroprosthesis.

Dr. Hansen finished his psychiatric training in 1984. As a child and adolescent psychiatry fellow at the Yale Child Study Center, Dr. Hansen was awarded both the Berger Research Fellowship and the Merck Fellowship.

Along with his clinical training in analytically-grounded developmental psychiatry, Dr. Hansen was involved in cutting-edge research on rare conditions, using basic neuroscientific, gene cloning and other molecular genetic methodologies.

Dr. Hansen has decades of experience with rare diseases, neural trauma and both acquired and inherited neuroimmunological conditions.

Dr. Hansen was involved in the care of a child who developed an HIV-associated immunodeficiency from the in utero transfer of the mother's HIV infection.

Dr. Hansen has been a sought after expert and consultant. He has published articles in the areas of toxicology, neurobiology and developmental neuropsychiatry.

Dr. Hansen is a senior medical doctor with advanced medical knowledge and clinical expertise relevant to the management of the SARS-CoV-2 COVID-19 pandemic.