The following is a summary of a recent national health care webinar that I participated in on January 27 regarding COVID-19, subvariants, long-COVID, and treatments. This is the 24th update.

COVID-19 and Subvariants

As of January 20, the COVID subvariant JN.1 expanded to 85.7% of all cases. HV.1 is 5.3%, JD 1.1 is 1.6%, and EG.5, HV.1, BA.2.86, and HK.3 are under 2%. This indicates how quickly subvariants mutate and then drop off. Subvariant JN.1 was first identified in Europe and is considered not as deadly as previous subvariants, but more infectious. Wastewater viral activity is decreasing slightly from a high in December. Health care professionals are encouraged to mask while others should mask in crowded interior spaces. The rapid COVID antigen tests that are currently being utilized will be viable even after the stated expiration date; however, they are less sensitive than the genomic tests.

New evidence shows that COVID infects atherosclerotic plaques in coronary arteries, producing a persistent inflammatory response, increasing the risk of cardiovascular events. In cases of mild to moderate COVID infection, Paxlovid continues to be the preferred antiviral medication. Lagevrio and Paxlovid greatly reduced the risk of hospitalization for adults 75 years of age and older in clinical studies.

Moderna COVID-19 vaccine-Spikevax, Pfizer-BioNtech COVID-19 vaccine-Comirnaty, and Novavax continue to lower the risk of hospitalization and protect individuals from viral infection and reducing the risk of long-COVID. The National Institutes of Health are launching major clinical trials (RECOVER Initiative) for long-COVID. Treatments to be trialed: Paxlovid for viral persistence, home-based transcranial direct-current stimulation and web-based brain training for brain fog, Modafinil, Solriamfetol, Melatonin, light therapy, and educational coaching for insomnia, and Immunoglobulin and Ivabradine for POTS (postural orthostatic tachycardia syndrome). Previous studies indicate Propranolol helps with tachycardia and exercise intolerance, migraine, and anxiety and Amantadine for brain fog and muscle weakness. FAD (flavin adenine dinucleotide) and NAD (nicotinamide adenine dinucleotide) are being administered for post-exertional malaise with favorable results. Dietary changes, anti-diabetic medications, reduced fructose intake, probiotics, and clinical trials with the symbiotic drug SMI01 have shown multi-symptom relief of long-COVID. Other supplements such as elderberry, echinacea, and ginger have demonstrated improved viral prevention and a reduction of COVID-19 symptoms.

Of particular concern are recent MRI studies with generalized diffusion, indicating damaged white matter in the brains of patients previously hospitalized for COVID-19 with persistent central nervous system symptoms. These studies are in addition to previous studies citing the thinning of gray matter in patients infected with COVID-19 Omicron.

Vigilance

It is clear the COVID-19 is still a significant danger to public health and long-COVID is in the early stages of clinical research and treatment. Immunizations, preventive health strategies, and effective personal hygiene are the tools we have to manage this crisis and protect ourselves and our loved ones. We need to use these tools wisely.