COVID-19—a very visible pandemic

We read the Correspondence by Johan Giesecke,[1] a senior consultant to the Swedish Public Health Agency, with considerable concern.

First, Giesecke correctly placed the Swedish death toll at less than the UK, Spain, and Belgium, and at more than its Nordic neighbours. But he did not acknowledge the scale of these differences. Despite similar epidemic start dates, population densities, and cultures, at the time of writing, Sweden had reported 7 times more COVID-19 deaths per person than Finland and Norway, and 3 times more than Denmark.

Secondly, to state that 98–99% of people infected with COVID-19 are "unaware or uncertain of having had the infection"[1] dangerously conflates asymptomatic cases with unconfirmed cases, and dismisses the lived experience of milder infections. Although a summary of 13 studies estimates that 56% of cases are asymptomatic at the point of testing, many go on to develop symptoms.[2] For Giesecke[1] to state that "COVID-19 is spreading like wildfire in all countries, but we do not see it" is contradictory.

Giesecke's further assertion that, as of April 29, 2020, 20–25% of the Stockholm region have been infected only serves to reinforce his opinion of unreported cases. But this assertion is based on a narrow view of available data at that time. Of the three preliminary and unpublished serology studies from Stockholm in April, 2020, only one study, testing 527 of 2000 health-care workers at a single hospital, is close to this estimate (20% seropositive).[3] However, community estimates range from 7·5% to 10%, and suggest considerable clustering.[4,5]

Indeed, serology data from other European settings in March and April, 2020, report low antibody prevalence, from less than 1·0% to 2·7% among tested blood donors;[6,7] 5·5% from a random population sample in Geneva;[8] and 11·2% from health-care workers in Spain.[9] The hotspot of Gangelt in Germany reported 15% patients with an infection,[10] substantially lower than the assumed 50–70% threshold needed for herd immunity. Therefore, it seems implausible to suggest that Europe is past the peak because of so-called silently acquired herd immunity, rather than as a result of active intervention.

Finally, the conclusion that stopping the spread of COVID-19 is futile ignores clear examples from New Zealand, Taiwan, Iceland, and Vietnam. It is disingenuous to dismiss these considerable successes of COVID-19 containment and, at least temporarily, suppression. The threat of future outbreaks is of course a real concern—look to Singapore for a stark warning.

But to state that slowing down the progression of COVID-19 is futile is cynical, as it implies that painfully acquired knowledge and efforts to develop or repurpose drugs and treatments will amount to nothing.

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Carina King, Lena Einhorn, Nele Brusselaers, Marcus Carlsson, Stefan Einhorn, Fredrik Elgh, Jonas Frisén, Åke Gustafsson, Stefan Hanson, Claudia Hanson, Thomas Hedner, Olle Isaksson, Anders Jansson, Åke Lundkvist, Jan Lötvall, Bo Lundback, Björn Olsen, Cecilia Söderberg-Nauclér, Anders Wahlin, Gunner Steineck, Anders Vahlne

carina.king@ki.se

Department of Global Public Health (CK, CH), Department of Microbiology Tumour and Cell Biology (NB), Department of Oncology-Pathology (SE), Department of Cell and Molecular Biology (JF), Department of Medicine (CS-N), Department of Neurology (CS-N), and Department of Clinical Microbiology (AV), Karolinska Institutet, Stockholm SE-171 77, Sweden; Institute for Global Health, University College London, London, UK (CK); Department of Mathematics, Lund University, Lund, Sweden (MC); Department of Clinical Microbiology (FE, ÅG) and Department of Radiation Sciences (AW), Umeå University, Umeå, Sweden; Institute of Medicine (JL, BL) and Institute of Clinical Sciences (GS), The Sahlgrenska Academy (TH, OI), University of Gothenburg, Gothenburg, Sweden; Department of Clinical Physiology, Danderyd Hospital, Stockholm, Sweden (AJ); Zoonosis Science Centre, Department of Medical Sciences (BO) and Department of Medical Biochemistry and Microbiology (ÅL), Uppsala University, Uppsala, Sweden; and Stockholm, Sweden (LE, SH)

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