Cryptocurrencies and Blockchain & Monoclonal Antibodies - Welcome to What Happens Next
January 2, 2022
Ari Ciment QA

Larry Bernstein:

If you want to read Ari Ciment's transcript from 12.21.29, here is the link for the transcript.

Ari Ciment:

There's been a discussion as to which monoclonal antibody to use if somebody gets COVID, so now that they're really drying up in these monoclonal antibody sites. The best thing you can do if you're, if you have any of the risk factors is to get the infusion as, as soon as possible. Against the Omicron variant, the one that works has been notably Sotrovimab. The question is should you try to get Sotrovimab, or should you get the Regeneron infusion?

A lot of places are getting flack for using Regeneron because the predominant strain is supposedly Omicron. But what is fascinating is that we're seeing more and more that the Omicron is less severe and there is actually a higher percentage of Delta variant than we originally thought.

Larry Bernstein:

Uh-huh (affirmative).

Ari Ciment:

So, you're probably better off getting Regeneron infusion, because it's gonna cover the Delta variant more than the Sotrovimab, or should you take the Sotrovimab, which gives you coverage against the Delta, maybe not as good, but it also covers Omicron.

Larry Bernstein:

I'll repeat it back to you to make sure so that the listeners can appreciate it.

Ari Ciment:

Yeah.

Larry Bernstein:

The CDC made an announcement earlier this week that the percentage of COVID cases that are Delta is much higher than they thought versus Omicron.

Ari Ciment:

Right.

Larry Bernstein:

I think they said something like 75% of cases nationwide are Delta and not Omicron.

Ari Ciment:

Right.

Larry Bernstein:

Omicron's growing, but it's still predominantly Delta. It turns out that Omicron is much less risky in terms of hospitalization than Delta. The more dangerous Delta is the one we need to worry about Ari which monoclonal is best against Delta??

Ari Ciment:

Regeneron. Regeneron.

Larry Bernstein:

And-

Ari Ciment:

And the other point is that... I think the overall major point that I would make is that if let's say you've had only two vaccines, you haven't had your booster yet, and then you got COVID, that, you could have a significant breakthrough infection. And so instead of sitting around and doing nothing and saying, "Oh, we don't have Sotrovimab, so why bother?" I would actually, especially if you have risk factors, you're older than 65, I would push to get the Regeneron, which is going to cover me for the 30 to 40% chance that maybe I have the Delta. The caveat is I think in different locations, the Omicron probably has a higher percentage. Like, I believe South Florida probably has a higher percentage of Omicron than in other places in the United States. But still, we don't know the numbers, so you have to imagine that you have the Delta.

Larry Bernstein:

Ari, you gave me a chart that I will make available on the transcript of today's program. The chart illustrates the response function of each of the various monoclonal antibodies to the different COVID variants. Here is the link.

Ari Ciment:

Yes.

Larry Bernstein:

... The experiment takes blood and bodily fluids that contains the COVID variant and then in a lab setting they combine the monoclonal antibodies with the variant and they see the scale of the response function.

Ari Ciment:

Right.

Larry Bernstein:

How do you interpret the Monoclonal Antibody results?

Ari Ciment:

The lowest possible number means the most effectiveness of this antibody, right? So, for instance, um, Regeneron 10933 versus the Delta is going to have a .009 whereas the Sotrovimab has a .2188, which is many-fold higher than that number of Regeneron 10933

Larry Bernstein:

Yeah.

Ari Ciment:

All those numbers are greater than 10. That's essentially saying that-

Larry Bernstein:

It's worthless.

Ari Ciment:

... in a Petri dish, it's worthless. It's not really doing anything whereas if you look at Sotrovimab, .0950, Sotrovimab certainly has activity against the Omicron.

Larry Bernstein:

Let’s review Regeneron is fabulous against Delta and worthless against Omicron. Sotrovimab is weak against Delta but is best in class against Omicron.

Ari Ciment:

Right.

But, you know, jury's still out, because we don't know for 100%, but it does seem that the Omicron typically is less severe.

Ari Ciment:

Omicron, if it comes, it goes, and boom, you're done. I think a better question is what do you do if you got COVID and you're asymptomatic and you feel fine. I've had this happen many times already. I do push for them to get the monoclonal, because of the fear of the cytokine storm later on. I've had some cases that they didn't take the, the medicine because they felt fine, and then they were sick later on.

Larry Bernstein:

Mm-hmm (affirmative).

Ari Ciment:

They sort of tempered, got through it with a little steroid and was fine, but I'm just saying, like, it can happen. The other interesting thing that, that's come up is whether or not you should take the BAM, , Etesevimab combination, because that's the other one that Eli Lilly drug, and it's been sort of at a favor, too. The answer is yes, you should take it, because that will cover the Delta variant. Some of these concierge practices are running out of Regeneron, and now they're telling the patients, "Hey, you know what? We have this other one. BAM Etesevimab combination. You could get this." Are they doing the ethically correct thing? And the answer is yes, because they're motivation is to cover the Delta variety, which is accomplished with that.

Larry Bernstein:

Let's imagine you test positive for COVID. I think a critical piece of information is is it Omicron or Delta. Can we do a test to find out if you've got one or the other very quickly?

Ari Ciment:

No. you can't, you can't test this. The departments of health, they take a random sampling of, of the county and they decipher what the percentage is.

Another interesting thing, Larry-

if you go, especially to a lot of concierge practices, you have acute COVID, they will charge or, you know, either giving you the monoclonal antibody because they have it, but they'll also give you medicines like Zithromax, vitamins, they'll give you sometimes infusion of normal saline. But one of the more interesting things that a lot of the places are giving is Fluvoxamine.

Larry Bernstein:

Yeah, I don't know it.

Ari Ciment:

Yeah, Fluvoxamine is an antidepressant. It's an SSRI, and it has been studied actually positive trials. I believe the dose is something like 100 milligrams three times a day, and it's for 10 days. And I have treated many, many, many patients with COVID. I sort of shy away from it even though I believe in it and I, I believe it works, and I've seen anecdotally patients who've been on SSRIs who have not developed severe COVID pneumonia, and I think that's thought-provoking and, and years from now, I think it will probably be a treatment for flu and other viruses.

Ari Ciment:

Um, that being said, you have to take into account you're putting on a medicine that is three or four times the normal dose for anxiety and depression, and there could be significant side effects coming up.

So to, to base a practice, I think it's safer to give a one-time infusion of monoclonal than to be, you know, using this Fluvoxamine right now. If you're in a third-world country or somewhere else, you know, let's say you're going on a trip somewhere-

Larry Bernstein:

Yeah.

Ari Ciment:

... I think it's a good thing. I think it is a, a reasonable thing to consider taking or having available as a possibility. And you could look up the data. It's Fluvoxamine, 100 milligrams TID, three times a day for 10 days. As far as Zithromax, there are some studies showing anti-inflammatory properties, but there's no rip-roaring amazing study as with Ivermectin and Zithromax. A lot of the concierge practices are using all of them in combination.

Larry Bernstein:

A number of my friends went on vacation overseas and many of them are coming down with COVID as soon as they land. Maybe it's a good idea to bring some COVID medicine along. Last time when we spoke, you recommended a Z-Pak. Should we bring a Z-Pak or any other medications with us, especially if we are going to a developing country that does not have easy access to medicines?

Ari Ciment:

Yeah. I, I don't even know of the legality, honestly. Are you allowed to prescribe prophylactically? I don't know. I don't know the legality.

Larry Bernstein:

Is a Z-Pak over the counter?

Ari Ciment:

Z-Pak is not over the counter. It's-

Ari Ciment:

... a prescribed medicine, but we do give it to, you know, patients that are going away sometimes, you know, if they, there's a lack of medicine in, in the country that they're going to. That's reasonable. The, the legality, I don't know about, like prescribing, which I haven't, like, uh, Fluvoxamine. "Oh, just in case you get COVID. Here, here's 100 TID of Fluvoxamine." So that, that's an interesting question. Are you allowed to, to do that? Just like are you allowed to take, Regeneron with you? You know, you buy it-

Larry Bernstein:

(laughs)

Ari Ciment:

I would probably take a Z-Pak and definitely a steroid stash.

Larry Bernstein:

All right. So, what steroid would you bring? Would you bring the Dexa?

Ari Ciment:

I would bring, uh, Prednisone. I would bring, like, 20 milligrams, a 30-day supply just to have available, I think it's reasonable.

I think I would want to have access to that in a third-world country.

Larry Bernstein:

When I was in the hospital with COVID, you prescribed me zinc, vitamin D, melatonin/That's over a year now, what do you think of those drugs now?

Ari Ciment:

Yeah. I mean, zinc actually was studied, and it was a negative trial.

Ari Ciment:

Melatonin had some definite antiviral activity, but it also-

Larry Bernstein:

Didn't make the cut.

Ari Ciment:

It wasn't a... Did not pan out. A, a very good resource for anybody listening, actually I'm not, I don't work for them, but The Medical Letter. The Medical Letter, they provide free, free of charge, you could see a table. What I like about is it goes through the evidence of everything that has been out there; Vitamins, zinc, Zithromax, Fluvoxamine, even the vaccines. They do a great job. You could be as knowledgeable as Dr. Ari Ciment.

Here is the link to the Medical Letter on COVID.

Larry Bernstein:

Yeah, that I don't believe.

Let’s say You're 55. You may be starting to show some symptoms, but you've got no preexisting conditions. What, what should I do next?

Ari Ciment:

You're 55 and you have, you have no preexisting conditions?

Larry Bernstein:

I'm fully vaccinated with the booster, but I am showing some symptoms.

Ari Ciment:

Yeah. So you should rest assured that you're gonna be okay, and by the guidelines, you really don't meet the criteria for the monoclonal.

Larry Bernstein:

So-

Ari Ciment:

However, in, in a perfect world like we were a month ago when there wasn't an outbreak, Ari Ciment would advise you to get the monoclonal, figure out a way to get the monoclonal, but in a pandemic where it's limited resources and you have to go by the guidelines, then, you know, you'll, you'll be okay.

Larry Bernstein:

I'll change the facts. I'm unvaccinated.

Ari Ciment:

Unvaccinated, you need to figure out a way to get that monoclonal right away, but you also have a, a different avenue. Right away, you could go on online and go clinical trials, and see what the closest clinical trial.

Larry Bernstein:

Mm-hmm (affirmative).

Ari Ciment:

Again, Regeneron versus another po- polyclonal antibody, and you can get it and get paid for it, too.

Larry Bernstein:

Love it. And then, um, double vaccinated with a booster, over 65.

Ari Ciment:

Yeah. So I would in that case still, for the, for the very, very rare occurrence that you could get sick, I would still push for monoclonal. Anytime, just to modify your question, if that guy was under 65 and 40 or 30, even 25 but had a BMI greater than 25 or 30, I would also push for the monoclonal. In other

words, if you have any of the risk factors, BMI, diabetes, hypertension, I would push for trying to get the infusion. The benefits far outweigh the risks.

Larry Bernstein:

We touched on this briefly. Nationwide, the ratio of Omicron to Delta is 25 to 75, but I have a feeling that in New York City and Miami Beach, it's much different. Do you have a guess what that ratio of Omicron to Delta is in the Omicorn hotspots?

Ari Ciment:

I think it's probably 80/20.

Larry Bernstein:

If you're in New York or Miami Beach and you test positive for COVID does this change your decision on which monoclonal to ask for? Or at all?

Ari Ciment:

Um, it does. It does, and, and I think the, the thing that could tell, you could sort of tell the difference is the Omicron typically is a sinusitis.

Larry Bernstein:

Ah.

Ari Ciment:

They come in like, you could hear them sound like this, and they sound nasal, and they have a little sore throat, that's Omicron. When they have high fevers that are persisting, and feeling so weak and, "I can't move," that's when I'm thinking, "Oh, you know what?

Larry Bernstein:

That's Delta.

Ari Ciment:

This sounds like the old bad therein." That's the guy that I'm going to try to figure out how we can get them treatment fast.

Larry Bernstein:

Okay. Ari, end each episode with a note of optimism. What do you have for us this week?

Ari Ciment:

We're, we're making changes. The CDC is finally, you know, coming through for, for everybody and, and lowering the amount of time people will be back in the workforce. People will be more adherent to masks, and, uh, I think it's just... We're four to six weeks away from being back to normal.

Larry Bernstein:

Every college kid has been on vacation, and everyone is dispersed, and now they're going to get back together. Do you think the return of kids to school and employees back to work will cause a surge in COVID cases?

Ari Ciment:

That's why I think the timing was brilliant. I mean, to put this, this five-day period, because it's going to get through it. It's just the reality, and we're going to have to sort of deal with it. I think now, also, people, because it's five days and it's, I think people understand the risk more, and they're more appreciative. And they're going to wear the mask, they're going to be more careful, they're going to do things outside, they're going to make more of a conscious effort.

Larry Bernstein:

Last week, Ari said that the CDC on Monday was going to change their recommendation that if it's Omicron, you're no longer contagious after five days. And literally, was it Monday, Ari? Did you nail it to the day?

Ari Ciment:

I think it was Tuesday.

Larry Bernstein:

Ari was correct. It did go down to five. Ari, just as a follow-up on that, given the high amount of Delta in there, and that you don't know if you've got Delta or Omicron, and Delta is really a 10-day limit and Omicron's a five-day limit, what should you be telling people, uh, about how many days to get, get back to work?

Ari Ciment:

It would still be the same thing about getting back to work. It was probably overblown in the first,

Larry Bernstein:

I see.

Ari Ciment:

The key is that even if you go back to society, you should just be happy that you're back, but wear the mask and be, be cognizant of other people. If everybody does that, even though the masks question

whether or not it's even efficacious, if you have COVID, I would recommend wearing two masks during that time around other people just so you don't spread it? Probably even better.

Larry Bernstein:

Two weeks ago, when Omicron was on the rise, the CDC decided to stop providing hospitals with Regeneron because it didn't work in the lab. The CDC reversed itself, but many people are sick with Delta where Regeneron is very effective, and patients can't get it. What do you make of this public health error?

Ari Ciment:

There are people that unfortunately are going to pass away for the lesson that we're going to all learn.

Larry Bernstein:

Ari, thank you very much.

Ari Ciment:

Thank you.