THE informed PARENT
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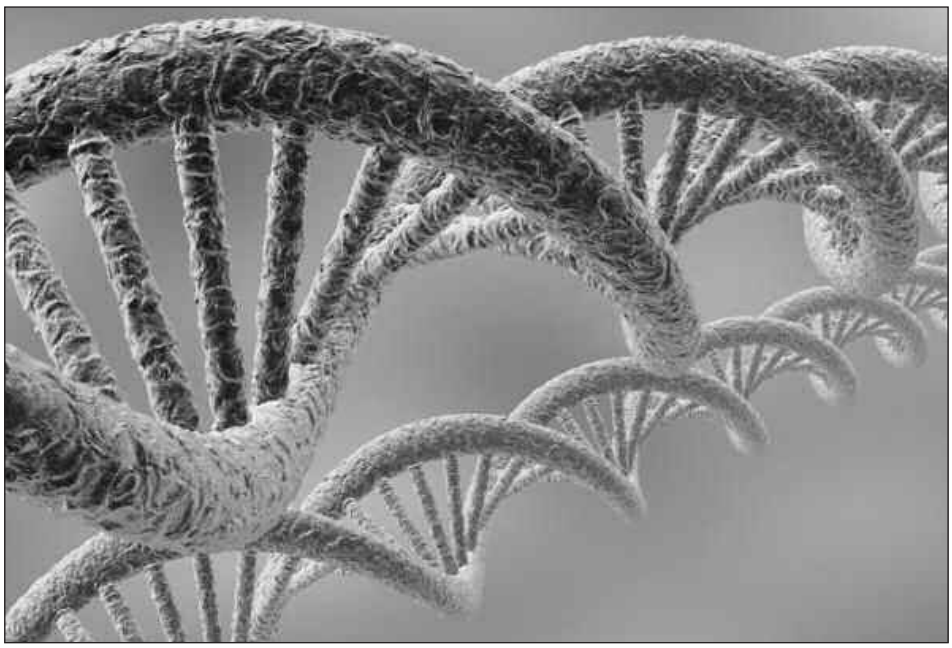
What if HPV does NOT cause cervical cancer?

BY NORMA ERICKSON AND PETER H. DUESBERG, PHD

http://sanevax.org/hpv-not-cause-cervical-cancer/
January 20th 2015



THE TITLE of a paper recently published by McCormack et al in Molecular Cytogenetics says it all, "Individual karyotypes at the origins of cervical carcinomas." If the findings in this paper are true, a vaccine against human papillomavirus (HPV) is extremely unlikely to protect against cervical cancer.

According to this paper neither genetic predisposition nor HPV infections are necessary for the development of cervical cancer. All cervical cancer cells investigated during the course of this study contained new abnormal karyotypes. The clonality (genetic makeup) of these new abnormal karyotypes indicates the cervical cancers originated with these karyotypes - NOT from a virus.

In order to grasp the potential significance of these statements, one must have a basic understanding of karyotypes. Most living things have chromosomes, or units of genetic information, in their cells.

The number and appearance of chromosomes varies from one species to another. A karyotype is the number, size, and shape of chromosomes in any given organism.

Every human has 23 pairs of chromosomes (46 total), with the last pair determining the sex of any particular human. Any different number would indicate a different species. For example, apes have 48 chromosomes and kangaroos 20. The number, size and shape of the chromosomes in any given cell reveals the species of origin for that cell.

Cancer-specific karyotypes explained

"All cancers have individual clonal (cells descended from and genetically identical to the parent cell) karyotypes (number, size and shape of chromosomes) and thus phenotypes (expressed physical traits). No two cancers are the same."

All cancers have individual clonal (cells descended from and genetically identical to the parent cell) karyotypes (number, size and shape of chromosomes) and thus phenotypes (expressed physical traits). No two cancers are the same. See the karyotype arrays in the paper named above and referenced at the end of this article.

The karyotype determines the phenotype via thousands of messenger RNAs (about a thousand per chromosome), which in turn make thousands of proteins - at concentrations (copy numbers) that are cancer karyotype-specific – all cancer cells are individually very different from normal cells. In this respect, cancer cells resemble a new cellular species existing within the human body, much like a parasite.

The genes and proteins within cancer cells are expressed at very abnormal concentrations when compared to the normal cells surrounding them. However, since all genes and proteins expressed within cancer cells originated from human cells, cancers are not immunogenic (able to produce an immune response) – despite their huge biological differences from surrounding normal cells. This is the reason the immune system cannot "see" cancers.

Since the new carcinoma karyotypes express thousands of normal genes abnormally they generate numerous new cancer-specific phenotypes that correlate one-to-one with the new karyotypes of cancer cells. Cervical cancer cells are one example.

Think about Down syndrome as a model; one extra small 21 chromosome changes a lot. Cancers typically have 60-

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Editor's note

Magda Taylor

WELCOME TO THE FIRST EDITION OF 2015. Meningitis W has been hitting the headlines in recent weeks, and it appears that the vaccine schedule is due for further changes in the near future. It is likely that the average person would not have heard of meningitis W before the recent media coverage, which reminds me of when the Hib vaccine was introduced in 1992. Prior to that most people were not aware of this particular disease, and I don't recall my health visitor telling me 'if only we had a vaccine to protect against Hib' when my daughters were young. There was no mention of the disease until the vaccine was ready to launch. Suddenly cases of Hib meningitis hit the headlines, followed by the announcement that a vaccine had been developed - indicating in so many words that a Hib vaccine was available just in the nick of time! I must admit that, in my opinion, it seemed more like strategic marketing to create a demand for the vaccine and justification in adding it to the immunization schedule.

The latest meningitis W reports indicate that there is no vaccine as such but 'fortunately' a vaccine for meningitis B would also protect against the W strain. The MenB vaccine Bexsero was licensed in Europe in January 2013. According to the Meningitis Research Foundation the Joint Committee on Vaccination and Immunisation (JCVI) 'initially rejected the the vaccine on cost effectiveness grounds but invited comment from stakeholders, an opportunity we couldn't miss. After taking into account the new evidence they received from MRF and other stakeholders we were very pleased that the JCVI recommended the vaccine for routine use in 2, 4 and 12 month olds in March 2014. But months later we are still waiting to hear when babies will be immunised on the NHS.'

Now we are seeing headlines such as, ' Hurry up with meningitis vaccine deal, government told' and 'Fears Raised Over Meningitis Vaccine Delay' (LBC Radio, 21/3/15) with the opening lines reading:

'The Department of Health was told by its immunisation advisory body (meaning the JCVI) it should make the new meningitis B vaccination available to children a year ago.'

So I can't help wondering if the latest scares about meningitis W are a means to speed up the introduction of the MenB vaccine into the schedule?

I do not know how many of the present 15 members of the JCVI have financial ties with pharmaceutical but past details have shown that they are far from independent. For example, in 2011, Dr Lucija Tomlijenovic PhD. obtained documents from the Joint Committee on Vaccination and Immunisation (JCVI) and the UK Department of Health (DoH). She used the Freedom of Information Act to request transcripts and other papers which otherwise would not have made it into the public domain, and was shocked at what she uncovered.

Tomlijenovic states: "The transcripts of the JCVI meetings also show that some of the Committee members had extensive ties to pharmaceutical companies and that the JCVI frequently co-operated with vaccine manufacturers on strategies aimed at boosting vaccine uptake. Some of the meetings at which such controversial items were discussed were not intended to be publicly available, as the transcripts were only released later, through the Freedom of Information Act (FOI). These particular meetings are denoted in the transcripts as "commercial in confidence", and reveal a clear and disturbing lack of transparency."

One thing is for certain, the first question we should be asking is why is there an increase in meningitis W, which essentially is a disease of a compromised immune system? Perhaps there is a correlation with the ever increasing vaccines that children, teenagers and young adults are being bombarded with in recent years?

MAGDA TAYLOR, EDITOR. MARCH 2015

› *from p01*

70 chromosome variations compared the 46 +1 of Down syndrome.

THE HUMAN PAPILLOMAVIRUS (HPV) CAUSES CERVICAL CANCER HYPOTHESIS

This hypothesis states that HPV encodes proteins which cause cancers as the virus replicates. Having common transforming proteins, all cervical carcinomas would be more or less the same if this were accurate. Since viral proteins are foreign to humans, viruses, virus-infected cells and possibly virus-transformed tumor cells would inevitably be immunogenic and as such eliminated by the host's immune system within weeks to months after infection.

This is the reason why HPV-induced warts are eliminated by the immune system within weeks to months after infection.

THIS HYPOTHESIS RAISES FOUR QUESTIONS:

Why would only 1 in 10,000 HPV-infected women develop cervical cancer?

Why would cervical cancers only develop 20 to 50 years after infection? – In other words, why would the virus not cause cancers when it is biochemically active and causing warts, namely before it is neutralized by natural anti-viral immunity?

Why are cervical carcinomas individually very distinct from each other in terms of malignancy, drug-resistance, cell histology, as originally described by Papanicolaou et al. in Science in 1952, although they are presumably caused by the same viral proteins?

Why are cervical carcinomas that are presumably generated by Human Papillomavirus proteins not immunogenic and thus not eliminated by natural antibodies?

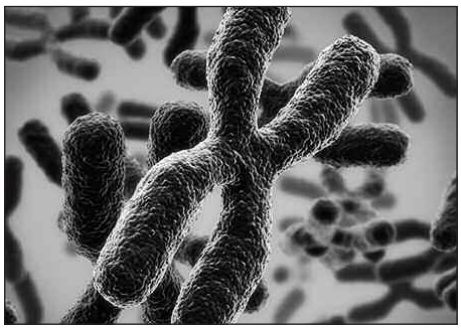
Despite over 25 years of research on the HPV causes cancer hypothesis, there are no direct answers to these questions.

Instead poorly defined "co-factors" are mentioned as "collaborators" of HPV in the causation of carcinomas. Poorly defined cellular mutations are mentioned as the causes of the cervical carcinomas of HPV-negative women. Moreover, about 30% of cervical cancers are virus-free. In these cases the virus couldn't even theoretically be responsible for the cancer.

The Karyotypic Speciation Theory of Cervical Cancer Development

The McCormack et al. study, "Individual karyotypes at the origins of cervical carcinomas" advances the theory that carcinogenesis is a form of speciation (See Duesberg et al., "Is carcinogenesis a form of speciation?" Cell Cycle 2011).

According to this theory karyotypic



"The karyotypic cancer theory sheds light on the presumed long latent periods from HPV infection to cancer. This huge latent period suggests evidence of two entirely unrelated events"

evolutions generate new cancer species from normal cells after exposure to carcinogens (e.g. cigarette smoke or X-rays) or after spontaneous mitotic accidents. The common function of carcinogens is the induction of aneuploidy (chromosomal disruption, either gains or losses). By unbalancing thousands of genes aneuploidy automatically destabilizes the normal human cell karyotype and thus catalyzes random karyotypic variations. Selections of variants with proliferative phenotypes form nonclonal pre-neoplastic hyperplasias (enhanced growth of non-neoplastic cells in a tissue or an organ) with persistently varying karyotypes. Very rare karyotypic variations form autonomous (capable of replicating without influence from surrounding host cells) new cancer species with individual clonal karyotypes. Cancer karyotypes are stabilized within narrow margins of variation by clonal selections for cancer-specific autonomy. Since this mechanism is very inefficient, it predicts long latent periods from carcinogen exposures to cancers with individual clonal cancer karyotypes.

In agreement with this theory, the authors discovered new, cancer-specific karyotypes and phenotypes in all cervical carcinomas tested so far – both in HPV-DNA-positive and negative carcinomas.

Furthermore, they discovered the individual karyotypes of each carcinoma correspond 1 to 1 to their individual phenotypes (e.g. invasiveness and resistance to chemotherapeutic drugs). This is proof-of-principle that these karyotypes determine the phenotypes of cancers - rather than the defective and latent Papilloma-virus DNAs.

According to the karyotypic speciation theory, the defective viral DNAs of "HPV DNA-positive" carcinomas are functionally irrelevant, because they are not expressing any viral proteins. Instead they are non-immunogenic fossils of long past Papilloma-virus infections. As such they are no matches for the thousands of cellular genes that are abnormally expressed in cervical carcinomas.

Karyotypic speciation theory explains paradoxes presented by the HPV causes cancer hypothesis.

WHY WOULD ONLY 1 IN 10,000 HPV-INFECTED WOMEN DEVELOP CERVICAL CANCER?

According to the karyotypic carcinoma theory this discrepancy is the result of the facts that HPV infection and carcinogenesis are two entirely independent events:

- No specific correlation exists between HPV and cervical carcinoma. HPV is very common, about 70 to 80% endemic in the American population. The rest of the population is HPV-free. The virus is typically sexually transmitted at young age. Since cervical carcinomas occur in both HPV-positive and HPV-negative females, there is no specific correlative evidence that HPV plays any role in causing cervical cancer.
- There is also no specific functional correlation between HPV-infection and carcinogenesis. As shown from the clonal karyotypes of cervical cancers, cancers originate from a major rearrangement of the karyotypes of normal cells. Since this is true for cervical carcinomas of HPV-positive and of HPV-negative females – and is indeed true for all cancers – there is no functional evidence that HPV plays a role in the development of carcinomas.

This conclusion is consistent with the fact that carcinomas with new clonal karyotypes arise only 20 to 50 years (!) after infection by HPV, which we discuss next. Thus there is neither a specific correlation between the presence and/or the functions; or lack of functions of HPV and carcinogenesis.

WHY WOULD CERVICAL CANCERS ONLY DEVELOP 20 TO 50 YEARS AFTER HPV INFECTION?

The karyotypic cancer theory sheds light on the presumed long latent periods from HPV infection to cancer. This huge latent period suggests evidence of two entirely unrelated events:

- Infection with a sexually transmitted, benign Human Papillomavirus at young age, and
- A cervical cancer diagnosis – 90% of which occur over the age of 50

The presumed long latent period could be a result of the low probability of forming a new autonomous cancer species from a normal somatic cell by random karyotypic rearrangements. The evolution of a new individual species of cells (cervical cancer cells) with the ability to reproduce independent of influence from surrounding human cells by random karyotypic variations of precursor cells takes time.

The very low probability of evolving a new autonomous cancer species by random karyotypic evolution explains not only the long and unpredictable time intervals between HPV infection (if it occurs) and cervical carcinomas, but aso the classical age bias of all cancers. The age bias of cancer says that over 90% of all cancers only occur at ages over 50 years. The authors concluded the chronological discrepancies between HPV infection and carcinogenesis exclude a direct mechanism of action connecting viral infection and the development of cancer. Instead the time-dependent evolution of a new cancer-specific karyotype supports the karyotypic theory of the origin of cervical carcinomas.

WHY DO CERVICAL CARCINOMAS HAVE INDIVIDUAL KARYOTYPES AND PHENOTYPES – RATHER THAN COMMON PHENOTYPES AS PREDICTED BY THE VIRUS HYPOTHESIS?

The probability of forming the karyotype of a new autonomous cancer-species by random karyotype variations is very low and thus unlikely to ever generate the same new species twice – much again as in conventional speciation. Thus all cancers caused by karyotypic speciation will have individual, if sometimes similar phenotypes.

WHY ARE PRESUMABLY VIRAL CERVICAL CARCINOMAS NOT IMMUNOGENIC AND THUS NOT ELIMINATED BY NATURAL ANTIBODIES?

The karyotypic speciation theory explains why presumably viral cervical carcinomas are not immunogenic and are thus able to grow in HPV-DNA-positive people, which contain anti-HPV antibodies produced as a result of prior infection(s) by the virus.

According to the karyotypic cancer theory, carcinomas are generated de novo from cellular chromosomes, genes and proteins, which are not immunogenic in the host of origin (just like all other cancers). By contrast, hypothetical cancer cells generated by viral proteins would be immediately eliminated by antiviral immunity.

Since cervical carcinomas have clonal carcinoma-specific karyotypes, we know they were generated via chromosomal rearrangements of thousands of normal cellular genes, which are not immunogenic.

According to the authors, fragments of inert HPV DNA found in 70 to 80% of cervical cancers (and in 70 to 80% of all women in the US!) are left-overs of by-gone infections or warts that occurred 20-50 years prior to carcinogenesis. Infections and resultant symptoms were eliminated by natural anti-HPV antibodies.

Should the Karyotypic Speciation Theory be proven correct, HPV vaccines could not possibly reduce the incidence of cervical cancer – or any other type of cancer for that matter.

WHAT DO WE DO NOW?

Until such time as scientists can verify or disprove the Karyotypic Speciation Theory of cervical cancer development, medical comsumers must proceed with caution. This is a scientific debate which cannot be ignored. Public health authorities and medical professionals must apply the precautionary principal by suspending the use of HPV vaccines and supporting the already proven, safe and effective method of controlling cervical cancer - Pap screening.

It is this method which, after its introduction by George Papanicolaou et al. in Science in 1952, reduced the incidence of cervical cancer in the US from the most common of the 10 most common cancers of women to one that no longer belongs to this list. Moreover, this proven test for cervical carcinomas, termed Pap screen after Papanicolaou, costs only a small fraction of the $300-500 for the Gardasil and Cervarix vaccines and has NO serious adverse effects.

Immediate independent studies must be conducted to discover which of the theories discussed above is accurate. If HPV does not cause cancer - HPV vaccines are useless. If HPV vaccines are useless, it is certainly not worth submitting yourself (or your loved ones) to the 2.3 to 2.5% risk of serious adverse reactions AND the 2.4 to 3.3% risk of developing a new medical condition potentially indicative of autoimmune disorders experienced by Merck's Gardasil 9 clinical trial participants.

ALL RISK AND NO BENEFIT IS NOT A WISE MEDICAL CHOICE UNDER ANY CIRCUMSTANCES.

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- ***Is carcinogenesis a form of speciation (Duesberg et al., Cell Cycle 2011)***
- ***FDA approved Gardasil 9: Malfeasance or Stupidity? (Erickson, 2014) Gardasil 9 Prescribing Information Leaflet***

WHY WE MAY NEED VIRUSES MORE THAN VACCINES

BY SAYER JI

28 November 2014

http://www.activistpost.com/2014/11/why-we-may-need-viruses-more-than.html

A GROUNDBREAKING study published this month in Nature challenges a century-old assumption about the innate pathogenicity of these extremely small, self-replicating particles known as viruses.

Titled, "An enteric virus can replace the beneficial function of commensal bacteria," researchers found that an "enteric RNA virus can replace the beneficial function of commensal bacteria in the intestine." Known as murine (mouse) noravirus (MNV), researchers found that infecting germ-free or antibiotic-treated mice infection with MNV "restored intestinal morphology and lymphocyte function without inducing overt inflammation and disease."

THE RESEARCHERS FOUND:

Importantly, MNV infection offset the deleterious effect of treatment with antibiotics in models of intestinal injury and pathogenic bacterial infection. These data indicate that eukaryotic viruses have the capacity to support intestinal homeostasis and shape mucosal immunity, similarly to commensal bacteria. Despite the commonly held belief that viruses are vectors of morbidity and mortality that must be vaccinated against in order to save us from inevitable harm and death, the new study dovetails with a growing body of research showing that our own genome is 80% viral in origin.

REPORTING ON THE NEW STUDY, IN AN ARTICLE WELL WORTH READING THE SCIENCE DAILY STATES:

The new findings are the first strong evidence that viruses in the gastrointestinal tract can help maintain health and heal a damaged gut.

THEY SUMMARIZED THE STUDY'S FINDINGS AS FOLLOWS:

The team infected germ-free mice and antibiotic-treated mice with MNV and found that the infection triggered the repair of intestinal tissue damaged by inflammation, restored intestinal cell numbers, restored intestinal cell function, and normalized tissue architecture. The results were apparent after just 2 weeks of MNV infection.

Infection with MNV also helped restore the gut's immune system. The investigators do not yet know how the virus supports the immune system. They did find, however, increased signaling by antiviral type 1 interferon proteins, suggesting the virus was playing a key role in driving the immune response.

"Despite the commonly held belief that viruses are vectors of morbidity and mortality that must be vaccinated against in order to save us from inevitable harm and death, the new study dovetails with a growing body of research showing that our own genome is 80% viral in origin."

The investigators also documented a doubling of T-cell levels in the blood and detectable levels of antibodies in the gut and blood of antibiotic-treated mice after MNV infection. These measures were consistent with a normalization of the immune response.

The authors conclude that viral infection of the gut may be helpful once antibiotic treatment has wiped out intestinal bacteria.

Treatment with MNV was also able to improve survival in antibiotic-treated mice receiving the damaging chemical dextran sodium sulphate.

As our knowledge of the critical role of microbes increases, a paradigm-shift is occurring in medicine that is only beginning to trickle down to clinical practice.

If our very identity depends on 'germs' - e.g. the bacteria within our body account for 10 times more cells and 99% more genetic material than found in the human body itself – the discovery that the viruses in our body – the total number referred to as the virome - also perform indispensable functions in supporting and maintaining our health, turns on its head widely held assumptions about their role in contributing to human disease and various pathologies.

AS REPORTED IN THE SCIENCE DAILY ARTICLE, THE SENIOR INVESTIGATOR OF THE STUDY KEN CADWELL, PhD, FROM NEW YORK UNIVERSITY, STATES:

We have known for a long time that people get infected all the time with viruses and bacteria, and they don't get sick. Now we have scientific evidence that not every viral infection is bad, but may actually be beneficial to health, just as we know that many bacterial infections are good for maintaining health.

Consistent with the 'hygiene hypothesis,' natural infections during childhood and onward, may prime our immune system and help to balance the Th1 (innate) and Th2 (adaptive) poles of immunity, producing a healthy immune system as a result.

Vaccines, by disrupting this evolutionarily determined balance, may be contributing to widespread immune dysregulation, both suppressing innate immune mechanisms as well as over-stimulating the adaptive pole, contributing to widespread autoimmunity in exposed populations.

As science and molecular biology progresses and continues to reveal the inherent intelligence within the commensal relationship of the human body to the microbial universe, we are left with a crucial question: is the present-day globally orchestrated vaccine agenda really improving health, or does it belie a hubris that shirks the scientific evidence in favor of an agenda that wishes to exert control over the human body due to economic and socio-political agendas?

MARGARET MCCARTNEY: What use is mass flu vaccination?

MARGARET MCCARTNEY, GENERAL PRACTITIONER, GLASGOW
BMJ 2014; 349:G6182
margaret@margaretmccartney.com
(Published 20 October 2014)

IT'S FLU VACCINATION season again. People over 65 and those aged six months to 65 years who have a clinical risk factor (such as heart disease, asthma with regular inhaled steroid use, or chronic kidney disease) are eligible for the vaccine, along with people who live in residential care homes, pregnant women, and carers. Health and social care workers in direct contact with patients are also being encouraged to have the vaccine.

BUT DOES IT WORK?[1 2 3 4]

For each healthy adult, a Cochrane review found that vaccination saved an average of just 0.04 days off work and concluded that no evidence supported it as a routine public health measure.[5] And among over 65s, Cochrane reviews found only poor quality data and were unable to draw conclusions of any benefit, thus recommending more trials.[6] As for children, Cochrane again found the available studies to be of poor quality: the number needed to vaccinate to prevent one case ranged from seven (live vaccine) to 28 (inactivated vaccine),[7] and effectiveness varied greatly depending on the season.[8]

The evidence is uncertain among people with asthma[9]; however, flu vaccination does seem to usefully reduce exacerbations in people who have chronic obstructive pulmonary disease.[10] And a review of flu vaccination trials for healthcare workers who looked after older people in long term residential care found no meaningful difference in the number of cases of laboratory confirmed flu, admissions to hospital, or deaths from respiratory infections in residents.[11]

"Treating children is one thing; treating adults like children is quite another. The Department of Health wants trusts to achieve a 75% uptake in flu vaccination for staff,1 when it would be better off ensuring that resources are used where they can do some good."

So, why are we vaccinating so many people in whom we have no proof that it works? We should surely be doing randomised controlled trials of the vaccine in healthy over 65s and healthcare workers, at least.

The NHS has a "Flu Fighter" campaign to encourage uptake and offer incentives for staff to bare their biceps. In return for vaccination, hospitals have offered their staff entry into cash prize draws, as well as chocolates, lollipops, cakes, biscuits, stickers that read "I'm a Flu Fighter," and even an extra day's annual leave, some freedom of information requests have shown. But will those days off work be offset by the average 0.04 days saved through vaccination?

Treating children is one thing; treating adults like children is quite another. The Department of Health wants trusts to achieve a 75% uptake in flu vaccination for staff,[1] when it would be better off ensuring that resources are used where they can do some good. I would have the vaccination if a high quality trial showed that it was worth it for me or my patients. But flu vaccination is offered millions of times every year at huge opportunity cost; given so much uncertainty, this policy is impossible to justify.

FOOTNOTES

- Competing interests: I have read and understood the BMJ policy on declaration of interests and declare the following interests: I'm an NHS GP partner, with income partly dependent on Quality and Outcomes Framework points. I'm a part time undergraduate tutor at the University of Glasgow. I've written a book and earned from broadcast and written freelance journalism. I'm an unpaid patron of Healthwatch. I make a monthly

"THE IMPORTANT THING IS NOT TO STOP QUESTIONING. CURIOSITY HAS ITS OWN REASON FOR EXISTING."
~ ALBERT EINSTEIN

donation to Keep Our NHS Public. I'm a member of Medact. I'm occasionally paid for time, travel, and accommodation to give talks or have locum fees paid to allow me to give talks but never for any drug or public relations company. I was elected to the national council of the Royal College of General Practitioners in 2013.

- Provenance and peer review: Commissioned; not externally peer reviewed.
- Follow Margaret McCartney on Twitter, @mgtmccartney

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MEASLES – A VIEW 45 YEARS AGO

HAVING just recently looked through some of the early editions of The Informed Parent newsletter I thought I would include a snippet from an article I had included in Issue 14 1996 from the Morning Telegraph Kendal Correspondent published around 1970.

A local GP Dr George Ridley Dodds had this to say about why he had not notified the District Medical Officer of local measles cases during an epidemic at that time.

He said:

"I feel that reporting measles cases is a complete waste of time. It was all right in the days when you got complications. Now all that the figures do is give sub-section health officials, with a large staff, a job to do. I am sure the only reason that it is still reported is because of the half-crown fee doctors receive. Take the half-crown off and it would stop overnight. Measles and other minor illnesses should have been taken off the notifiable disease list a long time ago…"

Interesting that 45 years later doctors are terrifying new parents about the deadly measles!

There are lots of interesting articles featured in early editions of TIP newsletter so I have made a random bundle of 15 back issues (1992-2002) available for £8 (UK). You can order online or send a cheque if you prefer.

Measles Parties - A resurgence

DOCTORS 'USED NINE-YEAR-OLDS AS HUMAN GUINEA PIGS' FOR A NEW CERVICAL CANCER VACCINE... and they suffered side-effects including nausea, dizziness and weight-loss

BY GETHIN CHAMBERLAIN IN INDORE, INDIA, FOR MAILONLINE
PUBLISHED:12 January 2015

Brinda Karat at a press conference in New Delhi, another person speaking out against the use of a controversial cervical cancer vaccine

EXTRACTS

- Indian children 'were unaware' they were part of cervical cancer drug trial
- They were paid £10 to be injected with drug to fight cancer in west
- But court papers claim they were duped into taking part in the trial
- Children 'suffered side-effects from weight loss to dizziness to nausea'
- Cervical cancer victim Jade Goody's mum says: 'This is just not right'
- Doctor at centre of 'scandal' says participants were 'adequately informed'
- Merck, the company behind drug has also denied any wrongdoing

Children as young as nine suffered side-effects after being used as unwitting human guinea pigs for a new multi-billion pound anti-cervical cancer drug, it has been claimed.

The new anti-cancer drug has just been approved for use in the United States and is due to be released in Britain this year.

But MailOnline has learned that several of the children used as 'guinea pigs' for the drug trial in India reported suffering problems including weight loss, fatigue, dizziness and menstrual problems.

They and their parents claim they had no idea they were being used to test out Gardasil 9, which was then an untried drug.

The claims have sparked a furious row with the mother of reality TV star Jade Goody, one of the most high profile recent victims of cervical cancer, telling MailOnline: 'It is not right.'

Jackiey Budden said she would not have wanted her daughter - who died aged 27 in 2010 - to have been vaccinated with a drug that had been tested on children who did not know what was happening to them.

'Vaccination is a good idea but it shouldn't be tested on kids,' she said.

"Merck, which makes Gardasil 9, faces a hearing in India's Supreme Court tomorrow over the alleged use of young girls from poor tribal communities in trials of an earlier anti-cervical cancer drug.."

Drug firms are already facing claims that they exploited children in the developing world to develop the vaccine.

Merck, which makes Gardasil 9, faces a hearing in India's Supreme Court tomorrow over the alleged use of young girls from poor tribal communities in trials of an earlier anti-cervical cancer drug.

It also involves the Cervarix vaccine produced by GlaxoSmithKline, along with US-based health non-profit organisation PATH, which organised the trials with the backing of the Bill and Melinda Gates Foundation.

Seven girls died before the trials were halted, although those involved deny the deaths were linked to the vaccines.

An Indian government committee which investigated those trials concluded that they amounted to a serious breach of trust and medical ethics amounting to child abuse and 'a clear cut violation of the human rights of these girl children and adolescents'.

Now Merck is facing fresh claims that it put children at risk to satisfy the demand for a new vaccine.

Cervical cancer is the second most common type of cancer in women worldwide and kills more than 265,000 people every year, according to Cancer Research UK.

In the UK alone there were 920 deaths in 2012, the latest figures available.

Both America and Britain advise girls to be inoculated against the deadly disease while in adolescence - and the vaccination programme is worth huge sums of money to the pharmaceutical industry.

Merck's new drug, Gardasil 9, is designed to protect against the strains of Human Papillomavirus responsible for 90 per cent of cervical cancers.

Its effectiveness is not disputed: Merck's clinical trial data shows impressive results, with 99.5 of participants testing positive for antibodies after completing the trials.

But as the Indian test subjects discovered - and Merck's own published research confirms - some recipients of the vaccine do suffer side effects, known as systemic adverse reactions.

The most frequently reported side effects were headache, pyrexia [fever], nausea, dizziness and fatigue.

Kalpana Mehta highlighted a series of

drug trials on young girls in India which resulted in at least seven deaths. A public interest litigation she brought with two others left India's Supreme Court to request a government investigation into the trials and ultimately led to the court halting drug trials in India

In one trial more than 1,000 out of 7,071 subjects reported suffering headaches, with more than 200 reporting dizziness up to 15 days after the vaccination.

According to Merck, 305 people reported 'serious adverse events' and 321 reported new medical conditions 'potentially indicative of systemic autoimmune disorders'.

Its own report warns that the similarities between the new drug and its predecessor mean that when Gardasil 9 becomes more widely available, some users may also suffer problems reported during the use of Gardasil - including deep vein thrombosis, immune system disorders, gastrointestinal disorders and nervous system disorders such as Guillain-Barré syndrome - known as locked-in syndrome - and motor neuron disease.

Claims of such side effects have made the original Gardasil the subject of some controversy in the US, where some campaigners have questioned its safety. But last month, after studying the results from trials on at least 13,234 people {Merck also uses the figure of 13,236 in its published research} the US Food and Drug Administration concluded that the vaccine was safe and approved the vaccine for use on children aged nine and upwards. It is now expected to become one of the most widely used anti-cancer drugs in the world.

Baldo Study Authors Fail to Explain GSK Vaccine Deaths Following Puliyel Challenge

BY JOHN STONE

http://www.ageofautism.com/

Feb 9 2015

THE CHALLENGE by Dr Jacob Puliyel previously reported in AoA to explain an excess in 69 deaths from sudden infant death syndrome (SIDS) following the administration of GSK Infanrix Hexa hexavalent vaccine has met with an irrelevant response from the authors of a paper exonerating the vaccine. Elisabetta Franco, replying on behalf of the eight authors of the Baldo study writes: The opinion of all the Authors is that the suggested imbalance in reported SIDS between 0-9 days and 10-19 days periods represents a well recognised bias in spontaneous report reporting, where the shorter the time that has elapsed between the vaccination procedure and the event, the more likely it is to be perceived as a trigger and subsequently be reported.

As Puliyel (consultant paediatrician at St Stephen's Hospital, Delhi) points out this would have been alright if we were talking about adverse reaction reports but these are SIDS reports. Two of the study authors are direct employees of GSK and other have a multitude of conflicts acknowledged in their paper. The anomaly of the SIDS deaths came to light after an Italian court ordered the publication of the data following the regression of child into autism.

The original confidential report by GSK hid the possible impact of the vaccine by spreading the deaths over a three week period. Puliyel had written:

However if one analyses the data looking at deaths in first 10 days after administration of vaccine and compares it to the deaths in the next 10 days, it is clear that 97% of deaths (65 deaths) in the infants below 1 year, occur in the first 10 days and 3% (2 deaths) occur in the next 10 days. Had the deaths been coincidental SIDS deaths unrelated to vaccination, the numbers of deaths in the two 10 day periods should have been the same…The decelerating incremental-deaths further supports the contention that there is a clear relationship of 'sudden death' to the vaccination episode. 42 deaths had taken place in the first three days after vaccination, 16 deaths in the next 3 days between day 3 and day 5, 3 deaths between day 6 and day 8, 2 deaths between day 9 and day 11, and there were only 2 deaths in all of the remaining 10 days. The fact that rate of deaths decreases rapidly and continuously as time elapses after immunization, makes it clear that the deaths are related to the vaccination episode.

The 16 excess deaths on day 0 is perhaps an even more marked effect because infants are unlikely to be vaccinated at midnight and many of the background deaths will have occurred before administration. After several days Dr Franco has not been back to defend her explanation or comment further.

In a further answer to Dr Tamás Ferenci of Budapest details another study documenting the problem.

Finally, Dr Ferenci says that active vaccine safety studies are better than passively acquired data. For well designed, managed and executed studies I wholeheartedly agree with him.

The TOKEN study aimed to assess comprehensively a possible causal relationship between vaccination and unexplained sudden unexpected death of children between their 2nd and 24th month of life. The study was supported and sponsored by the Paul-Ehrlich-Institute (PEI) and the Federal Ministry of Health (Bundesministerium für Gesundheit). Unfortunately this large study with a wealth of data has not been published in an indexed peer reviewed journal as yet. It is available here:

Parents of children who had died of SIDS were requested to participate in the study. 37.6% (254 cases) could be included in the study, where parental consent was obtained. The data show significantly increased risk of unexplained sudden unexpected death in the first 3 days after hexa- or pentavalent vaccination (1st and 2nd year of life).

So it appears that active studies have confirmed that there are two vaccines which cause 'sudden deaths'. I am grateful that the Italian Court has allowed public scrutiny of GSK's PSUR reports held as confidential by the EMA.

It is evident that European Medicines Agency have been content to sit on this matter with GSK watching more infants die from the vaccine, and even now they fail to respond even though the matter has been brought glaringly into the open.

John Stone is UK Editor for Age of Autism.

http://www.ageofautism.com/

WHY YOU SHOULD AVOID TAKING VACCINES

BY JAMES HOWENSTEIN, M.D.
7/12/2003
www.newswithviews.com

Increased profits for the Pharmaceutical Companies

EXTRACTS

DR. JAMES R. SHANNON, former director of the National institute of health declared,

"The only safe vaccine is one that is never used."

Cowpox vaccine was believed able to immunize people against smallpox. At the time this vaccine was introduced, there was already a decline in the number of cases of smallpox. Japan introduced compulsory vaccination in 1872. In 1892 there were 165,774 cases of smallpox with 29,979 deaths despite the vaccination program. A stringent compulsory smallpox vaccine program, which prosecuted those refusing the vaccine, was instituted in England in 1867. Within 4 years 97.5% of persons between 2 and 50 had been vaccinated. The following year England experienced the worst smallpox epidemic [1] in its history with 44,840 deaths. Between 1871 and 1880 the incidence of smallpox escalated from 28 to 46 per 100,000. The smallpox vaccine does not work.

Much of the success attributed to vaccination programs may actually have been due to improvement in public health related to water quality and sanitation, less crowded living conditions, better nutrition, and higher standards of living. Typically the incidence of a disease was clearly declining before the vaccine for that disease was introduced. In England the incidence of polio had decreased by 82% before the polio vaccine was introduced in 1956.

In the early 1900s an astute Indiana physician, DR. W.B. Clarke, stated "Cancer was practically unknown until compulsory vaccination with cowpox vaccine began to be introduced. I have had to deal with two hundred cases of cancer, and I never saw a case of cancer in an unvaccinated [2]person."

There is a widely held belief that vaccines should not be criticized because the public might refuse to take them. This is valid only if the benefits exceed the known risks of the vaccines.

"Much of the success attributed to vaccination programs may actually have been due to improvement in public health related to water quality and sanitation, less crowded living conditions, better nutrition, and higher standards of living. "

DO VACCINES ACTUALLY PREVENT DISEASE?

This important question does not appear to have ever been adequately studied. Vaccines are enormously profitable for drug companies and recent legislation in the US has exempted lawsuits against pharmaceutical firms in the event of adverse reactions to vaccines which are very common. In 1975 Germany stopped requiring pertussis (whooping cough) vaccination. Today less than 10% of German children are vaccinated against pertussis. The number of cases of pertussis has steadily decreased [3] even though far fewer children are receiving pertussis vaccine.

Measles outbreaks have occurred in schools with vaccination rates over 98% in all parts of the US including areas that had reported no cases of measles for years. As measles immunization rates rise to high levels measles becomes a disease seen only in vaccinated persons. An outbreak of measles occurred in a school where 100% of the children had been vaccinated. Measles mortality rates had declined by 97% in England before measles vaccination was instituted.

In 1986 there were 1300 cases of pertussis in Kansas and 90% of these cases occurred in children who had been adequately vaccinated. Similar vaccine failures have been reported from Nova Scotia where pertussis continues to be occurring despite universal vaccination. Pertussis remains endemic [4] in the Netherlands where for more than 20 years 96% of children have received 3 pertussis shots by age 12 months.

After institution of diphtheria vaccination in England and Wales in 1948 the number of deaths from diphtheria rose by 20% in the subsequent 15 years. Germany had compulsory vaccination in 1939. The rate of diphtheria spiraled to 150,000 cases that year whereas, Norway which did not have compulsory vaccination, had only 50 cases of diphtheria the same year.

The continued presence of these infectious diseases in children who have received vaccines proves that life long immunity which follows natural infection does not occur in persons receiving vaccines. The injection process places the viral particles into the blood without providing any clear way to eliminate these foreign substances.

WHY DO VACCINES FAIL TO PROTECT AGAINST DISEASES?

Walene James, author of Immunization: the Reality Behind The Myth, states that the full [5] inflammatory response is necessary to create real immunity. Prior to the introduction of measles and mumps vaccines children got measles and mumps and in the great majority of cases these diseases were benign. Vaccines "trick" the body so it does not mount a complete inflammatory response to the injected virus.

VACCINES AND SUDDEN INFANT DEATH SYNDROME SIDS

The incidence of Sudden Infant Death syndrome SIDS has grown from .55 per 1000 live births in 1953 to 12.8 per 1000 in 1992 in Olmstead County, Minnesota. The peak incidence for SIDS is age 2 to 4 months the exact time most vaccines are being given to children. Eighty-five percent of cases of SIDS occur in the first 6 months of infancy. The increase in SIDS as a percentage of total infant deaths has risen from 2.5 per 1000 in 1953 to 17.9 per 1000 in 1992. This rise in SIDS deaths has occurred during a period when nearly every childhood disease was declining due to improved sanitation and medical progress except SIDS. These deaths from SIDS did increase during a period when the number of vaccines given a child was steadily rising to 36 per child.

Dr. W. Torch was able to document 12 deaths in infants which appeared within 3 and 19 hours of a DPT immunization. He later reported 11 new cases of SIDS death and one near miss which had occurred within 24 hours of a DPT injection. When he studied 70 cases of SIDS two thirds of these victims [6] had been vaccinated from one half day to 3 weeks prior to their deaths. None of these deaths was attributed to vaccines. Vaccines are a sacred cow and nothing against them appears in the mass media because they are so profitable to pharmaceutical firms.

There is valid reason to think that not only are vaccines worthless in preventing disease they are counterproductive because they injure the immune system permitting cancer, autoimmune diseases and SIDS to cause much disability and death.

ARE VACCINES STERILE?

Dr. Robert Strecker claimed that the department of defense DoD was given $10,000,000 in 1969 to create the AIDS virus to be used as a population-reducing[7] weapon against blacks. By use of the Freedom of Information Act

"There is valid reason to think that not only are vaccines worthless in preventing disease they are counterproductive because they injure the immune system permitting cancer, autoimmune diseases and SIDS to cause much disability and death."

Dr. Strecker was able to learn that the DoD secured funds from Congress to perform studies on immune destroying agents for germ warfare.

Once produced, the vaccine was given in two locations. Smallpox vaccine containing HIV was given to 100,000,000 Africans in 1977. Over 2000 young white homosexual males in New York City were given Hepatitis B vaccine that contained HIV virus in 1978. This vaccine was given at New York City Blood Center. The Hepatitis B vaccine containing the HIV virus was also administered to homosexual males in San Francisco, Los Angeles, St. Louis, Houston and Chicago in 1978 and 1979. US Public Health epidemiology studies have disclosed that these same 6 cities had the highest incidence of AIDS, Aids related Complex (ARC) and deaths rates from HIV, when compared to other US cities.

When a new virus is introduced into a community. It takes 20 years for the number of cases to double. If the fabricated story that green monkey bites of pygmies led to the HIV epidemic, the alleged monkey bites in the 1940s should have produced a peak in the incidence of HIV in the 1960s at which time HIV was non existent in Africa. The World Health Organization (WHO) began an African smallpox vaccination campaign in 1977 that targeted urban population centers and avoided pygmies. If the green monkey bites of pygmies truly caused the HIV epidemic the incidence of HIV in pygmies should have been higher than in urban citizens. However, the opposite was true.

In 1954 Dr. Bernice Eddy (bacteriologist) discovered live monkey viruses in supposedly sterile inactivated polio vaccine [8] developed by Dr. Jonas Salk. This discovery was not well received at the NIH and Dr. Eddy was demoted. Later Dr. Eddy, working with Sarah Stewart, discovered SE polyoma virus. This virus was quite important because it caused cancer in every animal receiving it. Yellow fever vaccine had previously been found to contain avian (bird) leukemia virus. Later Dr. Hilleman isolated SV 40 virus from both the Salk and Sabin polio vaccines. There were 40 different viruses [9] in these polio vaccines they were trying to eradicate. They were never able to get rid of these viruses contaminating the polio vaccines. The SV 40 virus causes malignancies. It has now been identified in 43% of cases of non-Hodgekin lymphoma[10], 36% of brain tumors[11], 18% of healthy blood samples, and 22% of healthy semen samples, mesothiolomas and other malignancies. By the time of this discovery SV 40 had already been injected into 10,000,000 people in Salk vaccine. Gastric digestion deactivates some of SV 40 in Sabin vaccine. However, the isolation of strains of Sabin polio vaccine from all 38 cases of Guillan Barre Syndrome[12] GBS in Brazil suggests that significant numbers of persons are able to be

infected from this vaccine. All 38 of these patients had received Sabin polio vaccine months to years before the onset of GBS. The incidence of non-Hodgekin lymphoma has"mysteriously" doubled since the 1970s.

Dr. John Martin, Professor of Pathology at the Univ. of Southern California, was employed by the Viral Oncology Branch of the Bureau of Biologics (FDA) from 1976 to 1980. While employed there he identified foreign DNA in the live polio vaccine Orimune (Lederle) that suggested serious vaccine contamination. He warned his supervisors about this problem and was told to discontinue his work as it was outside the scope of testing required for polio vaccine.

Later Dr. Martin learned that all eleven of the African green monkeys used to grow the Lederle polio virus Orimune had grown simian cytomegalovirus from kidney cell cultures. Lederle was aware of this viral contamination as their Cytomegaloviral Contamination Plan [13] clearly showed in 1972. The Bureau of Biologics decided not to pursue the matter so production of infected polio vaccine continued.

In 1955 Dr. Martin identified unique cell destroying viruses termed stealth viruses in patients with chronic fatigue syndrome. These viruses lacked genes that would enable the immune system to recognize them. Thus they were protected by the body's failure to develop antiviral antibodies. In March of 1995, Dr. Martin learned that some of these stealth viruses had originated from African green monkey simian cytomegalovirus of a type known to infect man.

The Lederle vaccine experience suggests that the higher-ups are not concerned about sloppy and dangerous preparation of vaccines. Animal cross infection is a huge unsolved current problem for all vaccine manufacturing. If this vaccine production sounds like an unbelievable mess to you, you are right.

OTHER DANGERS FROM VACCINES

In the March 4, 1977 issue of Science Jonas and Darrell Salk warn, "Live virus vaccines against influenza or poliomyelitis may in each instance produce the disease it intended to prevent. The live virus against measles and mumps may produce such side effects as encephalitis (brain damage).

The swine flu vaccine was administered to the American public even though there had never been a case of swine flu identified in a human. Farmers refused to use the vaccine because it killed too many animals. Within a few months of use in humans this vaccine caused many cases of serious nerve injury (Guillan Barre syndrome).

An article in the Washington Post on Jan. 26, 1988 mentioned that all cases of polio since 1979 had been caused by the polio vaccine with no known cases of polio from a wild strain since 1979. This might have created a perfect situation to discontinue the vaccine, but the vaccine is still given. Vaccines are a wonderful source of profits with no risks to the drug companies since vaccine injuries are now recompensed by the government.

"If there are important powerful groups of people that are determined to reduce the world population, what could be a more diabolically clever way to eliminate people than to inject them with a cancer-causing vaccine? The person receiving the injection would never suspect that the vaccine taken 10 to 15 years earlier had caused the cancer to appear.."

The steady escalation in the number of vaccines administered has been followed by an identical rise in the incidence of autoimmune diseases (rheumatoid arthritis, subacute lupus erythematosus, psoriasis, multiple sclerosis, asthma) seen in children. While there is a genetic transmission of some of these diseases many are probably due to the injury from foreign protein particles, mercury, aluminum, formaldehyde and other toxic agents injected in vaccines.

In 1999, the rotavirus vaccine was recommended by the Center for Disease Control for all infants. When this vaccine program was instituted several infants died and many had life endangering bowel obstructions. Prelicensure trials [15] of the rotavirus vaccine had demonstrated an increased incidence of intussusception 30 times greater than normal but the vaccine was released anyway without special warnings to practitioners to be on the lookout for bowel problems. Children's vaccines are often not studied for toxicity possibly because such study might eliminate them from being used.

A large study from Australia showed that the risk of developing encephalitis from the pertussis vaccine was 5 times greater than the risk of developing encephalitis by contacting pertussis by natural methods.

Naturally acquired immunity by illness evolves by spread of a virus from the respiratory tract to the liver, thymus, spleen, and bone marrow. When symptoms begin, the entire immune response has been mobilized to repel the invading virus. This complex immune system response creates antibodies that confer life long immunity against that invading virus and prepares the child to respond promptly to an infection by the same virus in the future.

Vaccination, in contrast, results in the persisting of live virus or other foreign antigens within the cells of the body, a situation that may provoke autoimmune reactions as the body attempts to destroy its own infected cells. There is no surprise that the incidence of autoimmune diseases (rheumatoid arthritis, subacute lupus erythematosus, multiple sclerosis, asthma, psoriasis) has risen sharply in this era of multiple vaccine immunization.

VACCINE INDUCED TYPE 1 DIABETES MELLITUS

Dr. John Classen has published 29 articles on vaccine-induced [16] diabetes. At least 8 of 10 children with Type 1 (insulin needing) diabetes have

this disease as a result of vaccination. These children may have avoided measles, mumps, and whooping cough but they have received something far worse: an illness that shortens life expectancy by 10 to 15 years and results in a life requiring constant medical care.

Dr. Classen has shown in Finland, the introduction of hemophilus type b vaccine caused three times as many cases of type 1 diabetes as the number of deaths and brain damage from hemophilus influenza type b it might have prevented.

In New Zealand, the incidence of Type 1 diabetes in children rose by 61 % after an aggressive vaccine program against hepatitis B. This same program has been started in the USA so we can now look forward to many cases of Type 1 diabetes in children. Similar rises in Type 1 diabetes have been seen in England, Italy, Sweden, and Denmark after immunization programs against Hepatitis B.

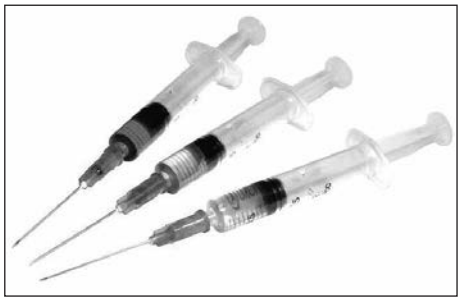
TOXIC SUBSTANCES ARE NEEDED TO MAKE VACCINES.

Vaccines contain many toxic substances that are needed to prevent the vaccines from becoming infected or to improve the performance of the vaccine. Among these substances are mercury, formaldehyde and aluminum. [17]

In the past 10 years, the number of autistic children has risen from between 200 and 500 percent in every state in the US. This sharp rise in autism followed the introduction of measles, mumps and rubella vaccine in 1975.

Representative Dan Burton's healthy grandson was given injections for 9 diseases in one day. These injections were instantly followed by autism. These injections contain a preservative of mercury called thimerosal. The boy received 41 times the amount of mercury which is capable of harm to the body. Mercury is a neurotoxin that can injure the brain and nervous system. And tragically, it did.

In the United States the number of compulsory vaccine injections has increased from 10 to 36 in the last 25 years. During this period, there has been a simultaneous increase in the



number of children suffering learning disabilities and attention deficit disorder. Some of these childhood disabilities are related to intrauterine cerebral damage from maternal cocaine use, but probably vaccines cause many of the others.

Many vaccines contain aluminum. A new disease called macrophagic

"Dr. Classen has shown in Finland, the introduction of hemophilus type b vaccine caused three times as many cases of type 1 diabetes as the number of deaths and brain damage from hemophilus influenza type b it might have prevented."

myofasciitis causes pain in muscles, bones and joints. All persons with this disease have received aluminum containing vaccines. Deposits of aluminum are able to remain as an irritant in tissues and disturb the immune and nervous system for a lifetime.

Nearly all vaccines contain aluminum and mercury. These metals appear to play an important role in the etiology of Alzheimer's Disease. An expert at the 1997 International Vaccine Conference related that a person who takes 5 or more annual flu vaccine shots has increased the likelihood of developing Alzheimer's Disease by a factor of 10 over the person who has had 2 or fewer flu shots.

When we take vaccines we are playing a modern version of Russian Roulette. We not only get exposed to aluminum, mercury, formaldehyde and foreign cell proteins but we may get simian virus 40 and other dangerous viruses which can cause cancer, leukemia and other severe health problems because the vaccine pool is contaminated due to careless animal isolation techniques. Congress has protected the manufacturers from lawsuits, so dangerous vaccines simply increase profits at no risk to the drug companies.

US children aged 2 months began receiving hepatitis B vaccine in December 2000. No peer-reviewed studies of the safety of hepatitis B in this age bracket had been done. Over 36,000 adverse reactions with 440 deaths were soon reported but the true incidence is much higher as reporting is voluntary so only approximately 10 % of adverse reactions get reported. This means that about 5000 infants are dying annually from the hepatitis B vaccine. The CDC's Chief of Epidemiology admits that the frequency of serious reactions to hepatitis B vaccine is 10 times higher than other vaccines. Hepatitis B is transmitted sexually and by contaminated blood, so the incidence of this disease must be near zero in this age bracket. A vaccine expert, Dr. Philip Incao, states that "the conclusion is obvious that the risks [18] of hepatitis B vaccination far outweigh the benefits. Once a vaccine is mandated the vaccine manufacturer is no longer liable for adverse reactions.

Dr. W.B. Clarke's important observation that cancer was not found in unvaccinated individuals demands an explanation and one now appears forthcoming. All vaccines given over a short period of time to an immature immune system deplete the thymus gland (the primary gland involved in immune reactions) of irreplaceable immature immune cells. Each of these cells could have multiplied and developed into an army of valuable cells to combat infection and growth of abnormal cells. When these immune cells have been used up, permanent immunity may not appear. The Arthur Research Foundation in Tucson, Arizona estimates that up to 60 % of our immune system may be exhausted

[19] by multiple mass vaccines (36 are now required for children). Only 10 % of immune cells are permanently lost when a child is permitted to develop natural immunity from disease. There needs to be grave concern about these immune system injuring vaccinations! Could the persons who approve these mass vaccinations know that they are impairing the health of these children, many of whom are being doomed to requiring much medical care in the future?

Compelling evidence is available that the development of the immune system after contracting the usual childhood diseases matures and renders it capable to fight infection and malignant cells in the future.

The use of multiple vaccines, which prevents natural immunity, promotes the development of allergies and asthma. A New Zealand study disclosed that 23 % of vaccinated children develop asthma, as compared to zero in unvaccinated children.

Cancer was a very rare illness in the 1890's. This evidence about immune system injury from vaccinating affords a plausible explanation for Dr. Clarke's finding that only vaccinated individuals got cancer. Some radical adverse change in health occurred in the early 1900s to permit cancer to explode and vaccinating appears to be the reason.

Vaccines are an unnatural phenomena. My guess is that if enough persons said no to immunizations there would be a striking improvement in general health with nature back in the immunizing business instead of man. Having a child vaccinated should be a choice not a requirement. Medical and religious exemptions are permitted by most states.

When governmental policies require vaccinations before children enter schools coercion has overruled the lack of evidence of vaccine efficacy and safety. There is no proof that vaccines work and they are never studied for safety before release. My opinion is that there is overwhelming evidence that vaccines are dangerous and the only reason for their existence is to increase profits of pharmaceutical firms.

"When governmental policies require vaccinations before children enter schools coercion has overruled the lack of evidence of vaccine efficacy and safety. There is no proof that vaccines work and they are never studied for safety before release. My opinion is that there is overwhelming evidence that vaccines are dangerous and the only reason for their existence is to increase profits of pharmaceutical firms."

If you are forced to immunize your children so they can enter school, obtain a notarized statement from the director of the facility that they will accept full financial responsibility for any adverse reaction from the vaccine. Since there is at least a 2 percent risk of a serious adverse reaction they may be smart enough to permit your child to escape a dangerous procedure. Recent legislation passed by Congress gives the government the power to imprison persons refusing to take vaccines (smallpox, anthrax, etc). This would be troublesome to enforce if large numbers of citizens declined to be vaccinated at the same time.

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DUMBED-DOWN POPULATIONS ACCEPT OUTRAGEOUS VACCINE LOGIC

BY JON RAPPOPORT
February 5, 2013
NoMoreFakeNews.com

EXTRACTS

I'VE WRITTEN ARTICLES attacking the theory and practice of vaccination from a variety of angles. But the whole issue also needs to be approached from the perspective of logic. Unfortunately, generations of people have been shut out of learning logic in school. They don't know what it is. Therefore, vaccine advocates have been able to peddle their basic theory without much challenge.

IT'S TIME TO PUT AN END TO THAT FREE RIDE.

First of all, I need to point out a massive contradiction. When a person receives a vaccine, it's said that his body produces antibodies against a particular germ and this is a good thing. Vaccination thus prepares the body for the day when that germ will really make its attack, at which point the immune system (including antibodies) will mount a successful defense.

However, let's look at another avenue: for many diseases, when a person is given a blood test to see if he is infected, quite often the standard for infection is "presence of antibodies."

This makes no sense at all. If vaccination produces those antibodies, it is heralded as protection. But if a diagnostic blood test reveals those same antibodies, it's a signal of infection and disease.

Vaccine-produced antibodies=health. Antibodies naturally produced by the body=illness.

Logically speaking, you resolve a contradiction by dropping one of the two sides and admitting it is false. Or you go deeper and reject some prior premise that led to the contradiction in the first place.

So let's go deeper. What does vaccination supposedly do to "prepare" the body against the future invasion of a particular germ? It stimulates the production of antibodies against that germ.

Antibodies are immune-system scouts that move through the body, identify germs, and paint them for destruction by other immune-system troops.

However, since the entire immune system is involved in wreaking that destruction, why is bulking up one department of the immune system - antibodies - sufficient to guarantee future protection?

On what basis can we infer that bulking up antibodies, through vaccination, is enough?

There is no basis. It's a naked assumption. It's not a fact. Logic makes a clear distinction between assumptions and facts. Confusing the two leads to all sorts of problems, and it certainly does in the case of vaccination.

Furthermore, why does the body need a vaccine in order to be prepared for the later invasion of germs? The whole structure/function of the immune system is naturally geared to launch its multifaceted counter-attack against germs whenever trouble arises. The antibodies swing into action when a potentially harmful germ makes its appearance, at age five, eight, 10, 15.

It's said that vaccination is a rehearsal for the real thing. But no need for rehearsal has been established.

And why are we supposed to believe that such a rehearsal works? The usual answer is: the body remembers the original vaccination and how it produced antibodies, and so it's better prepared to do it again when the need is real. But there is no basis for this extraordinary notion of "remembering."

IT'S ANOTHER ASSUMPTION SOLD AS FACT.

The terms "prepared for the real thing," "rehearsal," and "remember" aren't defined. They're vague. One of the first lessons of logic is: define your terms.

A baby, only a few days old, receives a Hepatitis B vaccine. This means the actual Hep-B germ, or some fraction of it, is in the vaccine.

The objective? To stimulate the production of antibodies against Hep-B. Assuming the baby can accomplish this feat, the antibodies circulate and paint those Hep-B germs for destruction now.

From that moment on, the body is ready to execute the same mission, if and when Hep-B germs float in the door. But when they float in the door, why wouldn't the body produce antibodies on its own, exactly as it did after the vaccination was given? Why did it need the vaccination to teach it how to do what it naturally does?

And why should we infer the baby body is undergoing an effective rehearsal when vaccinated, and will somehow remember that lesson years later?..

And "being a scientist" is not the same thing as knowing what science and logic actually are. The same fact can be applied to news anchors, public health officials, and politicians. They can say "the evidence for vaccinating is overwhelming," but so can a parrot in a cage, with enough training.

Of course, these so-called experts won't come out and engage in a serious debate about the theory and practice of vaccination. They refuse to.

Millions of people around the world would eagerly watch a true extended debate on the subject. Such debate used to be a standard practice when logic was studied, when it was understood to be vital for deciding the truth or falsity of a position.
Now, it's all about PR and propaganda, the modern version of logic for the dumbed-down crowd.

"THE FLU VACCINE IS PERFECTLY SAFE!"

BY ANNA WATSON

YES, YOU DID READ THAT CORRECTLY… this appeared on dozens of GP and CCG websites, newspaper public health announcements, and goodness knows how many letters home and GP conversations around the UK to none the wiser patients.

If your hairs are rising on the back of your neck, or your eye brows are raising at such a ridiculous and dangerous statement, then you will be delighted to hear that Dr Jayne Donegan invited me to start a little public health campaign of our own. The timing couldn't have been better as the proclamation 'The Flu jab is a waste of time' had just been beautifully put by the Daily Mail 5/2/15, when it was made public that this season's flu vaccine only worked in 3% of cases. What was shocking (as you probably wont be shocked to hear that the flu vaccine didn't work) was that the government kept this 'hush hush' for 7 months. 7 months of advertising and campaigning and pushing for a higher flu vaccine uptake, all the while they knew of it's ineffectiveness.

That is a story of merit in its own right but back to that perfectly safe flu vaccine!

Jayne drafted a letter which raised some pertinent questions which I elaborated upon in my own letters. For example:

'Dear Sir / Madam
I was shocked to read that many GP surgeries and CCGs are claiming that the flu vaccine is completely safe! I have attached a list of the ones I have come across for your information, with references to adverse reactions from all flu vaccines. My questions are in red.
I would like to know which 'flu vaccine' they may be referring to that is 'completely safe.'
Reading the Summary of Product Characteristics (SPC) for all of the 2014-15 'flu vaccines' I cannot find a single vaccine that has no adverse reactions*.
https://www.medicines.org.uk/emc/search
It is the duty of a doctor registered with the GMC to give accurate information to patients - or potential patients - in order for them to make an informed choice and to give informed consent. I feel as a patient that these comments contravene this requirement.

> "What was shocking (as you probably wont be shocked to hear that the flu vaccine didn't work) was that the government kept this 'hush hush' for 7 months. 7 months of advertising and campaigning and pushing for a higher flu vaccine uptake, all the while they knew of it's ineffectiveness.."

Is this a National campaign? Where did this statement originate as it is all over the web? "It's completely safe, it's free and it can't give you flu."
Furthermore, as the children's flu vaccine Fluenze is live and can shed the virus, I think the additional statements about the flu vaccine not giving the flu, needs a disclaimer for Fluenze, as this is very misleading to the general public.
Perhaps you would be good enough to either endorse these statements with references or let your members know that they can't make claims like this for the flu vaccine or any medical intervention.
I would like to know what action you will take.
I look forward to hearing from you,
Many Thanks
Anna

If we had space and the permission to print all correspondence during the past 4 months in full, I would but here are a few highlights…

I wrote to my local surgery who were using this phrase and they impressively took it off within 48 hours.

'We use a standard template from a specialist provider of GP websites, and will get in touch with them regarding the issues you raise.'

They edited their site and passed on their concerns to the PHE.

And Jayne's reply showing prompt action …

'Thank you for your recent email to Macmillan Cancer Support about the blog relating to the flu jab. It has been forwarded to me in the Cancer Information Development team. We develop and review all our content on the cancer information section of the website.
We have changed the sentence saying that the flu jab is completely safe to say only that it doesn't contain the live virus so it can't give you the flu.
Thank you for your interest in our information.
Kind regards
Macmillan Cancer Support'

However, the larger organizations took a while to unravel the issue, check their guidelines, discuss with more senior figures and respond appropriately.

The first priceless reply was from the Advertising Standards Authority (ASA) in reply to Oliver Muller from VIP (Vaccine Information Portal).

'While we understand your concerns about this ad, when making our assessment we have to consider how readers in general would be likely to interpret the claims made. In this case, considering the claim in the context of the ad as a whole, we regarded that readers would be likely to understand it to mean that the flu jab was unlikely to pose a serious risk of harm to their health.'

So the ASA makes a subjective judgement about how this may have been interpreted… shocking!

The Medicines and Healthcare Products Regulatory Agency (MHRA) shrugs it off because a trade name has not been mentioned. Thankfully with a little more insistence from Dr Jayne Donegan… 'Does this mean that if a

practice/ CCG/ health authority were to advertise paracetamol - as opposed to a trade named brand - as a cure for baldness or whatever, that would be OK as they hadn't mentioned a brand name?"

The following month the MHRA take back the shrug as you will read later.

Then a more senior ASA executive sees the light and considers the wider issue and escalates this to Public Health England (PHE).

'However, we consider that there is a wider issue at stake and that simply instructing .. practices to amend their websites would not go very far towards resolving the concerns you have. We have therefore been in contact with the MHRA to seek their view on whether the claims about flu jabs being "completely" or "perfectly" safe are in breach of any marketing authorisation the products might have. In this case, they have confirmed that as the ads do not promote a specific named medicine the terms of any marketing authorisations would not apply. However, they have confirmed that … have escalated it to Public Health England to cascade information about the wording to use to the relevant organisations. '

My letter to PHE (and Jayne's 5 letters to different individuals) finally receive a wonderful reply!

'You have rightly pointed out that no medical intervention is completely safe. … It appears that the quotes

NHS Flu Poster

and text you refer to, stating the vaccines are 'completely safe', may come from superseded material first developed in 2012 and re-issued through our NHS colleagues in Clinical Commissioning Groups (CCGs). We are making our NHS colleagues aware of our concerns in relation to this statement, so that any necessary action can be taken by them to ensure the statement is not repeated in forthcoming flu seasons…..
I hope this assures you that we have taken the necessary action to rectify this matter, as far as PHE is able to. Thank you once again for bringing this to our attention"

And then the MHRA confirms separately that they are talking with PHE

'… steps that have been taken to ensure that out of date material used by NHS colleagues in CCGs is not re-used in future.

and clarifies that even if a brand name was not mentioned action could be taken on misleading advertising!

'There are specific legal rules that permit advertising for medicines aimed at the public as part of a vaccination campaign but the rules do not permit misleading safety claims in advertising for any medicine. Either we or the ASA would be able to take action on misleading advertising that concerned a medicine, even if a brand was not mentioned.'

So not only did the flu vaccine not work for the last winter season, it cost £100,000 of your money. Whether it works next season remains to be seen but at least next season we shouldn't be told that the flu vaccine is perfectly safe.

If you hear this please let myself or Dr Jayne Donegan know!

Don't loose heart - if you see other outrageous statements about vaccines - please be encouraged to write and challenge again. Some very senior figures have clearly been discussing this phrase 'perfectly safe' and agreed it is not appropriate.

It is vital that we don't allow complacency as regards to the adjectives used by health institutions when describing medicines/vaccines and their safety and effectiveness.

SIDE EFFECTS OF THE FLU VACCINE LISTED ARE:

• Neuralgia • Paraesthesia • Febrile Convulsions • Neurological disorders, such as:

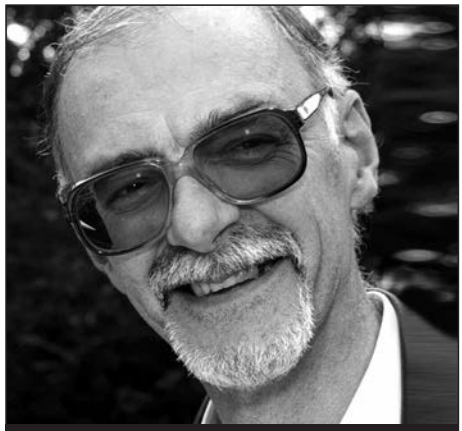
• Encephalomyelitis, Neuritis and Guillain Barré syndrome • Vasculitis associated in very rare cases with transient renal involvement • Allergic reactions (symptoms including Conjunctivitis), in rare cases leading to shock • Angioedema • Transient Thrombocytopenia • Transient Lymphadenopathy

• Generalised skin reactions including Pruritus, Urticaria or non-specific rash.

The Quanten Theory

TRUST ME I'M A DOCTOR

by Patrick Quanten MD



Patrick Quanten MD

A DOCTOR is a free professional who no longer is aware that his strings are being pulled.

Never mind the doctor, that is a lost cause. What about you? Did you get it already or are you still wondering around in the woods of confusion? Have you found your answers to the safety and efficacy questions on vaccination? We are almost drowning in it whilst the authorities are throwing floating devices by the dozen, hitting us over the head with them and causing us headaches, with some of us having epileptic fits.

LET'S PICK OUT A FEW AND SPELL IT OUT, ONCE MORE!

In the western world the number of whooping cough cases are rising every year, and this is mainly in teenagers and young adults. It is said that this is a major risk to babies as parents play an important part in transmitting the disease to the children. Hence the idea of vaccinating pregnant women, even though the same authority warns pregnant women against any kind of toxicity introduced into the body during pregnancy (alcohol, smoking, etc.). First indications are said to be very positive! When are first impressions by the admission of the authority ever not positive? They are always very encouraging! The explanation which you can trek back through time is a very interesting example of the way authorities want you to think: we are right even if the reality shows that we are wrong.

The first whooping cough vaccination, the whole cell version (DPT) was made from all parts of the inactivated pertussis bacteria. Never, at that time, did anyone suggest that parents were the cause of the infection. First impressions after mass vaccination programmes were introduced were very positive. Almost nobody died anymore from a doctor's diagnosis of whooping cough, as the poor man couldn't believe that a vaccinated person could get whooping cough. The medical authority admitted that some got permanent brain damage, but so what. You have to take some collateral damage for the good of the masses, don't you! Nevertheless they came up with a better vaccine version, when they were ready, the acellular version made from certain components of the inactivated bacteria. This was once again incorporated in a vaccine together with tetanus and diphtheria (DTaP) and then the five-in-one with polio and Hib (DTaP/IPV/Hib). A neat way to hide any detrimental side-effects is to mix it in with other stuff!

The first impressions of the new vaccine were very positive, even though the incidence of infections in vaccinated children grew steadily, year by year, since the introduction of the DTaP vaccine. It was stated that immunity dropped off quicker with the new safer vaccine, but this could be rectified by a simple booster injection at the age of four. Conveniently forgotten at this point is the fact that, traditionally, before the vaccination programme, whooping cough's dangers only existed in very small babies, first few weeks of life. The first impressions of the effect of the booster injection were very positive, although less than ten years later they are now crying out for a new whooping cough vaccine that should work better, because this one isn't doing the trick, they say. It has introduced whooping cough as a disease in older children and young adults where it previously was unseen. Luckily for the industry we have found willing subjects in fearful parents and grandparents to vaccinate with the same, now deemed to be ineffective, vaccine completely forgetting that these people (certainly the young parents) come from a generation that were already vaccinated against whooping cough on a promise of a lifelong immunity. Now that same "protected" generation has become a major threat to their own children, apparently.

Frits Mooi, who is the whooping cough project leader at the Centre for Infectious Diseases of the Dutch National Institute for Public Health, states: "There is a consensus that the diminishing immunity is the main cause for the increase of whooping cough incidences, but we know little or nothing about the reasons behind this." Allow me to repeat this statement, but in reverse. We know nothing about the reasons why whooping cough incidences are on the increase, but we are sure it is because of diminishing immunity. Would you love your car mechanic if he said to you "I have no idea why your car is behaving in this manner but I am sure it is the braking system"?

So, it isn't working. So, it has been responsible for introducing the disease later in life. What we now need is a new vaccine that we say is going to be better! Pull the other one!

Now, here we are, in the winter of 2015. Flu vaccine season! In the past three flu seasons, the CDC (USA) has claimed the flu vaccine's overall effectiveness clocked in at between 47 and 62 per cent while some experts have measured it at 0 to 7 per cent. Other studies suggest that when children get a flu shot every year it can interfere with healthy immune responses and make them more likely to get influenza. Independent medical literature reviews document that flu shots don't really prevent influenza or complications of influenza or influenza-like-illness associated with other types of viruses during any given flu season.

How does it work? Every spring, federal health officials select two influenza A virus strains (usually H1N1 and H3N2 subtypes) and one or two influenza B virus strains to include in flu vaccines released in the fall. This past December, CDC officials held a press conference and informed Americans that they were unaware during the selection process of last spring that one of the influenza A strains selected for the 2014/2015 flu vaccine - the H3N2 subtype - was starting to "drift." It turns out that the genetically mutated subtype is the dominant influenza A strain causing the flu epidemic this year but it is not included in the flu vaccine.

Let me put that in plain English for you. Every year, in spring, experts select usually three strains to include in the flu vaccine, ready for the fall. This selection is made on an estimated guess as to what the flu virus might look like at the end of the year. This means, per definition, that what is included in the flu vaccine never is the reality of the flu virus you might encounter in the following spring. Or, in other words, the flu vaccine can never initiate an accurate immune response against the actual flu virus of the moment. Or, a flu vaccine will never protect you against the flu of the future.

The ebola crisis has illustrated this point beautifully. In the midst of the crisis the focus of the medical authorities was on developing a vaccine. This created a lot of public support resulting in large sums of money being injected into the programme. The promise was that the vaccine would be ready and operational by the end of this year. That is how long it takes to develop, at high speed, a vaccine once you have material to base the vaccine on. The authorities, of course, also knew that within the space of three to six months the ebola outbreak would totally disappear by itself, but by that time lots of finances had been secured by the industry.

There is another problem with regards to flu vaccines and this stems from the fact that flu vaccinations come around every year and need to be planned properly. Let's go back and take a look at the 2003/04 flu season's epic influenza vaccine fail. In the spring of 2003, federal health officials did know ahead of time that the influenza A Panama strain they chose for the seasonal flu vaccine was not a match for the emerging mutated H3N2 Fujian strain which was making people very sick. Influenza experts told the FDA vaccine advisory committee that the flu vaccine would certainly fail if two specific genetic mutations of H3N2 were not included. So what was the government's rationale for allowing drug companies to produce a flu vaccine they knew was likely a non-starter from the very beginning? Well, the vaccine manufacturers said they couldn't include the mutated H3N2 subtype in the vaccine because they would miss the fall 2003 delivery and marketing deadline! In other words, it was all about protecting a multi-billion dollar flu vaccine market and not about the health and protection of the population. Money comes first; after that nothing matters.

"...Well, the vaccine manufacturers said they couldn't include the mutated H3N2 subtype in the vaccine because they would miss the fall 2003 delivery and marketing deadline! ."

How honest are the Disease Control Agencies in the western world with their respective governments who are voting to give medical authorities and drug companies billions of pounds or euros to produce influenza vaccines that are being aggressively pushed on the population, including infants, children, pregnant women and health care workers using a pathetically poor evidence base?

They see influenza viruses as always mutating and evolving, recombining with each other and creating new influenza strains being shed and transmitted in body fluids and waste products of animals and humans. Vaccine strain influenza viruses, which are man-made mutations, are being introduced in the bodies of the vulnerable. These vaccine strains too can interfere with the natural evolution of the strains, producing unknown effects on the body and the environment. And yet, billions of dollars are being spent by government and industry to build more flu vaccine plants to create genetically engineered flu vaccines that contain insect and animal DNA, foreign proteins and novel adjuvants designed to hyper-stimulate human immune responses. In an irrational crusade to outsmart influenza viruses vaccine risks are increasing while vaccine failures continue to haunt the entire money-driven enterprise.

After decades of government propaganda trumpeting the benefits and minimizing the risks of annual flu shots, one-size-fits-all, cradle to the grave, influenza vaccine recommendations should be revised. If we are not ready to face the world without flu shots then it is time to adjust our behaviour based on what we have learned. They should call it evidence based medicine! Flu shot mandates should be repealed and vaccine manufacturers should be held accountable for vaccine risks and failures in civil court. By the way, in 2014 the authority paid out over 3 billion dollars of vaccination compensation in America alone. Not a bad figure for something that is totally safe, as they keep repeating over and over again.

AND HERE IS ANOTHER ONE!

Get a measles vaccine and you won't get the measles, right? Wrong. In the US, the source of a measles outbreak can sometimes be traced to a vaccinated person. For example, a fully vaccinated 22-year-old theatre employee in New York City who developed the measles in 2011 was released without hospitalization or quarantine. This patient turned out to be unwittingly contagious, which is not possible in the current medical science! Ultimately, she transmitted the measles to four other people, according to a recent report in Clinical Infectious Diseases. Surprisingly, two of the 4 patients had been fully vaccinated too. And although the other two had no record of receiving the vaccine, they both showed signs of previous measles exposure that should have created life-long immunity, as medical knowledge has been so keen to assure us.

Although public health officials have assumed that measles immunity lasts forever, the case of this woman highlights the reality that "the actual duration [of immunity] following infection or

vaccination is unclear," says Jennifer Rosen, who led the investigation as director of epidemiology and surveillance at the New York City Bureau of Immunization. The possibility of waning immunity is particularly worrisome as the virus surfaces in major U.S. hubs like Boston, Seattle, New York, and the Los Angeles area. Once again we hear the words "protection against the disease is unclear, but policy should not be changed"! Rosen doesn't believe this single case merits a change in vaccination strategy- for example, giving adults booster shots- but she says that more regular surveillance to assess the strength of people's measles immunity is warranted. That will help! From the case mentioned above we can already learn that signs of good immunity does not provide you with protection against infection. But hey, let's do more tests; let's use more public money to keep the illusion alive we are looking after your health.

If it turns out that vaccinated people lose their immunity as they get older, that could leave them vulnerable to measles outbreaks seeded by unvaccinated people-which are increasingly common in the United States and other developed countries. This is the official point of view. Strange though that this kind of statement occurs in the aftermath of a well-publicised case of a vaccinated person being the cause of the outbreak!

In the medical journal Vaccine, Dr Gregory Poland, the journal's editor-in-chief, professor of medicine and founder and leader of Mayo Clinic's Vaccine Research Group, recently made surprising public statements about the poor effectiveness of measles vaccine in the MMR shot. For many years, Dr Poland has been a strong mandatory vaccination proponent and has criticized MMR vaccine safety critics.

Public health agencies have been reporting measles outbreaks in the US for the past few years, which they often blame on unvaccinated individuals, despite the fact that in 2012, 95% of children entering kindergarten had gotten two MMR shots and so had more than 90% of high school students. With this high degree of compliance with a supposedly effective measles vaccine, many people have been wondering why the U.S. is seeing a resurgence of measles cases (from January 1 to June 6, 2014, the CDC reported 397 cases of measles and 16 separate outbreaks in the US).

For starters, it's important to remember that, like B. pertussis whooping cough and other infectious diseases, measles has natural cyclical increases and decreases every few years.

"The tactic is to scare everybody if they even think about following a different train of thought, pursuing different evidence. And fear is a powerful factor. People drop their fear for something when they can replace it with a fear for something else, not to replace it with simple quiet acceptance."

These may occur even in highly vaccinated populations because the vaccine itself is not a guarantee of long lasting immunity and even two doses of MMR vaccine can fail to protect. According to Dr Poland, who is conducting research at Mayo Clinic to develop new measles, mumps and rubella vaccines: "…the immune response to measles vaccine varies substantially in actual field use. Multiple studies demonstrate that 2-10% of those immunized with two doses of measles vaccine fail to develop protective antibody levels, and that immunity can wane over time and result in infection (so-called secondary vaccine failure) when the individual is exposed to measles. For example, during the 1989-1991 U.S. measles outbreaks 20-40% of the individuals affected had been previously immunized with one to two doses of vaccine. In an October 2011 outbreak in Canada, over 50% of the 98 individuals had received two doses of measles vaccine… this phenomenon continues to play a role in measles outbreaks. Thus, measles outbreaks also occur even among highly vaccinated populations because of primary and secondary vaccine failure, which results in gradually larger pools of susceptible persons and outbreaks once measles is introduced.

This leads to a paradoxical situation whereby measles in highly immunized societies occurs primarily among those previously immunized."

Now you get it from the horse's mouth. Will you believe it now? Will it change our behaviour? Will we now relax in the knowledge that we can't protect ourselves and that all efforts to try and do so is making our situation worse?

I doubt it. Evidence based medicine is what the medical authorities throw out into the world, implying that nobody does a better evidence base than they do. How do they engage with the kind of evidence presented here? They file it very carefully. In the bin. They continue on the same line as if nothing has happened and they act just as surprised the next time the same "evidence" appears on the table.

The tactic is to scare everybody if they even think about following a different train of thought, pursuing different evidence. And fear is a powerful factor. People drop their fear for something when they can replace it with a fear for something else, not to replace it with simple quiet acceptance. It is what it is, can be heard a lot these days, but in practise people cringe when they are confronted with the reality of the statement. They still believe they have to do something. People who reject vaccinations are very often searching for other ways to "protect.".Same fear, I'm afraid. The truth, and serene calmness, comes from understanding life. In this case, know how infections truly come about. What do infections truly mean? I encourage you to understand what the origin of the germs is and to understand that viruses are not germs.

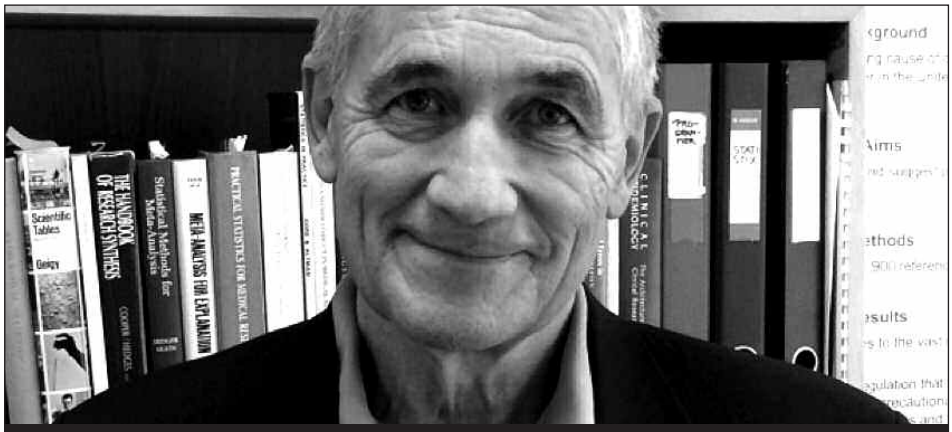
FURTHER INFORMATION

Read more about these issues and more on Patrick Quanten's website

www.activehealthcare.co.uk

PETER GOTZSCHE, founder of the Cochrane Collaboration, visits Australia to talk about dangers of prescription drugs

AMY CORDEROY, HEALTH EDITOR
THE SYDNEY MORNING HERALD
http://www.smh.com.au/
Feb 7th 2015



Professor Gotzsche, head of the Nordic Cochrane Centre

MANY of our most commonly used drugs, from painkillers to antidepressants, are dangerous and are killing us off in large numbers, says a leading researcher visiting Australia next week.

Peter Gotzsche, a co-founder of the Cochrane Collaboration, the world's foremost body in assessing medical evidence, arrives in Australia on Monday for a whirlwind speaking tour warning Australians about their use of prescription medications.

He estimates that 100,000 people in the United States alone die each year from the side-effects of correctly used drugs. Similar figures are not available in Australia, although the Australian Bureau of Statistics estimates that 3000 people died after complications with medical and surgical care in 2012.

"It's remarkable that nobody raises an eyebrow when we kill so many of our own citizens with drugs," Professor Gotzsche, who heads the Nordic Cochrane Centre, told Fairfax Media ahead of his visit.

Two of Professor Gotzsche's biggest targets are antidepressants and the painkillers described as "non-steroidal anti-inflammatories", such as ibuprofen, diclofenac and celecoxib. Another, sold under the brand name Vioxx, was withdrawn after it emerged it had caused up to 140,000 cases of serious heart disease in the US alone in the five years it was on the market - during which time its manufacturer, Merck was withholding information about its risks. About half the cases were thought to be fatal.

Professor Gotzsche says those deaths are only the tip of the iceberg and are representative of a system of drug regulation that simply does not protect patients.

Even the name for these drugs, "anti-inflammatory", is not supported by evidence, he says. He has conducted a clinical trial and review of the evidence that has found there is no proof they reduce inflammation.

> *"It's remarkable that nobody raises an eyebrow when we kill so many of our own citizens with drugs"*

"These terms for our drugs are invented by the drug industry," he said. "They had a huge financial interest in calling these things anti-inflammatory. It lured doctors into believing that these drugs somehow also had an effect on the disease process and reduced the joint damage."

In a paper last year in the Lancet Psychiatry journal, Professor Gotzsche argued our use of antidepressants is causing more harm than good.

He said as the evidence against drugs such as Valium and Xanax emerged, they have been replaced with antidepressants that are equally as addictive and their side-effects just as dangerous.

Furthermore, he says research that showed small benefits over placebos was biased, as it did not properly hide whether patients were in the active or placebo group.

Professor Gotzsche said the biggest victims of over-prescription are the elderly. For every 28 elderly people treated for a year with an antidepressant, one will die who would have lived otherwise, from causes including heart attacks, stroke and falls.

"Those who use arthritis drugs are mostly the elderly who are most at risk of dying of a heart attack caused by the drug or a bleeding ulcer," he said. "We have a high use of psychiatric drugs by the elderly and we kill an enormous amount of them."

Freedom-of-information requests lodged by Fairfax Media have shown more than 4 million antidepressant prescriptions a year are recorded for people aged over 67 - twice the rate for young Australians.

"These people get shoved in a nursing home and they get aggravated, so they're knocked out with an antipsychotic drug - it's very inhumane," Professor Gotzsche said.

Professor Gotzsche has been criticised for his stance that people should consider slowly going off their antidepressants if they are supported by their doctors in doing so.

He believes many doctors mistake withdrawal symptoms for depression, immediately returning patients to their normal medication dose if they experience symptoms, despite the fact antidepressant medications are supposed to take some time to begin working.

"If you get depressed by lowering the dose and then immediately increase

it to the normal dose, you will usually be well in a couple of hours," he said. "But if you get better straight away it is withdrawal, not depression."

But Peter McGeorge, the director of the St Vincent's mental health service, said the hospital will host Professor Gotzsche on Thursday "in the spirit of open inquiry".

"I have seen people respond dramatically to the use of antidepressants so I'm certainly not opposed to the use of medicine," he said.

"But I do think we have to be careful - and I'm talking more generally now - about just seeing medicine as the answer and prescribing it on the smallest indication it might be successful".

He said many hospitals, including the mental health service at St Vincent's, now did not accept drug company representatives, and there was increasing interest in other forms of psychological therapies to help people with mental illness.

PROFESSOR GOTZSCHE'S LIST OF WHAT TO AVOID

- Antidepressants for all, as they very likely don't even work for severe cases of depression
- All brain-active drugs in children
- Anti-psychotics and other brain-active drugs for the elderly.

Psychotropic drugs should be used as little as possible and mostly in very acute situations, as they are very harmful when used long term; Anti-dementia drugs, as they very likely don't work

- Non-steroidal anti-inflammatory drugs used for arthritis, muscle pain and headaches, including over-the-counter, low-dose ibuprofen. These drugs should be used as little as possible.
- Mammography screening, as it doesn't prolong life whereas it makes many healthy women ill through overdiagnosis and leads to the premature death for some because radiotherapy and chemotherapy increases mortality when used for harmless cancers detected at screening
- Drugs for urinary incontinence, as they very likely don't work.

Nearly half of California, Disneyland measles cases unvaccinated

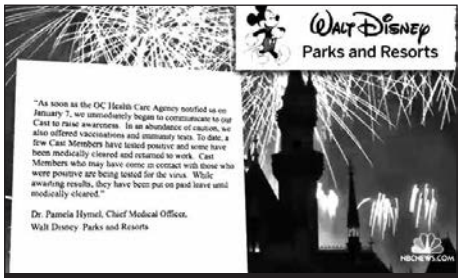
February 16, 2015
http://www.healio.com/

FORTY-FIVE PERCENT of measles cases in California that are part of an ongoing, multistate outbreak linked to Disneyland theme parks were unvaccinated for measles, according to the CDC.

On Jan. 5, an unvaccinated child with suspected measles was reported to the California Department of Public Health. The child, aged 11 years, had a rash onset on Dec. 28 and was hospitalized. The patient's only history of travel was to one of the two Disney theme parks in Orange County, California.

As of Feb. 11, 125 measles cases have been confirmed among U.S. residents and linked to Disneyland theme parks. Of these, 110 cases were Californians. Thirty-five percent of California cases visited one or both of the Disney parks during Dec. 17-20 and are considered to have been exposed there. Thirty-four percent of California cases have an unknown exposure source, and 31% are secondary cases.

Fifteen measles cases linked to Disneyland parks have been reported in Arizona (n = 7), Utah (n = 3), Washington (n = 2), Colorado (n=1), Nebraska (n = 1) and Oregon (n = 1). Canada (n = 10) and Mexico (n = 1) also have confirmed measles cases linked to the Disney outbreak.



NBCNEWS.COM Broadcast

"As a result of a vaccine, it is extremely difficult to find any proper data. Deaths occurring soon after receiving a vaccine would normally be dismissed as a timely coincidence and not recorded."

Of the unvaccinated California cases of measles, 12 were infants who were too young to be vaccinated, 28 were intentionally unvaccinated due to personal beliefs, and one was on an alternative plan for vaccination. Among the intentionally unvaccinated patients, 18 were children aged younger than 18 years; 10 were adults.

The source of initial exposure at Disneyland theme parks is unknown. Genotyping of 30 specimens from California cases indicated all were measles genotype B3, which has recently caused a large outbreak in the Philippines and has been identified in 14 countries, besides the U.S., in the last 6 months.

"International travel to countries where measles is endemic is a well-known risk factor for measles, and measles importations continue to occur in the United States," study researcher Jennifer Zipprich, PhD, of the California Department of Public Health, and colleagues wrote in MMWR. "This outbreak illustrates the continued importance of ensuring high measles vaccination coverage in the United States."

Disclosure: The researchers report no relevant financial disclosures.

MAGDA TAYLOR, EDITOR OF THE INFORMED PARENT:
This article was based on a paper published in the Morbidity and Mortality Weekly Report (MMWR): Measles Outbreak - California, December 2014-February 2015, Zipprich J, et al. which can be located at: (http://www.cdc.gov/mmwr).

Time and time again the headlines for reports such as these are usually skewed to give the impression that the unvaccinated are to blame. Why do they choose to say 'nearly half were

unvaccinated'? How about over half are likely to have been vaccinated? Also when you look at the figures in the MMWR it indicates the following:
'Among the 110 California patients, 49 (45%) were unvaccinated; five (5%) had 1 dose of measles-containing vaccine, seven (6%) had 2 doses, one (1%) had 3 doses, 47 (43%) had unknown or undocumented vaccination status, and one (1%) had immunoglobulin G seropositivity documented, which indicates prior vaccination or measles infection at an undetermined time.

Twelve of the unvaccinated patients were infants too young to be vaccinated.

Among the 37 remaining vaccine-eligible patients, 28 (67%) were intentionally unvaccinated because of personal beliefs, and one was on an alternative plan for vaccination. Among the 28 intentionally unvaccinated patients, 18 were children (aged <18 years), and 10 were adults.'

WHAT DO THESE FIGURES ACTUALLY INDICATE?

- *14 had received one or more doses of vaccine*
- *47 unknown or undocumented vaccination status (this usually means that the parents have indicated that their child had been vaccinated but there is no documented evidence. Otherwise they would have been swiftly added into the unvaccinated figure).*
- *12 were under the age of vaccination*
- *28 were intentionally unvaccinated due to personal beliefs*
- *1 was on an alternative plan for vaccination.*

THERE IS NO MENTION OF THE OTHER 8 CASES THAT WERE INCLUDED IN THE 'UNVACCINATED' CASES?

One could say that of the 110 cases only 28 cases occurred in individuals who had chosen not to vaccinate (25.5%) ie these children/adults are likely to be more health conscientious and probably raised with a more natural health lifestyle?

Also there is no mention of any serious sequelae in these 110 cases of measles in California and certainly no deaths. From a holistic viewpoint these individuals are likely to benefit from a bout of measles - throwing out a build-up of toxins - presenting as an acute rash disease. This is providing that the illness is allowed to run its course and the patient is relatively healthy, and nursed properly without the use of anti-fever medications or 'just in case' antibiotics etc.

REGARDING DEATHS RELATING TO MEASLES.

In the UK, according to the www.gov.uk ***site:***

Since the year 2000 there have been 11 measles deaths (9 in 15 years old+) There are no details of these cases and the general health of the individuals etc. However if we look back at the most recent so-called death from measles there is certainly enough evidence that this 'measles' death is questionable. For example, Peter Hitchen's blog, MailOnLine, 3 July 2013, reports on details regarding the 'measles death' of a young adult man in Wales, he states : 'Mr Williams was not in good health at the time that he contracted measles. At the age of 25, he was 5 feet 9 inches tall, but weighed only seven stone seven pounds (105 lbs), which the coroner, Philip Rogers, described as 'very underweight' . A doctor has told me that a more normal weight for a man of this age and height would be eleven stone seven pounds (161 lbs). He suffered, according to the coroner, from 'alcohol problems' or 'addiction to alcohol', for which he was undergoing 'treatment', said to have involved 'antidepressant' medication. The coroner said the drugs 'were used to manage withdrawal and other symptoms'. '

AS REGARDS TO DEATHS IN THE UK FROM MMR:

As a result of a vaccine, it is extremely difficult to find any proper data. Deaths occurring soon after receiving a vaccine would normally be dismissed as a timely coincidence and not recorded. In October 2010 the Sunday Times reported on '40 deaths linked to child vaccines over seven years' and stated: 'The data, disclosed by the Medicines and Healthcare products Regulatory Authority (MHRA) following a request by The Sunday Times under the Freedom of Information Act, shows that, since 2003, there have been more than 2,100 serious adverse reactions to childhood vaccines, some of which were life-threatening.'

Across the water in the US, according to Brian Shilhavy, Health Impact News Editor:

'First, the Centers for Disease Control and Prevention (CDC) keeps a weekly tally of disease outbreaks, including deaths. According to a statement made by Dr. Anne Schuchat, the director of CDC's National Center for Immunization and Respiratory Diseases, in an Associated Press story picked up by Fox News on April 25, 2014: There has been NO measles deaths reported in the U.S. since 2003.

Brian Shilhavy goes on to report:

'What about deaths due to the measles vaccine during the same time period? The U.S. Government keeps a database of reports called The Vaccine Adverse Event Reporting System (VAERS). The database is available to the public, and there is a search portal the public can use at Medalerts.org.

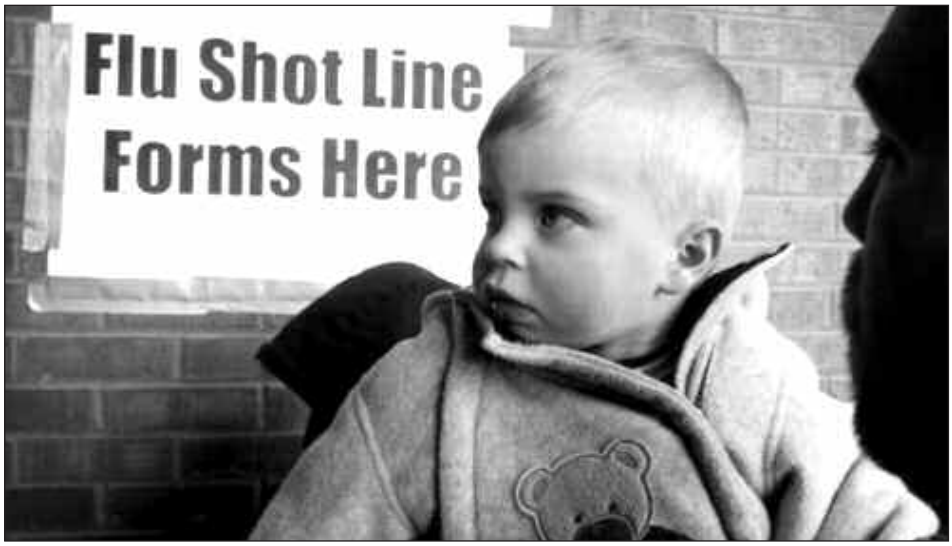
We ran a search for a ten year period for deaths due to all measles vaccines, including a few that are no longer in production. The search result contained 108 deaths over this period, resulting from four different measles vaccines sold in the United States during the past 10 years.

"LOOK DEEP INTO NATURE, AND THEN YOU WILL UNDERSTAND EVERYTHING BETTER."
~ ALBERT EINSTEIN

VACCINES PROVEN TO CAUSE SUDDEN DEATH IN CHILDREN:

67 deaths only explicable as caused by Vaccines – Drug Safety Regulators had the information for over 2 years and let children die

January 13, 2015 by ChildHealthSafety
https://childhealthsafety.wordpress.com/



THIS CONFIRMATION vaccines cause children to die suddenly was published this month on the US National Library of Medicine's website.

For decades regulators and public health officials have insisted parents were wrong to blame vaccines when their children died suddenly shortly after vaccination. It was coincidence they would say – nothing more.

The deaths were no more than the number usually to be expected they would add.

But all the time drug safety regulators appear to have been holding the evidence.

A confidential 1271 page GSK document ordered recently by an Italian Court to be published shows that multiple vaccines cause sudden child deaths. [The document is a formal confidential previously unpublished submission by GlaxoSmithKline to the European Medicines Agency from 2011 and 2012.]

The GSK document contains data about deaths occurring as a result of administration of Prevenar 13 vaccine [from Pfizer], Infanrix Hexa from GSK and some other vaccines. Prevenar 13 is given to all British children.

The analysis has been published on the US National Library of Medicines website using the data GSK provided to the European Medicines Agency. The data is conclusive. It is very clear and there is no room for argument.

And the analysis is simple. Anyone can understand it. The very plain data the document contains proves the matter without any doubt whatsoever.

Here is the key point from the published analysis [but there is more to read online]. It is not rocket science but very simple to understand:

(Source: Table 36 The GlaxoSmithKline Biological Clinical Safety and Pharmacovigilance report to Regulatory Authority)… if one analyses the data looking at deaths in first 10 days after administration of vaccine and compares it to the deaths in the next 10 days, it is clear that 97% of deaths (65 deaths) in the infants below 1 year, occur in the first 10 days and 3% (2 deaths) occur in the next 10 days. Had the deaths been coincidental SIDS deaths unrelated to vaccination, the numbers of deaths in the two 10 day periods should have been the same. Similarly in children older than 1 year, 87.5% deaths (7 deaths) occurred in the first 10 days and 12.5% (1 death) occurred in the next 10 days.

(The data presented in a way that the clustering of deaths can be seen clearly is available on the Child Health Safety website, details above - below headline.)

The clustering of deaths around the time of vaccination demonstrates a link between the vaccination and the sudden deaths. It indicates this is not by chance as otherwise the deaths would be spread across the entire 20 days. Rather than showing the total deaths each day, GlaxoSmithKline showed the cumulative figures which had the effect of disguising the clustering of deaths around vaccination. They did this by listing the cumulative number of deaths. So by day 19 after vaccination GSK's total was 67 deaths. But there had only been two deaths in those last 10 days and not 67. In contrast 65 deaths occurred on the first day of vaccination up to the 10th day following vaccination.

The way GSK's Table 36 is prepared disguises the clustering of deaths around the time of vaccination – the total cumulative number of deaths up to 10 days from vaccination is 65. That number over the next 10 days increases by only 2. So in 10 days there were 65 deaths and between day 11 to day 20 after vaccination there were only another two deaths. So only the vaccine can be the cause of this.

Here is a serious issue. This kind of information is routinely provided to regulators like the MHRA but never made public. On the one occasion such a document is published as a result of the actions of a judge in an Italian Court it is possible to show beyond any doubt that multiple vaccines cause sudden deaths in children.

This appears a serious failing of European regulators.
All the EU regulators including the MHRA have had this information for at least three years and failed to act on it. Further, the MHRA has an agreement with the drug industry not to publish information like this despite the provisions of the UK Freedom of Information Act.

Rubella: Disease, Vaccine and Congenital Rubella Syndrome Part 2

BY DR JAYNE LM DONEGAN
GP & HOMOEOPATH

DR JAYNE L.M. DONEGAN

THE POINT of vaccinating against rubella is to eradicate Congenital Rubella Syndrome.

Are cases of CRS reliably reported?

Looking at the figures from the British Paediatric Surveillance Unit (BPSU), one comes across the remarkable fact that national surveillance for children born with congenital rubella syndrome was not started until 1971, one year after the vaccine was introduced in 1970 so there are no figures to compare. Case detection, such as it was, relied on haphazard voluntary reporting by paediatricians if they happened to notice the symptoms of CRS. With this method, 39 cases of CRS were reported in the five years before introduction of the vaccine and 454 in the ten years after, with 333 in the years 1980-1989. This was still a passive system, not always based on immunological tests, and we know from Dr Kibrick in 1964 (featured in part 1 of this article), that this is not reliable ("no correlation"). That it is still unreliable is shown more recently by Dr Davidkin's team in Helsinki, Finland 2004:

"Less than 1% of clinically suspected rubella cases could be laboratory confirmed between 1983-1995, indicating the low positive predictive value of clinical diagnosis at this stage of control."' (Davidkin 2004)

It was only in the ten years since the beginning of active surveillance in 1990, that the number of cases notified decreased to 46 (44 live born, two stillborn) of whom the majority were born to mothers from abroad or who acquired the disease abroad. Serological testing is still not a requirement for notification of a baby with congenital rubella syndrome so most of the figures from when there was no surveillance; passive surveillance; and active surveillance are pretty meaningless. Twenty infants with CRS were born since 2000- 2012, including two born in Ireland or Northern Ireland, and two who were stillborn. Although 12 were imported cases with maternal infection acquired abroad (seven in Southern or South Eastern Asia, five in Africa), eight infants were born to women whose infection occurred in the UK or Ireland. (Tookey BPSU 2004)

Recording cases of CRS and all other cases of congenital anomalies relies on paediatricians being alert to the possibility. A study published in 2005 in the British Medical Journal found that paediatricians are not very good at doing this. The authors concluded:

"The surveillance of congenital anomalies in England is currently inadequate because ascertainment to the national register is low and non-uniform and because no data exist on termination of pregnancy resulting from prenatal diagnosis of fetal anomaly." (Boyd 2005)

Dr Pat Tookey of the British Paediatric Surveillance Unit (BPSU), admits

'It is possible that since the introduction of MMR, children with isolated sensorineural hearing loss due to CRS have not been identified and reported, because by the time hearing loss is investigated, many children have already been vaccinated, and diagnosis is then less straightforward. Furthermore, since rubella is now so rare, health professionals might not consider CRS as a possible diagnosis in infants with non-specific or atypical signs.' (Tookey 2004)

'there are a variety of problems associated with congenital rubella, and it is possible that infants without obvious manifestations at birth may not be diagnosed and reported; however, infants with symptoms at birth are likely to be reported in a consistent manner " (Tookey 2005)

However, congenital rubella syndrome is an evolving disease, which continues to progress after birth – the child may excrete virus for over a year. Some children in Gregg's original series were not deaf at birth but became so as the disease progressed after they were born.

From 1970-current there are published cases in medical journals of mothers known to have had laboratory confirmed natural or vaccine antibody levels regarded as indicating immunity, giving birth to babies with CRS. There are more published reports of cases following vaccination induced than after naturally acquired disease. A table of these can be downloaded free from my website (details at the end of article): CRS after Vaccine/Natural/ Unknown Source of Immunity.

It seems that rubella vaccination stops you from getting clinical (with symptoms) but not subclinical (without symptoms) infection and that in the presence of a rubella epidemic or prolonged close contact, such within a family at home, or soldiers in a barrack, you will not be protected (Horstmann 1970). This is the similar to outbreaks in measles and polio vaccinated polpulations.

THE VACCINATION DECISION

If you have had the rubella vaccine and a blood test has shown that you are immune, you can still get rubella infection when you are pregnant and give birth to an affected baby.

If you have had rubella natural infection and a blood test has shown that you are immune, you can still get rubella infection when you are pregnant and give birth to an affected baby, although this is likely to occur

less often than after vaccination for the reasons stated above.

In all countries where rubella vaccine has been introduced the disease is pushed into older age groups which is the opposite of what is desirable. Rubella continues to circulate both in the UK and USA (although it was declared eliminated there in 2004) with Hispanic mothers in the USA and Asian and African mothers in the UK being most at risk.

Dr Jennifer Best (1989) summed the situation up from a doctor's point of view:

"Cases in which fetal damage results from maternal reinfection by rubella may raise medicolegal issues. If an affected baby was born to woman with evidence of pre-existing immunity (fulfilling acceptable criteria) the doctor or manufacturer of the vaccine could not be considered to have been negligent. Nevertheless, unless a no fault compensation scheme is established such cases are likely to entail parents in considerable expense over a prolonged period and create considerable adverse publicity for rubella vaccination. Indeed, this has occurred recently; it would be unfortunate if such adverse publicity destroys the public's confidence in a remarkably effective and safe vaccine." (Best et al 1989)

VACCINE VIRUS SPREAD TO OTHERS

The rubella vaccine is a live vaccine and recently vaccinated individuals can spread the vaccine virus to others. The United States Advisory Committee on Immunization Practices states:

"Small amounts of rubella vaccine virus are detected in the noses or throats of most rubella susceptible persons 7 to 28 days post-vaccination." "No documented confirmed cases of transmission of rubella vaccine virus have been reported" (McLean ACIP 2013)

However in 1974, Dr. Lewis B Lefkowitz Jr and team at Vanderbilt University School of Medicine, Nashville, Tn, USA tested 85 non immune placebo rubella vaccine recipients who were exposed to vaccinated siblings diagnosed with rubella vaccine disease. One of the 85 developed a vaccine virus antibody response showing infection. The authors say:

"Although this response might have resulted from her having received vaccine by mistake, the possibility of intrafamilial spread of vaccine-strain virus must be seriously considered."

And in 1993, Dr Judith Wolf and others of the Department of Medicine, Thomas Jefferson University, Philadelphia, Pa, USA reported the case of a 15-month-old boy who developed fever and a rash ten days after his MMR vaccine (vaccine virus disease). Two days later his healthy 34 year old mother developed a feverish illness as well. Her symptoms resolved within 48 hours but one day later, she developed classic rubella joint disease. Her rubella antibodies were checked and two samples eight weeks apart showed a 16-fold rise in IgG but not IgM indicating reinfection not a primary infection.

"Each time we have a feverish illness/ infection managed appropriately we get stronger. Our immune system gets better at its job."

Dr Wolfe makes the point that rubella vaccinees are known to shed virus, and the RA27/3 rubella vaccine, which replaced earlier versions as it was said to be more immunogenic, had had its potential for spread to contacts subjected to less scrutiny than its predecessors. In addition:

"Although no viral cultures were obtained in the patient described here, the fever and arthritis associated with her illness suggest that she was actively viremic (virus multiplying in the blood stream) despite the presence of rubella antibody. This has broader implications for women of child-bearing age who might be pregnant at the time that older children are receiving routine immunization. As we have shown, vaccine strain virus is transmissible even to an immune individual, and thus poses a theoretical risk to a developing fetus." (Wolf 1993)

WHERE DOES THAT LEAVE YOU REGARDING PROTECTING YOUR UNBORN BABY OR THAT OF YOU DAUGHTER?

Whether you vaccinate against rubella or you do not, the most important factor in whether you get infected, clear the virus, produce good quality long lasting antibodies, as well as stimulate cell mediated, tonsillar and other immunity, or you fail to clear the virus, have viral persistence and immune complex disease, is the state of your immune system when you meet the organism, and how you manage the infection when you get it (and how much practice you have had doing this).

YOU HAVE TO GO BACK TO BASICS

Your health regarding rubella is not a result of just what happens when you meet the rubella organism. Your health is based on how you have treated all the other feverish illnesses that you have acquired in the past and this determines the state of health of your body now and in the future.

EXPOSURE TO GERMS IS NECESSARY

Humans acquire infectious diseases, some of which have names and others which are called 'non-specific viral illnesses' (code for 'I don't know what it is and I am not sending specimens off to find out), at appropriate times in their development. Children acquire them as part of learning what to do with their immune system as well as to clear out junk, so that they can go up the next developmental step. Adults generally get them when they are exhausted, and need a rest – usually if they could have done that first, they would not have needed to get ill.

Each time we have a feverish illness/ infection managed appropriately we get stronger. Our immune system gets better at its job. 'Practice makes perfect'. Management which supports the body in the process of elimination, whether by production of mucus, fever, diarrhoea, vomiting or a rash, helps to externalise the disease process making internalisation of symptoms or complications, less likely.

With all viral illnesses what determines whether the virus is eliminated or persists to cause continuing inflammatory damage is dependent on how good you are at this process. It is very easy to get sidetracked from the obvious basics of what you need to be healthy by concentrating on particular organisms and what their names are, when every organism you meet, whether you become infected with it or not stimulates your immune system and is capable of killing you if wrongly managed.

Ideally your child would get rubella naturally. You probably won't know when this happens as up to 85% of infections are subclinical which means that there are no symptoms and be sure to treat all infections supportively, not suppressively. (Donegan 2008)

WHEN YOUR DAUGHTER REACHES PUBERTY YOU COULD ASK YOUR GP TO CHECK HER RUBELLA ANTIBODIES

If she has what is regarded as protective levels, this is no guarantee that her baby in the future will be protected, but as antibodies are all you get from the vaccine, there will be no point in her having the vaccine as she already has what the vaccine can give her regarding rubella protection. If they are negative you will have to decide then what to do, bearing in mind that the vaccine does not give 100% protection from getting rubella reinfection or having a rubella affected baby. However. at least having a vaccine at that age will make it more likely that she still has antibodies when she becomes pregnant.

THEN WHAT CAN YOU DO WHEN YOU ARE PREGNANT?

Make sure you continue with your healthy lifestyle.

"How can I?" You say, "How can I always be health, happy, calm, and eat the right things?"

The answer is, that you can't, well not if you are a fairly normal person. So you need to recognise when you do veer from the straight and narrow path regarding natural hygiene, that you will get ill.

THIS IS A SIGN OF HEALTH, NOT DISEASE

Manage the illness correctly: rest yourself, rest your digestive system, have the window open at night, start the day with hot water and a slice of lemon, drink plenty of clean water, and when you are on the mend, eat simply prepared good quality food, maybe treat yourself to a soak in an epsom salt bath with some lavender oil and spend time with people who love you.

Continue this throughout your pregnancy, the birth of your child and the rest of your life.

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© 2014 Dr Jayne L.M. Donegan
MBBS DRCOG DFFP DCH
MRCGP MFHom
Telephone/Fax 0044 (0)20 8632 1634
Email: jaynelmdonegan@yahoo.com
Website: www.jayne-donegan.co.uk/
Dr Donegan runs a series of talks and workshops on Vaccination and other health related topics, see website for details:
www.jayne-donegan.co.uk
If you are interested in hosting one of these lectures or workshops, please contact Dr Donegan at: tel/fax 0044 (0) 208 632 1634 (ansafone) or email jaynelmdonegan@yahoo.com

Forthcoming Lectures by Dr Jayne Donegan

NURSING CHILDREN SUPPORTIVELY THROUGH ACUTE ILLNESS

26 April 2015, Sunday afternoon, 12.45 for 1-3pm, Chatham, Kent ME4 4HF
14 May 2015, Thursday evening, 6.15 for 6.30-8.30pm Blackheath London SE3 7SE
31 May 2015, Sunday afternoon, 1.45 for 2-4pm Farnham, Surrey GU9 8RL
19 November 2015, Thursday Evening, 6pm for 6.30-8.30 London W1W 7BE

'VACCINATION – THE QUESTION'

19 April 2015, Sunday afternoon, North London NW4
03 May 2015, Sunday afternoon, Maidstone, Kent ME14

TRAVEL MEDICINE – WHAT YOU NEED TO KNOW BEFORE YOU TRAVEL

10 May 2015, Sunday afternoon, Brighton BN2
17 May 2015, Sunday Afternoon, North London NW4
21 May 2015, Thursday Evening, London W1W 7BE

See website for further information:
http://www.jayne-donegan.co.uk/lecturesworkshops

AIMS & OBJECTIVES OF THE *informed* PARENT GROUP

1. To promote awareness & understanding about vaccination in order to preserve the freedom of an informed choice
2. To offer support to parents regardless of their decisions
3. To inform parents of the alternatives to vaccinations.
4. To accumulate historical & current information about vaccination & to make it available to members & interested parties.
5. To arrange & facilitate local talks, discussions and seminars on vaccination, childhood illnesses & the promotion of health.
6. To establish a nationwide support network and register (subject to members permission).
7. To publish a newsletter for members.
8. To obtain, collect and receive money and funds by way of contributions, donations, subscriptions, legacies, grants or any other lawful methods; to accept and receive any gift of property and to devote the income, assets or property of the group in or towards fulfilment of the objectives of the group.

THE INFORMED PARENT COMPANY LIMITED. REG.NO. 3845731 (ENGLAND)

The views expressed in this newsletter are not necessarily those of The Informed Parent Co. Ltd.
We are simply bringing these various viewpoints to your attention. We neither recommend nor advise against vaccination. This organisation is non-profit making.

THE INFORMED PARENT, PO BOX 4481, WORTHING, WEST SUSSEX, BN11 2WH.
Tel: 01903 212969 web: www.informedparent.co.uk