

Results of Treatment of Patients with COVID-19 and the Role of Cooling and Overheating in the Development of Viral Respiratory Infections

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Abstract: During the Covid-19 pandemic in Serbia on March 6. to 03.04.2020. I cured 41 cases with a very severe clinical picture of influenza or possibly Covid-19. At that time, the Health Center in Sjenica did not have the material for the diagnosis of Covid-19, and the patients refused to go to the neighboring Health Center because of the fear that caused sudden deaths. In my scientific work: "The role of cold in the origin and development of diseases with special review of some diseases of the respiratory system - treatment and prevention", I proved the effect of cold and overheating on all organs and effective treatment. Under the effect of cooling, vasoconstriction, impaired circulation and impaired metabolism occur. Macrophage motility is reduced, phagocytes are weakened, ingestion, which causes easy implantation of the virus in the lungs. All the viral infections I followed for more than 35 years passed with mild symptoms if there was no previous cold or during the illness, even with the highly infectious Mexican flu (A/H1N1) and influenza. Patients with Covid-19 reported minimal, minor or more intense colds, which also determined the severity of the clinical picture.

Key words: Distance, mask, disinfection, vaccine, prevention "without cooling and overheating" of the organism - respiratory tract, proper use of corticosteroids - gradual abolition, prevention of obesity, adequate physical activity.

1. Introduction

As a general practitioner at the Health Center in Sjenica, I gained rich experience in treating the sick. I noticed a significant role of cold in the origin and development of the diseases, which surprised me, because cold as an etiological factor is absolutely neglected in the medical literature, ie medicine. In the medical literature, the common cold is only associated with a viral infection (rhinovirus) (in the other literature, respiratory syncytial virus, corona viruses are also mentioned). I constantly follow 9 adults and 15 children of my family from 1980-1992. Then, as the only specialist in pulmonology, I have been working since 1989. in the Dispensary of Lung Diseases (DLD) of the Health Center in Sjenica. Since 1992, I begin to record diseases caused by previous

colds. Relying on the official medical literature in physiology, pathophysiology, histology and pathoanatomy, I managed to definitively establish a theory about the role of cold in the development of lung infections in 1993, and the role of cold and overheating in the origin and development of certain diseases I published the in 1999.

At the specialization in Pulmonology at the Institute of Lung Diseases in Belgrade, meetings with teenagers with iatrogenic Cushing's syndrome and DLD with young children with asthma were very unpleasant for me, due to the fact that only after 20-30 days they become seriously ill again, although the therapy was applied in a timely manner. I noticed that almost all the worsening was accompanied by a viral infection. So, even if complete remediation of the obstruction is not achieved, the new virus is easily implanted in the hyperemic and edematous bronchial mucosa.

My first patients in DLD were: children treated directly in the Children's Department and adults in the Internal Department, who had dyspnea and wheezing even after intensive therapy. All children due to severe general condition caused by dyspnea, or hypoxia, received: Adrenaline s.c, then Aminophyllin and finally corticosteroids; adult Aminophyllin and corticosteroids when life-threatening, and not infrequently Adrenaline s.c. Since the day of publishing my scientific papers, no child with severe asthma has received Adrenalin s.c. at the Children's Department.

By introducing corticosteroids as the first medicine for asthma and applying the rules of prevention, I have prevented or reduced the recurrence of the disease and the frequent use of corticosteroids, which have, in addition to a number of side effects, stunted children. The number of hospitalized children and adults from obstructive pulmonary disease has been reduced by 70%.

Through long research, I came to the data that adults and children adapted to temperature changes, irritants and allergens of the environment in which they live, get the first obstructions by intensive cooling after intensive overheating of the airways. The amplitude from vasodilation to vasoconstriction primarily determines the degree of hyperreactivity of the tracheobronchial tree from mild to malignant. The appearance of hyperreactivity is often accompanied by a viral infection, which makes the clinical picture more difficult. The virus is present in the tissue for about 6 days, so the slightest mistake in therapy and prevention easily worsens the obstruction.

Children who overheat and keep themselves indoors so that they do not catch a cold, get the first obstruction most often in the second year of life, because then they inevitably avoid the control of caring parents. Easy cooling causes easy implantation of the virus and the development of hyperreactivity, ie airway obstruction. Then the children are covered even more, which creates an even greater condition

for worsening, ie increasing the degree of hyperreactivity of the tracheobronchial tree.

After the development of hyperreactivity (increased reaction to violent, followed by mucosal edema, then inflammation, increased secretion of the mucoid apparatus and spasm of the bronchial musculature, the threshold of irritation for cold and heat increasingly decreases with the appearance of new obstructions. The first obstructions can also be caused by: inhalation of toxic substances, allergens, parenteral medication (rarely per os) to which the person is sensitized, but this rarely happens.

With the development of tracheobronchial tree hyperreactivity, all noxae that cause vasoconstriction and vasodilation may worsen or cause new exacerbations. For example, drugs that have a vasodilating (feeling of heat after application) effect can cause cough, worsening of suffocation, edema...; loud laughter causes an irritating cough; carbonated drinks and cooled at room temperature...

My research into the appearance of the virus in the atmosphere lasted 35 years. Until the advent of Covid-19, the rule was that a new virus would appear every 20 to 30 days. The high incidence of Covid-19, severe clinical picture and high mortality, has caused neglect in the identification of other respiratory viruses. At the beginning of my treatment of obstruction in DLD, asthma sufferers were always the first to be infected because their hyperreactive mucosa of the tracheobronchial tree is easily susceptible to viruses.

Covid-19 is a virus that is more contagious, more pathogenic and more virulent than the influenza virus. In the pathogenesis of the influenza virus, there is a toxic effect of the virus, especially on capillaries and nerve substance. In deaths caused by influenza, the brain and cerebellum are damaged and full-blooded, and bleeding and degenerative damage can be seen on ganglion cells. Catarrhal and necrotic-hemorrhagic changes with exfoliated ciliated epithelium and stripped submucosa were expressed on the respiratory

tree. The lungs are full of blood with capillary bleeding, and numerous viral and bacterial foci are often seen.

All these pathological changes probably occur in patients with Covid-19, but to a greater extent. Probably different in the Covid-19 mutant than in Omicron, which is the most contagious but causes lighter clinical pictures and lower mortality. Due to the significantly higher contagiousness, virulence and pathogenicity of Covid-19 than the influenza virus, the pathological changes in Covid-19 are more extensive and intense. That is why the Covid-19 virus causes the rapid development of severe symptoms and high mortality. When the endothelium is damaged, thrombosis, decomposition and detachment of the formed thrombi is an expected pathological process. Autopsies of Covid-19 deaths as a precaution against infection are probably not yet being performed. Would 20 million people have died during the "Spanish flu" if today's medical achievements had existed in 1918?

1.1 The Goal of the Work

The aim of this paper is to prove that prevention "without cooling the airways and overheating, ie the organism, can prevent the spread of the virus, reduce the number of patients and death from Covid-19, in addition to: wearing a mask, avoiding contact, vaccination, disinfection. Then the aim of the paper is to point out the incorrect use of corticosteroids, explain and prove why the correct use of corticosteroids can, among other therapies, accelerate the sanation of Covid-19 infection, reduce the severity of the clinical picture, and of course reduce mortality.

2. Material, Methods and Results

Thanks to the prevention "without cooling and overheating of the airways and the body" and adequate therapy, I achieved a high effect of treatment of infected with Covid-19. Covid-19 virus can be

transmitted from a sick person to a healthy person, so there are no periods without Covid-19, but after relaxing and re-enabling mass contact, there is a sudden increase in the number of patients, which is not related to the time period. While influenza in Serbia occurs once a year in the cold months.

Influenza, although a respiratory infectious disease, passes as a mild respiratory infection if no cooling has occurred before or during the illness. Refrigeration most often complicated influenza: bronchopneumonia, pneumonia and bronchitis without or with airway obstruction. Implantation of the virus first occurs in the nasal mucosa, nasopharynx, but with chronically altered lung tissue, any virus can be implanted first on the parenchyma or bronchi and later manifested by rhinitis.

All viral infections that I followed for more than 35 years passed with mild symptoms if there was no previous cold or during the illness. During the disease, new cooling and overheating causes the virus to spread to healthy parts of the lungs. From 1995 to 1997 (Table 1), I treated 80 cases of influenza: 37 cases were preceded by cold, 22 cases were feel cold during the disease, and 21 cases did not report cold because at that time and patients with mild clinical symptoms came to DLD.

There is a possibility that the cooling happened because at the time when I did not insist on data on taking fizzy drinks, taking cold food. In the case of the A/H1N1 pandemic in November 2009, I treated 69 patients. All patients stated in the anamnesis that the disease was preceded by a cold. Although there were severe exacerbations of asthma, pneumonia, bronchopneumonia, all complications are treated on an outpatient basis in 7-10 days. After publishing and presenting my scientific work on the role of cooling and overheating in the onset and development of disease, DLD was visited mainly by cases that had complications on the respiratory organs.

Table 1 Influenza treated at the Dispensary of Lung Diseases (DLD) in the period 1995-1997 in relation to the role of cooling.

| Year | Influenza without cooling | Cooling preceded influenza | Cooling during influenza | Total |
|-------|---------------------------|----------------------------|--------------------------|-------|
| 1995 | 6 | 12 | 8 | 26 |
| 1996 | 4 | 9 | 2 | 15 |
| 1997 | 11 | 16 | 12 | 39 |
| Total | 21 | 37 | 22 | 80 |

Table 2 Influenza in January, February and March (April) in the period 2007-2012 treated at the DLD in Sjenica.

| Time from the first to the last influenza patient | Men with influenza | Women with influenza | Total got sick from influenza | Influenza it's not preceded by cooling | Influenza preceded cooling easy or harder |
|---|--------------------|----------------------|-------------------------------|--|---|
| 18.01.-28.02.2007 | 15 | 16 | 31 | 0 | 31 |
| 14.01.-07.02.2008 | 3 | 19 | 22 | 0 | 22 |
| 06.02.-04.03.2009 | 1 | 3 | 4 | 0 | 4 |
| 05.01.-11.01.2010 | 3 | 2 | 5 | 0 | 5 |
| 05.01.-23.02.2011 | 15 | 19 | 34 | 0 | 34 |
| 12.03.-23.04.2012 | 6 | 5 | 11 | 0 | 11 |
| Total | 43 | 64 | 107 | 0 | 107 |

Table 2 shows that all influenza virus patients reported pre-cooling.

Probably the effect of cold on the organism in medicine, ie medical literature is neglected because different people feel the same temperatures differently which depends on: adaptation to cold (temperature changes), current mental state, condition of blood vessels, acute or chronic tissue changes, whether the cooling was preceded by overheating of the organism or organs.

That is why the term "cooling" is adequate, and means to feel cold. A common cold is an unpleasant feeling of cold, while cooling can be pleasant. For example, on warm days, opening the window while driving, turning on the air conditioner, taking cold water after hard work, fizzy drinks after a meal, causes a pleasant emotion. Any trip carries a risk of overheating and cooling the organism.

If the infectious agent is located on the tissue in physiological conditions (opportunistic bacteria or arrived by respiration), due to favorable conditions: reduced macrophage motility, humidity and favorable temperature, multiplication begins. Refrigeration is always more intense if it was preceded by overheating of the body or respiratory tract, when it can cause mild

to severe obstruction. Wet clothes for any reason (usually sweaty) cool the body. It is necessary to immediately replace with dry clothes or continue moving to the conditions for replacement.

Under the effect of cooling, vasoconstriction, impaired circulation and impaired metabolism occur. Accumulated metabolites at the tissue level, when the effect of cold on a larger area of the body ceases, suddenly penetrate into the blood, causing high temperature of "unknown" etiology.

Cooling of internal organs occurs through the skin and fibromyotic (FM) tissue, or through anatomical structures with which the organism is in contact with the external environment. Drinking cold and carbonated drinks will cool the nasopharynx, trachea and large airways, while sinusitis will develop by cold through the skin and FM tissue of the face, or both factors will act simultaneously, especially if there is chronic sinusitis or chronic rhinitis.

Overheating causes a condition for easy cooling, but it is also an important etiological factor that can precede, cause, worsen and maintain the disease.

Overheating has also been neglected in the medical literature as an etiological factor in the onset and development of disease, maintenance and

exacerbation. It is described as an etiological factor in sunburn, burns. Overheating is less intense than the first degree of burns. That is why overheating is not a trauma and I single it out as a special etiological factor. It can be passive and active. Active overheating occurs during physical work (housework, field work, playing sports). Passiveness most often occurs due to staying in an overheated room, overheating clothes or heating parts of the body, usually where the sick person feels cold. If the patient has asthma, irritable tracheitis, inhalation of

warm air, warmer foods and drinks, can cause irritating cough or worse suffocation. Feeling of heat and irritable cough can be interrupted by 2-3 sips, of water at room temperature or short-term inhalation of fresh air. I have extensively explained overheating as an etiological factor and prevention in my scientific work "Overheating as an etiological factor in airway obstruction" [1].

In other respiratory infections were recorded: Nasopharyngitis, Tracheitis, Laryngitis, Laryngotracheitis.

Table 3 Acute respiratory diseases treated in the Dispensary of Pulmonary Diseases (DLD) in the period from the year 1992-2016 in relation to cooling.

| Year | Pneumonia and bronchopneumonia | | Acute bronchitis | | Other acute respiratory diseases | | Total |
|------------------------------|--------------------------------|-------|------------------|-------|----------------------------------|-------|-------|
| | Men | Women | Men | Women | Men | Women | |
| 1992 | 35 | 19 | 41 | 41 | 117 | 179 | 432 |
| 1993 | 46 | 47 | 50 | 69 | 192 | 222 | 626 |
| 1994 | 24 | 48 | 23 | 24 | 64 | 97 | 280 |
| 1995 | 19 | 51 | 52 | 73 | 157 | 271 | 623 |
| 1996 | 11 | 12 | 31 | 45 | 73 | 74 | 246 |
| 1997 | 15 | 19 | 25 | 34 | 80 | 111 | 284 |
| 1998 | 27 | 29 | 20 | 51 | 117 | 216 | 460 |
| 1999 | 45 | 43 | 61 | 92 | 163 | 261 | 665 |
| 2000 | 20 | 29 | 51 | 62 | 142 | 225 | 529 |
| 2001 | 13 | 41 | 36 | 80 | 116 | 236 | 522 |
| 2002 | 23 | 28 | 33 | 47 | 94 | 187 | 412 |
| 2003 | 17 | 14 | 34 | 60 | 86 | 158 | 369 |
| 2004 | 7 | 10 | 27 | 45 | 48 | 139 | 276 |
| 2005 | 13 | 12 | 45 | 66 | 52 | 153 | 341 |
| 2006 | 10 | 9 | 44 | 59 | 80 | 166 | 368 |
| 2007 | 18 | 19 | 42 | 57 | 106 | 160 | 402 |
| 2008 | 20 | 18 | 30 | 52 | 81 | 144 | 345 |
| 2009 | 17 | 19 | 23 | 52 | 79 | 127 | 317 |
| 2010 | 17 | 16 | 20 | 61 | 121 | 236 | 471 |
| 2011 | 11 | 14 | 16 | 29 | 81 | 125 | 276 |
| 2012 | 13 | 6 | 25 | 15 | 50 | 85 | 194 |
| 2013 | 17 | 19 | 27 | 51 | 36 | 88 | 238 |
| 2014 | 23 | 14 | 45 | 59 | 33 | 51 | 225 |
| 2015 | 20 | 22 | 74 | 66 | 47 | 69 | 298 |
| 2016 | 17 | 17 | 77 | 102 | 87 | 121 | 421 |
| Total | 498 | 575 | 952 | 1,619 | 2,300 | 3,928 | 9,872 |
| Preceded by cooling diseases | 498 | 575 | 952 | 1,619 | 2,300 | 3,928 | 9,872 |

It can be seen from the Table 3 that all persons suffering from acute respiratory diseases reported pre-cooling. Most of these acute respiratory illnesses began with sneezing and coughing. Of the 9,872 patients before the onset of the first symptoms of acute respiratory diseases, they had airway cooling with cold drinks, fizzy drinks, cold meals, chest cooling, or whole body cooling.

2.1 Why Are Asthmatics Most at Risk for Covid-19 Implantation in the Lungs

At the Conference of Pulmonologists of Serbia in 1994 in Soko Banja, I presented the theory of “etiology, prevention and successful treatment of obstructive pulmonary disease” for the first time, and then definitely at the IV Congress of Internal Medicine of Yugoslavia (Igalo, 1997) and Yugoslav Pediatric Days (Nis, 1997) [2]. After the presentation of Prof. dr. Andjelka Đorčeva at the IV Congress of Internal Medicine of Yugoslavia, which ended with the sentence: “In any case, on the threshold of the 21st century, great efforts are being made to solve the enigma called bronchial asthma”, followed by the presentation of my theory [3].

Until then, all etiological factors described in the medical literature could not explain airway obstruction because their removal could not cure the obstruction (due to alleged allergies, parents changed various bedding, threw away unnecessarily things I talked about extensively in the scientific paper “Etiology of suffocation at night (in sleep) in asthmatics and the high preventive effect of ketotifen” [4]).

In addition to the obligatory prevention “Without Cooling and Overheating of the Airways with Adaptation, Excellently by Walking”, I introduce:

1. corticosteroid if there is no contraindication, as the first medicine for asthma 7-15 days (sometimes shorter, especially in children) with gradual discontinuation from the day when dyspnea is cured - it is applied for 8 hours per os or for 12

- hours parenterally in adequate doses;
2. corticosteroid for 5-7 days with gradual discontinuation as stabilization therapy for obstructive bronchitis after a weak effect of treatment with bronchodilators and corticosteroids in aerosol;
3. preventive corticosteroid (Prev. Cort.) In 1 to 2 doses every 6-8 hours which the patient takes in a timely manner before obstruction occurs;
4. timely use of Beta 2 agonists in the aerosol in case of unpleasant feeling of heat and during physical work that causes warming of the organism.

I achieved a very high effect of treating airway obstruction in mild and moderate hyperreactivity and high in severe and malignant. Whether the obstruction has healed, ie whether excellent stability of the tracheobronchial tree has been achieved, the best evidence is a respiratory viral infection and the absence of obstruction.

I presented the first results of the high effect of treatment thanks to prevention “without overheating and cooling of the airways with timely use of bronchodilators and corticosteroids” in asthma through several scientific papers published in Proceedings or Journals. All my scientific papers are in my book “THE SECOND SUN IS IN US” which I published in 2014, and is in the World Health Organization.

All definitions of asthma given in the medical literature since Hippocrates (460-370 BC) are not adequate.

By me:

- Asthma is Severe or Malignant Hyperreactivity (Tracheo) - of the Bronchial Tree Accompanied by Dyspnea in Peace.
- Obstructive Bronchitis Is Light or Medium Hyperreactivity (Tracheo) - of the Bronchial Tree Accompanied by Dyspnea during Physical Effort.

I presented the first results of the treatment of airway obstruction in several papers until 1997.

From 1998 to 2007, I treated 457 patients with mild

and moderate hyperreactivity, and 78 patients with severe and malignant hyperreactivity (asthma). In all cases, I achieved remediation of the obstruction, regardless of how long they had been treated before (many from 5 to 14 years old). Later, very rare exacerbations occurred in cases that did not adhere to prevention. There are cases that come to the DLD after 5-10 years for treatment of other diseases, who allegedly “forgot” that they used to suffocate.

2.2 Results of Treatment of Patients with Covid-19

In the paper “Influenza during the COVID-19 pandemic and effective treatment thanks to adequate therapy and prevention” [5], I presented a cure in DLD 41 cases of influenza or Covid-19 from 06.03 - 03.04.2020. It is impossible to say with certainty that it was Covid-19 because there were no diagnostic methods in the Health Center Sjenica at that time to confirm the presence of Covid-19 infection, and influenza was verified by doctors in January and February in my absence due to vacation. All patients had moderate, severe and very severe clinical pictures. Virus sufferers refused to go to the neighboring Health Center due to fear, which caused the deaths of Covid-19 sufferers who were sent to hospital in the afternoon and during the night. Three patients voluntarily left the hospital from the Internal Department at the Health Center in Sjenica due to worsening obstruction due to treatment at the DLD. One patient had asthmatic status. All patients with influenza or possibly Covid-19 with complications, I heal in 7 to 10 days.

D. K., a man aged 48 years. He has a history of colds. In addition to high temperature up to 39 °C, he had bilateral bronchopneumonia and tracheitis with induration. He resolutely refused to go to the neighboring Health Center, although I insisted, primarily because of the PCR test. After 5 days of treatment, he felt much better. Antipyretics, Amp Gentamycin 120 mg and Lemod solu 20 mg for 12 hours 4 days, then 2 days antibiotic and Lemod solu

10 mg im for 12 hours. Per os antibiotics and Aminophyllin 350 2 x 1/2 are continued until complete recovery. Covid-19 confirmed after a month of positive IgG.

Ill with Covid-19, F. L. J., age 56, light weight, sales woman. She fell ill in early April 2020. She got an elevated temperature of 38.2 °C and coughs dry and irritating. On the X-ray of the lungs, a smaller pneumonic shadow. She was hospitalized in Zemun after receiving a positive test for Covid-19. She feels well after the applied therapy. The repeated test was negative. She was released for home treatment in good general condition. The husband was infected by contact from his wife but the disease passed without symptoms. Before getting a high temperature and the appearance of an irritating cough, the patient drank cold whey from the refrigerator for 4 days.

In the second wave in June and July 2020, I treated my family members with Covid-19

B. K., a 68-year-old woman with asthma and chronic irritable tracheitis. Body weight in surplus 20 kg. There is evidence of cooling before the onset of Covid-19 symptoms. She had her first asthma suffocation 15 years ago. She has had a tachyarrhythmia for 7 years. She takes Bisoprolol a 5 mg 1 x 1 and Aspirin 100 at bedtime. She felt faint, muscle aches, fever slightly, loss of smell, cough and choking. Timely included: antibiotic, Pronison 20 mg 3 x 1/2 3 days, then 3 x 1/3 3 days and 2 days 3 x 1/4 to 1/5, Aminophylline 350 mg 3 x 1/2, Berodual 2 x 1 inhalation and if necessary, Paracetamol 3 x 1 at elevated temperature. Complete remediation occurs in 7 days. Continue inhalation of Berodual 2 x 1 breath with a feeling of warmth, and Duo Resp Spiromax 4.5 /160 micrograms 2 x 1 breath for 7 days and then as needed.

M. K., a man aged 41 years. Body weight 7 kg in surplus. Cough, mild fever, loss of sense of smell. Rehabilitated with antibiotics, antipyretics as needed, Aminophyllin 350 mg 2 x 1/2 due to prolonged cough. Rehabilitated in 5 days. There is evidence of a cold.

E. G., a male aged 38 years. Body weight adequate. A healthy athlete who waited in line in front of the bank for 2 hours, inadequately dressed in the morning. He felt cold all the time and most of them didn't have masks. Had an elevated temperature of 38-39 °C, cough, loss of sense of smell. Rehabilitated in 5 days with antibiotics and antipyretics.

H. G., a man aged 70 years. Ten days before the onset of symptoms, Covid-19 has an acute insular infarction manifested by Nominal aphasia. He was in contact with his son with Covid-19. Body weight in surplus 10 kg. Fever, cough, malaise are the only symptoms. He repeated the easy cooling because the recurrence of the temperature up to 38 °C lasted 7 days. The disease was cured in 8 days with antibiotics and antipyretics. At the same time applied neurological therapy.

I. G., a woman aged 65 years. She got a Covid-19 infection from her son. She has a history of easy cooling of the chest. Coughs intensely at night and rarely during the day, malaise and has a loss of smell and taste. Therapy: antibiotic, Pronisona 20 mg 3 x 1/2 2 days, 3 x 1/3 2 days, 3 x 1/4-1/5 3 days, Diclofenac 100 2 x 1 2 days, Aspirin 150 mg at bedtime 1 hour. Cough is cured in 3 days, other problems in 7 days.

K. S., a 70 year old man. Body weight 10 kg in surplus. Cough, mild dyspnea, fever up to 38 °C, malaise, loss of sense of smell. Treated in DPB for obstructive bronchitis 4 years ago. He no longer had exacerbations until infection with the Covid-19 virus. He received amp Gentamycin 80 mg, amp Lemod solu 20 mg i.m. for 12 hours 4 days and continued by inhalation of Symbicort 4.5/160 micrograms 2 x 1 breaths for 7 days.

S. S., a woman aged 62 years. Body weight in surplus 15 kg. Treated in DPB for asthma malignant hyperreactivity. Excellent stability of the

tracheobronchial tree was achieved, so that it had only 1 exacerbation of mild obstruction in the last 5 years. Provides information on cooling before the onset of symptoms. Cough, mild fever, malaise, dyspnea, loss of sense of smell. Repair all problems in 7 days. Received amp Gentamycin 80, amp Lemod solu 20 iv in 250 ml of saline for 12 hours 5 days and continued by inhalation of Symbicort 4, 5/160 micrograms 2 x 2 inhalation for 3 days, then 2 x 1 inhalation for 7 days, Berodual aerosol 2 x 1 inhalation as needed for sensation heat, choking, or irritating cough.

All patients with Covid-19 reported easy or more intense cooling. Rehabilitation of Covid-19 followed quickly in all cases without consequences. During the treatment, all patients followed the rules of prevention without cooling and overheating of the respiratory tract, especially emphasizing the ban on cold and carbonated drinks, cold food.

15 days ago, 4 members of my family became ill with Omicron mutant Covid-19 (2 men aged 64, 34 and 2 women 55 and 32). They received 2 doses of the vaccine 8 months ago. The clinical picture was easy. They had fever, malaise, sneezing, coughing and short-term loss of smell. They took antipyretics and due to the persistence of cough after 2 days, they also took antibiotics. They feel good now.

After my retirement, contact with patients with asthma and Covid-19 took place over the phone or patients carried my reports on which therapy was written at the time of asthma exacerbations. Data on asthma sufferers whether they had Covid-19 and on the applied therapy can be found in the computer of the Health Center in Sjenica. I referred only to asthma patients who first appeared in the DLD from 2017-2019. Then I reviewed the medical reports of some of the most severe cases that had been treated for asthma for over 10 years and more.

From Table 4, it can be seen that of the 15 patients

with malignant hyperreactivity asthma, 12 had Covid-19 infection and 3 did not have Covid.

Table 4 Patients with asthma-malignant hyperreactivity for the first time in DLD from 2017-2019 in relation to Covid-19 disease and treatment outcomes.

| Age | Total | Male | Female | Suffering from Covid-19 | Not suffering from Covid-19 | Corticost. Were given + other th | Cured | Died |
|---------|-------|------|--------|-------------------------|-----------------------------|----------------------------------|-------|------|
| 15-24 | 2 | | 2 | 1 | 1 | 1 | 1 | 0 |
| 25-44 | 1 | | 1 | 1 | 0 | 1 | 1 | 0 |
| 45-54 | 2 | 1 | 1 | 2 | 0 | 2 | 2 | 0 |
| 55-64 | 3 | 1 | 2 | 1 | 2 | 1 | 1 | 0 |
| 65-70 | 1 | 1 | 0 | 1 | 0 | 1 | 1 | 0 |
| Over 70 | 6 | 3 | 3 | 6 | 0 | 6 | 6 | 0 |
| Total | 15 | 6 | 9 | 12 | 3 | 12 | 12 | 0 |

In Table 5, 11 of 22 patients with severe hyperreactivity asthma were infected with Covid-19. Covid infection was not present in 50% of patients with severe hyperreactivity asthma. Susceptibility to the Covid-19 virus of hyperreactive mucosa is very high, because patients generally adhered to the rules of prevention “without cooling and overheating”. The errors are minimal and sufficient for the implantation of the most pathogenic respiratory virus Covid-19.

Then, most importantly, we notice that not a single Covid-19 patient died.

All patients received corticosteroids in addition to the usual therapy. Abrupt discontinuation of corticosteroids after ampoules is impossible because all the patients I have treated are already familiar with duplicating aerosol corticosteroid therapy for a few days and then applying the usual doses.

Table 6 shows asthma patients who first appeared in DLD 10 or more years ago. Of the 26 patients

treated for asthma, 16 or 38% developed Covid-19. Not a single case died. M. M., a 67-year-old woman was hospitalized. In addition to antibiotics, corticosteroids, Aminophylline at 12 hour iv in 250 ml of infusion solution received oxygen and inhalation of Beta 2 agonists. M.M. has been suffering from malignant hyperreactivity asthma for 35 years. Prior to her treatment at DPB, she received a Dexason amp. i.v. at the Emergency Service almost every night. In the last 7 years, exacerbations of obstruction have been rare.

N. Č., A 86-year-old woman has been treated for asthma for 50 years. She first came to DLD 35 years ago. With the application of prevention and adequate therapy, she has not had asthmatic suffocation for the last 15 years. Uses Berodual aerosol rarely. Her grandson was treated in DLD for asthma when he was 4 years old. Asthma was cured after 2 years thanks to the prevention and timely use of preventive corticosteroids. “Prev. cort”.

Table 5 Patients with asthma-severe hyperreactivity for the first time in DPB from 2017-2019 in relation to Covid-19 disease and treatment outcomes.

| Age | Total | Male | Female | Suffering from Covid-19 | Not suffering from Covid-19 | Corticost. Were given + other th | Cured | Died |
|---------|-------|------|--------|-------------------------|-----------------------------|----------------------------------|-------|------|
| 15-24 | 1 | | 1 | 1 | 0 | 1 | 1 | 0 |
| 25-44 | 8 | 2 | 6 | 2 | 6 | 2 | 2 | 0 |
| 45-54 | 3 | 2 | 1 | 2 | 0 | 2 | 2 | 0 |
| 55-64 | 3 | 0 | 3 | 1 | 2 | 1 | 1 | 0 |
| 65-70 | 4 | 1 | 3 | 3 | 1 | 3 | 3 | 0 |
| Over 70 | 3 | 3 | 0 | 2 | 2 | 2 | 2 | 0 |
| Total | 22 | 8 | 14 | 11 | 11 | 11 | 11 | 0 |

Table 6 Patients with asthma-malignant hyperreactivity, first in DLD 10 and more years ago in relation to Covid-19 disease and treatment results.

| Age | Total | Male | Female | Suffering from Covid-19 | Not suffering from Covid-19 | Corticost. Were given + other th | Cured | Died |
|---------|-------|------|--------|-------------------------|-----------------------------|----------------------------------|-------|------|
| 15-24 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 25-44 | 4 | 4 | 0 | 2 | 2 | 2 | 2 | 0 |
| 45-54 | 6 | 0 | 6 | 3 | 3 | 3 | 3 | 0 |
| 55-64 | 6 | 2 | 4 | 3 | 3 | 3 | 3 | 0 |
| 65-70 | 7 | 3 | 4 | 7 | 0 | 7 | 7 | 0 |
| Over 70 | 3 | 0 | 3 | 1 | 2 | 1 | 1 | 0 |
| Total | 26 | 9 | 17 | 16 | 10 | 16 | 16 | 0 |

2.3 Applied Therapy in Patients with Covid-19 Infection

Treatment with Covid-19 depended on the presence of fever, previous and current tracheobronchial tree hyperreactivity, viral or bacterial pneumonia or bronchopneumonia, cough intensity, tracheal irritability, inflammation, and interstitial edema.

In mild cases of patients with Covid-19, it is enough to use antibiotics and antipyretics, vitamins. If the cough persists, Aminophylline 350 mg 2 x 1/2 or 3 x 1/2 is included. I have explained the effect of Aminophylline in detail in my scientific work "Therapeutic effect of bronchodilators and possible mechanism of action" [6].

The antibiotic prevents the growth of opportunistic bacteria and superinfection. It can be avoided only in young people who have a fever and do not cough.

If Covid-19 infection started abruptly with a dry, irritating cough, the use of amp antibiotics, amp Lemod salu 20 mg or Dexason 1/2 ampoule for 12 hours im or iv in saline, can stop the spread of the virus and the development of complications. In 1-3 days, the progression of the disease is completely stopped if there is no new cooling, overheating, drinking cold, hot or carbonated drinks.

In developed obstruction, the dose of corticosteroids is increased to 40 mg every 12 hours with gradual reduction after dyspnea remediation, while Aminophyllin 350 mg 3 x 1/2, later 2 x 1/2 and corticosteroid and bronchodilator aerosols are retained

until complete remediation. Giving higher doses is justified if the doctor estimates that due to the current condition there would be a therapeutic justification. In the elderly, high doses can strengthen heart strength and deplete cardiac reserve, which could cause sudden heart failure.

At elevated temperatures, an antipyretic is used per os, and if the temperature persists above 38 °C or rises, a saline solution of 500 ml with Novalgetol is given.

In pneumonia caused by Covid-19, the use of broad-spectrum antibiotics, and then according to the antibiogram, is justified due to the possible simultaneous bacterial infection or prevention of superinfection. Antibiotics, when exclusively viral infection is present, should not be given to patients for 1-2 days until interstitial edema and obstruction of the tracheobronchial tree with adequate doses of corticosteroids are removed. Antibiotics are then included due to possible superinfection (the effectiveness of antiviral drugs is still being proven) and corticosteroids are gradually excluded. All antibiotics have less anti-inflammatory and antiplatelet effect, so the introduction of Aspirin 100 mg 30 minutes to 1 hour before bedtime was enough. But the use of antithrombotic agents is necessary in inactive, obese, elderly, and patients at risk of possible thrombus development.

Corticosteroids (glucocorticoids) have anti-inflammatory, antiallergic and immunosuppressive effects. In all exclusively viral pneumonias, corticosteroids in smaller doses for 12

hours 1-2 days would release interstitial edema, inflammatory material, and exudates. Then, in a more physiological environment, the effect of antibiotics is maximum and necessary. Corticosteroids should never be switched off abruptly, as capillary permeability; inflammation and exudation return or become higher. In asthma, corticosteroids are the first drug, which does not depend on whether the exacerbation is caused only by overheating and cooling, or whether the virus is implanted. Administration of corticosteroids that does not last longer than 7 days may not have an immunosuppressive effect because otherwise the obstruction caused by the virus could not be cured. I explained in my scientific paper "Development of a higher degree of hyperreactivity of the tracheobronchial tree due to inadequate use of corticosteroids and errors that can worsen viral infection" [7].

2.4 Covid-19 Prevention

The high effect in the treatment of exacerbations of asthma caused by the virus is the best proof of the effectiveness of prevention "without cooling and overheating of the respiratory tract, i.e. the organism", with adequate therapy. The presence of the virus and the absence of obstruction is evidence that high stability of the tracheobronchial tree has been achieved.

Wearing a mask is a good barrier to viruses because viruses are found in Flügge's droplets that are retained on certain materials. "Physical distance" is necessary 1.5-2 m, which allows short-term greetings by touching the fists of outstretched hands. The wrong term "social distance" is still used by some doctors and journalists, even though there is communication by phone, video call.

If small children are isolated, they will eventually lose the achieved adaptation of the tracheobronchial mucosa to temperature changes. With the decline in adaptation to minor cooling, viruses are easily

implanted. Children adequately trained through outdoor play achieve good adaptation to temperature changes and thus better defense of the organism. Movement in fresh air maintains the balance between warming the body with movement and cooling the airways with inhaled air, which enables physiological circulation. Children socializing and collective games strengthen resilience, but physical distance cannot be achieved. Therefore, the risk of infection with the Covid-19 virus is very high.

Physical activity during walking is the healthiest and most adequate way to fight the virus and achieve the adaptation of the respiratory tract and the organism to temperature changes. Adaptation is carried out gradually a few days after recovery. Although hospitalization is necessary to cure a patient with Covid-19, it does not provide the possibility of avoiding new cooling or overheating of the organism (ventilation of patient rooms in the presence of patients, impossibility to change sweaty clothes). The suits of the medical staff overheat the organism from certain materials. That is why cotton medical suits or uniforms are the most adequate because they can be washed at high temperatures and ironed. So, overheating and cooling in hospital conditions will cause worsening of the disease in addition to therapy. If corticosteroids are abruptly discontinued, then worsening can be life-threatening.

Young people like carbonated drinks, children ice cream (after tonsillectomy, children are given ice cream because they reduce hyperemia and pleasure alleviates discomfort). Although children and adults have a high adaptation to the cold (some drink water exclusively from the refrigerator) at the time of the appearance of the most pathogenic and virulent virus Covid-19, cooling can cause implantation of the virus in the nasopharynx but not manifest the disease. They can then infect healthy people with the Covid-19 virus, or cause the virus to spread to other parts of the airways, ie the lungs, by cooling down again.

2.5 Vaccine

Any vaccine against the Covid-19 virus will create immunity that will alleviate the clinical picture and reduce mortality. But any cooling and overheating can weaken the body in defense against antigens and the production of specific antibodies. Cooling can occur while waiting in line for a vaccine when the chance of getting Covid-19 is very. If it happens that the patient receives the vaccine and gets the Covid-19 virus, then the organism fights against the vaccine and the live virus, which the patient can interpret as a problem caused by vaccination.

Patients with obstructive diseases have always had an advantage in receiving the vaccine against influenza, because the infection with the flu virus caused the most severe obstructions with complications. Although they received the vaccine long enough before the epidemic, they received severe exacerbations of influenza virus obstruction. After treatment in DPB and mandatory adherence to prevention rules, the influenza vaccine in asthmatics had a high preventive effect. There were healthy patients who received the vaccine in a timely manner and still suffered from severe influenza with high fever, pneumonia, bronchopneumonia or first bronchial obstruction. Patients relying on the vaccine behaved in a relaxed manner, so the flu was preceded by more intense cooling. For example, a nurse's mother received the vaccine in November 2011, and contracted influenza with bronchopneumonia and bronchial obstruction. Although the flu was preceded by a long and intense cold, she still categorically refused new vaccinations, because she was convinced that the vaccine had caused the disease.

2.5.1 Why there is a fear of the Covid-19 vaccine

Information about the presence of chips in the vaccine against Covid-19 is appearing on the Internet. This claim is incorrect because the vaccines are made by the 4 largest powers in the world. Wouldn't there be a revelation of each other. Then you can read on the Internet that there were deaths that caused fear of

vaccination. If the data are correct, very serious research must be done. For example, Č. H. a 68-year-old man dies of a myocardial infarction after receiving the vaccine for 6-7 hours. Many associated it with the vaccine and ignored the fact that he already had anginal problems and irresponsibility towards the necessary treatment. It is possible that the fear of the vaccine, which was caused by "anti-vaxxeres" from his environment, influenced the spasm of already narrowed coronary arteries.

2.5.2 Why do obese people suffer more from Covid-19

Obese people have been shown to suffer more from Covid-19. Obese people have reduced lung ventilation due to the increase in the volume of the abdominal organs that compress the lungs. The excursion of the lungs is reduced, which causes impaired ventilation, circulation, and less possibility of the action of defense cells. Developed atherosclerosis and arteriosclerosis cause impaired circulation and easy cooling. Obese people sweat and get cold easily due to being overweight. After large meals, they like to drink carbonated drinks for better digestion and a feeling of lightness. The dissolved carbon dioxide that is released causes cooling of the nasopharynx, tonsils, larynx and trachea. Then the virus continues to spread to other parts of the lungs, and with easy overheating and, of course, the slightest cooling, and the virus spreads quickly to healthy parts of the lungs. Obese people over the age of 60 often have heart failure, so the load of volume (food, fluid) causes increased permeability of the pulmonary capillaries, so Covid-19 will easily cause pathological changes in the already injured alveolocapillary membrane.

2.5.3 Why do more elderly people suffer from Covid-19

In addition to chronic diseases and altered tissue, the elderly have less potential for the body's defenses. Tissue vulnerability (for example, the appearance of hematomas on the skin, although they do not remember that they were injured) in the elderly due to the loss of elastic fibers allows easy and rapid

implantation of highly pathogenic and virulent Covid-19 virus. Then, due to impaired circulation, the elderly feel colder, then dress too much “not to freeze”, which causes sweating and the inevitable feeling of cold (both disorders of the vasomotor center and inadequate transmission of vasoconstrictor and vasodilator impulses). Vasodilation and wet clothing cause cooling and easy implantation of the virus. Older people are mostly obese because their metabolism is significantly reduced and physical activity is reduced, and the habit of eating more food is maintained.

3. Conclusions

After reporting the first case of coronavirus Covid-19 (SARS-CoV-2) on December 1, 2019 in the Chinese city of Wuhan to this day, data on Covid-19 symptoms vary, and are changing. The Covid-19 incubation was said to be about 14 days, today from 1-14 days. Fever, dry cough, fatigue, expectoration of mucus, dyspnea, headache [8], gout, muscle pain, joint pain, shivering, nasal congestion, diarrhea, nausea and vomiting rarely. All these symptoms also occur in influenza. However, what is specific about Covid-19 is the loss of smell and taste, but not all, and that further development can lead to severe pneumonia and acute respiratory distress syndrome (ARDS). Influenza can be complicated by viral and bacterial pneumonia, but the severe clinical picture does not develop as rapidly as with Covid-19. ARDS is rare in influenza except in asthma, malignant hyperreactivity, heart failure followed by pulmonary congestion [9].

Healing 41 patients, regardless of the severity of the clinical picture of influenza or perhaps Covid-19 (or Flurona already existed at that time) from 06.03.2020 to 03.04.2020, it is proof that a viral infection with complications can be cured by prevention “without cooling and overheating of the respiratory tract,

organism” and adequate therapy. It is very important that during the treatment there is no new cooling and overheating of the respiratory tract, ie the organism, because new vasoconstriction and especially vasodilation worsen inflammation, edema of the mucosa and interstitium, and the inevitable spread of the virus to the remaining healthy lungs.

The susceptibility of Covid-19 virus to hyperreactive mucosa in asthmatics is very high. Although diseased with asthma and malignant hyperreactivity have long adhered to the rules of prevention, they have a high percentage of diseased from Covid-19. Minimal errors are sufficient to accelerate the implantation of the most contagious respiratory virus, Covid-19. If the mucosa of the tracheobronchial tree is still hyperemic and edematous after the exacerbation of asthma, the Covid-19 virus will implant and cause worsening of asthma even though there has been no previous cooling or overheating.

Treatment with antibiotics, antipyretics and the use of theophylline and corticosteroids depending on the pathological change in the tracheobronchial tree or parenchyma due to the high therapeutic effect is evidence that therapy for influenza and Covid-19 is not significantly different, except for antithrombotic drugs. Prevention “without cooling and overheating” during treatment is very important in all viruses, but in the most pathogenic and virulent virus Covid-19 is more important because the fastest and most intense worsening of pathological changes in the lungs. When cooling or overheating again, a new increase in body temperature occurs. Overheating and abrupt cessation of corticosteroids exacerbate inflammation and interstitial edema, which can be life-threatening for Covid-19.

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