

Dr. Ari Ciment Q&A – What Happens Next
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Larry Bernstein:

Ari, welcome back to the show. What are you seeing this week in the hospital?

Ari Ciment:

The hospital numbers are coming down as the percent positivity of cases locally are coming down. The oral antivirals are not really accessible in any hospital. They're only for outpatients. It's now widely available to get Paxlovid and Molnupiravir. And it's still very available even to get outpatient monoclonal antibody. Ironically, it's easier to get monoclonal antibody sotrovimab through concierge practices than it is through hospitals.

Larry Bernstein:

Omicron has been the dominant variant for a while now. What would you recommend as the treatment for a Covid positive patient who is 55 years old without comorbidities?

Ari Ciment:

Part of your question should also be, vaccinated or unvaccinated? Or double vaccinated, or triple vaccinated?

So, we'll go through your scenarios. If you're not vaccinated, you're going to need to be so aggressive. In fact, I got a call yesterday about a 25-year-old, unvaccinated. That patient needs to be very aggressive, and needs to get sotrovimab. You need to look for a reason to qualify if you're unvaccinated.

If you're double vaccinated and you're 55 years old, I would also recommend trying to be as aggressive, either the monoclonal antibody or the Paxlovid. I still don't think that there's a need to get Molnupiravir, if you have a better medicine out there, Paxlovid. So, I would use either Paxlovid or the monoclonal. If you're triple-vaccinated, then it's case-by-case. But the likelihood of being hospitalized, triple vaxxed, is very, very low. I think the number is something like five in a million.

Larry Bernstein:

So, forget about it.

Ari Ciment:

I wouldn't say forget about it. I would still offer the Paxlovid, for anybody over 55, and offer the sotrovimab. If there are any risk factors that give you a higher risk: diabetes, obesity, hypertension, then the risk/benefit ratio then shifts in favor of taking something like Paxlovid, and then you can see how you can have symptoms with the medicine, then you can stop it.

Larry Bernstein:

How should you incorporate having had COVID in that calculus?

Ari Ciment:

The data keeps on switching back and forth. It looked like before delta came along, natural immunity wasn't as good as double vaccine. And then after delta, natural immunity was better than the vaccine. So now with omicron, maybe the vaccines are actually better, if you have triple. I would say a general rule of thumb, it seems to me that natural immunity is equivalent to two vaccines.

I think the takeaway message is if you had COVID before, and I'm not talking about COVID, like, in the last month, I'm talking about COVID, like, back in 2020, I would get one more shot, even if it's the baby booster Moderna, just to cover yourself.

Larry Bernstein:

Does having COVID symptoms change the dynamic?

Ari Ciment:

Another great question. With the other variants, we were so fixated, rightly so, not on the actual illness itself, but on the cytokine storm. And even if you were asymptomatic you would be pushing the monoclonal ASAP. It seems that omicron is really a completely different bug. And the way we've been practicing, and it's turned out if you get over the omicron, there doesn't seem to be a secondary phase, like there was before. Do you're feeling better, we don't have to give you the Paxlovid. We don't have to give you the sotrovimab.

One caveat is that we do see secondary bacterial infections that have developed shortly after the omicron infection. And, getting the immune system a little boosted might help prevent that. That's speculation. But it might have prevented some of those secondary bacterial infections we saw in some of those patients. And the flip side is, people who have post-COVID syndrome, should we be more aggressive treating those asymptomatic, or lower symptomatic patients early on, to prevent that post-COVID syndrome? No one knows the real answer to that. The way we've been practicing is, you're asymptomatic, or low symptoms, then we're not really pushing those medicines.

Larry Bernstein:

My dad was a cardiologist. And he got really frustrated when patients would take antibiotics when they had a virus. But what you're describing to me is that post-omicron you have a bacterial infection. How do you feel about antibiotics in lieu of monoclonals, how would you feel about going with a Z-Pak or other antibiotic to reduce the chance of getting a post-bacterial infection?

Ari Ciment:

A lot of the concierge practices are sending home patients with a Z-Pak and, and Paxlovid together. There is no clear evidence to do that. In fact, you might make things worse by giving an antibiotic too early, because that patient can now develop some resistant bug later on. If I am going to use an antibiotic, it does make sense to give them macrolide antibiotic, doxycycline has some at least in-vitro activity antiviral effect. But it has no clear, documented anti-COVID in vivo evidence. There's a risk of

giving antibiotics for a viral infection. Potentially, you're going to provoke further resistance later on. Just, the point is that you should be on the lookout, because you are immunosuppressed after a virus.

Larry Bernstein:

How does the cytokine storm, the pneumonia and the bacterial infection interrelate?

Ari Ciment:

The cytokine storm that we were seeing with the other variants was not necessarily a bacterial super-infection. The markers didn't demonstrate that there was another infection going on. It was just a heightened inflammatory response causing inflammation in the lungs. We would treat it with anti-inflammatories and not antibiotics. The vast majority of people with omicron will just get better afterwards. But there are some people that have immunosuppression develop some sort of bacterial superinfection, which is different than the cytokine storm that we were seeing before, where it's just a pure inflammatory response.

Larry Bernstein:

Can you recommend treatments for long COVID?

Ari Ciment:

There aren't any specific treatments for "Diagnosis: long COVID syndrome."

Long COVID covers everything. It's either fatigue. It could be shortness of breath if there's actually lung involvement. It could be like persistent brain fog or word recall problems.

You're gonna see different treatments based on who you see. So if you see a neurologist because you're thinking slow and inkinetic, Dexedrine and Adderal and Ritalin. But if you see a pulmonologist like myself because you're short of breath, you might get an inhaler with inhaled steroids and an albuterol, breathing exercises.

There are some antioxidants people use, like atecylcystein. There is no FDA-approved medicine currently for long COVID syndrome other than off-label drugs that we use for other things. So, for instance pirfenidon is a drug that we use for idiopathic pulmonary fibrosis. They are currently in Phase 2 trials looking at a form of pirfenidon for long COVID pulmonary issues.

If you do have long COVID syndrome and try to enroll in one of these trials. A lot of these medicines have very few side effects. So there's one trial in vitamin C and a slew of vitamins. I have to admit that I have used concoctions of vitamins for patients to see if it helps their long COVID syndrome. Vortioxetine is an SSRI that being studied for cognitive effects. There is a trial with medical cannabis.

Larry Bernstein:

I had long Covid after I left the hospital in December 2020. I had poor balance and couldn't walk a block. I got a physical trainer and got my strength back in six months. My pneumonia was pretty bad and got easily winded and had poor aerobic capability, but over 6-12 months I got my conditioning back. I had

brain fog but that went away after a year. Does exercise and the benefit of time the answer or does a patient need a pharmaceutical solution?

Ari Ciment:

Certain patients like yourself had a pulmonary condition. You really had some damage done, and it takes time for the lung cells to regenerate. And, in your case specifically, you want to buy time and try to limit the amount of pharmacologic interventions, which all have some certain side effects. Sunlight, PT/OT, increase your stamina, that's much better than taking Adderall and Dexedrine, and you just needed time. But it was clear in your case that you had pulmonary involvement.

There are other patients that have cognitive defects and they don't have those infiltrates ever on their CT scans and their x-rays. Those are the ones that explore pharmacologic options. A patient with severe brain fog was also desaturating while walking. I actually put him on steroids, even though it's late. And he immediately got better. If you go to some rheumatologist, they give crazy high doses, that will give IV a gram a day for three days. I've seen that used for long COVID. I personally think that's very, very high.

The vast majority of people do get better over time. So, if you could do natural things like increasing physical activity, going outside, getting sun, that is (laughs) definitely the best.

Larry Bernstein:

Let's talk about steroids next. You gave me old-time generic steroids when I was in the hospital with COVID and it worked like a charm. What do you think of using steroids for long COVID?

Ari Ciment:

I think we learned a lesson about steroids themselves. We are sometimes our own enemies: We're over-combatting the illness; we're causing this inflammatory response and that's what the steroids are doing. We're gonna slow it down."

For years we always have said, "if you have influenza and you have a viral illness, don't give steroids." That's why it was very difficult early on to adopt steroid usage when it came to coronavirus, because people were really scared that you were going to cause the virus to blow out of control.

But once we saw a lot of the cases were actually dramatically improved, then we started employing it as an outpatient therapy too. And reluctantly would first wait a few days. If the oxygen levels dropped, then you would get the steroid and then miraculous things happen.

I think we are going to be using steroids more frequently for viral infections whatever it may be.

Larry Bernstein

Let's say, post-COVID you have this nagging cough. Anything to be concerned about there?

Ari Ciment:

it's very common after any viral illness that your whole body is out of whack and the same things that cause cough before are likely what's causing it now, post-nasal drip, reflux. So, before somebody starts to think that they have a recurrence or they have a severe pneumonia, it might be worthwhile to see regular treatments over the counter like intranasal Fluticasone. Or nasal sinus rinses, neti pot, Pepcid, omeprazole treatments, stuff over the counter.

Larry Bernstein:

Next topic is Masks. Cities like NYC have announced an end to the mask mandate. But each individual can make their own decision based on their own health risk profile and the situational risk. Are there situations where you would suggest mask wearing or social distancing?

Ari Ciment:

Right now, our percentage rate is 13% local positivity. We're still considered high risk because we're above 10%. But we're not wearing masks because Omicron is basically a cold if you have three vaccines. So, at this point, even from a sense of responsibility to another person, it's okay to go mask-free.

Unfortunately, the people that are immunosuppressed are at higher risk. They, unfortunately, will have to wear a N95 mask. That's my opinion. So, at this point in the game, we should wear it around somebody that is having symptoms and if you're having symptoms.

But not have to go out wearing the mask everywhere. Again, that's my opinion.

Larry Bernstein:

Let me give you some hypotheticals.

Would you go to a Miami Heat game, 15,000 people in an indoor stadium? And if you do attend, wear a mask or not?

Ari Ciment:

I would bring my mask. And I wouldn't wear it because I am triple vaccinated. The variant that's around here locally is Omicron. And I am going to bring it with me because if the guy next door to me is coughing up and looks pretty sick, I'm going to put on.

Larry Bernstein:

Why not just go home?

Ari Ciment:

(Laughs) Or I'll go home. Depends how good they play.

Larry Bernstein:

(Laughs)

Ari Ciment:

Larry, that's a very important point because whether or not you believe or don't believe in masks, the very basic idea is that even if you're wearing a mask, you're not protected if somebody is highly infected blowing virions your way for two hours.

It's like you're wearing a raincoat and somebody is blowing a hose at you. Eventually you're going to get wet.

Don't let it get in the way of your life and other people's lives, you also have to be mindful.

Larry Bernstein:

I think you're making a statistical argument that if the mask protects you from 90% of the virus, if you get a very large viral load, 10% of a lot is a problem.

Ari Ciment:

To follow that point, that's why it's called an N95. It's not an N100. N95 filters out 95% of particles. But there's five percent that come in.

Do you know what the N stands for in N95?

Larry Bernstein:

No.

Ari Ciment:

Not for oil.

Larry Bernstein:

(Laughs)

Larry Bernstein:

That's funny. I don't wear N95's. I wear these paper and cloth masks that I buy on Amazon, does it do any good? I like it because it doesn't interfere with my breathing or get me too warm. Does it materially reduce the likelihood of infection?

Ari Ciment:

Yes that just came out in a case-controlled test negative study. It was done by MMWR. You can look at in February 4th. They tried to look at whether or not masks work. And which mask is the best to use. What they did is they tested people. If you're positive or negative, either way they would call two days later. And, the people that were positive were then matched with people that are negative the same age and sex.

That's what the case-control was and it's a test negative study. And what they found was that if you were positive, they ask you questions. You were wearing the mask, all of the time. 60% of those patients said they were.

If they were negative, 70% said that they were wearing it all the time. So, basically, what they were saying is that shows that you were much likelier to be wearing a mask, be negative.

You have an 83% less likelihood of getting of testing positive for a N95, you're 66% less likely if you wear a surgical mask.

And then in their diagram they even wrote, "You have a 56% lower risk, if you wear a cloth mask." But if you look closely at the article, for cloth mask it crosses one, the P values so it's not even statistically significant. So that's a little misleading there.

There's a lot of criticism of this article, if you want to hear a very good rebuttal you could watch Vinay Prasad who's a very brilliant guy. He's a MPH, MD MPH. But he wrote a paper in November of 2021 at Cato Institute and it was very anti-mask, he's looking for flaws, be mindful for it.

Larry Bernstein:

Let's have some fun and learn about your mask decision making process. You get into an UBER with a driver who is a stranger, mask or no mask?

Ari Ciment:

If there was a low threshold of pain, I would personally wear a mask.

Larry Bernstein:

You go to your local synagogue and its packed?

Ari Ciment:

I would say now is the time to come off with the mask and show that it's safe to be with people.

Larry Bernstein:

Give me some examples where you would wear your mask?

Ari Ciment:

Somebody had recent COVID and he's day five. I'll bring a mask for that interaction.

Larry Bernstein:

You are on a flight from Miami to NYC for 3 hours.

Ari Ciment:

If it's not mandated, I would say, how I acted pre-pandemic....

Larry Bernstein:

Put a fork in it. You're done.

Ari Ciment:

Yeah, pretty much done for the time being with an open mind, that if we have another variant that's scarier, do it again.

Larry Bernstein:

This is the part of the show where I end in a note of optimism. What are you optimistic about?

Ari Ciment:

I'm optimistic numbers keep on going down and I'm hopeful that this is it.

Larry Bernstein:

Thanks Ari for joining us again.