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Editorial

COVID-19 WAR, Unusual Vaccines versus Platelets

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As are described/predicted previously, pandemic attacks via COVID-19 mutants cause more than three million causalities, and counting, which exact mechanism is not completely elucidated yet (May 2021). Ironically we are still surviving the global contamination after 20 months neither because of professional scientific-based approaches nor due to excellent specific drugs/ vaccines developed lately. Surprisingly, the detailed mechanism of actions of COVID-19 induction of platelet disorders is not elucidated completely. Moreover, asking frankly whether our turn might be in the near future with(out) vaccines administration or not? Most people still are not sure whether take a vaccine shot or not needed anymore, after 20 months of struggling with biotechnologically developed superbug microorganisms?

Basic Scientists around the world are studying (Nano-)microscopic interactions to unravel and tackle different kinds of mutated COVID-19, under ex-vivo and/or in-situ conditions [1-4]. Current research studies either molecular basic or cellular clinical over the mechanism of COVID-19 infection machinery, revealing the cellular structures of the immune response did not result in standard practice for fitting Medicare/Medicaid of COVID's patients. The death cause in ICU's department is obviously recognized eventually i.e. primary platelet disorders with catastrophic induction of the thrombophilia, thrombocytopenia (ITP or TTP), thrombosis, thromboembolism, and blood clotting side effects i.e. random organs' shut down [1-5]. Although the exact mechanism is still not revealed as such that pharmacologists and manufacturers can produce standard antiCOVID-19-drug/vaccines, however.

The latest hastily established unusual vaccines and unstandardized treatment programs, increased anxieties over the possible rise of new mutants, more destructive than existing diffused vaccine variants [1]. One might ask why manufacturers did not produce old fashion vaccines against COVID-19 variants, which have repeatedly shown beneficial effects, in the last Century. For instance live

attenuated organisms that are well attained by using strains, which are virulent for Up to now, more than 6 sort vaccines produced, which are modern and based on all recent information gathered from the last 30 years i.e. based on killed-alive viruses, DNA- RNA-mRNA, and different proteins/peptides. Though, none of these produced vaccines are equally affected volunteers' immune system with the correlated standard side effect(s), similarly. Every vaccine has its own efficacy/side effects and usefulness on human health (and underlying symptoms); indicating all developers have their own protocols (or not) and have had not followed standard GMPs, GLPs, SOPs, globally. One might ask a sincere question 'how it could be possible that no standard SOPs and GMPs were done by the manufacturers, despite the fact no standard antiCOVID-19 drugs/vaccine produced yet?'. Why they do not use one standard protocol against COVID-19? Would it possible that COVID-19 is a superbug and not just a virus/microorganism. IVAN Roitt pronounced in his book Essential Immunology book 7th Edition that Jenner's had a remarkable demonstration, which has showed cowpox could protect against smallpox in humans. Still, attenuation of microorganism's virulence is being a very effective tactic. One might wonder why during COVID-19 vaccines production manufacturers used alive viruses instead of attenuated animal versions.

After all, we are observing that COVID-19 mutants are insensitive to physical parameters i.e. materials and temperature globally. The study report of different groups indicated that the virulency of COVID-19 variants significantly is (dis-) similar. Nonetheless, their COVID-19-associated drugs/vaccines all are

another species, but a-virulent in humans.

temperature dependently produced. Recall, concerning storage and amount to applying manner, and the final concentration of the different COVID-19-drugs/ vaccines are significantly inconsistent.

As predicted, platelet disorders do not occur physiologically, which are leading to premature thrombophilia, hypo-hyperactivity of plateletsin circulation [6], thrombosis, thromboembolism ,blood clotting [5], and unknown pathological random shut down of organs, contrariwise.

Both studies of Peyvandi et al. 2020 [5,6] according to the analyses of their laboratory biomarkers of pro-and anticoagulants, together with data regarding the viscoelastic properties of blood of the COVID-19 patients did not support hematological characteristics of disseminated intravascular coagulation –in contrast, they demonstrated the presence of a prothrombotic phenotype that did head into a procoagulant / pro-thromboticim balance.

Whether neutrophils, Megakaryocytes, and leucocytes wereinvolved in COVID-19 collateral damages was not elucidated completely.

Mizukoshi et al. 2021 [2] postulated that most viruses emitted from a patient'scough and vocalization (Room Temperature 18-24ºC (RT) are distributed to the room's air and various indoor surfaces and transferred to the target subject while being decreased by viral inactivation and ventilation

Recall, cold inducesplatelet activation [7], and because the global' s RT varies between 10 up to 32 ºC, geologically;

getting primary thrombocy to penia is not pathologic but mightbe a rather reversible physiologic reaction [6]. From different classical studies is demonstrated that microorganisms are temperature dependent. One micro organismis at cold (in-) active, and another at warm circumstances are (in-) activated. Most viruses become active in the animals/human body when the temperature rises above 37ºC, on one hand. On the other hand, viruses are mainly inactive in lower body temperatures for example when they want to penetrate the skin and peripheral exposed tissues (± 28-32 ºC), where most might have a temperature lower than 20 ºC, speculatively. One might hypothetically say that entrance of virusesneeds a hypothermic environment but their pathological binding effects need increased body temperature (pyrogenic actions), simultaneously, platelets become prone to phagocytes at a lowertemperature, as described [7].

Obviously, (non-)aerosolized and temperature independency of new COVID-19 variants are making them superbugs entities, with self-sufficiency metabolism to reproduce/spread/ penetrate gas-liquid-vast (in-) organic materials, unexpectedly. It seems the whole world is contaminated but only 150 million people are contracted with COVID-19 mutants. What would be the reason that from 8 milliard people only 150 million are contaminated after 20 months? Besides, personal protective equipment decreased the infection risk by 63%– up to >99.9% [2]. One might wonder why everybody is not stimulated to use personal rather than general common materials, overall. So many unanswered simple questions that remained unsolved, eventually.

Taken together, the droplet spraying is recognized as the major infection pathway, contributing to 60%–86% of cases, and hand contact via contaminated surfaces contributed to 9%–32% of cases of infection [2], One might ask the sincere question why surface disinfection got not appropriate attention, eventually i.e. using warmed-, nanomaterials covered surfaces in the Hospitals and the ICUs. We are fighting different insensitive-temperature

independent superbugs called COVID-19 variants, let's think together and make a standard drug(s)/vaccine(s) based on commonly agreed SOPs, GMP's, and the same GLPs, synchronically.

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