Private insurance companies, which do the best liability studies, have totally abandoned coverage for damage to life and property due to:

- **Acts of God**
- **Nuclear war & nuclear power plant accidents**
- **Vaccination**

VACCINATION QUOTES

"I found that the whole vaccine business was indeed a gigantic hoax. Most doctors are convinced that they are useful, but if you look at the proper statistics and study the instances of these diseases you will realize that this is not so . . My final conclusion after forty years or more in this business [medicine] is that the unofficial policy of the World Health Organization and the unofficial policy of the 'Save the Children's Fund' and ... [other vaccine promoting] organizations is one of murder and genocide. . . . You cannot immunize sick children, malnourished children, and expect to get away with it. You'll kill far more children than would have died from natural infection."
Dr Kalokerinos M.D.

"There is growing suspicion that immunization against relatively harmless childhood diseases may be responsible for the dramatic increase in autoimmune diseases since mass inoculations were introduced. These are fearful diseases such as cancer, leukemia, rheumatoid arthritis, multiple sclerosis, Lou Gehrig's disease, lupus erthematosus, and the Guillain-Barre syndrome."--Dr. Mendelsohn, M.D.

"The medical authorities keep lying. Vaccination has been a disaster on the immune system. It actually causes a lot of illnesses. We are changing our genetic code through vaccination."--Guylaine Lanctot M.D. Canadian author of the best-seller 'Medical Mafia'.

"Probably 20% of American children-one youngster in five--- suffers from "development disability". We have inflicted it on ourselves.. "development disabilities" are nearly always generated by encephalitis. And the primary cause of encephalitis in the USA and other industrialized countries is the childhood vaccination program... a large proportion of the millions of US children and adults suffering from autism, seizures, mental retardation, hyperactivity, dyslexia, and other shoots or branches of the hydra headed entity called "development disabilities", owe their disorders to one or another of the vaccines against childhood diseases." - Harris Coulter, Ph.D.

The idea of poisoning healthy people with vaccine virus . . . is irrational. People make a great ado if exposed to a contagious disease, but they submit to being inoculated with rotten pus...

Palmer BJ. The Science of Chiropractic: Its Principles & Adjustments. Davenport, IA: The Palmer School of Chiropractic, 1906, p 17.

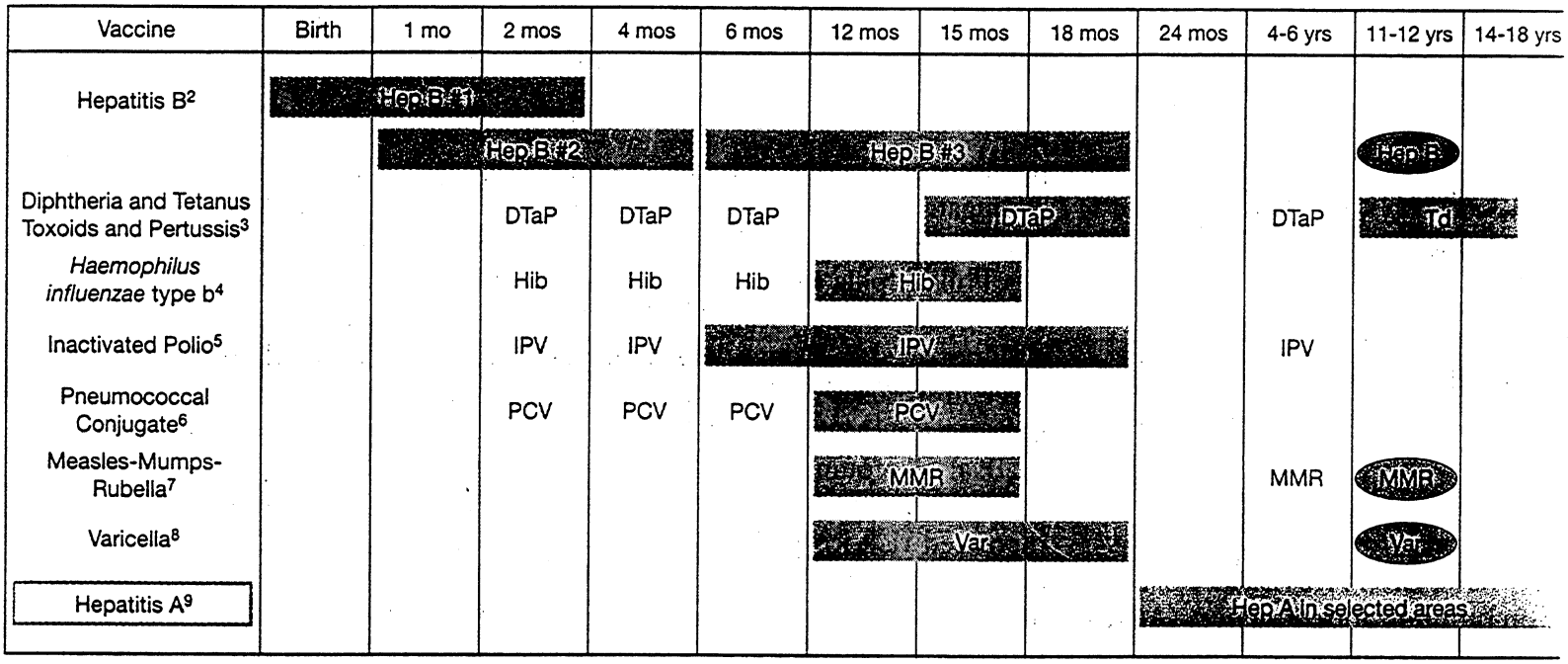
It is unreasonable for the chiropractic profession to be taken seriously in the arena of preventive healthcare when a vocal proportion of the profession openly, completely, and without reservation opposes the most widely accepted and documented preventative procedure available: immunizations.
Cheryl Hawk, DC, Ph.D.

Hawk C. Should chiropractic be a "wellness" profession? Topics in Clinical Chiropractic 7:23-6, 2000 (March 2000). Cheryl Hawk, D.C., Ph.D., a researcher at Palmer College

FROM THE CENTERS FOR DISEASE CONTROL AND PREVENTION

30 39

Recommended Childhood Immunization Schedule[1]—United States, January-December 2001



[1] This schedule indicates the recommended ages for routine administration of currently licensed childhood vaccines as of November 1, 2000, for children through age 18 years. Additional vaccines may be licensed and recommended during the year. Licensed combination vaccines may be used whenever any components of the combination are indicated and the vaccine's other components are not contraindicated. Providers should consult the manufacturer's package inserts for detailed recommendations.

[2] **Infants born to hepatitis B surface antigen (HBsAg)–negative mothers** should receive the first dose of hepatitis B vaccine (Hep B) by age 2 months. The second dose should be administered at least 1 month after the first dose. The third dose should be administered at least 4 months after the first dose and at least 2 months after the second dose, but not before age 6 months. **Infants born to HBsAg–positive mothers** should receive Hep B and 0.5 mL hepatitis B immune globulin (HBIG) within 12 hours of birth at separate sites. The second dose is recommended at age 1-2 months and the third dose at age 6 months. **Infants born to mothers whose HBsAg status is unknown** should receive Hep B within 12 hours of birth. Maternal blood should be drawn at delivery to determine the mother's HBsAg status; if the HBsAg test is positive, the infant should receive HBIG as soon as possible (no later than age 1 week). **All children and adolescents (through age 18 years)** who have not been immunized against hepatitis B should begin the series during any visit. Providers should make special efforts to immunize children who were born in or whose parents were born in areas of the world where hepatitis B virus infection is moderately or highly endemic.

[3] The fourth dose of diphtheria and tetanus toxoids and acellular pertussis vaccine (DTaP) may be administered as early as age 12 months, provided 6 months have elapsed since the third dose and the child is unlikely to return at age 15-18 months. Tetanus and diphtheria toxoids (Td) is recommended at age 11-12 years if at least 5 years have elapsed since the last dose of diphtheria and tetanus toxoids and pertussis vaccine (DTP), DTaP, or diphtheria and tetanus toxoids (DT). Subsequent routine Td boosters are recommended every 10 years.

[4] Three type b (Hib) conjugate vaccines are licensed for infant use. If Hib conjugate vaccine (PRP-OMP) (PedvaxHIB or ComVax [Merck]) is administered at ages 2 and 4 months, a dose at age 6 months is not required. Because clinical studies in infants have demonstrated that using some combination products may induce a lower immune response to the Hib vaccine component, DTaP/Hib combination products should not be used for primary immunization in infants at ages 2, 4 or 6 months unless approved by the Food and Drug Administration for these ages.

[5] An all-inactivated poliovirus vaccine (IPV) schedule is recommended for routine childhood polio vaccination in the United States. All children should receive four doses of IPV at age 2 months, age 4 months, between ages 6 and 18 months, and between ages 4 and 6 years. Oral poliovirus vaccine should be used only in selected circumstances (1).

[6] The heptavalent pneumococcal conjugate vaccine (PCV) is recommended for all children age 2-23 months. It is also recommended for certain children age 24-59 months (2).

[7] The second dose of measles, mumps, and rubella vaccine (MMR) is recommended routinely at age 4-6 years but may be administered during any visit, provided at least 4 weeks have elapsed since receipt of the first dose and that both doses are administered beginning at or after age 12 months. Those who previously have not received the second dose should complete the schedule no later than the routine visit to a health-care provider at age 11-12 years.

[8] Varicella vaccine (Var) is recommended at any visit on or after the first birthday for susceptible children (i.e., those who lack a reliable history of chickenpox [as judged by a health-care provider] and who have not been immunized). Susceptible persons aged 13 years should receive two doses given at least 4 weeks apart.

Would you use physician records?

"When it comes to vaccine-related deaths and injuries, the prevailing attitude among physicians is, 'What must not be, cannot be.'"

W. Ehrengut, M.D.

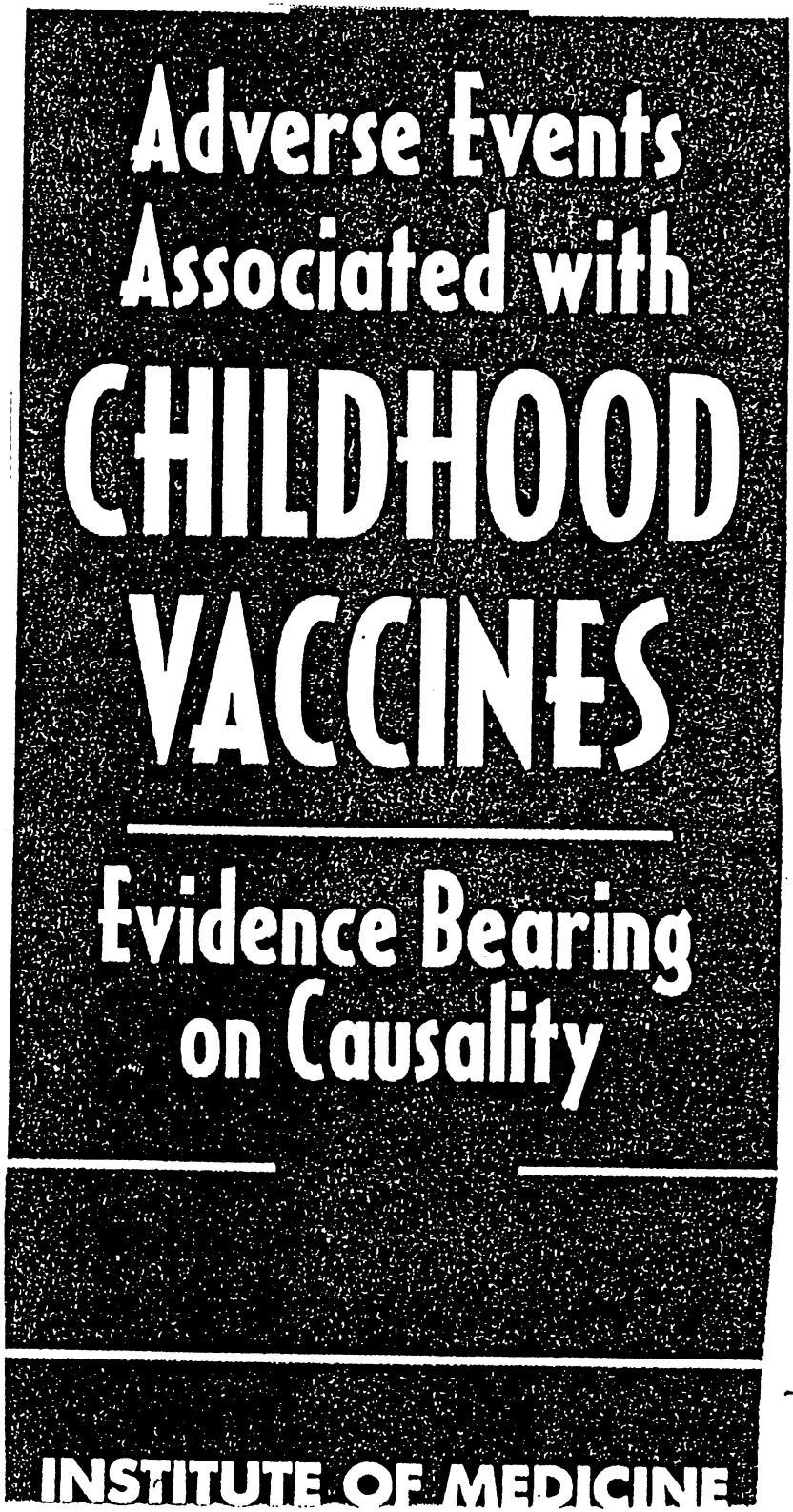
Doctors under-report adverse vaccine reactions by 90%

U.S. Food and Drug Administration

There is about a 50-fold underreporting of adverse events.

James Froeschle, Connaught Laboratories in Adverse Events Associated with Childhood Vaccines. Evidence Bearing on causality. Institute of Medicine. May 11, 1992, Washington, D.C. Appendix B.

So you wouldn't rely on doctor's records to get an accurate assessment.



Shannon Dixon, Honolulu, Hawaii Mr. Dixon explained that he deve oped poliomyelitis in 1962 following receipt of oral poliovirus vaccine. H made a complete recovery and lived an active life until the early 198(when he began to develop symptoms that have been diagnosed as post-pol syndrome. He is now severely physically disabled and requires attenda care. Mr. Dixon urged the committee to recognize that recovery from pol is not always the end of medical problems for patients with polio. He not that the National Vaccine Injury Compensation Program must take in account the possibility of post-polio syndrome when developing compens tion plans for those who contract polio from the oral vaccine.

Jesse Ferguson, Milwaukee, Wisconsin Mr. Ferguson described heal problems that began shortly after receipt of tetanus toxoid following a wor related injury. These health problems culminated in the loss of use of h right arm and a diagnosis of brachial neuritis. More than a year later, I was still unable to return to construction work and had been told that h medical condition would not improve. Mr. Ferguson urged the committ to ensure that the public is made more aware of the possible side effects vaccines and to consider new guidelines for the implementation of vaccin tion programs.

Barbara Loe Fisher, Dissatisfied Parents Together, Vienna, Virginia Mr Fisher expressed concern about the concurrent administration of multip vaccines to children—particularly the possibility that multiple vaccinatic might result in a greater risk of adverse reactions and/or interference wi proper immune response. She maintained that large-scale definitive scie tific studies of the effects of simultaneous administration of vaccines hav not been carried out and that, in the absence of such studies, it is n possible to make decisions about safety.

James Froeschle, Connaught Laboratories, Swiftwater, Pennsylvania D Froeschle gave information about adverse events following diphtheria an tetanus toxoids (DT) that had been reported to Connaught. From a compari son of spontaneous reports with postmarketing surveillance data, the com pany estimates about a 50-fold underreporting of adverse events in the pas sive reporting system. The distribution of types of events, however, wa found to be approximately the same; in both cases, the majority of reporte events were local reactions or fever. The company has seen a marke decrease in adverse event reports since the inception of VAERS late i

"When I once pointed out to an officer of the United States Public Health Service that articles on vaccination 'adverse reactions' often misrepresented the facts and were rarely supported by statistical or other evidence, he responded: 'That's true, but it doesn't make any difference; we already know that these vaccines are entirely safe.'"

Harris L. Coulter, Ph.D. A Word About Official U.S. Pro-Vaccination Literature.

The Effect of Investigator Compliance (Observer Bias) on Calculated Efficacy in a Pertussis Vaccine Trial

James D. Cherry, MD, MSc*; Ulrich Heininger, MD‡; Klemens Stehr, MD‡; and Peter Christenson, PhD*

ABSTRACT. *Background.* In the course of a large pertussis vaccine efficacy trial we realized that investigator compliance could have a major impact on calculated vaccine efficacy.

Design. In our pertussis vaccine efficacy trial, the study investigators were to monitor illness in study families by telephone every 2 weeks. If a cough illness of ≥7 days duration was noted, the study child was to be evaluated. If the cough illness persisted for ≥14 days, the child was to be referred to a central investigator. For this report we analyzed study physician evaluation rates and rates of referral to the central investigators. Physician practices were separated into three compliance categories: high, intermediate, and low. We analyzed vaccine efficacy of an acellular pertussis component DTP vaccine (DTaP) and a whole cell pertussis component DTP vaccine (DTP) by compliance category. *Bordetella pertussis* infection was documented by culture of the organism in the study child or in a household contact or by a significant antibody response to pertussis toxin determined by enzyme-linked immunosorbent assay.

Results. Using a clinical case definition that included both mild and typical pertussis (cough illness ≥7 days duration) efficacy of DTaP vaccine was 40% (95% confidence interval [CI] = −3–65) in the high compliance category and 78% (95% CI = 65–86) and 75% (95% CI = 53–87) in the intermediate and low compliance groups, respectively. Similar, but less marked, differences in efficacy were noted with DTP vaccine recipients. Using a clinical case definition that required ≥21 days of cough with paroxysms, whoop, or vomiting (typical pertussis) the efficacy of DTaP vaccine was 69% (95% CI = 41–83) in the high compliance category and 86% (95% CI = 76–92) and 84% (95% CI = 64–93) in the intermediate and low compliance groups, respectively. In contrast, the efficacy of DTP vaccine did not vary by compliance category using this case definition. The attack rate in children vaccinated with diphtheria and tetanus toxoids vaccine (DT) was twofold less in low compliance physician practices when compared with the rates in high and intermediate groups. The DT/DTaP and DT/DTP fold-change differences were less in the high compliance group compared with the intermediate and low compliance groups.

Conclusions. Our data suggest that observer compliance (observer bias), can significantly inflate calculated vaccine efficacy. It is likely that all recently completed efficacy trials have been effected by this type of observer bias and all vaccines have considerably less efficacy against mild disease than published data suggest. *Pediatrics* 1998;102:909–912; *observer bias, vaccine efficacy, acellular pertussis vaccine, whole cell pertussis vaccine, investigation compliance.*

ABBREVIATIONS. DTP, diphtheria–tetanus toxoids, whole cell pertussis vaccine, adsorbed; DTaP, diphtheria–tetanus toxoids, acellular pertussis vaccine, adsorbed; WHO, World Health Organization; PT, pertussis toxin; DT, diphtheria and tetanus toxoids vaccine; CI, confidence interval.

More than 3 years ago seven efficacy trials involving eight different acellular pertussis component (diphtheria–tetanus toxoids, whole cell pertussis vaccine, adsorbed [DTP] vaccines) (diphtheria–tetanus toxoids, acellular pertussis vaccine, adsorbed [DTaP] vaccines) were completed and the results of these trials have been published.[1-7] The eight vaccines in these seven trials were all different and reported efficacy of the products varied considerably. In preparing for our vaccine efficacy trial,[1,8] we established a pertussis laboratory in Erlangen, Germany, and to test its functionality we asked physicians to send us nasopharyngeal specimens from children with cough illnesses regardless of whether or not they thought the children had pertussis.[9] To our surprise many children from whom *Bordetella pertussis* was isolated did not have classic pertussis; specifically 47% coughed for 28 days or less and 26% coughed for 21 days or less. More recently we examined the duration of illness in 1548 culture positive unvaccinated children and found that 17.4% coughed for ≤3 weeks and 37.9% coughed for ≤4 weeks.[10]

In January 1991, an ad hoc World Health Organization (WHO) committee met to plan a universal case definition for the DTaP vaccine efficacy trials in infants that were being planned or were underway.[11] The WHO definition was: 21 days of paroxysmal cough plus positive culture or titer rise to pertussis toxin (PT), filamentous hemagglutinin, or fimbrial antigens by enzyme-linked immunosorbent assay or a household contact with a culture confirmed case. Examination of data from a previous Swedish efficacy trial completed more than 10 years ago in which a PT toxoid vaccine and a PT toxoid/filamentous hemagglutinin vaccine were evaluated, indicated that the use of a case definition similar to the WHO definition resulted in the removal of many cases of

From the *Department of Pediatrics and the University of California, Los Angeles Center for Vaccine Research, University of California, Los Angeles School of Medicine, Los Angeles, California; and the ‡Klinik mit Poliklinik für Kinder und Jugendliche der Friedrich-Alexander-Universität Erlangen-Nürnberg, Erlangen, Germany.

Received for publication Jan 22, 1998; accepted Mar 19, 1998.

Reprint requests to (J.D.C.) Department of Pediatrics, UCLA School of Medicine, 10833 Le Conte Ave, Los Angeles, CA 90095-1752.

Griffin, Marie R., Wayne A. Ray, Edward A. Mortimer, Gerald M. Fenichel, and William Schauffner. "Risk of Seizures and Encephalopathy After Immunization with the Diphtheria-Tetanus-Pertussis Vaccine." JAMA 263:12 (March 23/30, 1990), 1641-1645.

A study of vaccination outcomes in 38,171 Tennessee children for whom Medicaid records were available. The authors of the article never spoke to one single parent, the whole study is an analysis of doctors' paper records. Even so they found reactions in 1187 children. This is 3%, a sizable figure, especially in view of underreporting.

If the numbers make you look bad, whittle them down...

Of the 1187 reactions *reported* exclude 359 from the study because records "were not available for review." This leaves 828.

If they still make you look bad, whittle them down some more...

Of the 828, exclude 470 as not meeting your "case definition." ("The first nonneonatal seizure or episode of encephalopathy that resulted in a Medicaid reimbursement." Hence an "event" was excluded if judged to be a "neonatal seizure" (?). This is a completely arbitrary act by the authors. The 470 excluded children consisted of "34 neonatal seizures only, 160 instances of a chronic preexisting neurological abnormality without seizures (in a 2-3 month old baby??), 18 spells that were not *clearly* seizures, 82 diagnoses of failure to thrive, 121 other non-neurological events, and 65 miscoded records." This leaves 358.

If the numbers still make you look bad, don't stop now...

2 children who developed encephalopathy more than 2 weeks after the shot were excluded from the study. This leaves 356. Then make the following conclusions:

"The prevalence of...neurological defects is the same whether the children are immunized or not."

Few authors report financial interests

Any promising discovery—be it a drug, software advance, or novel catalyst—can attract investors willing to help transform that inspiration into a bankable product. Journal readers are often understandably curious, therefore, whether authors exaggerate a claim of research success in hopes of increasing financial gain. This has been prompting publications to develop financial-disclosure guidelines for their authors. However, a new study finds, in more than 70 percent of journals with such policies, not a single author reported such financial ties in 1997.

This might mean that the vast majority of reported work had no corporate influence or bias. More likely, says Sheldon Krimsky of Tufts University in Medford, Mass., authors are simply failing to report potential conflicts of interest. Indeed, research that his team reported last year showed that some 34 percent of all Boston-area authors who published papers in 14 major journals during 1992 had financial stakes in the outcome of the research—even though none disclosed those stakes in the articles.

Krimsky and L.S. Rothenberg of the University of California, Los Angeles have now updated their study and expanded its focus to 1,400 of the research community's high-profile journals. By 1997, they found, 215 publications had a formal financial-disclosure policy for their authors. The pair then examined every article published in 210 of these journals. The other five were not available to the researchers.

The 184 journals in the group that were peer-reviewed published a total of 61,594 articles. In only 327 articles—just 0.53 percent—did any author acknowledge a potential for financial gain from the reported work. When Krimsky and Rothenberg included articles published in the non–peer-reviewed journals, the disclosure rate was still just 0.55 percent.

Their new survey turned up an equally provocative highlight. Five biomedical journals required authors to check off a box alongside a formal statement that best characterized their commercial ties. On average, Krimsky and Rothenberg found, 13 percent of the authors filled in boxes indicating they had at least the potential for direct financial gain from their research.

Because "there is no reason to believe that these journals have authors who are more involved than usual in commercial activities," Krimsky concludes that such "templates are especially effective at eliciting disclosures." —*J.R.*

An analysis of the CDC's own data demonstrates that the number of actual injuries from the rotavirus vaccine is 500 times the injuries reported to VAERS

In article <7ntm9s$e0v$1@nnrp1.deja.com, andysch@my-deja.com wrote: An analysis of the CDC's own data demonstrates that the number of actual injuries from the rotavirus vaccine is 500 times the injuries reported to VAERS:
From http://www.cdc.gov/epo/mmwr/preview/mmwrhtml/mm4827a1.htm:

VAERS reported "11 developed intussusception within 1 week of receiving RRV-TV" out of 1.8 million doses administered, which is a rate of about 0.6 out of 100,000. Kaiser Permanente studied the rate for its patients and found that "Among children who had received RRV-TV during the previous week, the rate was 314 per 100,000 infant-years." Minnesota did a study in its state and found that "the observed rate of intussusception within 1 week of receipt of RRV-TV was 292 per 100,000 infant-years."

Hence the actual rate of this adverse effect from the rotavirus vaccine was about 300/0.6 = 500 times the rate reported through VAERS! From the CDC at http://www.immunize.org/nslt.d/n18/vaers.htm: "VAERS currently receives approximately 800-1000 reports each month." Based on the above data, the actual adverse effects following vaccines could easily be 500 times the reported effects, or 500,000 per month.

So why is only the rotavirus vaccine being halted based on the above data, and not the Hepatitis B and chickenpox vaccines as well? Do we have to wait for Kaiser Permanente to study them, while the injuries accrue nationwide? Perhaps Kaiser Permanente, like its fellow California HMO PacifiCare, prefers to discourage unnecessary vaccines like the chickenpox vaccine (see http://www.insure.com/health/chickenpox.html). After all, the HMO may have to pay health costs for the unnecessary adverse reactions.

The Dept of Justice website strategic goals for this department is to successfully DENY 85% of all monies claimed against the Government. And they don't set goals they can't easily achieve.

"The majority of preterm infants tolerated immunizations with DPT and HibC without ill effects. However, 12 (12%) infants experience a recurrence of apnea, and 11 (11%) had at least a 50% increase in the number of apneic and bradycardic episodes in the 72 hours after immunization."

(Sanchez and Laptook, et al. Journal of Pediatrics 1997,130:746-51)

Instead of hiding our heads in the sand to protect the status quo, it is time to admit that the US Government has failed the American public by not funding adequate studies to determine the long-term affects of vaccines on our children and future generations.

We have yet to conduct adequate scientific research to rule out a connection between vaccines and autism, or to determine whether low-birth weight or pre-term babies should receive the same dose of vaccine and use the same shot schedule.

We have not funded studies or research to indicate whether it is okay to vaccinate a child who has repeated ear infections and rounds of antibiotics, or to determine what children are likely to be adversely affected by vaccines.

US Rep. Dan Burton. April 24, 2000 LA Times

"How confident in the safety and need for specific vaccines would doctors and parents be if they learned the following:

1. That members, including the Chair, of the FDA and CDC advisory committees who make these decisions own stock in drug companies that make vaccines.

2. That individuals on both advisory committees own patents for vaccines under consideration or affected by the decisions of the committee.

3. That three out of five of the members of the FDA's advisory committee who voted for the rotavirus vaccine had conflicts of interest that were waived.

4. That seven individuals of the 15 member FDA advisory committee were not present at the meeting, two others were excluded from the vote, and the remaining five were joined by five temporary voting members who all voted to license the product.

5. That the CDC grants conflict-of-interest waivers to every member of their advisory committee a year at a time, and allows full participation in the discussions leading up to a vote by every member, whether they have a financial stake in the decision or not.

6. That the CDC's advisory committee has no public members - no parents have a vote in whether or not a vaccine belongs on the childhood immunization schedule. The FDA's committee only has one public member.

These are just a few of the problems we found."

Opening Statement http://www.house.gov/reform/hearings/healthcare/00.06.15/index.htm Chairman Dan Burton Committee on Government Reform "FACA: Conflicts of Interest and Vaccine Development: Preserving the Integrity of the Process" Thursday, June 15, 2000 1:00 PM 2154 Rayburn House Office Building Washington, DC 20515

The federal Vaccine Adverse Event Reporting System (VAERS) received a total of 54,072 reports of 'adverse events' (defined as diseases, injuries or deaths) - at least 471 deaths – following vaccination in a 43-month period from 4/90 to 11/93. At least 1,094 deaths were reported from 1990 to 1997. Vaccines have consistently killed about 3 children per week since the reporting system began. CFIC Vaccination Draft dated April 15th

Approximately one-half of the hundreds of parents who call our office each month report that their child became autistic shortly after receiving a vaccination. Portia Iverson, founder and president of the Cure Autism Now [CAN] foundation in Mothering July/August 1998 p.46

Using the coercive apparatus of the state to force people to submit to the ministrations of doctors of medicine is persecution in the name of health, exactly as using the coercive apparatus of the state to force people to submit to the ministrations of doctors of divinity was persecution in the name of God. Thomas Szasz, M.D. *Reason*, June 1998 p.11

While prenatal care clearly has some benefits, the public health and clinical community may have oversold the idea of increasing prenatal care utilization as a way of decreasing low birth weight and preterm delivery. There is little reason to believe that simply increasing utilization of prenatal care would have the desired effects on pregnancy outcomes. Benefits and Limitations of Prenatal Care. Editorial. JAMA May 27, 1998 Vol. 279, No.20

From the British government:
The policy of encouraging all women to give birth in hospitals cannot be justified on grounds of safety.... It is no longer acceptable that the pattern of maternity care provision should be driven by presumptions about the applicability of a medical model of care based upon unproven assertions.... Hospitals are not the appropriate place to care for healthy women.... We recommend that the Department of Health vigorously pursue the establishment of best practice models of team midwifery care.... [House of Commons, Session 1991-92, Health Committee, Second Report, Maternity Services, Vol. 1, March 4, 1992, HMSO, London.]

"Much of what you have been led to believe about immunizations simply isn't true. I not only have grave misgivings about them; if I were to follow my deep convictions...I would urge you to reject all inoculations for your child. I won't do that, because parents in about half the states have lost the right to make that choice. Doctors, not politicians, have successfully lobbied for laws that force parents to immunize their children as a prerequisite for admission to school."

Robert Mendelsohn, M.D. (The medical time bomb of immunization against disease. East West Journal/November 1984)

Robert Mendelsohn, M.D.

"For a pediatrician to attack what has become the 'bread and butter' of pediatric practice is equivalent to a priest's denying the infallibility of the pope."

"The greatest threat of childhood diseases lies in the dangerous and ineffectual efforts made to prevent them through mass immunization...There is no convincing scientific evidence that mass inoculations can be credited with eliminating any childhood disease...There are significant risks associated with every immunization and numerous contraindications that make it dangerous for the shots to be given to your child...

"It is commonly believed that the Salk vaccine was responsible for halting the polio epidemics that plagued American children in the 1940s and 1950s. If so, why did the epidemics end in Europe, where polio vaccine was not so extensively used?

"While the myriad short-term hazards of most immunizations are known (but rarely explained), no one knows the long-term consequences of injecting foreign proteins into the body of your child. Even more shocking is the fact that no one is making any structured effort to find out.

"<u>Have we traded mumps and measles for cancer and leukemia?</u>"

How To Raise A Healthy Child In Spite Of Your Doctor, Robert Mendelsohn, M.D. Contemporary Books: Chicago 1984

A major cause of the Roman Empire's decline, after six centuries of world dominance was its replacement of stone aqueducts by lead pipes for the transport and supply of drinking water. Roman engineers, the best in the world, turned their fellow citizens into neurological cripples. Today our own "best and brightest," with the best of intentions, achieve the same end through childhood vaccination programs yielding the modern scourges of hyperactivity, learning disabilities, autism, appetite disorders, and impulsive violence.

—Harris L. Coulter, Ph.D.

WHAT'S IN A VACCINE?

"Vaccines consist of a solvent and live or attenuated biological material. Solvent is a saline solution containing **formaldehyde, aluminum hydroxide** or **aluminum phosphate, mercury compound (thiomersal),** all of which are highly noxious substances. There is no safe level of formaldehyde injected into a living body.
Added into the solvent are live or attenuated viruses (foreign bodies, foreign proteins). Everybody knows that the body will mount a reaction to expel any foreign substances which enter the living organism, and just about everyone knows about anaphylactic reaction. However, fewer people know that injecting any foreign substance into the body results in a sensitization to that substance. Vaccines do not immunize, they sensitize." Scheibner, (12/12/93, personal communication):

Vaccines are produced (cultured) on live animal or human tissue. By virtue of this they are inevitably contaminated by a host of animal and human viruses which were not intended to form part of the vaccines. There is no way to get them out without totally destroying the virus or bacterium which is supposed to be in the vaccines. A viable residue of these always remains. To mention just a few examples: simian viruses like SV-40 have been found and extensively studied in polio vaccines. Indeed millions of American children were found to contain antibodies to SV-40 which was also found to be cancer-producing in a number of animal speciesand in humans. It has been demonstrated that the batches of polio vaccine tested in certain African countries contained another simian contaminant: the simian immunodeficiency virus (SIV) suspiciously and ominously similar to the co-called human immunodeficiency virus (HIV). It is not coincidental that these nations and tribes are now dying of AIDS.

Childhood Vaccination
Questions All Parents Should Ask

1. Are vaccinated children healthier than unvaccinated children?
2. Do vaccines have any long-term side effects or damage that may not surface for months or years?
3. Can vaccines cause cancer or fertility problems?
4. Do vaccines cause SIDS (Sudden Infant Death Syndrome also known as Crib Death)?
5. What are the chances that my child may be hurt or killed by a vaccine?
6. Do the assumed benefits of vaccination outweigh the risks?
7. Didn't vaccines get rid of acute infectious childhood diseases?
8. What about polio? Wasn't it eliminated due to vaccination?
9. Was the polio shot given in the 50's and 60's contaminated with monkey virus? Is it causing cancer?
10. Are there any benefits to a child having acute infectious childhood diseases?
11. Are the ingredients in vaccines safe?
12. How do vaccines work on a cellular level?
13. How do vaccines affect the immune system on a cellular level?
14. How do vaccines affect the nervous system on a cellular level?
15. How do vaccines cause damage on a cellular level?
16. Do vaccines affect genetic material? Can vaccines we (or our children) receive today affect our grandchildren or great grandchildren?
17. Are multiple vaccines safe?
18. Is there a conflict of interest in vaccine policy decisions?

(The answers are discussed in detail. To get a copy see www.korenpublications.com. Also on the web site are vaccine articles free to download or copy)

One of the clearest examples of science/government collusion and disregard of the safety and health of the American people was the case of a family with three children in Middletown, Ohio. Two of the three chldren were killed by vaccination with DPT. In spite of this terrible tragedy, state authorities demanded that the third child be vaccinated!

The mother refused to offer another child sacrifice at the altar of vaccination science. Not recognizing the utter preposterousness of their position (bureaucrats are like that), they threatened her with "legal action" if she did not give her child up for almnost certain permanent crippling or death.

Because of the arrogance and utter irresponsibility of the health officials in this case, even a generally quiescent and submissive press had endured enough and gave this shocking story of government arrogance wide publicity. The bureaucrats backed off and the mother has heard no more about the absolute necessity for vaccination of her only surviving child.

As Dr. Harris Coulter so aptly put it: "Since the repeal of compulsory military service, compulsory vaccination is the only time an American is asked to risk their life for their country."

William Campbell Douglas, MD

NO SUBSTANTIAL DIFFERENCE B/W DTP AND DTaP VACCINES

There is a refrain about the acelullar Pertussis vaccine that has been used in this last six years: it is sure, without any risk. The old cellular vaccine was terrible.

Well, now we can read what is written in a document by the Italian Institute of Health (ISS) titled:

'Progetto Pertosse 1992-1994 - Rapporto Istisan'

(Pertussis Project 1992-1994 - Istisan Report). In this study ISS tested (often without informed consent) the new acellular vaccine on more of 15.000 children. The conclusion was (pag. 18): "The frequency of severe adverse reactions was exactly identical for the two vaccines, acellular and cellular."

Secrets From A Vaccine Lawyer

I am observing, with great interest, the insidious campaign by the pharmaceutical industry to paint the picture of hysterical parents and crazed elements in our society, banding together to bash our nations "valued vaccine supply." Historically, in the early 1980's Wyeth, Lederle, and Connaught were under seige by parents of brain damaged children, and their greedy lawyers. These evil people were trying to make the public aware of the dangers of DTP vaccine, and the incredible threat that that particular vaccine presented to our children. According to the parents of the children affected, and their greedy lawyers, the DTP vaccine was impure, varied in potency from lot to lot, and was lethal to too many children, while, at the same time, the pharmaceutical companies had technology available to them since the early 1930's to make it safer.

As one of the "greedy lawyers," I have represented over 400 families whose lives have been forever altered by the course of corporate greed on the part of the manufacturers. There can be no question that there is adequate proof of causation, especially if congress is willing to pay billions of dollars under the Vaccine Compensation System (which also is very broken). The company documents that I have seen have demonstrated that they knew the vaccines were bad, and did little to nothing to control and improve it. I can not discuss many of the specifics, as there are certain orders of courts that I am under, but let it suffice to say that I still have many cases pending against the manufacturers, and they are relentless adversaries!

On April 4, 2000 in Marshall Texas we will be on trial against Lederle Labs. This will be the first trial against a manufacturer, since the early 1990's There will be a lot of interesting things happening in that trial that I can not discuss....but if some of you were in court, you could see it for yourselves and then the shroud of secrecy would be gone.

Mike Hugo
mhugo@hugoandpollack.com

VACCINES.

What you <u>don't</u> know could hurt your child.

"When it happens to your child, the risks are 100%"

Learn More.

1-800-909-SHOT

National Vaccine Information Center
512 W. Maple Ave. #206
Vienna, VA 22180

A national, non-profit organization dedicated to preventing vaccine injuries and deaths through education.
Written information available upon request.

"In regions in which there is no organized vaccination of the population, general paralysis is rare. It is impossible to deny a connection between vaccination and the encephalitis (brain damage) which follows it."

Journal of the American Medical Association July 3, 1926, p.45

"No batch of vaccine can be proved safe before it is given to children."

Surgeon General of the United States Leonard Scheele, addressing an AMA convention in 1955

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

Dr. James A. Shannon, National Institutes of Health

"The decision to have your children vaccinated is yours, alone, to make."

Parents Guide to Childhood Immunization, page 5, USPHS/CDC, 1977.

"The chances of getting Alzheimer's Disease is ten times higher if an individual has had five consecutive flu shots between 1970 and 1980 (the years studied) than if they had one, two or no shots."

Hugh Fudenberg, M.D. [redacted]. immunogeneticist. NVIC First International Conference, September 1997, Arlington, Virginia. Dr. Fudenberg stated that it might be because of the mercury and aluminum in the vaccines. Mercury and Aluminum are present in childhood vaccines.

Neuroimmuno Therapeutic Research Foundation,
Spartanburg, S.C.
864-591-0944

Immunologic findings in children with abnormal reactions after vaccination

Cesk Pediatr 1993 Jan;48(1):9-12 Dankova E, Kasal P, Bergmannova V, Stehlikova J, Domorazkova E Detska klinika, Fakultni nemocnice v Motole, Praha. [Article in Czech]

In a group of 89 children with abnormal reactions after administration of the mixed vaccine against diphtheria, tetanus and whooping cough, after the mixed vaccine against diphtheria and tetanus, the live measles vaccine and oral poliovaccine, a detailed analysis was made of the case-history, and basic parameters of cellular and humoral immunity were examined. In these children the intensity of post-vaccination reactions was beyond the range of accepted criteria of mild and medium reactions or complications. In 17.3% of the children with an abnormal reaction after the mixed vaccine against diphtheria, tetanus and whooping cough a reduced IgA level was proved, while in the control group a reduced level was found only in 3.3%. 50% of the children who developed an abnormal reaction after the oral poliovaccine and the mixed vaccine against diphtheria, tetanus and whooping cough and at the same time some relative suffered from clinical signs of atopia, a reduced number of E rosettes of lymphocytes was recorded. 80% of the children who developed an abnormal reaction after the measles vaccine and some relative suffered from atopic disease, had low titres of specific antibodies against tetanic toxoid. Evidence was provided that children with certain precisely defined abnormal reactions after vaccination suffered significantly more frequently from reduced immune reactivity than children examined because of a suspected immunity defect.

An example of the medical profession's unwillingness ever to admit fault is seen in the history of bloodletting. Phlebotomy was phased out slowly in the end of the 19th century and beginning of the 20th century, but it was never stated to have been an error; indeed, the medical profession held, in the late 19th century, that the "nature of diseases" had changed from earlier times, that bloodletting was justified then, but was no longer needed in the new circumstance.
Harris Coulter Ph.D. medical historian. Personal correspondence to Tedd Koren, D.C.

"When it comes to vaccine-related deaths and injuries, the prevailing attitude among physicians is, 'What must not be, cannot be.'" W. Ehrengut, M.D.

"Much of what you have been led to believe about immunizations simply isn't true. I not only have grave misgivings about them; if I were to follow my deep convictions...I would urge you to reject all inoculations for your child. I won't do that, because parents in about half the states have lost the right to make that choice, Doctors, not politicians, have successfully lobbied for laws that force parents to immunize their children as a prerequisite for admission to school." Robert Mendelsohn, M.D. The medical time bomb of immunization against disease. East West Journal November 1984.

"Immunizations, including those practiced on babies, not only did not prevent any infectious diseases, they caused more suffering and more deaths than has any other human activity in the entire history of medical intervention." Viera Scheibner, Vaccination. The Medical Assault on the Immune System.

Now that the draft has been abolished, mandatory vaccination remains the only time an American is asked to risk his life for his country. Harris L. Coulter, Ph.D.

Medical Nemesis by Ivan Illich, Ph.D.

Bantam Books: New York 1976
(Chapter 1 – The Epidemics of Modern Medicine)

The combined death rate from scarlet fever, diphtheria, whooping cough, and measles among children up to fifteen shows that nearly 90% of the total decline in mortality between 1860 and 1965 had occurred before the introduction of antibiotics and widespread immunization.

In part this recession may be attributed to improved housing and to a decrease in the virulence of micro-organisms, but by far **the most important factor was a higher host resistance** due to better nutrition.

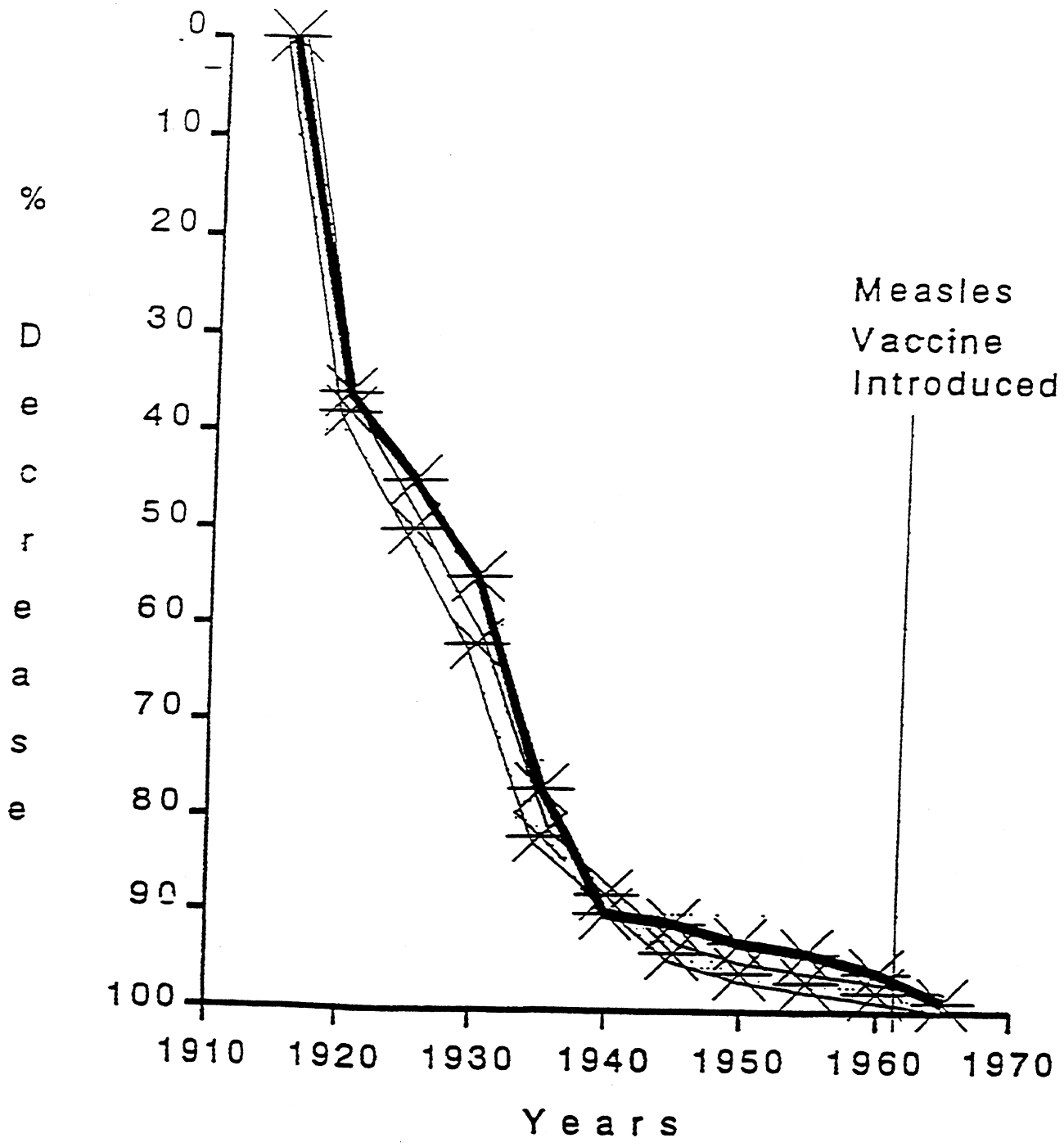
In poor countries today, diarrhea and upper-respiratory-tract infections occur more frequently, last longer, and lead to higher mortality where nutrition is poor, **no matter how much or how little medical care is available.**

The study of the evolution of disease patterns provides evidence that during the last century doctors have affected epidemics no more profoundly than did priests during earlier times. Epidemics came and went, imprecated by both but touched by neither.

Figure 5:

The MEASLES DEATH RATE DECREASED by MORE THAN 95% *BEFORE* the VACCINE WAS INTRODUCED

(Figures are from 1915 to 1958)

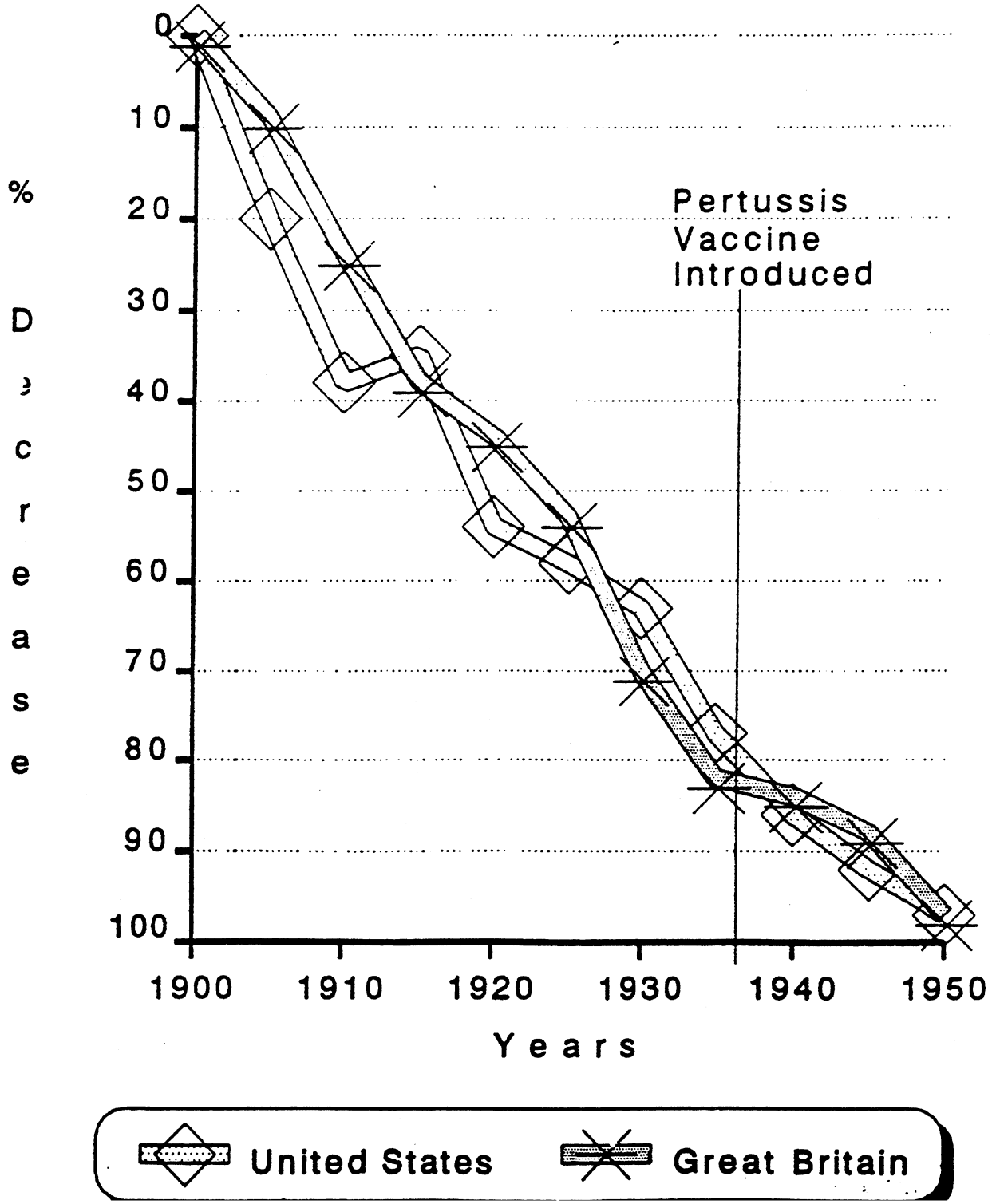


 By Neil Miller

Figure 7:

The PERTUSSIS DEATH RATE DECREASED by MORE THAN 75% *BEFORE* the VACCINE WAS INTRODUCED

(Figures are from 1900 to 1935)

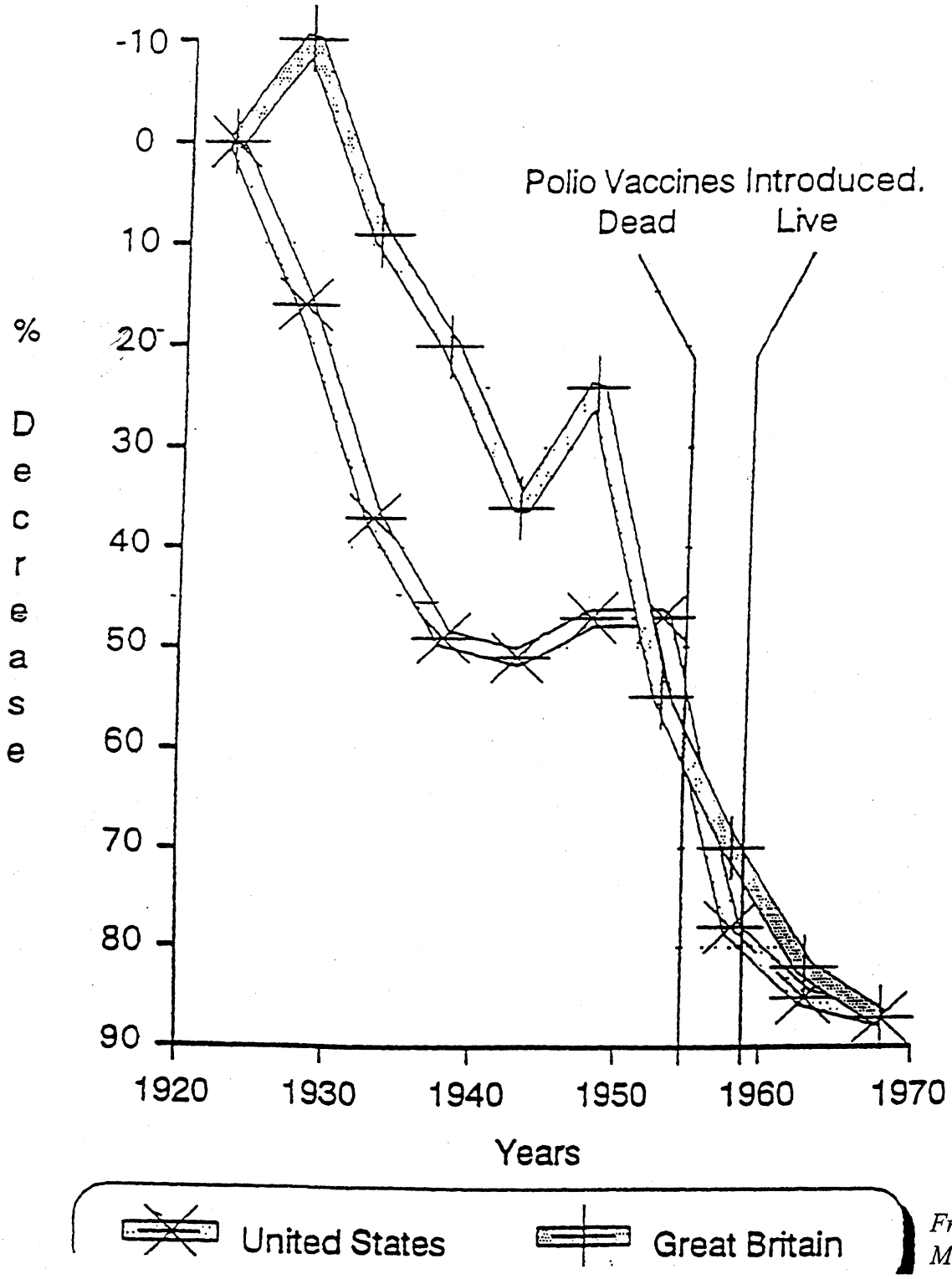


Vaccine was not in widespread use until the '50s.

Figure 1:

The Polio Death Rate Was Decreasing On Its Own Before the Vaccine Was Introduced

(Figures are from 1923 to 1953)

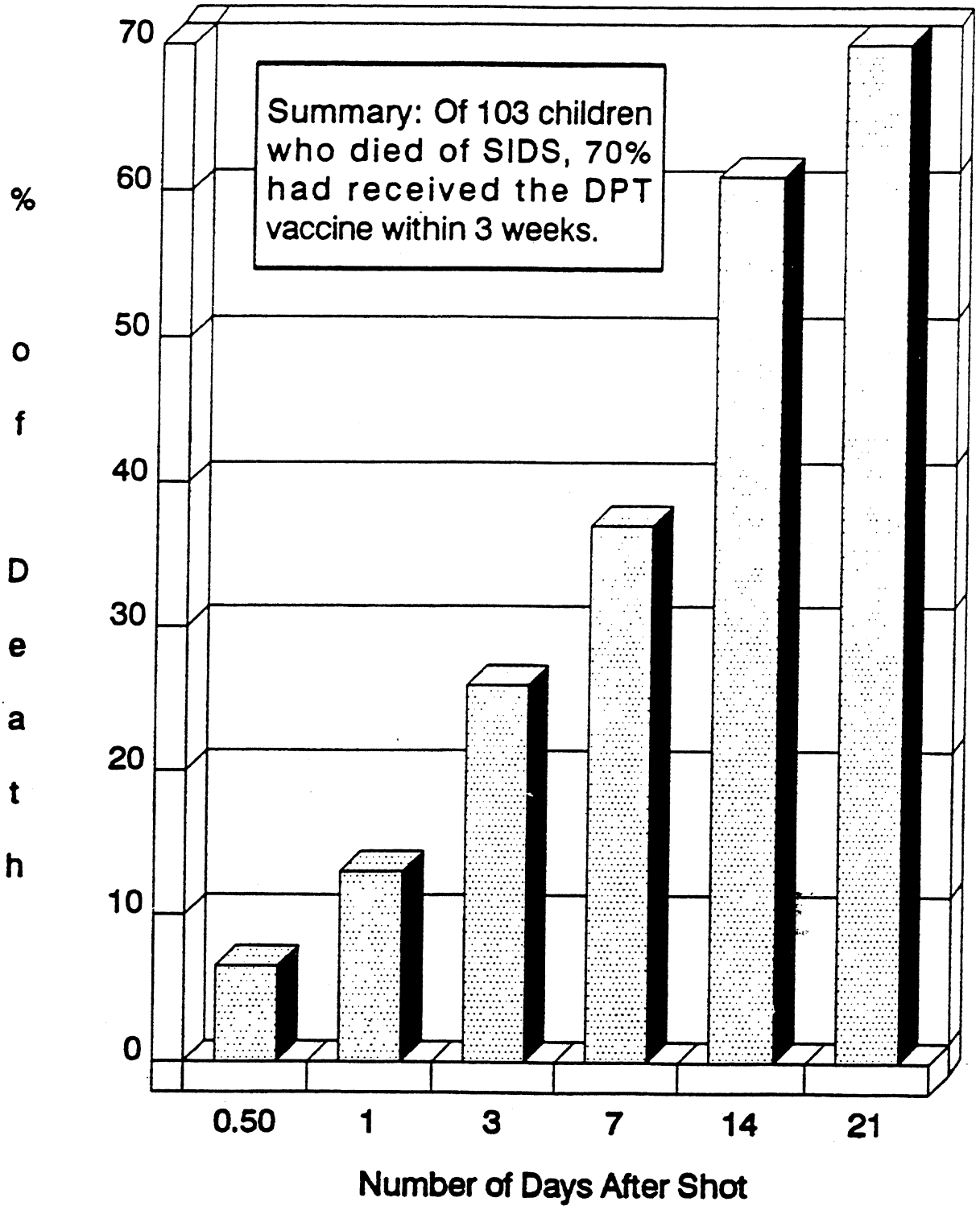


From: Miller

Figure 10:

PERTUSSIS VACCINE and SUDDEN INFANT DEATH SYNDROME (SIDS)

(A Correlation Study)



SOURCE: Cournoyer, C: What About Immunization? Exposing The Vaccine Philosophy; pp 36-43

Per Year in the U.S. of Children Vaccinated With DPT

RATES OF REACTION PER NUMBER OF CHILDREN

- 1 in 20 persistant Crying
- 1 in 66 high fever
- 1 in 180 high pitched screaming
- 1 in 350 convulsions
- 1 in 350 shock or collapse
- 1 in 22,000 acute brain disorder
- 1 in 62,000 permanent brain damage
- 1 in 71,600 death

Number of Children Affected Per Year	Symptoms
35,000	
11,000-12,000 per year may go on to exhibit these conditions, (which could include)	developmental delay learning disabilities hyperactivity behavior disorder autism epilepsy profound retardation

- There is a 94 times greater risk of dying from the vaccine than from whooping cough itself
- There is a 3,888 times greater risk of acquiring long-term damage from the vaccine than from whooping cough itself.

And if that doesn't shock you, there are about 10 deaths per year from the disease and at least 943 deaths per year from the vaccine.

There are only 3 cases of long-term damage from the disease per year, but at least 11,666 cases of long-term damage per year from the vaccine.

Mothering, Winter 1997.
Dear Mothering,

I teach anatomy, physiology, human development, and research methods and design at Bastyr University. Over the past two years, student interest and the safety, efficacy, and suitability of childhood vaccinations has increased dramatically.

When our daughter was born, my husband and I read everything we could find on the subject and decided that I would breastfeed her for at least a year, then consider selective vaccinations. At her eight-week examination, the MD interrupted me as I explained our decision. She began yelling and proceeded to tell me of a pertussis outbreak at a nearby elementary school. I asked her if the children had been vaccinated, and she said, "Of course, but that's irrelevant." She then stormed out of the room, saying she couldn't ethically be my child's pediatrician and that I should find someone else.

The chief pediatrician at the practice apologized for the incident and promised to reprimand my daughter's doctor, but, more importantly, he set up a meeting between the direction of vaccination research at the medical center and my husbband and I. Later, this doctor told us that he agreed with our decision and even confided that he had stopped vaccinating his own children after the first shot because they developed fevers and it scared him.

Our three year old has never had a fever, ear infection, or been seriously ill, and she is unvaccinated. Her one-year-old sister is healthy and happy, too. Neither are vaccinated. I breastfed both of them, and we minimized contact with other children for the first six months. In addition, my children have never been enrolled in a daycare. These are small prices to pay for great, healthy kids!
W. Nelson, PhD
Seattle, Washington

Acute Poliomyclitis

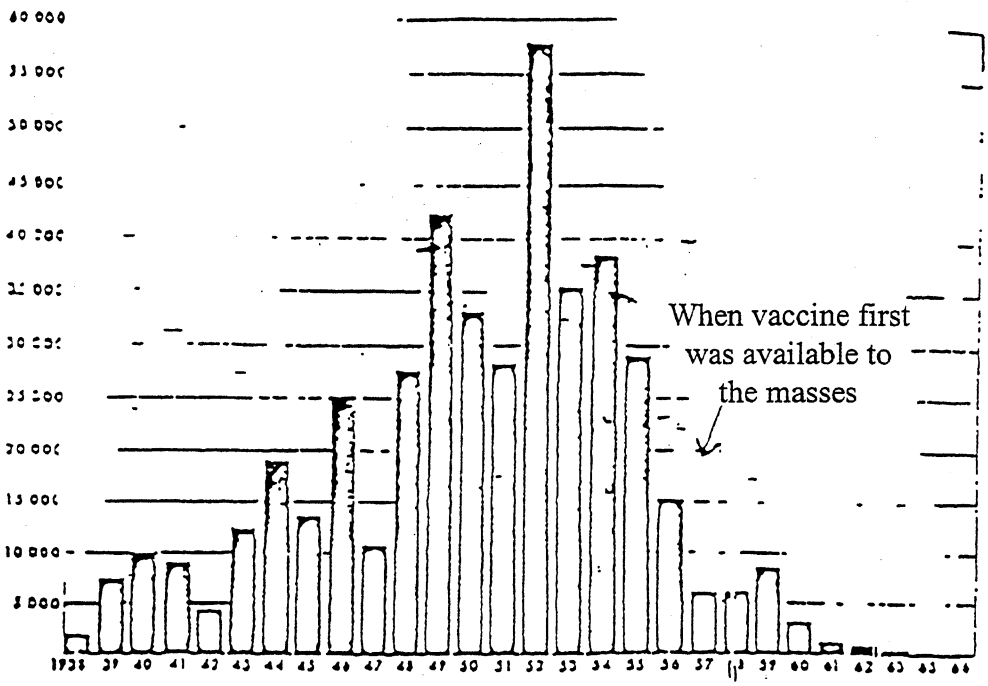


Fig. 1 - Annual incidence of poliomyclitis from 1938 to 1965. All reported cases in U.S.A.
(From U.S. Public Health Service Reports)

In U.S., 1982, 9,027 cases of ASEPTIC MENINGITIS (Polio)

DISEASE	52nd WEEK ENDING			CUMULATIVE, FIRST 52 WEEKS		
	January 2 1982	December 27 1980	MEDIAN 1976-1980	January 2 1982	December 27 1980*	MEDIAN 1976-1980
Aseptic meningitis	91	92	99	9,027	7,774	6,496

POLIO STATISTICS

Date	Meningitis	Polio
July 1955	50	273
July 1961	161	65
July 1963	151	31
Sept. 1966 [1]	256	5
Oct. 15, 1962 [2]	312	3

Notes: [1] Figures indicate five year median.
[2] Includes cases reported in last two years.

"Most cases reported prior to July 1, 1958, as non-paralytic poliomyelitis are now reported as viral or aseptic meningitis."

Source for data: Los Angeles County Halth Index: Morbidity and Mortality, Reportable Diseases.

How Many Cases Of Polio are Occurring in the U.S. Today?

It is reported that there are 8 - 10 cases of vaccine - associated poliomyelitis (VAPP) each year in the United States.

However, families living through the epidemics knew plenty of things happened to those infected. Some had very mild cases and quickly returned to 'normal' and their activities, others had major problems and did not go home for months, others even died.

Our curiosity thus was aroused and we commissioned an OPV Vaccine Report and started making all kinds of other inquires. The OPV Vaccine report that we received was a shocking report. The following is the summary a less than 5 year period:

The number of Vaccine Associated events that occurred:	**13,641**
The number of events requiring emergency room visits	**6,364**
The number of life threatening events	**236**
The number of events requiring hospitalization	**1,726**
The number of events with unknown recovery status	**1,695**
The number of events resulting in permanent disability	**133**
The number of events resulting in death	**540**

We have exposed this nonsense of 8-10 cases of vaccine associated Poliomyelitis (VAP) each year' for what it is and as the saying goes we seem to have opened Pandora's Box. We also wonder how a figure of 8-10 VAP per year can be arrived at when there are in a full 5 years over 1,695 events (330 events per year) with unknown recovery status. How can any figure be valid with so many unknowns?

Also, the report covering somewhat less than 5 years and since the Sabin Vaccine has been utilized starting in 1961 a period of almost 35 years has passed. Therefore, one can now multiply each of the above noted figures by about 7 to find out what the Sabin 'live' vaccine has cost us.

http://www5.ios.com/~w1066/poliov6.html#gordon
Polio Connection Of America
Po Box 182, Howard Beach, Ny, 11414

Dr. Bernard Greenberg, a biostatistics expert, was chairman of the Committee on Evaluation and Standards of the American Public Health Association during the 1950s. He testified at a panel discussion that was used as evidence for the congressional hearings on polio vaccine in 1962. He disputed claims for the vaccine's effectiveness. He attributed the dramatic decline in polio cases to a change in reporting practices by physicians.

"Prior to 1955 the diagnosis at that time in most health departments followed the World Health Organization definition: Spinal paralytic poliomyelitis: signs and symptoms of non-paralytic poliomyelitis with the addition of partial or complete paralysis of one or more muscle groups, detected on two examinations at least 24 hours apart."

In 1955 the criteria were changed to: residual paralysis 10 to 20 days after onset of illness and again 50 to 70 days after onset.... This change in definition meant that in 1955 we started reporting a new disease, namely, paralytic poliomyelitis with a longer-lasting paralysis.

Furthermore, diagnostic procedures have continued to be refined. Coxsackie virus infections and aseptic meningitis have been distinguished from paralytic poliomyelitis. Prior to 1954 large numbers of these cases undoubtedly were mislabeled as paralytic poliomyelitis. Thus, simply by changes in diagnostic criteria, the number of paralytic cases was predetermined to decrease in 1955-1957, whether or not any vaccine was used.

Polio-Cancer Connection

Government scientists learned by the late 1950s that the polio vaccines were contaminated with more than 40 monkey viruses and that one of these viruses, SV40, could cause cancer in rodents. The public was not notified; the contaminated vaccine was continued to be sold.

Between 1955 and 1963, tens of millions of American children and adults were given killed polio vaccines contaminated with SV40. By 1961, more than 90% of U.S. children and many millions of adults had received the vaccine.

In the past few years scientists have been culturing out DNA of SV40 from the tumors of children and adults with:

- rare ependymomas (brain tumors)
- osteosarcomas (bone tumors) and
- mesotheliomas (tumor of the lining of the lung and chest cavity).

Note: More than 2,000 Americans are suffering from mesotheliomas today as compared to very rare cases in 1960. Mesothelioma rates increase with age; the children who got polio vaccine in 1955 would be under 50 today and would not yet have reached the high risk age for mesotheliomas.
The National Cancer Institute has only collected data since 1973. Children who received the polio vaccine and died of cancer before 1973 are not known by them.
Howard Urnovitz, Ph.D., microbiologist and founder of Chronic Illness Research Foundation and Walter Kyle, Esq., author of a 1992 article in *The Lancet* assert that HIV-1 was created when live polio vacccines contaminated with simian immunodeficiency virus (SIV) were introduced into the human population in African experimental trials. Urnovitz maintains that SIV recombined with normal human genes and created a money/human hybrid retrovirus now known as HIV-1 and has suggested that an AIDS vaccine would not work because it would be "built against a normal human gene."
For more information contact: The National Vaccine Information Center 1-800-909-SHOT.

INCURABLE BONE CANCER MAY BE LINKED TO SV-4O POLIO VACCINE

The Daily Telegraph
Thursday October 21, 1999

An incurable bone cancer may be linked to contaminated polio vaccine and exposure to herbicides, a researcher said yesterday.

Multiple myeloma attacks bone marrow, has no cure and causes bone collapse, fractures and paralysis.

The head of the myeloma clinic at the Cedars-Sinai Centre in Los Angeles, Professor Brian Durie, said in Sydney that while the disease commonly affected people over 65, an increasing number of baby boomers were being diagnosed.

"In recent years we found that not only has the incidence [of the diseases[gone up, but it's occurring in somewhat younger people." he said.

Professor Durie believes evidence that some myeloma patients have a cancer-causing virus called SV40, which contaminated early batches of polio vaccine in the 1950s and 1960s, may explain why baby boomers are developing disease.

The email address of the Daily Telegraph is dtmletr@matp.newsltd.com.au

Oncogene (1994), 9, 1781–1790

Simian virus 40-like DNA sequences in human pleural mesothelioma

Michele Carbone[1]*, Harvey I. Pass[2], Paola Rizzo[1], MariaRita Marinetti[3], Marcello Di Muzio[3], Daphne J.Y. Mew[2], Arthur S. Levine[1], and Antonio Procopio[3]

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Mesotheliomas are pleural, pericardial, or peritoneal neoplasms frequently associated with asbestos exposure, and it is estimated that over the next twenty years up to 80,000 new cases are expected in the USA alone. We found simian virus 40-like DNA sequences in 29 of 48 mesotheliomas studied (60%) and demonstrated simian virus large-T antigen expression in 13 of 16 specimens. The matching lung samples did not contain simian virus 40-like sequences; however, they contained asbestos. These findings are to our knowledge the first demonstration of a physical link between DNA virus-like sequences and human mesothelioma. We suggest that a simian virus 40-like virus may act independently or as a co-carcinogen with asbestos. Moreover, the selective large T antigen expression by mesothelioma and not by the surrounding pulmonary parenchyma may have both diagnostic and therapeutic implications.

Introduction

Malignant mesothelioma is a tumor associated-with asbestos exposure which originates from the serosal lining of the pleural, peritoneal, or pericardial cavities. Survival from diagnosis is usually less than one year and none of the currently available therapeutic approaches has been shown to alter the natural history of this disease (for reviews see Henderson *et al.*,1992a; Antman *et al.*, 1993; Mew & Pass, 1993).

The incidence of malignant mesothelioma in Europe and in the United States until the 1940s was extremely low (Robertson, 1928; Fisher, 1931; Willis, 1938; Mark & Yokoi, 1991; H.L. Stewart, personal communication). Most pathologists at that time believed that mesotheliomas did not exist at all, but that neoplasmas involving the pleura always originated from other primary tumors, usually from "microscopic nodules of cortical broncho-pulmonary carcinomas" (Robertson, 1928; Fisher, 1931; Willis; 1938). During the second half of the twentieth century, the incidence of mesotheliomas increased dramatically (Wagner *et al.*, 1960; Mark & Yokoi, 1991; Mew & Pass, 1993). In an attempt to assess if the increased incidence of mesotheliomas resulted from increased awareness of this disease among pathologists and to determine the background level of mesotheliomas before the commercial use of asbestos, Mark & Yokoi, 1991, analyzed retrospectively the autopsy files of The Massachusetts General Hospital. In a 95 year review they recorded approximately 100 pleural mesotheliomas at autopsy, all of which occurred in the most recent 45 years, finding no evidence for background mesotheliomas prior to the commercial use of asbestos (Case record of the Massachussets General Hospital, 1947; Mark & Yokoi, 1991). Thus, it has been suggested that mesothelioma might be a "new disease" (Mark & Yokoi, 1991; H.L. Stewart, personal communication). The incidence of mesotheliomas continues to rise and they represent a serious threat to public health with approximately 2000-3000 cases per year in the United States (Antman et al., 1993). The prevalence of mesotheliomas in people with prolonged heavy exposure to asbestos is 2% to 10%, and the latency period between initial exposure and manifestation of disease is usually 20 to 50 years (Selikoff *et al.*, 1980; Lanphear & Buncher, 1992). It is not clear why only a relatively small proportion of people exposed to asbestos develop mesotheliomas, or why approximately 20% of patients with mesothelioma lack a history of asbestos exposure (Roggli, *et al.*, 1992c). Asbestos, however, is the only *known* agent that has been associated with the development of mesotheliomas, and appears to have different effects on different cell types, i.e. as a complete carcinogen on mesothelial cells, and more like a co-factor combined with cigarette smoke on bronchial epithelial cells (Churg, 1993). Although asbestos and cigarette smoke act in a multiplicative fashion to increase the risk of lung cancer, cigarette smoke itself is not associated with the development of mesotheliomas (Muscat & Wynder, 1991). It seems possible that as is described in lung cancer, additional as-yet-unknown factors might act as co-carcinogens with asbestos in the induction of mesotheliomas (Peterson et al., 1984; Roggli et al., 1992a).

The exact biochemical mechanism whereby asbestos can induce mesothelioma is unclear (Weitzman & Graceffa, 1984; Jaurand *et al.*, 1987; Weissman & Antman, 1989; Brown *et al.*, 1990; Mossman *et al.*, 1990; Roggli *et al.*, 1992a; Roggli *et al.*, 1992c; Antman *et al.*, 1993; Pass & Pogrebniak, 1993). In tissue culture, asbestos fibers can cause mutagenic events, including DNA strand breaks and deletion mutations, through the production of hydroxyl radicals and superoxide anions, and alter chromosome morphology and ploidy by mechanically interfering with their segregation during mitosis. Furthermore, macrophages will produce DNA-damaging oxyradicals following phagocytosis of asbestos fibers, and elaborate lymphokines which may depress the host immune response. Finally, asbestos fibers can mediate transformation of monkey cells by exogenous plasmid DNA (Appel *et al.*, 1988), and similarly facilitate transformation of mouse cells by simian virus 40 (SV40) (Dubes, 1993).

SV40 is a DNA tumor virus that induces tumors in rodents (Topp *et al.*, 1981), and immortalizes human mesothelial

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Use of Oral Poliomyelitis Vaccine Retards Environmental Polio Eradication Efforts

WESTPORT, CT (Reuters Health) Oct 27 - Attenuated polioviruses used in oral vaccines frequently revert to a more virulent type following vaccination and excretion into the environment, a Japanese team reports in the October 28th issue of *The Lancet.*

Until oral vaccine is replaced by inactivated polio vaccine, environmental poliovirus will probably not be eradicated, Dr. Hiromu Yoshida, of the National Institute of Infectious Diseases, in Tokyo, and associates conclude.

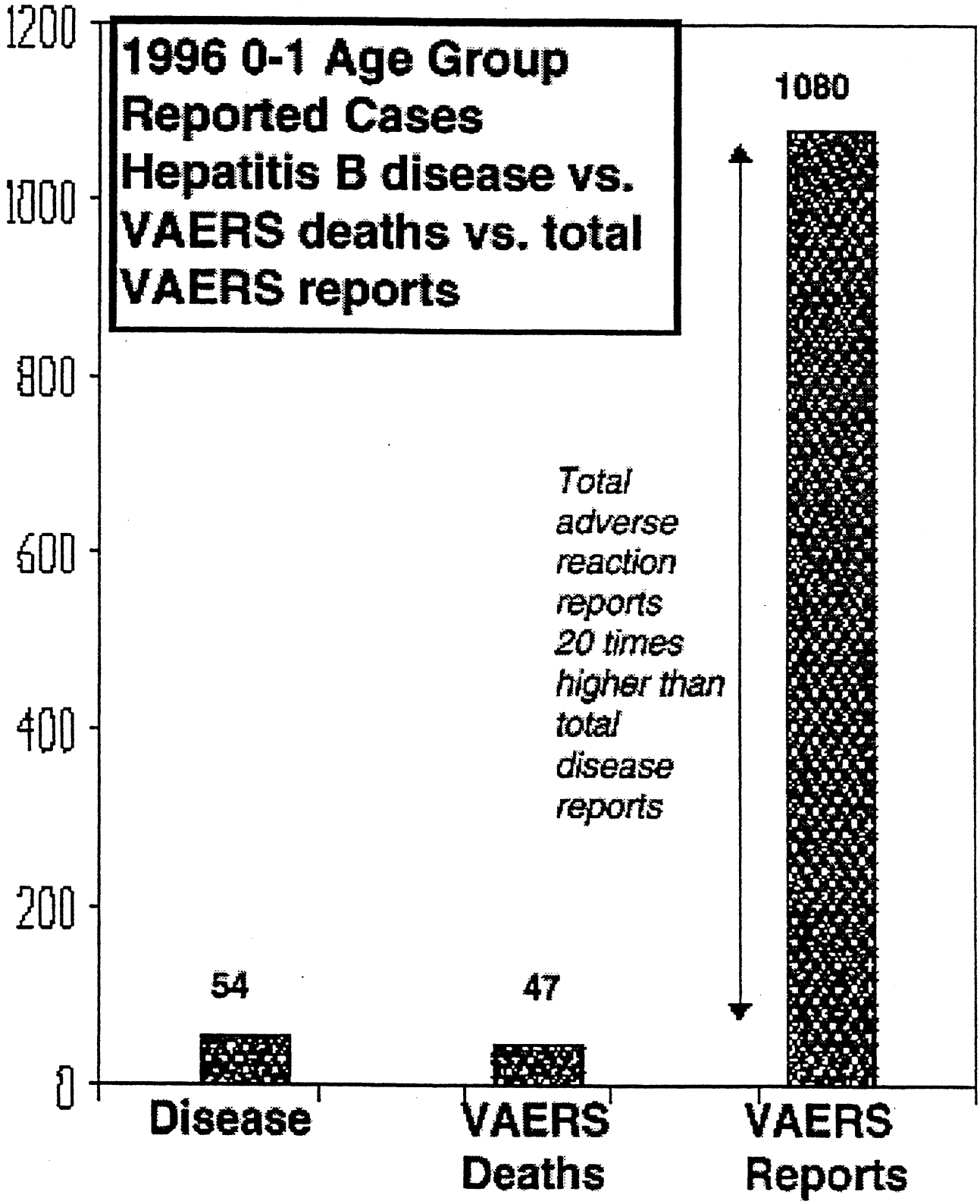
The investigators collected sewage and river water twice monthly between 1993 and 1995. Poliovirus was isolated by inoculating samples into three different cell types. Virulence of isolates was analyzed by polymerase chain reaction and restriction-enzyme cleavage, testing for 472-C revertants, the mutation for which the authors note increases the virus' neurovirulence.

Thirty-one type 3 poliovirus strains were isolated within about 3 months of local biannual immunization regimens, including three strains isolated from river water. The investigators found that these isolates were derived from vaccine strains.

More than half of the strains "contained 2% to 91% 472-C revertants, which is much higher than the stipulated 1% above which type 3 vaccine viruses are deemed unsafe," the investigators write. The proportion of 472-C revertants in the three river water isolates ranged from 88.1% to 90.7%.

Based on these findings, Dr. Yoshida's group concludes that susceptible individuals are at risk of infection with poliomyelitis if exposed to river water harboring the virulent type 3 strains.

Lancet 2000;356:1461-1463.


1996 0-1 Age Group
Reported Cases
Hepatitis B disease vs.
VAERS deaths vs. total
VAERS reports
1200
1000
800
600
400
200
0
54
47
1080
Total adverse reaction reports 20 times higher than total disease reports
Disease
VAERS Deaths
VAERS Reports

VACCINE ADVERSE EVENT REPORTING SYSTEM

VAERS

24 Hour Toll-free information line 1-800-822-7967
P.O. Box 1100, Rockville, MD 20849-1100
PATIENT IDENTITY KEPT CONFIDENTIAL

For CDC/FDA Use Only

VAERS Number _____

Date Received _____

Patient Name:

_____
Last First M.I.

Address

_____

_____

_____

_____
City State Zip

Telephone no. (_____)_____

Vaccine administered by (Name):

_____

Responsible Physician _____

Facility Name/Address

_____

_____

_____

_____
City State Zip

Telephone no. (_____)_____

Form completed by (Name):

_____

Relation to Patient ☐ Vaccine Provider ☐ Patient/Parent ☐ Manufacturer ☐ Other

Address *(if different from patient or provider)*

_____

_____

_____

_____
City State Zip

Telephone no. (_____)_____

1. State	2. County where administered	3. Date of birth mm dd yy	4. Patient age	5. Sex ☐ M ☐ F	6. Date form completed mm dd yy
		/ /			/ /

7. Describe adverse event(s) (symptoms, signs, time course) and treatment, if any

8. Check all appropriate:

- ☐ Patient died (date ___/___/___ mm dd yy)
- ☐ Life threatening illness
- ☐ Required emergency room/doctor visit
- ☐ Required hospitalization (_____days)
- ☐ Resulted in prolongation of hospitalization
- ☐ Resulted in permanent disability
- ☐ None of the above

9. Patient recovered ☐ YES ☐ NO ☐ UNKNOWN

12. Relevant diagnostic tests/laboratory data

10. Date of vaccination mm dd yy	11. Adverse event onset mm dd yy
/ /	/ /
Time _____ AM PM	Time _____ AM PM

13. Enter all vaccines given on date listed in no. 10

	Vaccine (type)	Manufacturer	Lot number	Route/Site	No. Previous doses
a.					
b.					
c.					
d.					

14. Any other vaccinations within 4 weeks of date listed in no. 10

	Vaccine (type)	Manufacturer	Lot number	Route/Site	No. Previous doses	Date given
a.						
b.						

15. Vaccinated at:
☐ Private doctor's office/hospital ☐ Military clinic/hospital
☐ Public health clinic/hospital ☐ Other/unknown

16. Vaccine purchased with:
☐ Private funds ☐ Military funds
☐ Public funds ☐ Other /unknown

17. Other medications

18. Illness at time of vaccination (specify)

19. Pre-existing physician-diagnosed allergies, birth defects, medical conditions (specify)

20. Have you reported this adverse event previously? ☐ No ☐ To health department ☐ To doctor ☐ To manufacturer

Only for children 5 and under

22. *Birth weight* _____ lb. _____ oz.

23. *No. of brothers and sisters*

21. Adverse event following prior vaccination (check all applicable, specify)

	Adverse Event	Onset Age	Type Vaccine	Dose no. in series
☐ In patient				
☐ In brother or sister				

Only for reports submitted by manufacturer/immunization project

24. *Mfr. / imm. proj. report no.*

25. *Date received by mfr. / imm. proj.*

26. *15 day report?* ☐ Yes ☐ No

27. *Report type* ☐ Initial ☐ Follow-Up

Health care providers and manufacturers are required by law (42 USC 300aa-25) to report reactions to vaccines listed in the Vaccine Injury Table.
Reports for reactions to other vaccines are voluntary except when required as a condition of immunization grant awards.

Form VAERS -1

"Fold in thirds, tape & mail - DO NOT STAPLE FORM"

NO POSTAGE NECESSARY IF MAILED IN THE UNITED STATES OR APO/FPO

BUSINESS REPLY MAIL

FIRST CLASS MAIL PERMIT NO. 1895 ROCKVILLE, MD

POSTAGE WILL BE PAID BY ADDRESSEE

VAERS
c/o Ogden BioServices Corporation
P.O. Box 1100
Rockville MD 20849-1100

DIRECTIONS FOR COMPLETING FORM

(Additional pages may be attached if more space is needed.)

GENERAL

- Use a separate form for each patient. Complete the form to the best of your abilities. Items 3, 4, 7, 8, 10, 11, and 13 are considered essential and should be completed whenever possible. Parents/Guardians may need to consult the facility where the vaccine was administered for some of the information (such as manufacturer, lot number or laboratory data.)
- Refer to the Vaccine Injury Table (VIT) for events mandated for reporting by law. Reporting for other serious events felt to be related but not on the VIT is encouraged.
- Health care providers other than the vaccine administrator (VA) treating a patient for a suspected adverse event should notify the VA and provide the information about the adverse event to allow the VA to complete the form to meet the VA's legal responsibility.
- These data will be used to increase understanding of adverse events following vaccination and will become part of CDC Privacy Act System 09-20-0136, "Epidemiologic Studies and Surveillance of Disease Problems". Information identifying the person who received the vaccine or that person's legal representative will not be made available to the public, but may be available to the vaccinee or legal representative.
- Postage will be paid by addressee. Forms may be photocopied (must be front & back on same sheet).

SPECIFIC INSTRUCTIONS

Form Completed By: To be used by parents/guardians, vaccine manufacturers/distributors, vaccine administrators, and/or the person completing the form on behalf of the patient or the health professional who administered the vaccine.

Item 7: Describe the suspected adverse event. Such things as temperature, local and general signs and symptoms, time course, duration of symptoms diagnosis, treatment and recovery should be noted.

Item 9: Check "YES" if the patient's health condition is the same as it was prior to the vaccine, "NO" if the patient has not returned to the pre-vaccination state of health, or "UNKNOWN" if the patient's condition is not known.

Item 10 and 11: Give dates and times as specifically as you can remember. If you do not know the exact time, please indicate "AM" or "PM" when possible if this information is known. If more than one adverse event, give the onset date and time for the most serious event.

Item 12: Include "negative" or "normal" results of any relevant tests performed as well as abnormal findings.

Item 13: List ONLY those vaccines given on the day listed in Item 10.

Item 14: List ANY OTHER vaccines the patient received within four weeks of the date listed in Item 10.

Item 16: This section refers to how the person who gave the vaccine purchased it, not to the patient's insurance.

Item 17: List any prescription or non-prescription medications the patient was taking when the vaccine(s) was given.

Item 18: List any short term illnesses the patient had on the date the vaccine(s) was given (i.e., cold, flu, ear infection).

Item 19: List any pre-existing physician-diagnosed allergies, birth defects, medical conditions (including developmental and/or neurologic disorders) the patient has.

Item 21: List any suspected adverse events the patient, or the patient's brothers or sisters, may have had to previous vaccinations. If more than one brother or sister, or if the patient has reacted to more than one prior vaccine, use additional pages to explain completely. For the onset age of a patient, provide the age in months if less than two years old.

Item 26: This space is for manufacturers' use only.

MOTHERING. January/February 1999. P. 23

Between ages 17 to 38 I went from private to major in the USAF, pioneered the B-52 and B-58 bombers, studied at eight major universities, retired, and became a doctor. I am now in my 27th year of practice as a family doctor and have been a lifelong observer of the transmission aspect of disease ever since I noted (in the 1940s) that the only GIs who "caught" meningitis were the freshly vaccinated recruits - the girls who worked in the PX and played "kissy face" with the young recruits never "caught" meningitis.

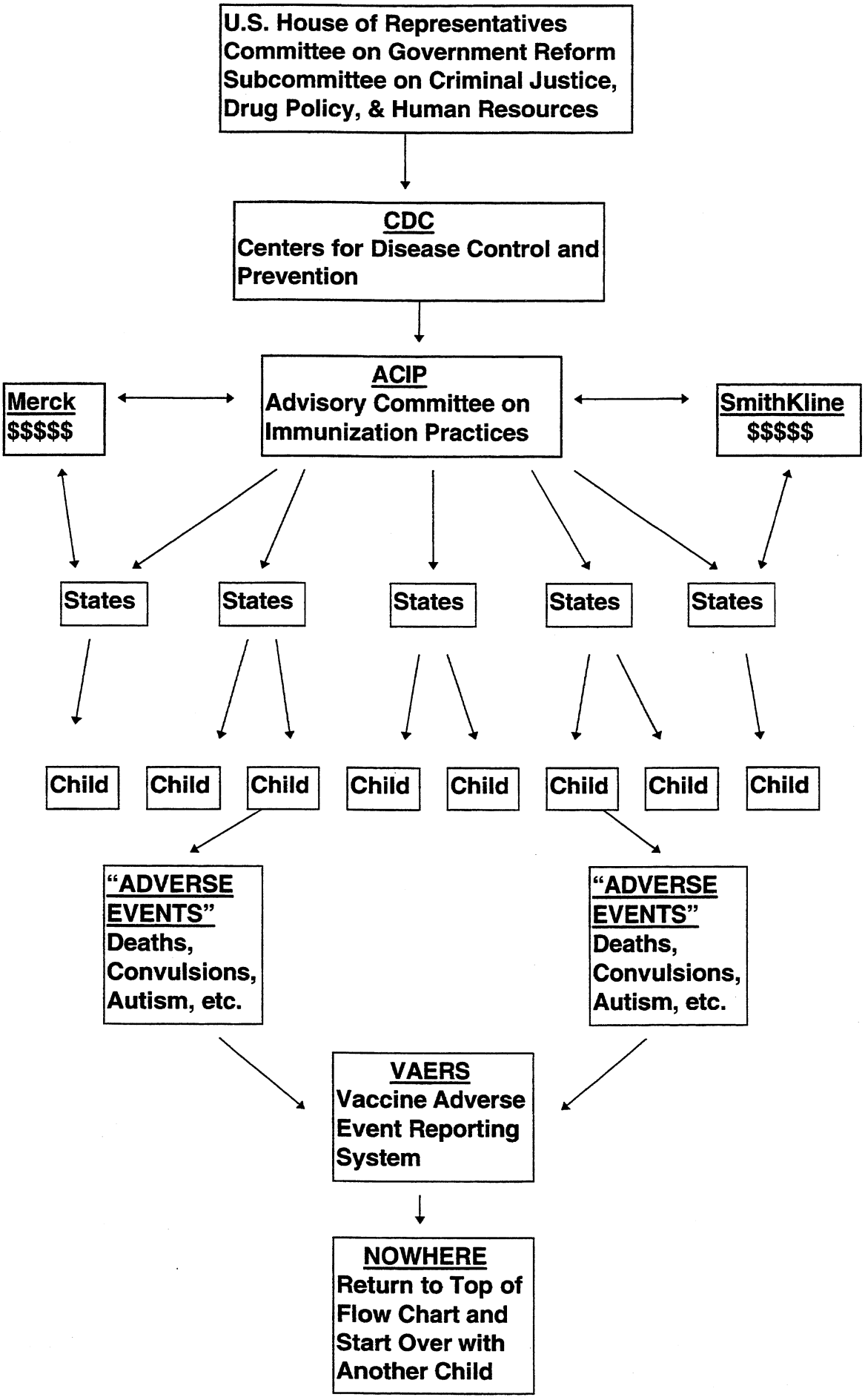
I have also investigated every single case of "infectious" hepatitis that crossed my path, and have never found a relative of the "infected" person to also have the disease.

Similarly I do not know of any doctor who has "caught" the disease from a patient, nor do I know of any doctor who has "caught" AIDS from a patient...

When a doctor or government employee can take control of your child's health and welfare because you have better common sense and are better informed then they are, the republic is in great danger.

Dr. Daniel H. Duffy Sr.
Geneva, Ohio

UNITED STATES VACCINATION POLICY FLOWCHART



American
Academy of
Pediatrics

141 Northwest Point Blvd.
P.O. Box 927
Elk Grove Village, IL 60009-0927
Phone (312) 228-5005

February 12, 1988

P. Roy Vagelos, M.D.
President & Chairman
Merck & Company, Inc.
P.O. Box 2000
Rahway, N.J. 07065-0900

Dear Dr. Vagelos:

Dan Branda from MSD's regional office delivered Merck's final pledge payment of $25,000 to the "Growth for the Future" campaign. We deeply appreciate your generous $100,000 grant, which has played a significant role in the success of the campaign.

We are also appreciative of the fine working relationship that we have had with your associates in addressing major child health issues. Thank you for your ongoing commitment to our activities and concerns.

Sincerely,

James E. Strain, M.D.
Executive Director

cc: Daniel Branda
Edward A. Fitzpatrick

IV 30

Benefits of Acute Diseases

Viera Scheibner, Ph.D.: "There is no need to protect children from contracting infectious diseases of childhood. These diseases are there to prime and mature their immune system."

"An unvaccinated child will have a couple of common colds within the first year of life while chronic ill-health, a constant stream of common colds, otitis media, and upper and lower respiratory tract diseases is well-documented in vaccinated children.

"A well-nourished child will go through rubella, whooping cough, chicken pox and the rest with flying colors. Only the vaccinated develop atypical forms of the diseases (atypical measles, mumps and whooping cough) which are much more dangerous.

"Having measles not only protects against measles later on, it has been demonstrated that suppressing measles fever and rash by vaccination leads to cancer and degenerative diseases of bone and cartilage as documented in Lancet 1985 September 5.

"According to the British Medical Journal suppression of skin eruptions like eczema leads to cancer.

"In 1958 there were 800,000 cases of measles and from 1974-1976 there were only 30,000 cases. Today about 800,000 die of cancer each year. Is the upsurge of child leukemia and cancer coincidental with the mass use of vaccines (especially the polio vaccines)?"

The Lancet · Saturday 5 January 1985

MEASLES VIRUS INFECTION WITHOUT RASH IN CHILDHOOD IS RELATED TO DISEASE IN ADULT LIFE

TOVE RØNNE

Department of Epidemiology, State Serum Institute, Copenhagen, Denmark

Summary The presence of measles specific antibodies is usually taken as evidence of typical measles in the past; in the present study it was regarded as evidence of infection with measles virus, but not necessarily of the common disease accompanied by a typical rash. The association between a negative history of measles in childhood and certain diseases later in life was investigated by a historical prospective method, based on school health records combined with self-reporting in adulthood, and tests for specific IgG measles antibody. There was evidence of association between a negative history of measles, exposure in early life (possibly injection of immune serum globulin after exposure), and development of immunoreactive diseases, sebaceous skin diseases, degenerative diseases of bone and cartilage, and certain tumours. It is suggested that the presence of measles virus specific antibodies at the time of acute infection interferes with development of specific cytolytic reactions, and enables intracellular measles virus to survive the acute infection. If this hypothesis is verified, use of immune serum globulin after measles exposure has to be reconsidered.

Introduction

MEASLES is a highly communicable disease; in countries where routine measles vaccination is not practised, most children contract the disease in the first few years of life. Measles virus is also causally related to subacute sclerosing panencephalitis (SSPE), a rare, slow-virus infection of the central nervous system, which mainly attacks children who have had measles in early childhood.[1,2] In the USA, the number of SSPE cases has declined substantially, in parallel with the decline in measles cases observed after introduction of routine measles vaccination.[3]

The role of measles virus in multiple sclerosis (MS) has been investigated intensively, without conclusive results. If MS is related to measles virus, one would expect an association with measles infection unusually late in life. This is supported by the fact that MS mainly affects individuals with early birth order positions (ie, number 1 or 2 in a family).[4] Early birth orders tend to delay exposure to an infectious agent, from early childhood to a later age, and vice versa.

Adults who have not had measles have either escaped exposure, or have responded without manifesting the pathognomonic rash. In general, the presence of measles virus antibodies is taken as evidence of past infection;[5] in the present investigation, it was regarded as evidence of viral infection, but not necessarily of clinical measles.

The pathogenesis of the measles rash is not completely understood, although certain facts have been established. Thus, circulating antibody is usually first detected 24–28 hours after onset of the rash. Children with agammaglobulinaemia are capable of manifesting a rash and immunity,[6] whereas infection in children with impaired cellular immunity may result in giant cell pneumonia without a rash.[7] Measles virus antigen has also been shown to disappear from skin cells 3–4 days after onset of the rash.[8] It is assumed, therefore, that the rash is caused by a cell-mediated immune reaction, which damages cells infected with measles virus.[9] If this assumption is correct, absence of a rash may imply that intracellular virus escapes neutralisation during the acute infection, and this, in turn, might give rise to

Can Measles Prevent The Development Of Atopic Allergies?

News from "the Lancet" Heinz Wittwer, Switzerland *Homeopathic Links* (1996)

It is a widespread experience that an infectious disease in childhood can be favourable to the child's general development. A study recently published in the medical journal "The Lancet" now suggests, that people who did not undergo a measles infection are at higher risk to develop an atopic allergy. (1) This for the first time is a hint that childhood diseases could also have very distinct beneficial effects.

The study was done among the indigenous population of a semi-rural part of Guinea-Bissau, a small state south of Senegal, West Africa. The people there are living in multi-family houses made of mud-bricks, that sometimes were even shared with pigs. Between 1978 and 1980 there had been a campaign of nutrition and child health during which small children were registered and vaccinated against measles in case they had not had them yet. In 1994 those individuals still living in the same area were tested for atopy by applying the seven most common antigens with a skin-prick test. Analysis of the results showed, that atopic allergy (mostly against house dust mites) was only half as frequent in the group of those young adults who had had measles in early childhood (17 cases of atopy among those 133 participants who had had measles, compared with 33 cases among 129 vaccinated participants, who didn't have the infection). In accordance with studies conducted elsewhere in the world the risk of atopy in Guinea-Bissau was also related to a shorter period of breast feeding and a higher socioeconomic status. When the results were corrected for these two potentially confounding variables, the correlation between measles infection and low risk of atopy became even stronger.

One could suspect, that the higher incidence of atopy among vaccinated individuals might be a negative effect of the vaccination itself. Probable damage to the immune system by measles vaccination is being discussed even by the allopathic community (see Homoeopathic Links 4/94, p. 41), but a study conducted in Great Britain failed to give a correlation between atopy and measles vaccination. So most probably we are facing here a true benefit of measles infection.

Could it be that an infectious disease in early childhood helps to prevent the development of an atopic allergy? The study in Guinea-Bissau seems to tell us so. The same hypothesis is also supported by the findings of German epidemiologists that the risk of atopy is decreasing as the number of siblings a child grew up with is increasing (potential sources of infection!). It is still to early for a definite answer but it looks as if the price for the presently tempted eradication of the typical childhood diseases might be higher than expected. Maybe we soon will all be longing back to the good old times of measles again.

Heinz Wittwer
Schöneggplatz 1
8004 Zürich, Switzerland

Bibliography: 1. Lancet, Vol. 347, p. 1792-96 (1996) and references cited therein.

Atopy in children of families with an anthroposophic lifestyle

Johan S Alm, Jackie Swartz, Gunnar Lilja, Annika Scheynius, Göran Pershagen

Summary

Background Increased prevalence of atopic disorders in children may be associated with changes in types of childhood infections, vaccination programmes, and intestinal microflora. People who follow an anthroposophic way of life use antibiotics restrictively, have few vaccinations, and their diet usually contains live lactobacilli, which may affect the intestinal microflora. We aimed to study the prevalence of atopy in children from anthroposophic families and the influence of an anthroposophic lifestyle on atopy prevalence.

Methods In a cross-sectional study, 295 children aged 5–13 years at two anthroposophic (Steiner) schools near Stockholm, Sweden, were compared with 380 children of the same age at two neighbouring schools in terms of history of atopic and infectious diseases, use of antibiotics and vaccinations, and social and environmental variables. Skin-prick tests were done for 13 common allergens, and we took blood samples from children and their parents for analysis of allergen-specific serum IgE-antibodies.

Findings At the Steiner schools, 52% of the children had had antibiotics in the past, compared with 90% in the control schools. 18% and 93% of children, respectively, had had combined immunisation against measles, mumps, and rubella, and 61% of the children at the Steiner schools had had measles. Fermented vegetables, containing live lactobacilli, were consumed by 63% of the children at Steiner schools, compared with 4·5% at the control schools. Skin-prick tests and blood tests showed that the children from Steiner schools had lower prevalence of atopy than controls (odds ratio 0·62 [95% CI 0·43–0·91]). There was an inverse relation between the number of characteristic features of an anthroposophic lifestyle and risk of atopy (p for trend=0·01).

Interpretation Prevalence of atopy is lower in children from anthroposophic families than in children from other families. Lifestyle factors associated with anthroposophy may lessen the risk of atopy in childhood.

Lancet 1999; **353:** 1485–88
See Commentary page 1457

Department of Laboratory Medicine, Division of Clinical Immunology (J S Alm MD, Prof A Scheynius MD), **Karolinska Institute and Hospital; and Division of Environmental Epidemiology, Institute of Environmental Medicine, Karolinska Institute** (Prof G Pershagen MD), **Stockholm; Vidar Clinic, Järna** (J Swartz MD); **and Sachs' Children's Hospital, Stockholm** (G Lilja MD, J S Alm), **Sweden**

Correspondence to: Dr Johan S Alm, Sachs' Children's Hospital, Box 179 12, S-118 95 Stockholm, Sweden (e-mail: Johan.Alm@sos.ki.se)

Introduction

Every third child in many industrialised countries has an atopic disorder.[1] Although hereditary factors are important for the risk of developing allergic disorders, the increase in prevalence observed in recent years[2,3] suggests that non-hereditary risk factors must play a substantial part. Immunological data show that different infections can either promote atopy (respiratory syncytial virus infections)[4] or inhibit atopy (measles, hepatitis A, tuberculosis).[5–7] A change in childhood infectious diseases, vaccination programmes, or both could partly explain this increase, although studies in Sweden[8,9] did not show that BCG vaccination protected against atopy.

The immunological role of intestinal microflora in the development of allergy has also been investigated. Children in Estonia have lower rates of atopy than Swedish children and their intestinal microflora contains a larger amount of lactobacilli.[10] *Lactobacillus plantarum*, most common in spontaneously fermented vegetables, can colonise the human intestinal mucosa and affect indigenous strains.[11] Animal experiments and studies in vitro have shown that lactobacilli can change the interleukin profile and inhibit antigen-induced IgE production.[12,13] Infants with milk allergy and atopic dermatitis had milder symptoms and fewer markers of intestinal inflammation if their milk formula was fortified with lactobacilli.[14] Thus, intestinal microflora could play a part in the development of atopy.

The school of anthroposophy (Greek: wisdom about man) was founded in the early 20th century by Rudolf Steiner.[15] Anthroposophy has been applied to education (Steiner schools), medicine, art, architecture, and agriculture (biodynamic farming).[16] Anthroposophical doctors restrict the use of antibiotics, antipyretics, and vaccinations.[17] Most children are vaccinated only against tetanus and polio, and most vaccinations are given later than recommended by the Swedish health authorities. As a result, in Sweden, measles occurs primarily in anthroposophic families.[18] They also consume mostly local foods produced according to biodynamic principles. Vegetables preserved by spontaneous fermentation are a common dietary element, even for small children.[19]

We aimed to compare the prevalence of atopy in children from anthroposophic families, who attend Steiner schools, with that of children at conventional schools.

Methods

In a cross-sectional study, children from two Steiner schools (A, B) in a village located 60 km south of Stockholm, Sweden, were compared with children from two control schools (C, D) in the same area. Steiner school A is situated in the countryside, in buildings constructed in the 1970s in the typical anthroposophic style. School B is located in a traditional school building from the 1930s in a built-up area. School C, adjacent to school B, was built in the 1960s, and school D is in a nearby village and was built in 1995.

All parents of children born in 1982–92 and enrolled in one of the four schools received basic information about our study

Med Hypotheses 1998 Oct;51(4):315-20

Febrile Infectious Childhood Diseases In The History Of Cancer Patients And Matched Controls

Albonico HU, Braker HU, Husler J. Dept of Mathematical Statistics, University of Berne, Switzerland.

The present study was designed to investigate the hypothesis that febrile infectious childhood diseases (FICDs) are associated with a lower cancer risk in adulthood, since biographical considerations are of great importance in anthroposophic medicine. Cancer patients and control patients of 35 anthroposophic general practitioners in Switzerland were matched with respect to gender, age and physician. All patients completed a questionnaire on their FICD. We collected 424 cases; of these we could analyze 379 matched pairs. **The study consistently revealed a lower cancer risk for patients with a history of FICD.** The strongest associations were found between patients with non-breast cancers and rubella respectively chickenpox. A strong association was also found with the overall number of FICD both 'classical' (measles, mumps, rubella, pertussis, scarlet-fever and chickenpox) and 'other'. None of these associations was apparent for patients with breast cancer. Unexpectedly, we found that cancer was diagnosed significantly earlier in life in cancer patients with a history of FICD compared to those without FICD. Our retrospective study showed a significant association between FICD and the risk of developing cancer. The number of FICD decreased the cancer risk, in particular for non-breast cancers. The relationship with tumor site seems to be important also, but can only be addressed in a larger study.
PMID: 9824838, UI: 99042279

J Cancer Res Clin Oncol 1991;117(4):339-44

Common Infections In The History Of Cancer Patients And Controls

Abel U, Becker N, Angerer R, Frentzel-Beyme R, Kaufmann M, Schlag P, Wysocki S, Wahrendorf J, Schulz G. Tumorzentrum Heidelberg/Mannheim, FRG.

The association between the frequency of manifest infectious diseases and cancer risk was investigated in a case-control study at Heidelberg, FRG. A total of 255 cases with carcinomas of the stomach, colon, rectum, breast, and ovary, as well as 255 population controls and 230 hospital controls were interviewed using a standard questionnaire. Controls were matched to the cases for age, sex, and region of residence at the time of the interview. **A history of common colds or gastroenteric influenza prior to the interview was found to be associated with a decreased cancer risk.** Thus the odds ratios for "three or more common colds per year (on average)" versus "no common cold within the last 5 years prior to the interview" were 0.18 (95% CI = 0.05-0.69) and 0.23 (95% CI = 0.06-0.89) relative to population controls and hospital controls, respectively. There was no apparent relationship between childhood infections or other diseases reported in the earlier history, and cancer risk. **While the findings are supported by previous studies and fit well into the results of other fields of cancer research, a conclusive interpretation and biological explanation cannot yet be given.**

PMID: 2066354, UI: 91294214

Age of entry to day nursery and allergy in later childhood

U Krämer, J Heinrich, M Wjst, H-E Wichmann

Summary

Background Infections in early childhood may prevent allergies in later life. If this hypothesis is true, early exposure to childcare outside the home would protect against atopy by promotion of cross infections. We investigated whether children who attend a nursery at a young age have a lower rate of atopy and fewer allergies than children who attend from an older age.

Methods In a cross-sectional study carried out in 1992–93, we examined 2471 children in three age-groups (5–7, 8–10, and 11–14 years) from the towns of Bitterfeld, Hettstedt, and Zerbst in eastern Germany. The children's parents answered a questionnaire about allergies and symptoms, attendance at day care, and related factors. Sensitisation was assessed by skin-prick tests and measurement of allergen-specific IgE antibodies in serum.

Findings In 669 children from small families (up to three people), the prevalance of atopy was higher among children who started to attend day nursery at an older age than in those who started to attend at a younger age ($p<0.05$). Compared with children who first attended at age 6–11 months, the adjusted odds ratios for a positive skin-prick test were 1·99 (95% CI 1·08–3·66) for children who attended at age 12–23 months and 2·72 (1·37–5·40) for those who attended at age 24 months and older. In 1761 children from large families (more than three people), age of entry to day nursery had no effect on atopy.

Interpretation Our findings accord with the hypothesis that early infection may protect against allergies in later life.

Lancet 1998; **352:** 450–54

Medical Institute of Environmental Hygiene, Heinrich Heine University Düsseldorf, Düsseldorf (U Krämer PhD); **GSF Research Centre for Environment and Health, Institute of Epidemiology Neuherberg, D-85764 Oberschleissheim, Germany** (J Heinrich PhD, M Wjst MD, Prof H-E Wichmann PhD); **and Department of Epidemiology, Ludwig-Maximilians University Munich, Munich** (Prof H-E Wichmann PhD)

Correspondence to: Dr J Heinrich (e-mail: Joachim.Heinrich@gsf.de)

Introduction

The prevalence of childhood allergies has increased during the past decades.[1] One hypothesis is that a decline in exposure to infections early in life may be partly responsible for this trend.[2–4] An inverse relation has been shown between some childhood infections and atopy in later life.[5–7] Stimulation of Th1 lymphocytes by infections that may inhibit the expansion of allergen-specific Th2 lymphocytes at a critical time during early childhood could explain these results,[8,9] although lack of effect of early vaccination on the development of atopy is puzzling.[10] Indirect evidence of an inverse relation between early childhood infections and allergies in later life comes from studies that reported an inverse relation between the number of siblings and allergic sensitisation.[7,11,12] Siblings promote cross infections and this effect also takes place in day-care centres. Children who attend day nursery have more infections,[13–16] especially infections of the respiratory tract,[17–19] than children who do not attend day nursery. If this infection hypothesis is true, children who attended day nursery should have fewer allergies in later life than children who did not. Comparisons between the two groups showed no differences in allergies or allergic sensitisation in schoolage children[20] or in young adults.[12] Why preschool nursery attendance does not seem to reduce the rate of atopy in later life is not known.[21]

An increase in the risk of respiratory illness associated with attendance at day nursery is most pronounced or even detectable if a child has no older siblings.[22] Marbury and colleagues[18] reported that the effect of day-care attendance on respiratory illness is stronger in firstborns than in those not born first. Therefore, a reduction in atopy associated with preschool nursery attendance might be detectable only in firstborns or in families with only one child.

We aimed to investigate the association between preschool attendance at day nursery and atopy in later life in a cross-sectional survey of children aged 5–14 years from eastern Germany.

Methods

Participants

Between September, 1992, and August, 1993, 2773 children from the towns of Zerbst, Bitterfeld, and Hettstedt in southern Sachsen-Anhalt, eastern Germany, were selected to take part in the study.[23] There were three age-groups: 5–7 years (school entrants), 8–10 years (third grade), and 11–14 years (sixth grade). In Zerbst and Hettstedt, we enrolled all children in the three age-groups. In Bitterfeld, a random sample that represented a third of all schools and kindergartens (for school entrants) in the region formed the population base used to recruit study participants.

Study design

To keep variability between observers to a minimum, physical examinations and functional tests were done in the three towns by the same team of one physician and one nurse who used standard methods. To exclude seasonal influences, the team

Childhood Illnesses Have Adult Implications

A study from researchers at Pennsylvania State University found that individuals with a childhood history of sickness are more prone later to diseases such as cancer, lung disease, cardiovascular disease, arthritis and rheumatism.

"Our findings show that persons with childhood health problems were twice as likely to develop cancer or chronic lung disease by late middle age," said Mark Hayward, Penn State professor of sociology and demography, and director of the school's Population Research Institute. "The prevalence of arthritis was about 33 percent higher with this group," Hayward said, noting that even socio-economic well-being doesn't seem to be much of a buffer against a history of illness.

The researchers based their conclusions on a sub-sample of 654 Americans from the 1996 Health and Retirement Study, which looked at people between the ages of 55 and 65. Seventeen percent reported health conditions as children that severely limited their activities and cut back their class time. That same sample reported higher than average incidences of serious adult illnesses, leading investigators to believe there must be a linkage.

Hayward says as more Americans are living longer, understanding that link and heading off or treating illnesses that have implications later in life have tremendous implications on future generations' physical and financial health. "Investing in children's health is sound policy for both individuals and societies," he said.

The Penn State study was published in the journal *Social Science and Medicine*.

Note: Researchers are referring to chronic, not acute childhood diseases

Shot Increases Babies' Risk For Measles

A study from the Centers for Disease Control and Prevention finds that unvaccinated babies whose mothers were vaccinated against measles are considerably more likely to catch the disease than unvaccinated babies whose mothers were not vaccinated. CDC researchers looked at 128 infants born in New Jersey and Texas who were exposed to measles between 1989 and 1991. During that period, measles had a resurgence in the United States, infecting some 55,000 people and killing 120, The Associated Press reports.

Infants whose mothers were vaccinated against measles inherit few natural antibodies and are far more likely to catch the virus than infants of older, unvaccinated mothers.

After interviewing the infants' mothers, the researchers found that unvaccinated infants of mothers born after 1963 (the year the measles vaccine was first licensed) were 7.5 times as likely to catch measles as the unvaccinated infants of mothers born before 1963. The researchers say this is because the babies of vaccinated mothers are inheriting few natural antibodies to the illness. Women who have actually had measles have much higher levels of disease-fighting antibodies in their blood than vaccines provide, and they pass these on to their babies at birth, the AP says. The researchers say their findings highlight the importance of getting babies vaccinated against measles by the age of 12 months. The study was published in the journal Pediatrics.

November 1999, *Pediatrics*

Post–Encephalitic Syndrome

(From Vaccination, Social Violence and Criminality, The Medical Assault on the American Brain by Harris L. Coulter. 1990 North Atlantic Books: Berkeley.)

- **Allergies and Immune System Abnormalities:** food allergies (wheat and milk especially), arthritis, lupus, celiac disease, pernicious anemia. (P.154)
- **Anorexia** (stop eating, death due to "cachexia") and **Bulimia** (morbid hunger) "postencephalitic obesity" or "pathological obesity"
- **Hyperactivity and attention span difficulties** - perpetual urge to move about, often with excessive talkativeness; more rare: Hypoactivity (sluggishness).
- **Developmental delay (physical, emotional or intellectual) disabilities; "Minimal Brain Damage"; Stuttering; Dyslexia; Hypoactivity, Learning Disabilities**
- **("Physical immaturity of the nervous system due to impairment of the myelination process – or even it's undoing". Coulter p. 157)**
- **Gender Identity Disorders: confused sexual identity, homosexuality and bisexuality. Hyper-sexuality.**
- **Cranial Nerve** (vision, hearing, voice and speech) **impairments.** Taste and smell are preserved unimpaired in autistics. These cranial nerves are not myelinated. *The fact that encephalitis – including that caused by vaccination – can cause demyelination has been known since the 1920s!* Coulter (p. 157) citing Rivers TM. "Encephalomyelitis Accompanied by Myelin Destruction Experimentally Produced in Monkeys." *J Exp. Med.* 61 (1935), 689-702.
- **Hypotonia** (loss of muscle tone)
- **Mental Retardation** (from slight decline in intellectual potency to total idiocy); **Epilepsy and Seizure disorders, Infantile spasms; Cerebral Palsy and Paralyses**
- **Respiratory Problems: Asthma and SIDS** (due to vagus nerve palsy).
- **Developmental Delay** in all areas of physical, emotional, and intellectual development (walking, talking, growth, bed wetting)
- **Ego Weakness, Alienation, Egotism**
- **Related disorders: Tourette's Syndrome, Uncontrollable temper, impulsive rage and anger, Uncontrollable violence; head banging; self mutilation;**

Note: While writing *DPT: A Shot in the Dark*, Coulter and Fisher were surprised to learn that about half of the children who were vaccine damaged had no acute reaction. P. 119.

Pertussis toxoid is used as an "adjuvant" to induce allergic encephalomyelitis in experimental animals.

Jagdis F, Langston C, Gurwith M

Encephalitis after administration of live measles vaccine.

Can Med Assoc J (Canada), Apr 19 1975, 112(8) p972-5

In a previously well child with no evidence of pre-existing immunologic defect a fatal encephalitis developed 10 days after administration of measles vaccine. There was pathologic evidence of an early viral encephalitis characterized by perivascular mononulcear infiltrates. Although the virus was not recovered, the diagnosis of a measles virus infection and encephalitis is supported by the postmortem findings of Warthin-Finkeldey cells in lymphoid tissues, an intranuclear inclusion in the brain and histologic changes of encephalitis.

Jorch G, Kleine M, Erwig H

Coincidence of virus encephalitis and measles-mumps vaccination.

Monatsschr Kinderheilkd (Germany, West), May 1984, 132(5) p299-300

A 15-month-old girl developed meningoencephalitis 7 days after measles/mumps vaccination, and died 3 days later. No measles or mumps virus was found in brain tissue, but echovirus type 5 could be cultered postmortally on a cervical lymph node.

Martinon-Torres F, Magarinos MM, Picon M, et al.

Self-limited acute encephalopathy related to measles component of viral triple vaccine

Rev Neurol (Spain), May 1-15 1999, 28(9) p881-2

CLINICAL CASE: A 16 month-old baby with a clinical picture of self-limiting acute encephalopathy characterized by cerebellar ataxia and alterations in behavior, accompanied by the clinical signs of attenuated measles. The negative results of complementary tests and an obvious time-relationship with a triple virus vaccination lead us to interpret the condition as being secondary to the measles component of the vaccine. **CONCLUSIONS: We consider that although there is a low incidence of complications, the index of suspicion is also low, and even lower in cases with only minor neurological signs. It is therefore possible that such reactions are under-reported.**

Belgamwar RB, et al (1997).

Measles, mumps, rubella vaccine induced subacute sclerosing panencephalitis.

J Indian Med Assoc. 1997

Nov;95(11):594. No abstract available. PMID: 9567594; UI: 98229001.

SSPE in a thirteen-year-old girl who had been immunized against all childhood diseases; receiving the MMR vaccine at the age of nine months. The girl's intellectual functioning until development of illness had been very good. After illness developed, the child verbalized little and was socially inappropriate; her memory and thinking abilities were impaired. She grew progressively worse, and added myoclonic jerks of the upper limbs, with depressed deep tendon reflexes. The authors concluded that Subacute, Sclerosing

Vaccines blamed
EDITION: 2

Meningitis and Vaccination

SECTION: FEATURES:LETTERS
Waikato Times (New Zealand)

The New Zealand meningitis epidemic has raged for nine years, causing more than 3000 cases and 142 deaths. Overseas researchers like Dr A Wakefield (London), Dr H Coulter, Dr L Horowitz (US) and Dr G Buchwald (Germany) say that vaccinations are the leading cause of the increases in brain disorders such as dyslexia, learning difficulties, attention deficit hyperactive disorder (ADHD), autism and meningitis.

It is interesting to note that the increase in meningitis cases followed the introduction, in 1990, of the MMR-vaccine into the New Zealand vaccination schedule, while the cost of drugs used to treat ADHD in New Zealand also sky-rocketed, from $76,000 in 1992 to $796,000 in 1996.

The injection of three live viruses (measles, mumps and rubella) appears to overwhelm children's immune systems to such an extent that they become vulnerable to meningitis, especially where conditions of poverty give rise to malnutrition and overcrowding. We believe that contaminating the organisms of babies of consenting parents with yet another vaccine, in addition to the 25 vaccines (including boosters) they are already given between the ages of 6 weeks and 15 months, will only compound the problem likely to have been caused by vaccination in the first place.

ERWIN ALBER Spokesperson,
Vaccination Information Network, Kaeo

Between 15 and 20 percent of American school children are considered to be learning disabled with minimal brain dysfunction directly caused by vaccine damage.

Harris L. Coulter, Ph.D.

Vaccination, Social Violence and Criminality: The Medical Assault on the American Brain

Harris Coulter, Ph.D.

"No one at the time, or for many decades thereafter, noted that the first cases of autism emerged in the United States at a time when vaccination against whooping cough was becoming increasingly popular and widespread."

Coulter, H. Vaccination, Social Violence and Criminality. p.1

Autism, Encephalitis, & Vaccination

Tedd Koren, D C

Autism, from the Greek word (auto (self) was first described in 1943 by psychiatrist Leo Kanner: "This condition differs markedly and uniquely from anything reported so far," said Kanner. Autistic children are totally self-absorbed and alienated - they are in their own world, detached, unresponsive, unable to relate to others, often mentally retarded, hyperactive and violently aggressive.

"This disorder is difficult to characterize, but a very prominent feature is the inability to relate to or communicate with other human beings in ways that are natural or meaningful," says Bernard Rimland, Ph D, director of the Autism Research Institute. Rimland's 1964 book *Infantile Autism - the Syndrome and It's Implications for a Neutral Theory of Behavior* is credited with demolishing the idea that bad parenting or mental illness caused autism. "Autism is a biological disorder, not an emotional illness. Refuse psychotherapy, psychoanalysis and intensive counseling. These approaches are useless," recommends Rimland. (From Autism, Journey Out Of Darkness by Karolyn A. Gazella (Health Counselor Magazine, Vol. 3, No. 6, June/July 1994).

Five out of 10,000 babies are autistic and it's cause is considered unknown. Although each autistic child is different, in general about 75% have some degree of mental retardation and another 10% are known as autistic savants. (Like the character Dustin Hoffman played in Rain Man.) Now that emotional factors have been ruled out, experts are now looking for a brain malfunction caused by physical, chemical, or biological abnormalities. Its cause is a mystery.

But not to medical researcher and historian Harris Coulter, PH D. "The first victims of the medical assault on the American brain were the austistic children," says Dr. Coulter. "Austistics ordinarily suffer from a multitude of disorders - mental, retardation, epilepsy, cerebral palsy, and others - which are clearly of neurologic origin, autism (is) a neurological disorder. The first cases of autism emerged in the United States at a time when vaccination against whooping cough was becoming increasingly popular." (Vaccination Social Violence and Criminality, The Medical Assault on the American Brain by Harris Coulter, PH D, the following quotes of Coulter are from his book.)

How does vaccination cause autism? The answer, encephalitis. Although encephalitis or "brain inflammation" can be caused by severe infection, trauma to the head and severe burns, those occur rarely compared with post-vaccinal encephalitis - encephalitis following vaccination.

Autism (and minimal brain damage) while rare before mass vaccination programs began is now widespread disorders. Coulter's claim that they are the result of post-encephalitic syndrome resulting from childhood vaccination should be disturbing to anyone with a child who has a learning disorder, is hyperactive, dyslexic, suffers from cranial nerve damage, or is, of course, autistic.

"Kanner was mistaken in thinking that autism differed from other diseases," says Coulter. "He may be excused for his error, he was not a neurologist but a psychiatrist. The symptoms Kenner called autism would have been immediately recognized by a neurologist as post-encephalitic syndrome."

Encephalitis was well known in the second and third decades of this century. Infectious encephalitis occurred in epidemic numbers - mental institutions and reform schools were the home of many "post encephalitic syndrome" individuals who were left with a wide variety of neurological conditions after the encephaltitis ravaged their brains - creating conditions often identical to post-vaccine damage, among them autism.

"In examining the enormous literature on infectious encephalitis, I realized very quickly that the long-term effects of encephalitis is totally congruent with what we see today in the DSM3 of the American Psychological Association as "Disorders usually evident in infancy or childhood" (developmental disabilities). That includes autism, hyperactivity, dyslexia, attention span difficulties and several dozen other conditions."

"This is, at first glance, a startling omission," says Coulter. When the neurologic (as opposed to psychological) nature of autism was finally revealed, "mental health professionals should have immediately appreciated the tie with encephalitis. Furthermore, it had long been known that a variety of encephalitis was caused by vaccination. But this is precisely why physicians shied away from the topic! Since no one wanted to impugn the vaccination_ programs, encephalitis was never discussed openly and fully.

"The Vaccine Compensation Bill of 1986 provided for the establishment of a committee under the National Academy of Sciences Institute of Medicine to review data on vaccine damage. This committee has published two books - one in 1989 and one in 1993 on the damage of various vaccines and they have stated in the first of these books that the evidence supports the existence of a casual relationship between the DPT vaccine and encephalitis. That has changed the whole terms of the debate because now you can talk of vaccine damage in terms of encephalitis - that is a much more solid scientific basis.

"But no biological phenomenon is either all or nothing. Vaccination cannot be considered to either leave a child perfectly normal or have a very severe impact on a child. There's got to be a range of effects - how about the children in the middle? How about those who are slightly affected by the vaccine? Anybody who knows anything about the biology of medicine knows that this has to be because it would be impossible to stress a large group of people, like two million babies a year in the United States and not have the reactions go along a whole range of effects. Some of the side effects or long term effects make themselves felt not the next week or two weeks later but five or ten years later when the parent realizes that their child is not acting or behaving like other children act and tries to figure out what the reason for that is."

The numbers of damaged children we are dealing with appear to be very high. Although medical authorities may claim that perhaps "one child in hundreds of thousands of children are in any way affected by vaccination" that may be a pathetic underestimation.

For example, in the first book to seriously attack the medical myth of vaccine safety, DPT: A Shot In The Dark. Coulter and Fisher estimate that 12,000-15,000 cases of severe neurological damage are caused by childhood vaccines each year. However those numbers pale beside Coulter's statement that "one child in five or six is affected to some degree by the vaccination, about 20% of the population."

When some researchers investigate this information they are led to state, as does Viera Scheibner PhD in her incredible book, Vaccination: The Medical Assault on the Immune System, (one of the greatest anti-vaccination books written to-date). "Vaccination is the epitome of ignorance and the unscientific approach to illness. Immunizations, including those practiced on babies, not only did not prevent any infectious diseases, they caused more suffering and more deaths than has any other human activity in the entire history of medical intervention. It will be decades before the mopping-up after the disasters caused by childhood vaccination will be completed. All vaccination should cease forthwith and all victims of their side-effects should be appropriately compensated."

Let us close with Dr. Coulter, who reminds us that this subject is difficult to discuss, in spite of the evidence. "Awareness of the relationship between these neurological disabilities and the post-encephalitic syndrome has been blocked, by reluctance to admit that the childhood vaccination program is the only possible cause of a mass epidemic of clinical and sub-clinical encephalitis."

What will you think the next time you see a deaf child signing, a child in a wheel chair or a hyperactive child? Bad luck, bad genes or bad vaccines?

For more information on these topics the above mentioned books, Vaccination, Social Violence and Criminality ($14.95) by Harris Coulter, Ph D, A Shot in the Dark ($9.95) by Fisher and Coulter and Vaccination, The Medical Assault on the Immune System ($30.00) by Viera Scheibner, Ph D, are available from Koren Publications, 2026 Chestnut Street, Philadelphia, PA 19103, 1-800-537-3001. Please add $4.50 shipping and handling per total order.

Portia Iverson, founder and president of the Cure Autism Now [CAN] foundation:

"Approximately one-half of the hundreds of parents who call our office each month report that their child became autistic shortly after receiving a vaccination."

Mothering July-August 1998 p.46

Biological mechanisms by which the components of MMR vaccine can cause encephalopathy which leads to autism.

1. It may be caused by immune complexes (molecules of antigens and antibodies linked together) blocking small blood vessels in the brain. (1)

2. The distinguished neurologist Dr. Charles M. Poser has drawn the link between the vaccines and demyelination. Almost any...vaccination can lead to a non-infectious inflammatory reaction involving the nervous system.... The common denominator consists of a vasculopathy that is often.... associated with demyelination. (2)

3. Some experts believe that there is a connection between autism and peptides leaking through the gut wall. Damage to the gut wall is caused by inflammatory bowel disease, reportedly caused by the vaccine. (3)

References

(1) The Biology of Autistic Syndromes: Christopher Gilberg and Mary Coleman: MacKeith Press 2nd Ed. pg 22.

(2) Posner CM. Neurological syndromes that arise unpredictably. Consultant January 1987 pp. 45-46.

(3) Wakefield AJ, Murch S, Anthony a, et al. Ileal lymphoid nodular hyperplasia, non-specific colitis, and regresssive developmental disorder in children. Lancet 1998;351:637-41.

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RAPID COMMUNICATION

Serological Association of Measles Virus and Human Herpesvirus-6 with Brain Autoantibodies in Autism

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Considering an autoimmunity and autism connection, brain autoantibodies to myelin basic protein (anti-MBP) and neuron-axon filament protein (anti-NAFP) have been found in autistic children. In this current study, we examined associations between virus serology and autoantibody by simultaneous analysis of measles virus antibody (measles-IgG), human herpesvirus-6 antibody (HHV-6-IgG), anti-MBP, and anti-NAFP. We found that measles-IgG and HHV-6-IgG titers were moderately higher in autistic children but they did not significantly differ from normal controls. Moreover, we found that a vast majority of virus serology-positive autistic sera was also positive for brain autoantibody: (i) 90% of measles-IgG-positive autistic sera was also positive for anti-MBP; (ii) 73% of measles-IgG-positive autistic sera was also positive for anti-NAFP; (iii) 84% of HHV-6-IgG-positive autistic sera was also positive for anti-MBP; and (iv) 72% of HHV-6-IgG-positive autistic sera was also positive for anti-NAFP. This study is the first to report an association between virus serology and brain autoantibody in autism; it supports the hypothesis that a virus-induced autoimmune response may play a causal role in autism.

Key Words: autism; autoimmunity; autoantibodies; developmental disorders; virus serology; measles; HHV-6; child behavior; brain disorders.

INTRODUCTION

Autism is an idiopathic neurodevelopmental disorder of unknown etiology. It is an early-onset disorder manifesting behavioral problems: impairment of verbal and nonverbal communication; difficulties with social relationships and social understanding; and repetitive, inflexible, sometimes bizarre behavior and resistance to change. While the cause of the disorder is not well known, autoimmunity has been implicated in the pathogenesis of autism (1, 2). Autoimmunity is most commonly believed to be triggered by environmental exposures such as viral infections. Virus serology is an excellent tool for studying virus infections but serological studies have not been performed in autism. Thus, we conducted a serological study of measles virus and HHV-6 in autistic children, in particular to explore if this virus serology is related to brain autoantibodies (anti-MBP and anti-NAFP). In this paper, we show that positive measles or HHV-6 titers are related to autoantibodies (especially anti-MBP) in autistic children but not in normal controls. This finding may provide a new clue for linking environmental factors to the etiology of autism.

METHODS

The study involved two groups of subjects: autistic children and normal controls. There were 48 children (age 4 to 12 years) with the diagnosis of autism and 34 normal controls (age 5 to 50 years) that included 19 normal children under 12 years of age and 15 normal adults. The serum samples of autistic children were provided to us by their parents nationwide. The clinical diagnosis of autism was made by child psychiatrists and psychologists according to standard DSM-IIIR criteria. The normal control sera were the same as used previously (1–3). Our research protocol involving human subjects was approved by the Institutional Review Board (IRB) committee of the University of Michigan. Subjects taking prescription medication such as neuroleptics or antipsychotics were not included in this study.

Brain autoantibodies were detected by an immunoblotting method essentially according to our published reports: MBP antibody by Singh *et al.* (1) and NAFP antibody by Singh *et al.* (3). Briefly, the proteins (bovine myelin basic protein from Upstate Biotechnology Inc., Lake Placid, NY and bovine spinal cord neurofilament protein preparation from before (3)) were separated in 12% polyacrylamide Ready Mini-Gels (Bio-Rad Labs., Richmond, CA) under the denaturing conditions of sodium dodecyl sulfate (SDS) and 2-mercaptoethanol. The gels were run at 150 V for about 45 min and protein transfer was achieved by a double-sandwich technique for over 20 h at room temperature.

0090-1229/98 $25.00

The syndrome of autism is a clinical entity affecting 20 out of 10,000 children. **We have evaluated the possible role of MMR in the pathogenesis of autism by comparing rubeola titers in autistic and normal children. Among 16 children diagnosed with autism followed in our clinical practice, we noted these children to have a 3 fold increase in their rubeola titers over expected normal range.** A Wilcoxon Kruskal Wallis test comparing 13 rubeola titers from normal children reveals a statistically significant P-value of 0.0050. Subjectively, parents have stated that their children's developmental milestones deteriorated following MMR vaccination. **Neurological sequelae following MMR are widely reported. MMR therefore may play a role in the pathogenesis of autism. The elevated titers of anti-measles antibodies in autistic children may signify a chronic activation of the immune system against this neurotropic virus.**

Elevated Rubeola Titers in Autistic Children, T. Zecca, D. Graffino, M. Lania-Howarth, M. Passannante, J. Oleske NJMS, Children's Hospital of NJ, Newark, NJ

From Vaccination, Social Violence and Criminality by Harris L. Coulter, Ph D, North Atlantic Books, Berkeley, California 1990, P 15-16,23

"Physicians and scientists eventually came to appreciate that autistics ordinarily suffer from a multitude of other disorders-mental retardation, epilepsy, cerebral palsy, and others - which are clearly of neurologic origin. This strengthened the arguments of those who had called autism a neurologic disorder all along."

"The relationship with mental retardation was the first to attract attention. Kanner had thought that autistic children were of at least normal intelligence but suffered from an "innate ability to form affective contact with people." Indeed, encounters with individuals possessing "Splinter skills" - powerful memories, extraordinary imitative abilities, remarkable musical talent - convinced him that autistics, by and large, were of superior intellectual ability. Later research, however, has revealed that three-quarters are mentally retarded, while forty percent have an IQ lower than 50."

Some twenty to thirty percent of autistics are now known to have a seizure disorder convulsions, fits, clonic spasms, infantile spasms, hypsarrhythmia, temporal lobe epilepsy, psychomotor epilepsy, "strange quivering tensing of all muscles in a kind of passing paroxysm," grand mal, petit mal, "absence seizures," or "starting spells," and combinations of all these.

Other conditions found in autistics

Cranial nerve palsies

- Eyes, eyeball and vision problems
- Ear and hearing problems (I e otitis media and ear infections, hearing impairments from tone deafness to overall deafness)
- Vocal and speech disorders
- Facial nerve impairment (rigid face)
- Taste and smell are not impaired in autistics. Possibly because "these cranial nerves, unlike the others, are not myelinated"
- Vagus nerve. Many kinds of breathing difficulties are common in autism. These include breath-holding attacks, hyperventilation, deep inspiration followed by grunting, exhalation, future autistics have sometimes been noted to suffer from asthma in infancy, but this relationship has been insufficiently stressed

Thus autism and SIDS appear to be generated in the same way - by an encephalitis most commonly caused by vaccination.

Early report

Ileal-lymphoid-nodular hyperplasia, non-specific colitis, and pervasive developmental disorder in children

A J Wakefield, S H Murch, A Anthony, J Linnell, D M Casson, M Malik, M Berelowitz, A P Dhillon, M A Thomson, P Harvey, A Valentine, S E Davies, J A Walker-Smith

Summary

Background We investigated a consecutive series of children with chronic enterocolitis and regressive developmental disorder.

Methods 12 children (mean age 6 years [range 3–10], 11 boys) were referred to a paediatric gastroenterology unit with a history of normal development followed by loss of acquired skills, including language, together with diarrhoea and abdominal pain. Children underwent gastroenterological, neurological, and developmental assessment and review of developmental records. Ileocolonoscopy and biopsy sampling, magnetic-resonance imaging (MRI), electroencephalography (EEG), and lumbar puncture were done under sedation. Barium follow-through radiography was done where possible. Biochemical, haematological, and immunological profiles were examined.

Findings Onset of behavioural symptoms was associated, by the parents, with measles, mumps, and rubella vaccination in eight of the 12 children, with measles infection in one child, and otitis media in another. All 12 children had intestinal abnormalities, ranging from lymphoid nodular hyperplasia to aphthoid ulceration. Histology showed patchy chronic inflammation in the colon in 11 children and reactive ileal lymphoid hyperplasia in seven, but no granulomas. Behavioural disorders included autism (nine), disintegrative psychosis (one), and possible postviral or vaccinal encephalitis (two). There were no focal neurological abnormalities and MRI and EEG tests were normal. Abnormal laboratory results were significantly raised urinary methylmalonic acid compared with age-matched controls (p=0·003), low haemoglobin in four children, and a low serum IgA in four children.

Interpretation We identified associated gastrointestinal disease and developmental regression in a group of previously normal children, which was generally associated in time with possible environmental triggers.

Lancet 1998; **351**: 637–41
See Commentary page 611

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Introduction

We saw several children who, after a period of apparent normality, lost acquired skills, including communication. They all had gastrointestinal symptoms, including abdominal pain, diarrhoea, and bloating and, in some cases, food intolerance. We describe the clinical findings, and gastrointestinal features of these children.

Patients and methods

12 children, consecutively referred to the department of paediatric gastroenterology with a history of a pervasive developmental disorder with loss of acquired skills and intestinal symptoms (diarrhoea, abdominal pain, bloating and food intolerance), were investigated. All children were admitted to the ward for 1 week, accompanied by their parents.

Clinical investigations

We took histories, including details of immunisations and exposure to infectious diseases, and assessed the children. In 11 cases the history was obtained by the senior clinician (JW-S). Neurological and psychiatric assessments were done by consultant staff (PH, MB) with HMS-4 criteria.[1] Developmental histories included a review of prospective developmental records from parents, health visitors, and general practitioners. Four children did not undergo psychiatric assessment in hospital; all had been assessed professionally elsewhere, so these assessments were used as the basis for their behavioural diagnosis.

After bowel preparation, ileocolonoscopy was performed by SHM or MAT under sedation with midazolam and pethidine. Paired frozen and formalin-fixed mucosal biopsy samples were taken from the terminal ileum; ascending, transverse, descending, and sigmoid colons, and from the rectum. The procedure was recorded by video or still images, and were compared with images of the previous seven consecutive paediatric colonoscopies (four normal colonoscopies and three on children with ulcerative colitis), in which the physician reported normal appearances in the terminal ileum. Barium follow-through radiography was possible in some cases.

Also under sedation, cerebral magnetic-resonance imaging (MRI), electroencephalography (EEG) including visual, brain stem auditory, and sensory evoked potentials (where compliance made these possible), and lumbar puncture were done.

Laboratory investigations

Thyroid function, serum long-chain fatty acids, and cerebrospinal-fluid lactate were measured to exclude known causes of childhood neurodegenerative disease. Urinary methylmalonic acid was measured in random urine samples from eight of the 12 children and 14 age-matched and sex-matched normal controls, by a modification of a technique described previously.[2] Chromatograms were scanned digitally on computer, to analyse the methylmalonic-acid zones from cases and controls. Urinary methylmalonic-acid concentrations in patients and controls were compared by a two-sample *t* test. Urinary creatinine was estimated by routine spectrophotometric assay.

Children were screened for antiendomyseal antibodies, and boys were screened for fragile-X if this had not been done

Now that the draft has been abolished, mandatory vaccination remains the only time an American is asked to risk his life for his country.

Harris L. Coulter, Ph.D.

The medical doctors and pharmaceutical companies "swore" there was no link between Multiple Sclerosis and vaccination....

The pathogenesis of multiple sclerosis. Additional considerations. Poser CM Department of Neurology, Harvard Medical School, Boston, MA. *J Neurol Sci* 1993 Apr; 115 Suppl:S3-15

Multiple sclerosis (MS) is acquired as a systemic "trait" by individuals who are genetically susceptible. This condition does not involve the central nervous system (CNS) and is **characterized by a state of hyperactive immunocompetent responsiveness. It develops as the result of an antigenic challenge by a viral protein, either from a viral infection or a vaccination.** In order for MS to become a disease affecting the CNS, it is necessary for the blood-brain barrier's (BBB) impermeability to be altered. This is now a fully recognized fact. As a result of this change, the MS lesion, which consists of edema and inflammation occurs. It may but need not lead to demyelination. Several mechanisms can cause this increased permeability of the BBB.

The role of the immune system, and in particular of T lymphocytes in initiating and continuing the process of lesion formation remains extremely controversial. In fact, there are unanswered questions regarding the actual target of MS: is it the myelin sheath itself or its forming cell, the oligodendrocyte, or is it the BBB itself leading to bystander demyelination? The role of mild, concussional trauma to the CNS in producing the alteration of the BBB and therefore acting as a trigger or facilitator in the development or enlargement of MS lesions in the CNS, is based on considerable clinical, neuropathological and experimental evidence.

Along with another viral infection, it must be one of the commonest causes of progression of MS, and quite often leads to the onset of the clinical manifestations of an hitherto asymptomatic condition.

The Dark Side of Immunizations?

A controversial hypothesis suggests that vaccines may abet diabetes, asthma

By NATHAN SEPPA

As newborns, human babies can't do much more than sleep, eat, cry, and—well, you know.

Even their immune systems seem idle. That's why babies are usually 2 months old before they are given vaccinations—to ensure that they can muster an adequate immune response. However, some scientists now believe that the seeds of immune system problems, perhaps including asthma, may be sown in the early weeks of life and activated later by vaccination. Recent studies suggest that juvenile-onset diabetes, an autoimmune disease, may take root because a baby's immune system is asleep at the switch early on.

Although some scientists have suggested that an unknown genetic component may predispose particular people to getting diabetes, that theory wouldn't explain the increases observed over recent decades. The genetic makeup of people in countries such as Finland and England, where juvenile diabetes has become more prevalent in the past 30 years, hasn't changed much in that time.

There seem to be one or more hidden environmental factors at work. Researchers have suggested exposure to viruses in utero, infant milk consumption, poor hygiene, and even cesarean birth as possible causes. So far, nothing stands out.

Now, J. Barthelow Classen, a physician who heads Classen Immunotherapies in Baltimore, has begun investigating whether infant vaccinations may influence the incidence of diabetes. Vaccination schedules vary from country to country, and some parents refuse to let their children be vaccinated at all, thereby providing control groups. Cross-checks of vaccination data against diabetes registries have loosely linked various vaccinations and juvenile diabetes.

Even if a connection between vaccinations and immune system disorders were firmly established, few people would suggest halting vaccination programs: Only a small fraction of children develop autoimmune diseases, whereas millions of children evade disease via vaccination. Yet a clear link between vaccines and immune disorders could offer a valuable clue to researchers still searching for the cause of diabetes and asthma.

Some research suggests babies should be vaccinated at birth, not at 2 months.

Classen suggests that a change in the timing of the vaccines—namely, adding one set at birth—might reduce the incidence of diabetes and still protect against viral diseases.

Viruses passed from mother to child at birth may inflame the insulin-producing islet cells of the pancreas, setting the stage for diabetes. Classen's hypothesis holds that vaccinations given at the age of a few months, while spurring immunity against disease, may also abet a lurking autoimmune challenge in some infants, allowing it eventually to develop into diabetes.

Meanwhile, a new study by researchers at the Wellington School of Medicine in New Zealand finds that unvaccinated New Zealand children report fewer cases of asthma than vaccinated children. Like diabetes, asthma is becoming more common and has no known cause.

There may also be a genetic predisposition to asthma, but don't blame the gene pool: The population mix isn't changing much in Australia, yet the number of asthma cases is rising there. Asthma researchers have puzzled over allergy-triggering agents in houses and schools, air pollution, the urban environment, secondary smoke, and low birth weights—without finding an answer. Whether vaccination will provide one remains to be seen.

Because vaccines are so efficient, and the case against them still sketchy, some scientists are skeptical. "It's a very intriguing hypothesis, but I don't think it's proven, by any means," says Patricia M. Graves, an epidemiologist at the University of Colorado Health Sciences Center in Denver.

Drawing a direct association between diabetes and vaccination "is pushing it," says Ronald E. LaPorte, an epidemiologist at the University of Pittsburgh. "It's very, very dangerous to say that immunizations cause autoimmune disease. It's right to publish [the data], but I don't think any conclusions can be made."

LaPorte and his colleagues keep a registry of diabetes in Allegheny County, Pa. The incidence of juvenile diabetes has risen sharply there in the last decade, even as vaccination schedules have remained static, he says.

Elsewhere, data hinting at a link don't focus on any single vaccine. New Zealand researchers report in the November EPIDEMIOLOGY that a review of 1,265 people born in 1977 shows that 23 didn't get any early childhood vaccinations. Of these people, none suffered childhood asthma. Of the remaining 1,242, who received polio and diphtheria-tetanus-pertussis vaccinations, more than 23 percent later had asthmatic episodes.

Similarly, a 1994 survey of 446 British children with an average age of 8 showed that 91 received no vaccinations in early childhood. Of this group, only one got asthma. About 11 percent of the children who had been vaccinated with pertussis and other vaccines had asthma.

Juvenile diabetes numbers are rising in Finland. Between 1970 and 1976, Finnish children under age 4 had a 12 in 100,000 chance of developing diabetes within a year. Between 1990 and 1992, that rose to 29 cases in 100,000. Classen reviewed vaccination programs in 17 countries in the Oct. 22 INFECTIOUS DISEASES IN CLINICAL PRACTICE. He noted that between 1976 and 1990, Finland began giving children a bolstered pertussis vaccine and hemophilus influenza B vaccine.

In Christchurch, New Zealand, juvenile diabetes, which averaged 11 cases per 100,000 between 1982 and 1987, rose to

LETTERS

Letters to the editor should be signed by all authors, typewritten in doublespacing, not exceed 500 words and 10 references References should be in the Vancouver style Over long letters may be shortened without reference to the author unless it is specifically stated otherwise Priority of publication may be given to short letters

Chelation therapy

Dr Anderson has either misread our letter or made his own personal judgements (NZ Med J 1996; 109: 172) Firstly, we were not concerned that active smokers were not excluded rather that the fact was concealed This gave the false impression that they had been excluded as required in van Rij's protocol It should also be noted that there was no evidence that blood nicotine levels were done to check those who stated that they had stopped smoking Neither were we concerned that the patients chosen for this small trial were amongst the worst possible cases (who still had legs to test) and in whom other medical and surgical treatments had failed Their likely prognosis was amputation Irrespective of the trial's apparent conclusions, we would be more concerned that chelation was continued after an inadequate number of treatments Anderson also incorrectly described the controls as placebos Both of the van Rij groups were given vasoactive treatment with one group being given additional EDTA. The results showed what can still be achieved in some of these seriously affected patients

It is our claim that van Rij's most serious fault was that he did not even discuss the statistical outlier and its impact on the study We consider this a serious ethical issue in that as a matter of practical importance, the outlier did indeed completely change the results of this barely statistically valid trial Dr Chappell, my coauthor and the president of the American College for Advancement in Medicine (ACAM), engaged a Washington University statistician to independently investigate the van Rij statistics This was a proper and ethical procedure which can be repeated and indeed in view of the implications, we would welcome an independent enquiry into the handling of the Otago University trial We are claiming that many people have suffered as a consequence of the widespread inaccurate publicity given to this study and it appears that if Anderson s opinion reflects that of general practitioners at large, they are also telling their patients that chelation is useless and that the chelating doctors are selling expensive useless "miracle cures"

Much larger well-designed multicentre EDTA trials, involving cardiologists with ACAM training, are now underway in England, Denmark Holland and the USA. These involve not only patients with intermittent claudication but also patients with angina where cardiac performance is being assessed They are state funded by the European Union and the US National Heart Lung and Blood Institute via the USNIH No less than 28 UK health authorities are now paying for EDTA chelation and one Dutch and two British hospitals are using chelation in their cardiovascular outpatient departments, where it ought to have been in the first place General practitioners are not in the position to study the biochemical or microbiological investigations that have confirmed the scientific rationale for the use of EDTA chelation in arteriosclerosis Their postgraduate education is predigested and greatly influenced by prevailing paradigms professorial opinions and the pharmaceutical industry They are entitled to make their own conclusions but likewise, overseas authorities and hundreds of overseas doctors have also made their own conclusions after studying the clinical effects over many years and having realised the cost-benefits Chelation costs are about a sixth of CABG and a third of PTCA, the results are longer lasting and far more widespread The evidence for this also comes from the many patients who have benefited from properly performed chelation after failed coronary or peripheral arterial surgery Who would in any case advocate amputation when there could be a safe and effective alternative?

ME Godfrey
Tauranga

NB This correspondence is now closed
Editor

Childhood immunisation and diabetes mellitus

We have demonstrated that immunisation starting at birth can prevent the development of diabetes in rodents and is associated with a decreased incidence of diabetes in humans[1] while immunisation starting after 6 weeks is associated with an increased risk of developing insulin dependent diabetes in humans and rodents[2] After a presentation of our data we were asked to evaluate the effect of a recent hepatitis B immunisation programme in New Zealand on the development of insulin dependent diabetes We found a large epidemic of diabetes, 60% increase, occurred in New Zealand following this immunisation programme and believe the most likely explanation is that the immunisation programme caused the diabetes epidemic

A massive hepatitis B immunisation programme was started in New Zealand in 1988 The programme was phased in so initially children 5 or under were immunised but the programme was extended over the next few years to include all children under 16 The acceptance rates were estimated to be above 70% (personal communication Dr H Nicholls, Ministry of Health) Children born in 1988 and 1989 were immunised at birth, however children born before or after this time were immunised after 6 weeks of age Based on our previous data we would thus expect the immunisation programme to increase the risk of diabetes in all groups except those immunised at birth thus an epidemic of diabetes would be expected The only diabetes registry that exists in New Zealand, to the best of our knowledge, is in Christchurch[3,4] which has prospectively followed a group of approximately 100 000 individuals under 20 since 1982 The incidence of diabetes in this group prior to the hepatitis B immunisation programme (1982-7) was 11.2 cases/100 000/year (range 7.6-13.2) while the incidence of diabetes following the immunisation programme (1989-91) was 18.2 cases/100 000/year (range 16.4-21.7) (p=0.001). Data has not yet been published on the incidence of diabetes after 1991

The hepatitis B vaccines have been noted in the package inserts and Physicians Desk Reference to cause several autoimmune diseases, and the FDA has gone on record that the hepatitis B vaccines cause the autoimmune disease alopecia (US FDA internet home page) The hepatitis B vaccine, as well as other vaccines, can potentially induce insulin dependent diabetes through the release of interferons since interferons have been implicated in causing autoimmunity including insulin dependent diabetes[5-7] Based on this mechanism and our early finding that diabetes epidemics have followed the widespread use of the Haemophilus influenza B vaccine[2] we expect a second epidemic of diabetes to follow the Haemophilus influenza B immunisation programme that was started in New Zealand in 1993/4 We hope that we can enlist the support of researchers in New Zealand to help us perform cohort epidemiology studies to substantiate our initial observations.

J Barthelow Classen,
Classen Immunotherapies Inc, Baltimore USA

1 Classen JB Classen DC Vaccines modulate type I diabetes Diabetologia 1996 April; 39
2 Classen JB Method and composition for an early vaccine to protect against both infectious diseases and chronic immune mediated disorders of their sequela. PCT patent application 1994; PCT/US94/08825
3 Scott R, Brown LJ, Darlow BA, Forbes LV Moore MP Temporal variation in incidence of IDDM in Canterbury New Zealand Diabetes Care 1992; 15: 395-99
4 Forbes LV Scott RS, Brown LJ Darlow BA Immunogenetic clinical and demographic characterisation of childhood type I diabetes in New Zealand. Diabetes Care 1995; 18: 1428-32.
5 Stewart TA, Hultgren B, Huang X, Pitts Meek S Hully J MacLachlan NJ Induction of type I diabetes by interferon alpha in transgenic mice Science 1993; 260: 1942-6.
6 Huang X Yuan J Goddard A, Foulis A et al Interferon expression in pancreases of patients with type I diabetes Diabetes 1995; 44: 658-64.
7 Murakami M, Iriuchijima T Mori M. Diabetes and interferon-alpha therapy Ann Intern Med 1995; 122: 318

The effects of ageing

In presenting the results of their survey of older adults, Richmond et al (NZ Med J 1996; 109: 122-5) indicate that the 50% of their respondents who disagreed with the statement that "most older people will face a loss of intellectual ability during their 60s and 70s" were correct. However, unless these respondents interpreted the statement as referring to dementia, as the authors assume, they were probably wrong The best recent research in ageing and cognition[1] suggests that the majority of people do lose some intellectual capacity in their 60s and beyond although the real-life consequences of such loss are largely unknown

Helen Pennington,
Psychology Department Massey University Palmerston North.

1 Schaie KW The course of adult intellectual development. Am Psychologist 1994; 49: 304-13

– Patient Report –

Link Between Increasing Rate of Pediatric Cancers and Childhood Vaccines

by Raphaele Moreau-Horwin and Michael Horwin

Alexander

My husband and I admire your publication for its objective focus on key medical issues. We have enclosed a copy of our letter to Congressman Dan Burton regarding the potential link between the increasing rates of pediatric cancers and the increasing numbers of childhood vaccines. We are interested in having you publish this letter to make more parents aware of the potential danger of vaccinations and the lack of freedom of choice they can expect if their child is diagnosed with a terminal disease. Freedom of choice and informed consent are both critical to making good decisions regarding the medical care of a child.

Our 2-1/2 year-old son Alexander was denied potentially lifesaving treatment because of FDA support of the international drug corporations. The therapy we selected to possibly save our child's life was denied us. We had no freedom of choice. Then we were threatened with court orders to hand Alexander over to oncologists so they could fill him with chemotherapy. Again, we had no freedom of choice other than to flee. The oncologists assured us that the chemo would work. However, Alexander died three months later (while on chemo). Later we checked the efficacy of this therapy by reading more than 1200 abstracts from the medical literature and found that chemotherapy for young children with medulloblastoma (the brain tumor Alexander had) was toxic, carcinogenic, unproven, and ineffective. After twenty years of this therapy there was absolutely no credible evidence that it had any value (other than to the oncologists prescribing it and the drug companies marketing it). Alexander's last months were spent in a hospital as he submitted to this barbaric and futile treatment. There was no informed consent here.

Informed consent is lacking in the medical community when it comes to childhood vaccination. There are so many unknowns with respect to any one vaccine that it is criminal to make vaccination mandatory and it is a lie to present it as basically safe. No one really knows the full extent of the damage caused to some children by the ever-enlarging childhood vaccination protocol.

Please find enclosed our testimony that suggests a possible link between vaccination and brain cancer in some children.

Vaccination Responsible for Brain Cancer

Congressman Dan Burton, Chairman
Government Reform Committee
US House of Representatives
2157 Rayburn House Office Building
Washington DC 20515 USA

Dear Congressman Burton:

This letter is in support of your Government Reform Committee on *Vaccines; Finding the Balance Between Public Safety and Personal Choice*. After speaking with your staff member, Mrs. Beth Clay, I had to forward you the appalling story regarding the death of our son, Alexander. I have also included some of the facts that my husband and I have uncovered since our son's death that link vaccination with brain cancer.

On August 10, 1998 our only child, Alexander, was diagnosed with the most common pediatric brain cancer, medulloblastoma. He was two years old. Our lives were shattered. The next six months became a race against time to try to understand the disease, find the appropriate treatment, and save Alexander.

After two brain operations Alexander recovered quickly. We wanted to give our son the most effective cancer therapy possible. After weeks of research, many conversations with parents who had children with brain cancer, and conversations with doctors from all over the world, we selected the Burzynski Clinic in Houston, Texas. We arrived there and incredibly, were turned away. Dr. Burzynski said he was *not allowed* to accept Alexander. I'll never forget it. We sat in an examining room. Alexander was smiling at the doctor.

"Why can't you take Alexander?" I asked Burzynski. "The FDA dictates who I can and can't accept," Burzynski said.

Burzynski explained to us that the FDA would only allow him to accept children who had suffered through chemotherapy and/or radiation and still had "measurable tumor" left in their brains. Alexander hadn't had either of these "world class treatments" but

Federal and state governments are mandating that infants and children swallow and be injected with substances that have never been tested for their ability to cause cancer, mutations (mutagenic) or developmental malformations (teratogenic)

VACCINE/MFGR/BRAND NAME/AGES/STUDIES ON CARCINOGENIC POTENTIAL ACCORDING TO MFGR

- Chickenpox (Varicella) Merck Varivax 12 months and older: **No studies conducted**
- DTP, Lederle, Tetramune 2 months to 5 years: **"Tetramune has not been evaluated for its carcinogenic or mutagenic potential."**
- DTP Lederle, Tri-Immunol 2 months to 7 years, **No studies conducted**
- DTP Connaught (subsidiary of Pasteur Merieux), Tripedia, 15 months to 7 years: **"Tripedia has not been evaluated for its carcinogenic or mutagenic potential."**
- DTP Lederle, Acel-Immune 17 months to 7 years: **"Acel-Immune has not been evaluated for its carcinogenic or mutagenic potential"**
- DTP(whole cell pertussis) SmithKline Beecham 6 weeks to 7 years:**"Animal and human studies concerning possible carcinogenic or teratogenic effects have not been done."**
- Hepatitis A SmithKline Beecham (subsidiary of Pasteur Merieux) Havrix Over two years old: **"Havrix has not been evaluated for its carcinogenic or mutagenic potential."**
- Hepatitis B Merck Recombivax "infants": **No studies conducted**
- Influenzae type b Haemophilus b conjugate with diphtheria protein Lederle HibTITER 2-71 months: **"HibTITER has not been evaluated for its carcinogenic or mutagenic potential."**
- Influenzae type b Haemphilus b conjugate with tetatus toxoid conjugate Connaught (subsidiary of Pasteur Merieux) ActHIB 2 months to 5 years: **No studies conducted**
- Measles live Merck Attenuvax 15 months and older: **No studies conducted**
- Measles Mumps Rubella live Merck M-M-R 15 mos and older **No studies conducted**
- Measles, Rubella (live) Merck M-R-Vax 15 months and older: **No studies conducted**
- Mumps (live) Merck Mumpsvax 12 months and older: **No studies conducted**
- Polio (live) Lederle Orimune 6 weeks to 18 years **No studies conducted**
- Poliovirus (inactivated) Connaught (subsidiary of Pasteur Merieux) IPOL **"infants, children and adolescents": "Studies in animals to evaluate carcinogenic potential have not been conducted."**
- Rubella/mumps (live) Merck Biavax II 12 months and older: **No studies conducted**
- Rubella (live) Merck Meruvax 12 months to puberty **No studies conducted**

Pediatric Cancer and Childhood Vaccines

Type of Vaccine	Manufacturer	Brand name	Ages Prescribed	Studies on Carcinogenic Potential According to Manufacturer
Chickenpox (Varicella)	Merck	Varivax	12 months and older	No studies conducted
DTP	Lederle	Tetramune	2 months to 5 years	"Tetramune has not been evaluated for its carcinogenic or mutagenic potential."
DTP	Lederle	Tri-Immunol	2 months to 7 years	No studies conducted
DTP	Connaught (subsidiary of Pasteur Merieux)	Tripedia	15 months to 7 years	"Tripedia has not been evaluated for its carcinogenic or mutagenic potential."
DTP	Lederle	Acel-Immune	17 months to 7 years	"Acel-Immune has not been evaluated for its carcinogenic or mutagenic potential."
DTP (whole cell pertussis)	SmithKline Beecham (subsidiary of Pasteur Merieux)	DTP	6 weeks to 7 years	"Animal and human studies concerning possible carcinogenic or teratogenic effects have not been done."
Hepatitis A	SmithKline Beecham (subsidiary of Pasteur Merieux)	Havrix	Over two years old	"Havrix has not been evaluted for its carcinogenic or mutagenic potential."
Hepatitis B	Merck	Recombivax	"infants"	No studies conducted
Influenzae type b Haemophilus b conjugate with diphtheria protein	Lederle	HibTITER	2-71 months	"HibTITER has not been evaluated for its carcinogenic or mutagenic potential."
Influenzae type b Haemophilus b conjugate with tetatus toxoid conjugate	Connaught (subsidiary of Pasteur Merieux)	ActHIB	2 months to 5 years	No studies conducted
Japanese encephalitis virus	Connaught (subsidiary of Pasteur Merieux)	JE-VAX	One year and older	"No studies have been performed to evaluate carcinogenicity or mutagenic potential."
Measles live	Merck	Attenuvax	15 months and older	No studies conducted
Measles, Mumps, Rubella live	Merck	M-M-R	15 months and older	No studies conducted
Measles, Rubella (live)	Merck	M-R-Vax	15 months and older	No studies conducted
Mumps (live)	Merck	Mumpsvax	12 months and older	No studies conducted
Polio (live)	Lederle	Orimune	6 weeks to 18 years	No studies conducted
Poliovirus (inactivated)	Connaught (subsidiary of Pasteur Merieux)	IPOL	"infants, childen and adolescents"	"Studies in animals to evaluate carcinogenic potential have not been conducted."
Rubella and mumps (live)	Merck	Biavax II	12 months and older	No studies conducted
Rubella (live)	Merck	Meruvax	12 months to puberty	No studies conducted

EXPERTS STUDY ALARMING RISE IN CHILDHOOD CANCERS

Facing a chilling rise in childhood cancer, health experts from across the country gathered Monday to try to map the best course for research on the effects of toxic chemicals in the environment on young bodies.

The U.S. Environmental Protection Agency sponsored a two-day conference to develop a national strategy to combat cancer in children that is rising by about 1 percent a year, and to determine if toxic chemicals such as pesticides are contributing to the increase.

``We've got to know more about the possible links between the environment and the alarming increase in new incidents of childhood cancer," EPA Administrator Carol Browner told the conference.

``In the past two decades, we have seen higher rates of accute lymphoblastic leukemia in children, higher rates of types of brain cancer in children, and higher rates of Wilms' tumor of the kidney. Testicular cancer in young men is up by nearly 70 percent," Browner said.

The death rate from childhood cancer has dropped, but that gain has been overshadowed by the fact that more children are getting sick.

The EPA has started an Office of Children's Health Protections to coordinate work on setting health and safety standards to protect the youngest populations that face higher exposures to pesticides and other environmental toxins through their diets and play.

``At least 75,000 new synthetic chemical compounds have been developed and dispersed into the environment. Fewer than half of these compounds have ever been tested for their potential toxicity to humans, and fewer still have been assessed for their toxicity to children," Landrigan said.

About 8,000 American children younger than 15 are diagnosed with cancer each year, and cancer is the second leading cause of death in children after accidental injuries. Leukemia and brain tumors are the most common childhood malignancies, with rates of accute lymphoblastic leukemia up 27 percent since 1973 and brain tumors up 40 percent, according to EPA figures. Wilms' tumor of the kidneys in children rose by 46 percent since 1973, and testicular cancer in young men has jumped by 68 percent.

Because many cancers likely resulted from a combination of the child's genetic susceptibility and environmental exposure, experts said case studies on environmental factors will have to be large and will be expensive to conduct. The conference also discussed possible links between parents' occupational exposure to toxins and cancer in their children, studies on prenatal vitamin supplements to lower cancer risks, and reducing exposure to pesticides. Reuter WASHINGTON. 09/15/1997

Functional Brain Disease and the Polio Vaccine

A cytopathic 'stealth' virus was cultured from the cerebrospinal fluid of a patient with a bipolar psychotic disorder who developed a severe encephalopathy leading to a vegetative state. DNA sequencing of a polymerase chain reaction-amplified product from infected cultures has identified the virus as an **African green monkey simian cytomegalovirus (SCMV)-related stealth virus.**

The virus is similar to the SCMV-related stealth virus isolated from a patient with chronic fatigue syndrome. **The findings support the concepts that stealth viruses can account for a spectrum of dysfunctional brain diseases and that some of these viruses may have arisen from live polio viral vaccines.**

Pathobiology 1996;64(2):64-6 Simian cytomegalovirus-related stealth virus isolated from the cerebrospinal fluid of a patient with bipolar psychosis and acute encephalopathy. Martin WJ Center for Complex Infectious Diseases, Rosemead, CA 91770, USA.

Mysterious Syndromes Studied

By LINDA A. JOHNSON The Associated Press

PISCATAWAY, N.J. (AP) - People desperate for explanations of mysterious health problems from chronic fatigue syndrome to multiple chemical sensitivity shouldn't blame the nearest toxic dump or exposure to chemicals, experts say.

Numerous illnesses for which doctors can find no cause - or even conclude it's all in the patient's head - probably are caused by multiple physical, psychological and social factors interacting in complex ways not yet understood, scientists said at a recent conference at Rutgers University.

About 100 physicians, psychiatrists, chemical experts, epidemiologists and other researchers participated in discussions on the role environmental factors play in medically unexplained symptoms. That's an issue of great interest in New Jersey, a state full of Superfund sites (113), chemical plants, clogged highways, an unexplained autism cluster in Brick Township and abnormally high cancer rates among children in Toms River.

When pain, nausea or other troublesome symptoms send patients to a doctor, Kipen noted, anywhere from 30 percent to 70 percent of those cases cannot be explained by any known disease.

That's according to numerous studies of patients with what conference participants called ``Multiple Unexplained Symptom Syndromes.'' The most common symptoms, at least in patients ill enough to seek medical help, include headaches, fatigue, trouble concentrating or remembering things, nausea, unusual chest pain, shortness of breath, trouble sleeping and musculoskeletal pain.

The conference was sponsored by government agencies, the petroleum industry and the 15-year-old Environmental and Occupational Health Sciences Institute in Piscataway, which is jointly run by Robert Wood Johnson Medical School and Rutgers University.

Environmental and Occupational Health Sciences Institute: http://www.eohsi.rutgers.edu

AP-NY-02-04-01 1201EST

Is Infant Immunization a Risk Factor for Childhood Asthma or Allergy?

Trudi Kemp,[1] Neil Pearce,[1] Penny Fitzharris,[1] Julian Crane,[1] David Fergusson,[2] Ian St George,[3] Kristin Wickens,[1] and Richard Beasley[1]

The Christchurch Health and Development Study comprises 1,265 children born in 1977 The 23 children who received no diphtheria/pertussis/tetanus (DPT) and polio immunizations had no recorded asthma episodes or consultations for asthma or other allergic illness before age 10 years; in the immunized children, 23 1% had asthma episodes, 22 5% asthma consultations, and 30 0% consultations for other allergic illness Similar differences were observed at ages 5 and 16 years These findings do not appear to be due to differential use of health services (although this possibility cannot be excluded) or confounding by ethnicity, socioeconomic status, parental atopy, or parental smoking (Epidemiology 1997;8:678–680)

Keywords: asthma, allergy, immunizations, children

The prevalence of asthma and allergic disease has increased in many countries,[1–4] and there has been a great deal of speculation as to possible causes,[5–11] including the possible role of immunization in promoting allergic sensitization [12] For example, pertussis vaccination acts as an adjuvant for antigen-specific responses in laboratory animals[13–15]; a specific immunoglobulin E (IgE) response to pertussis toxin itself has been identified in children receiving pertussis immunization[16]; and vaccination with some other organisms enhances histamine release in laboratory animals [17 18] In addition, two studies have found that pertussis infection increased the risk of atopy,[19 20] and another study found that aluminum-adsorbed vaccines produce greater IgE responses [21] It is therefore theoretically possible that immunization may contribute to the development of allergic disease, whether through reducing clinical infections in infancy,[12] or through the direct IgE-inducing effects of the vaccines themselves and/or the potentiating adjuvants We have therefore examined data from a New Zealand cohort study to investigate the relation between infant immunization and subsequent allergic disease

Methods

The Christchurch Child Development Unit comprises 1,265 children born in 1977 [22] Information on immunizations, asthma, and other allergic disease (collected annually until age 16 years) was obtained from (1) a medical diary supplied to all mothers, (2) direct questioning of the mother about medical contacts, and (3) cross-checking with the family doctor when maternal reports or diary records were vague or inconsistent Infants were scheduled to receive diphtheria/pertussis/tetanus (DPT) and polio immunizations at ages 3 and 5 months and measles immunization at 12–15 months; we did not consider subsequent immunizations, since our hypothesis focused on infant immunizations Data on asthma, eczema, and other allergies (including rhinitis, food allergy, and urticaria, but excluding drug allergies) were categorized as to whether children had consultations (reported medical contacts) or episodes (consultations plus reported episodes not medically seen) up to ages 5, 10, and 16 years A child was assigned to a negative category only if there were complete negative data for that child; a positive category was allocated if any episodes or consultations took place, whether or not the data were complete

We analyzed the data using the Mantel-Haenszel summary risk ratio[23,24] and Fisher exact methods where appropriate

From the [1]Wellington Asthma Research Group Department of Medicine, and [2]Department of the Dean Wellington School of Medicine Wellington New Zealand; and [3]Christchurch Health and Development Study, Christchurch School of Medicine Christchurch New Zealand

Address correspondence to: Neil Pearce Wellington Asthma Research Group Wellington School of Medicine P O Box 7343 Wellington South, New Zealand

This project was supported by the Guardian Trust (Trustee of the David and Cassie Anderson Medical Charitable Trust) The Wellington Asthma Research Group is funded by a Programme Grant, and Neil Pearce and Julian Crane are funded by Professorial Research Fellowships from the Health Research Council of New Zealand Financial support for the Christchurch Health and Development Study has been provided by the Health Research Council of New Zealand the Canterbury Medical Research Foundation and the National Children's Health Research Foundation

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Pertussis vaccine and asthma: Is there a link?

Odent MR, Culpin EE and Kimmel T: Letter to the editor. JAMA 272:592-3, 1994

An evaluation of health criteria in British school children has turned up an interesting connection. A total of 448 children and adolescents who had received only breast milk for the first six months of life, and in particular on the first day after birth were surveyed. All of the children were weaned after one year of age and were older than 4 years at the time the parents responded. The mean age was 7.87 years.

To the question "Has your child ever been diagnosed as asthmatic?" there were 30 positive answers (6.72%). The surprise came when the researchers classified the respondents according to whether or not they received the pertussis vaccine. **Among the 243 immunized children, 26 were diagnosed as having asthma (10.69%). In contrast, of the 203 children who had not been immunized, only 4 had asthma (1.97%). The relative risk of developing asthma from the pertussis vaccine was 5.43 in this study.** The significance of this finding was the P=.0005 level.

Even though all of the kids who received the pertussis vaccine received other vaccinations, the researchers felt the statistical evidence focused on pertussis. **Among the kids that did not receive the pertussis vaccine, most had received some other vaccination. Of the 91 subject of the study who received no vaccines, only 1 had asthma compared to 3 with asthma in the 112 who had other vaccinations. Therefore, the relative risk of developing asthma is about 1% in children receiving no immunizations, 3% in those receiving vaccinations other than pertussis, and 11% for those receiving pertussis.** Another finding to weigh, in the group not immunized to pertussis, 16 developed whooping cough compared to only one in the immunized group.

Dear Karin:

I am not at this time saying that children should be immunized at birth but that studies need to be performed immediately comparing immunization starting at birth to immunization starting at 8 weeks to no or minimal immunization. **My data proves that the studies used to support immunization are so flawed that it is impossible to say if immunization provides a net benefit to anyone or to society in general. This question can only be determined by proper studies which have never been performed. The flaw of previous studies is that there was no long term follow up and chronic toxicity was not looked at.** The American Society of Microbiology has promoted my research at the 36th ICAAC meeting and thus acknowledges the need for proper studies.

I do not believe that immunization in the first week will have an adverse effect on the developing immune system however this needs to be addressed in large studies with long term follow up. It is only theory whether it is safe or not safe. One point to remember that in natural birth, which still occurs in some third world countries, a child's immune system is stimulated at birth with a large amount of bacterial products. A child may be born on a dirt floor and the mother may bite the umbilicus in order to separate it. The child retains a long infected umbilicus and is at risk for a number of infections. The infections at birth may kill some children but protect the survivors from autoimmune diseases including insulin dependent diabetes. In industrialized countries we deliver babies in a sterile environment which protects them from deadly infections but may predispose them to autoimmunity. This theory is supported by data that NOD mice raised in sterile environments have a much greater risk of diabetes. Immunization at birth may act to properly turn on the immune system in a way similar to natural child birth.

Parents who choose to immunize their children should know about the effect of vaccines on diabetes. They want their child to receive hepatitis B vaccine or not and if they choose immunization they can choose to have it given at birth or after 2 months. If their child develops insulin dependent diabetes or another autoimmune disease, it may be related to immunization and the child is eligible for compensation. Prospective randomized clinical trial data from Finland showed that those immunized at birth had a greater risk of developing diabetes. This study should help parents in their efforts to receive compensation.

I will be happy to address comments and to go into detail on the data presented at ICAAC after the initial press release is sent to the group.

Sincerely, Bart Classen, John B. Classen M.D., M.B.A., 6517 Montrose Avenue, Baltimore, MD 21212 U.S.A.Tel: (410) 377-4549 Fax: (410) 377-8526 Email: Classen@worldnet.att.net

Study: Start Diabetes Tests Earlier

By BRENDA C. COLEMAN

CHICAGO (AP) -- People should be considered for diabetes testing beginning at age 25 -- 20 years earlier than now recommended -- to save them from blindness, kidney failure and amputations, government researchers say.

Earlier screening likely would mean earlier diagnoses and treatment to avoid the debilitating complications of the disease, said the researchers, led by Dr. Michael M. Engelgau of the federal Centers for Disease Control in Atlanta.

Their report was published in Wednesday's Journal of the American Medical Association.

Diabetes afflicts 16 million Americans, and at least a third of them are unaware they have the illness, experts estimate. It is the leading U.S. cause of blindness, kidney failure and amputations and kills 180,000 a year.

Dr. Gerald Bernstein, president of the American Diabetes Association, said in a telephone interview Tuesday:

"What we are learning, unfortunately, is this is now a disease of children," said Bernstein. One-fourth of new diabetes cases among people under age 20 are now type 2, he said.

Formerly called adult-onset or insulin-independent diabetes, type 2 diabetes generally develops after age 40 and is treated only with dietary changes and pills, though many type 2 patients now take insulin shots.
Type 2 is making alarming gains among youth because of rising childhood obesity and the prevalence of sedentary lifestyles, said Bernstein, who was not involved in the new study.

He noted that diabetes already costs about $100 billion annually, more than heart disease, cancer or AIDS.

Type 2 diabetes is often preceded by obesity or other health problems. It accounts for 95 percent of all diabetes cases. A slow-developing disease, it occurs when the body gradually loses its ability to use insulin properly and-or the pancreas, which produces insulin, fails to keep up with the body's need for it. Insulin is the hormone needed for cells to convert sugar into energy.

Type 1, formerly called juvenile-onset or insulin-dependent diabetes, develops much more rapidly and usually appears suddenly between ages 10 and 16. In type 1, the pancreatic cells that made insulin are destroyed by the body's immune system mistakenly attacking them.

The study found that routine screening of young adults -- ages 25 to 34 -- would have the best value, and the later screening began the less disability per dollar it would prevent. Screening all adults age 25 and up would decrease the average age at diagnosis by nearly six years, the researchers predicted. Without such screening, type 2 diabetes typically exists nine to 12 years before diagnosis, they said.

AP-NY-11-24-98 1820EST

Persons With Chronic Conditions

Their Prevalence and Costs

Catherine Hoffman, ScD; Dorothy Rice; Hai-Yen Sung, PhD

Objectives.—To determine (1) the number and proportion of Americans living with chronic conditions, and (2) the magnitude of their costs, including direct costs (annual personal health expenditures) and indirect costs to society (lost productivity due to chronic conditions and premature death).

Design.—Analysis of the 1987 National Medical Expenditure Survey for prevalence and direct health care costs; indirect costs based on the 1990 National Health Interview Survey and *Vital Statistics of the United States.*

Setting.—US population.

Participants.—For the estimate of prevalence and direct costs, the National Medical Expenditure Survey sample of persons who reported health conditions associated with (1) use of health services or supplies or (2) periods of disability.

Interventions.—None.

Main Outcome Measures.—The number of persons with chronic conditions, their annual direct health care costs, and indirect costs from lost productivity and premature deaths.

Results.—In 1987, 90 million Americans were living with chronic conditions, 39 million of whom were living with more than 1 chronic condition. Over 45% of noninstitutionalized Americans have 1 or more chronic conditions and their direct health care costs account for three fourths of US health care expenditures. Total costs projected to 1990 for people with chronic conditions amounted to $659 billion—$425 billion for direct health care costs and $234 billion in indirect costs.

Conclusions.—The prevalence and costs of chronic conditions as a whole have rarely been estimated. Because the number of persons with limitations due to chronic conditions is more regularly reported in the literature, the total prevalence of chronic conditions has perhaps been minimized. The majority of persons with chronic conditions are not disabled, nor are they elderly. Chronic conditions affect all ages. Because persons with chronic conditions have greater health needs at any age, their costs are disproportionately high.

JAMA. 1996;276:1473-1479

From the Institute for Health and Aging at the University of California, San Francisco. Dr Hoffman is now with the Henry J. Kaiser Family Foundation, Menlo Park, Calif. Dr Sung is now with the Department of Quality and Utilization, Kaiser Permanente Medical Group, Oakland, Calif.

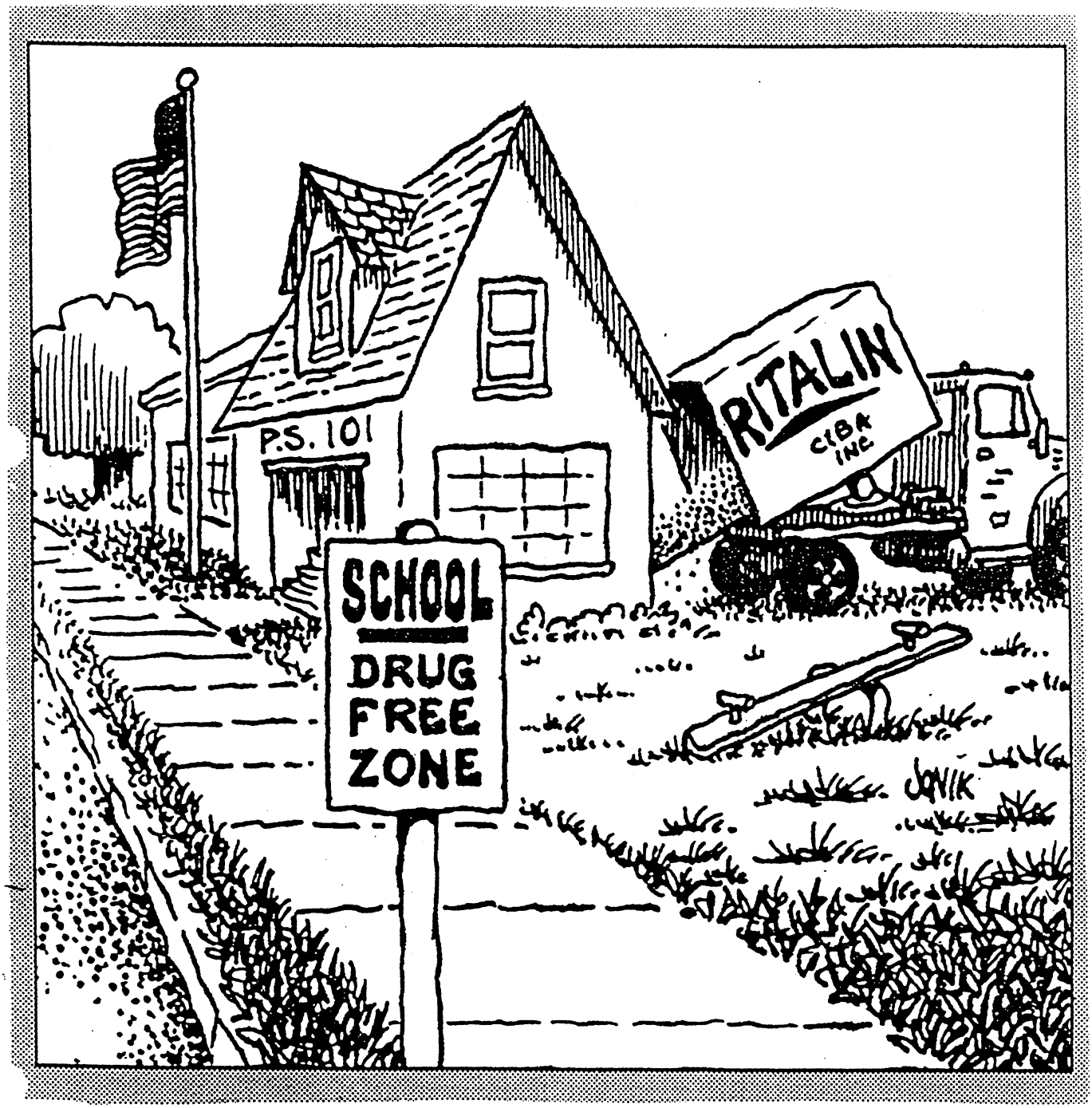
Reprints: Catherine Hoffman, ScD, The Henry J. Kaiser Family Foundation, 2400 Sand Hill Rd, Menlo Park, CA 94025.

CHRONIC health conditions, a general term that includes both chronic diseases and impairments, have been as a group the leading public health concern since the 1920s. Health statisticians noted then that chronic illnesses were replacing infectious diseases as the dominant health care challenge.[1] By the 1930s, community-based surveys had begun to demonstrate that chronic conditions were highly prevalent and while less life-threatening than infectious diseases, they were often disabling. The first National Health Survey conducted in 1935 found that 22% of the population had a chronic disease, orthopedic impairment, or a deficit in vision or hearing.[2]

From the outset, the costs of caring for chronically ill persons and how best to meet their needs have challenged individuals and families, medical care providers, the insurance industry, and policymakers. Our health care system remains firmly rooted in episodic and acute care, but it is unlikely to continue this way in the next century. Writing in 1987 about the paradox of the prevalence of chronic illness and the design of our health delivery system, Anselm Strauss said[3]:

> Although its prevalence has been recognized by some observers for at least three decades, neither the general public nor health professionals recognize the full implications of this for training, care, insurance, and indeed, for health institutions themselves. We are just beginning to pass into a period when chronic illness per se (rather than specific or categorical chronic diseases) is referred to, thought about, and acted upon as a general reality.

Escalating health care costs have been the major factor forcing us to reexamine the fit between the needs of many Americans and the design of our health care system. Both public and private payers have grown increasingly aware of the costs of chronic conditions and the disproportionate use of resources by a minority of Americans. In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•TYPICAL COURSE OF AN AUTISTIC PATIENT

1.Hepatitis B immunization at 12 hours after birth. DPT immunization at 4 and 8 weeks*; oral polio immunization also at 4 and 8 weeks, again at 3 months. Schedule now being changed; children will receive 2 doses of live attenuated oral polio and 2 doses killed polio; oral polio can cause disease; only killed polio is used in Europe.
2.Because of great decrease in cell-mediated immunity (CMI) in infants, the vaccines lower CMI further; one decreases CMI by 50%; two together by 70%. Longest safety trial of of the triple vaccine (MMR, all live attenuated viruses) was three weeks.
3.Repeated immunizations with 3 vaccines simultaneously, e.g., pneumococcus, hemophilus, etc. from 4 weeks to 12 or 18 months. Repeat DPT is given at 12 months.* All these triple vaccines markedly impair CMI.
4.Resultant decrease in CMI predisoposes to recurrent viral infections, especially otitis media, since CMI controls response to viruses (also fungi [e.g., Candida], parasites [e.g., leishmaniasis], mycobacteria [e.g., tuberculosis, even if drug resistant, and leprosy].
5.When infections occur, bacterial cultures rarely performed, yet infants repeatedly given antibiotics. Antibiotics are of asbsolutely no help in viral infections; in some countries, antibiotic administration without a prior cultutre is considered malpractice.
6.Antibiotics wipe out helpful bacteria in the gut (e.g., lactobacilli, bifidobacteria) which have important protective functions, including prevention of infection by yeast, pathogenic bacteria, and/or parasites. The protection is provided in part by the helpful bacteria clinging to the intestinal cell wall, thus preventing pathogenic microorganisms from getting to it. The pathogenic bacteria compete with the body for vitamin B-12 and perhaps other vitamins and minerals.
7.After helpful bacteria wiped out, Candida usually develops. Candida produces toxin. However its main deleterious effect is avid binding of coenzyme q10, usually at barely adequate levels in the diet of normals to begin with, to a far greater extent than by normal tissues. Candida is not the cause of increased intestinal permeability, except in rare instances, since substances passing into the body enter via the small intestine (jejeunum) whereas Candida is almost always confined to the large intestine (but if present in jejeunum, can be life-threatening).
8.The Candida infection is usually treated with ketoconazole or similar anti-yeast antibiotic.
9.Ketoconazole and similar compounds impair patient's liver function as shown by liver detoxification profile. This could also be a factor in increased intestinal permeability, because the liver also synthesizes the J piece (joining piece) that binds two molecules of IgA antibodies together to form secretory IgA, which protects the intestinal tract from a variety of damaging agents; severe diminution of secretory IgA predisposes to increased intestinal permeability. Furthermore, since the blood vessels from the colon go directly to the liver via the enterohepatic circulation, the various toxins from microorganisms and undigested food in the colon go directly to the liver and impairs the latter's detoxification mechanisms and its production of enzymes. (The liver produces the vast majority of the hundreds of different body enzymes necessary for normal metabolism.).
10.Decrease in production of the liver enzymes (phosphosulfotransferase and cytochrome p450 family) causes failure to break food proteins (including gluten and casein) into peptides. The intact proteins cross into circulation, and antibodies** are formed against them. The antibodies complex with the antigen to form antigen-antibody complexes, that in turn can enter various organs and seek out cells with receptors for antigen-antibody complexes, e.g., cells of the joints (causing arthritis), muscles (causing myalgia), or brain (causing cognitive dysfunction).
*DPT immunization in inbred mice has been shown to result in decrease synthesis of cytochrome p450 and of phosphosulfotransferase and of the messenger RNA's necessary for their production.
**If antibodies are not detectable, this may be due to immune complex in antigen access.

PREVENTION

1.The law states that infants with immune defects should not receive immunizations. But no pediatricians test for immune deficiency before giving immunizations. They are always given out of convenience for pediatricians at well-baby follow-ups at 4 and 8 weeks in this country.
2.Defer Rubella vaccine in males completely, in females defer until age when menses begins. Rubella is only a mild disease in the developed countries, with mild fever and "spots" for three days. Reason for females taking it a menses is because if Rubella occurs in the first trimester of pregnancy the child will develop severe congenital defects starts to prevent congenital defects. If administered during first or second trimester do not give to women for at least 2½ years following delivery of last child, as the vaccine virus is present in respiratory secretions for seven days and can cause disease.
3.Defer other immunizations until age 4 (except for tetanus and diphtheria toxin [?] which should be given at 2½ years).
4.Obtain IgG antibody titers from cord blood to all vaccines currently in use and store away a sample of serum so they can be tested for vaccines which will be introduced later (we are introducing 1-2 new immunizations each year). If any of the IgG antibody to DPT, MMR, polio (and in the British Commonwealth countries 16 Coxsackie viruses), get IgM on infant from the stored serum (divided into 2 parts), and the mother, father and the sib of closest age should be tested for IgG and IgM antibodies to the relevant virus.
5.Do not take influenza vaccines or other new vaccines. Ask the physician if the vaccine bottle contains mercury (thiomerol or alum [which boosts the response to various immunizing agents]). Also ask physician to obtain vaccines free of these. Repeat injections of these agents can cause all kinds of immunologic aberrations.
6.Nurses in newborn nurseries should not receive rubella vaccine. Rubella immunization of nurses in Philadelphia 12 years ago, because of several cases of rubella in newborn infants, resulted in a micro-epidemic of CFIDS.

TREATMENT of AUTISTIC SPECTRUM DISORDERS

A. NON-SPECIFIC THERAPIES (i.e., not limited to one disorder within the spectrum)

1.For Candida infections give Diflucan, asynthesized antifungal, but only if Candida is demonstrated in stool, urine, finger- and toe-nails, and/or vagina, etc., or if serum Candida detection test gives highly positive results. If present in stool, patient's own Candida should be tested against specific antifungals and six natural substances to see which of these the organism is mosr subseptible. Lactobacillus acidophilus and thermophilic bacteria to eradicate and put good bacteria back in the bowel. If refractory, use Candida-specific transfer factor.
2.If serious reaction to the immunization, measure antigen-antibody complexes by four methods. If elevated: (a) plasmapheresis or (b) Theoretical: a method that has been used for Digitalis toxicity: Couple antibody to offending toxin or vaccine virus to Sephadex Columns and pass plasma through this to remove anti-toxin or vaccine and return plasma to patient (if this is difficult to understand, it does not differ that much from dialysis for kidney failure.)
3.At age 15 months, get IgG titers to measles, mumps, rubella, HHV-6, DPT (all 3), cytomegalovirus, antibody to the "early" antigen EBV, also mycoplasma fermentens and chlamydia. (TF's available for most of these).
4.Often increased intestinal permeability; if present correct by appropriate dietary means (can be determined by very simple test). For most severe increased intestinal permitability, restrict diet to rice-based milk-free, wheat-free, corn-free, and sugar-free diet containing amino acids and proteins (astronauts' diet) for three months.
5.Comprehensive Stool Analysis (e.g., Great Smokies Diagnostic Laboratories-GSDL) for pathogenic bacteria, yeast, and parasites. If present, test sensitivity to natural agents and antibiotics; use those agents to which patient's pathogens are most sensitive. If chymotrypsin is subnormal in the stool, add oral enzymes, preferably alphazyme or gammazyme. If stool pH is alkaline and patient complains of upper abdominal distress, add betaine (tri-methylglycine). Take sublingual vitamins and zinc.
6.If elevated toxic metals or deficient trace minerals on screening by hair analysis, repeat abnormal levels by blood test. Also measure content of metals and minerals in drinking water.
7.Test for malabsorption, especially if stools float or are intermittently light colored. If so, oral vitamins and minerals are only partially absorbed; administer such sublingually.

B. SPECIFIC THERAPIES FOR DIFFERENT DISORDERS WITHIN THE AUTISTIC SPECTRUM

As indicated below, many different disorders are termed "Autism," although they differ in etiology, and hence require different therapy. A good analogy is anemia, which can be due to folic acid deficiency, vitamin B12 deficiency, iron deficiency, autoantibody destruction of one's own red cells, enzyme defect, or abnormal hemoglobin (e.g. sickle cell anemia). Symptoms, regardless of cause, are quite similar: pallor, shortness of breath, etc. Correct cause can be determined by laboratory tests. If due to folic acid deficiency, anemia responds to folic acid but not to other medications; if due to B12 deficiency, (pernicious anemia, cannot absorb B12) responds to B12 injection; if due to iron deficiency, responds to iron administration; if autoantibody to red cells, responds to Cortisone and nothing else; if enzyme deficiency, abnormal hemoglobin, etc., the only therapy at present is genetic engineering. (P.S. B-12 will not aid iron-deficiency anemia, and cortisone derivatives will often make it worse, since a chief cause is a silent, bleeding, peptic ulcer; cortisone causes exacerbation.)

1. Measles virus vaccine-induced (classic infantile autism, age of onset 15 months in US, 12 months UK and Canada): Antigen-specific Transfer Factor for measles vaccine virus.
2. Rubella virus vaccine-induced (often within 4 days of birth,m due to maternal immunization while in hospital): Antigen-specific Transfer Factor for rubella vaccine virus.

Some of the disorders lumped together as "Autism," different from classical infantile Autism, are listed below; they share some, but not all, clinical features; most have however a different age of onset, different immunologic features, and different optimal therapy:

A. PERVASIVE DEVELOPMENTAL DISORDER (PDD): due to (a) Clostridia toxins (b) Salmonella toxins (c) Aspergillosis

B. DELAYED DEVELOPMENTAL DISORDER (DDD) due to effects of one or more of 5 toxic metals on brain and thyroid; treatment chelation with appropriate chelating agent.

C. ATTENTION DEFICIT DISORDER (ADD): we find antibodies to the N-terminal end of growth hormone; treatment plasmapheresis.

D. LANDAU-KLEFFNER SYNDROME (AUTISM-EPILEPSY SYNDROME): we find antibodies to glutamic acid decarboxylase (GAD), very important in memory; treatment also plasmapheresis. If plasmaphersis fails and antibodies to myelin basic protein are present, try Intravenous Immunoglobulin (IVIG); after several infusions, symptoms of mild transfusion reaction may develop to due antibodies to antigens present on the surface of Immunoglobulin molecules (termed Gm allotypes for IgG, Am allotypes for IgA, Mm allotypes for IgM, etc.) lacking in the recipient. Analogy, infusion of Rh+ blood into Rh- recipient: the first time presents no problem. (For other autistic conditions with epilepsy, try neuronal calcium ion channel blockers; if of no help, photonic therapy.)

E. ASPERGER'S SYNDROME (defective socialization and clumsy motor movements, no other symptoms of autism): We have found serotonin deficiency in some. We use serotonin re-uptake inhibitor (e.g., Zoloft) to prolong time serotonin is available to brain receptors, results in rapid improvement.

RARE AUTISTIC DISORDERS

1. SEGMENTAL DEVELOPMENTAL DISORDER: Usually just severe speech deficit
2. FRAGILE X SYNDROME
3. X-LINKED 5'-NUCLEOTIDASE DEFICIENCY (Treatment: obtain enzyme from one of several research labs now using it for a rare immunodeficiency syndrome)
4. COLEMAN'S HYPOCALCEMIA AND HYPOCALCURIA SYNDROME: Investigations needed as to cause; abnormalities in thyrocalcitonin?
5. ATYPICAL AUTISM: such as that afflicting offspring of veterans sufferring from Gulf War Syndrome. Severity of autistic-like symptoms is proportional to severity of disease in parent when conception occurred.

RARE FINDINGS IN AUTISM, PRESUMABLY ETIOLOGIC

1. Antiboides to dopamine and/or serotonin
2. Antibodies to dopamine and/or serotonin receptors.
3. Antibodies to dopamine and/or serotonin transport proteins.
4. High or low levels of one or more catecholamines - this is probably due to vitamin (e.g., thiamin) deficiency causing decrease in activity of enzymes responsible for synthesis and for degradation of the various catecholamines.

Subsets of Autism.

What was called autism prior to 1973 was in reality Asperger's Syndrome, which has a much different clinical and immunological profile. Seventy percent of true autism is due to the measles virus vaccine (not the virus itself). We can prove that this is vaccine-related because the onset happens within a week of receiving the vaccine.

There are numerous subsets of autism (treatment is possible for the first three):

1. Asperger's Syndrome
2. Attention-Deficit Disorder without hypertension
3. Landau-Kleffner Epilepsy Autism Syndrome
4. Pervasive Development Disorder
5. Immunization against diptheria toxoid, tetanus toxoid and pertussis (given 4-8 weeks); some infants have violent adverse reaction against this mixture. It is possible that cerebral reactions followed by the sudden onset of autism are due to the interaction of the antigen introduced into the infant with maternal IgG antibody, which still persists in the infant's blood until about 2-1/2 years of age. The half-life of maternal antibody IgG titer in the infant is approximately 30 days. At birth, the infant's IgG antibody titers to various antigens are exactly those of the mother. If IgG antibody titer to a given antigen (such as if the mother was given tetanus antitoxin ater stepping on a rusty nail one year prior to delivery) was 10,000 units at delivery, the titer at 30 days (first DPT) would be 5,000; 60 days (8 weeks, second DPT), 2,500; and 90 days, 1250, etc.

Very Rare

1. Fragile X Syndrome (0.1 percent of all autistic children)
2. 5'-nucleotidase deficiency
3. Coleman Hypocalcemia & Hypocalcuria

Not Autistic but involved in differential diagnosis

1. Prader-Willi Syndrome
2. Rett Syndrome
3. Williams Syndrome
4. Miscellaneous: Mother given rubella vaccine before leaving hospital after giving birth to healthy infant; live rubella was present after 7-10 days. The child got rubella from inhaling this. There are three known cases.

[redacted]

UK Autism Expert Blows Whistle on MMR/Autism Link Denials

Tuesday, October 19, 1999

Finally, in the vaccine debate, the British government has been blatantly caught with its trousers down.

After many months of attempting to discredit the work of Andrew Wakefield and co of the Royal Free Hospital in London, the people who have steadfastly maintained that there may be a link between the triple measles-mumps-rubella (MMR) jab and autism, the government has suffered a defector among its ranks.

Dr Ken Aitkin, an authority on autism, commissioned by the government to allay fears about the link between the condition and the vaccine, has blown the whistle on the government's damage-limitation exercise.

Dr Aitken formed part of a 37-strong Medical Research Council panel to study evidence between the triple jab and autism. Last Spring, the findings of the panel were cited by then chief medical officer Kenneth Calman as a reason to definitely rule out any link.

Recently, however, Dr Aitkin admitted that the Department of Health did not accurately put forward the conclusion reached by the MRC. 'We did not conclude that autism was not linked to MMR,' he said recently. 'The view was that there was a problem which needed to be looked at very carefully and that there was not enough evidence to rule out a link'.

Even worse, as far as the government is concerned, Dr Aitkin is now sleeping with the enemy. **He agreed to act as an expert witness on behalf of the 100 parents of autistic children seeking compensation from three manufacturers of the MMR vaccine for allegedly damaging their children.** The case came to trial a month ago.

Dr Aitkin's apparent defection is all the more interesting considering that he was part of a panel that was handpicked by the government. General members of the public concerned about vaccine safety were not allowed to nominate their own members.

Despite assembling a large panel of independent experts, the government and the Public Health Laboratory put their own spin on the results of an independent committee to back up their desired conclusion.

And now the government's latest move is to ban single vaccines, with the spurious argument that the vaccines on their own are dangerous.

From What Doctors Don't Tell You - £44.95 pa for UK subscribers - 77 Grosvenor Avenue, London N5 2NN.

Childhood Vaccination and Asthma

From Emerging therapeutic targets in asthma and allergy: modulation of IgE by Farhad Imani. The Johns Hopkins University School of Medicine, Division of Clinical Immunology, Asthma and Allergy Center. Baltimore, MD, USA Emerging Therapeutic Targets (1999) 3(2):229-240

Childhood viral vaccinations are a common practice in medicine today. By developing a vigorous Th1-type immune response to respiratory viral strains, the incidence of IgE-mediated disorders may be reduced. **It is important to note that there may be an association between childhood viral vaccination and the observed increase in the incidence of asthma.** This may be due to the use of live viral vaccines which may bring about a Th2-type response, a possibility born out in our recent experiments using Measles-Mumps-Rubella (MMR) vaccine. Our data suggests that infection of human B-cells with MMR vaccine leads to IgE class switching [Kehoe K & Imani F, manuscript in preparation]. At least in theory, universal childhood vaccination using live viral strains may be contributory to the rise in IgE-mediated disorders. Therefore, if the vaccine/IgE hypothesis is correct, a change in viral vaccination regimen, from live virus to a safe immunogenic polypeptide vaccination (subunit vaccination), may be required in the future.

The Effects Of Diphtheria-Tetanus-Pertussis (DTP) Or Tetanus Vaccination On Allergies And Respiratory Symptoms Among Children And Adolescents In The United States

Symposium Proceedings World Federation of Chiropractic 5th Biennial Congress, Auckland, NZ, May 17-22, 1999.
Author: Hurwitz L, DCPhD and Morgenstern H, PhD Affiliation: UCLA School of Public Health and the Los Angeles College of Chiropractic - USA

Abstract

Background:

Finding from animal and human studies confirm that DTP and tetanus vaccinations induce allergic responses, and associations between childhood vaccinations and subsequent allergies have been reported recently.

Methods:

Interview data were used from 13,612 two month through sixteen year old children and adolescents from the Third National Health and Nutrition Examination Survey (NHANES 111), conducted between 1988 and 1994. Each subject's parent or guardian responded to questions regarding DTP or tetanus vaccination, physician-diagnosed asthma or hay fever, lifetime history of severe allergic reactions, and sinusitis, and other allergy related respiratory symptoms in the past 12 months. Effect estimates were controlled for age, parental history of allergies, and other confounders.

Conclusion:

DTP or tetanus vaccination in children is associated with a lifetime history and 12 month prevalence of many allergies and related respiratory symptoms. Although we have little power to detect interactions between vaccination and age, the effect of vaccination appears to e associated with different types of allergies at different ages... **Vaccination may be partly responsible for the increased prevalence of asthma and other allergic hypersensitivity disorders.**

Subj Study 7M Kids Have Hearing Loss
Date 98-04-07 16 41 07 EDT
From AOL News
BCC TKOREN1

Study: 7M Kids Have Hearing Loss

c The Associated Press

By BRENDA C COLEMAN

CHICAGO (AP) - More than 7 million children ages 6 to 19 have some hearing loss that is usually slight but may impair their speech and learning ability, says a new federal study that recommends more testing

Such hearing loss may escape detection in routine screenings that do not test separately for sensitivity to low- and high-frequency sounds, researchers say

Children should be screened in both frequency ranges in elementary, middle and high school, researchers recommended in Wednesday's Journal of the American Medical Association

Depending on the cause of the hearing loss - for example, if it's noise - with continued exposure, we know in adults that the hearing loss gets worse," said the lead author, nurse epidemiologist Amanda Sue Niskar of the Centers for Disease Control and Prevention

Catching the problem early can minimize the loss, she added in a telephone interview Tuesday from Atlanta

Other causes of hearing loss in children include impacted wax or swelling caused by infection, and side effects from medication or diseases such as meningitis, the researchers noted Whether hearing loss can be arrested or reversed varies case by case, Niskar said encephalitis

No national mandate exists for children's hearing screenings, and procedures vary state to state and school district to school district, Niskar said

Results of the study of 6,166 children nationwide from 1988 to 1994 found that 14 9 percent of those examined had some loss in at least one ear When applied to the general population, those figures mean more than 7 million children nationwide suffer some hearing loss, the researchers said

Researchers can't say whether the problem is worsening because no previous data are directly comparable, Niskar said Similar data were gathered in the 1960s, she said, but the technology and methods were so different that comparisons would be unreliable

About 90 percent of losses in the new study were too slight for children or parents to recognize Most were only in one ear But that doesn't mean they can't cause problems, Niskar said

For example, a young child who is even slightly impaired in the low frequencies might have trouble distinguishing between vowel sounds such as a" and o" in spoken words And high-frequency impairment might lead to difficulty distinguishing between consonant sounds such as th" and sh," she said

Adults with the same impairments might not notice because they can fill in the missed words or sounds by knowing what to expect, Niskar said

The researchers defined hearing loss as the inability to detect sound below 16 decibels in intensity in either the low or high frequencies in either ear Those levels are just a little louder than the noise from a gently gurgling waterfall (low frequency) or a very soft whisper (high frequency)

The 16-decibel level was chosen based on previous studies, current audiology textbooks and consultation with the American Speech-Language-Hearing Association, Niskar said

AP-NY 04-07-98 1639EDT

by ANDREA ROCK

WHEN MIRIAM SILVERMINTZ OF FAIR LAWN, N.J. TOOK HER SEVEN-month-old son Nathan to the pediatrician for his third series of vaccinations on Feb. 18, 1991, she was thrilled to hear the doctor say her baby was growing beautifully. Just five hours later, as Nathan lay in his crib, he shrieked in pain. Terrified, Miriam ran in and cradled her baby in her arms. Nathan collapsed, his eyes rolling back in his head, as he suffered a severe seizure. "We called 911, and they worked on him for 45 minutes," says Miriam, "but I knew when I held him in my arms that he was dying."

What killed Nathan? "When I first called the pediatrician after the ambulance arrived, he said Nathan probably was just having a reaction to his DPT shot," Miriam recalls. "But when Nathan died, the doctor did an about-face and said it had nothing to do with the vaccine." Nathan's death was officially attributed to a congenital heart defect. But Miriam, now 36, and her husband Steven, 37 (pictured on page 151), couldn't shake the feeling that Nathan's death was somehow linked to the shot.

They began to search for details on DPT, which prevents diphtheria, pertussis (familiarly known as whooping cough) and tetanus. The search led them to the National Vaccine Information Center of Vienna, Va., a 14-year-old nonprofit educational and support group for parents whose children have been harmed by vaccines. There, the Silvermintzes learned that a DPT shot can indeed cause death—as well as adverse reactions ranging from fever and irritability to the permanent brain damage suffered by Joshua Reed, now 13 (pictured opposite), of Great Bend, Pa. They also discovered that some batches of the vaccine cause more problems than others. In fact, because of lax federal recall regulations, Nathan appears to be the first of nine children who died shortly after getting a shot from the same DPT lot.

Finally, the Silvermintzes were confronted by the most painful discovery of all. "We learned," says Miriam, "that there were safer ways to manufacture DPT that weren't being used in this country."

In 1994, the U.S. Court of Federal Claims awarded damages to the Silvermintzes under the National Childhood Vaccine Injury Act of 1986. "It was bad enough suspecting that Nathan's death was caused by a vaccine," says Miriam, "but still I had believed it was one of those one-in-a-million things. When I learned that his death was followed within three weeks by another in New Jersey and then another in Illinois and another in Pennsylvania and five more after that while this batch of vaccine stayed on the market for an entire year, it broke my heart. I feel betrayed by the drug companies who make vaccines and by the doctors and government agencies I'd always trusted to protect us."

Brain damaged after a DPT shot, Joshua Reed (with his parents) wears a helmet to protect him during seizures.

With government approval, drug companies sell vaccines that can leave your child brain damaged, can spread polio from your baby to you—and can even kill. Safer stuff is available. Here's why you haven't been getting it.

Photographs by Lisa Spindler

Another Example of Manipulation of Vaccine Reports
A government agency's report was "edited."

Dear Dr. Levy (an American MD) (72320,275@compuserve.com),

You have quoted the CDC book called **ADVERSE EVENTS ASSOCIATED WITH CHILDHOOD VACCINES**, (editor Katherine Stratton). Pg. 229: "Anaphylaxis was not observed in the 166,757 children vaccinated with a plasma-derived vaccine in New Zealand (Morris and Butler, 1992)"

My name is Hilary Butler, and I am co-author of that report. The original submission sent to NIH included the complete Health Department Report in which were detailed 2 cases of anaphylaxis. We also included several Health Department memorandum detailing many cases of anaphylactoid reactions. On 30 September 1996, after viewing the FDA web site I sent Katherine Stratton the following E-mail:

> Dear Dr Stratton, As you may (or may not) remember, I wrote you a detailed six page letter of 7 January 1994 regarding a major error on pg 229 in your book on Adverse Events associated with childhood vaccines... you refused, or chose not to reply to it again. Now I see that the FDA has put your error onto the Internet. As I said to you at the time:
>
> > "This misrepresentation does a serious disservice to those who might believe that your book reports accurate data submitted to the Vaccine Safety Committee. If you disagree with this assessment, I will welcome your reasons for disagreement. However, if you agree that there is misrepresentation, I will welcome information on your planned corrective action."
>
> You did neither, and as a result of your inaction, a lie has been perpetrated. For the third time: What do you intend to do to correct an error brought to your notice two and a half years ago?"

Dr Katherine Stratton's reply was as follows:

> "I have just now reread material you and Dr Morris sent in 1992. I assume that the cases were not counted as positive indications of vaccine-caused anaphylaxis because the material presented was not specific enough to meet the criteria for anaphylaxis as laid out in the report. The report is final, and there is no action that can be taken to address your recent fax."

Dr. Butler: Those two cases of anaphylaxis were accepted as vaccine related, and were listed as such in the table. So, as the author of a very specific report sent to the NIH, with clear documentation of two clear-cut cases of anaphylaxis, which were dismissed because they did not fit the NIH criteria, I would like to ask some questions:

1. What right have the NIH to dismiss two cases of reported anaphylaxis, accepted by the NZ health Department medical assessor?
2. What right have the NIH to specifically change clear-cut information presented by myself to say something I did not say?

I have no confidence in the NIH so-called "gold-standard" book on vaccine safety, because my report was deliberately grossly misrepresented. I consider therefore, that the scientific accuracy of everything else published by the NIH to be similarly tainted. I do not have the luxury of studying everyone else's factual reports to know whether similar statistical sculpturing has been achieved. But I do have the "luxury" of being able to put my submission and the book together, and knowing that NIH totally stuffed it up. Knowing that the FDA continues this myth, and that on the 16 September, so did you, gives me even less confidence in the truthfulness of the rest of your information.

Subj: HEPATITIS B

Date: 95-08-28
From: via@eden.com (karen schumacher)
To: via@eden.com (Vaccine Information & Awareness)

COMPLIMENTS OF: KWNVIC@aol.com

August 24, 1995

Ms. Linda S. Johnson
Immunization Program Manager
Washington State Department of Health
P.O. Box 47843
Olympia, WA 98504-7843

Dear Ms. Johnson,

This letter is written on behalf of Washington members of the National Vaccine Information Center, (NVIC), a national non-profit organization dedicated to preventing vaccine injuries and deaths. While I am unable to attend the open public meetings concerning the proposal to include hepatitis B vaccine on the list of required vaccines, I would request that my comments be included as part of the record.

The National Vaccine Information Center has been monitoring vaccine policies since 1982. NVIC worked with parents of vaccine-damaged children and Congress to pass the National Childhood Vaccine Injury Compensation Act of 1986, PL-99-660. Even with all the problems this program has, the government has paid over $500 million for vaccine injuries and deaths.

As you know, hepatitis B disease is transmitted through blood and body fluids. The vaccine was originally developed for high-risk groups such as intravenous drug users, homosexuals and prostitutes.

While attending a Centers for Disease Control, ACIP meeting in Atlanta, GA, it was suggested by one drug company representative to inject the vaccine into the arm of every high school child in the country if the high-risk groups would not use the vaccine.

Studies show that high-risk groups did not use the vaccine and only 25% of medical personnel were vaccinated against hepatitis B in 1992. It seems ironic that this vaccine, which has been available for more than ten years, is now being recommended for use in healthy newborns, a group not at risk for the disease.

In your assessment of whether to add hepatitis B to the recommended list of vaccines for use in infants, you will find it difficult if not impossible to determine the long-term risk of

administering this vaccine to healthy newborns. This is because the studies have not yet been done.

You must also take into account the extent of the threat from hepatitis B disease. Over half the people infected with hepatitis B never develop symptoms and are not aware that they have contracted the disease unless they have a blood test. In those who develop an acute infection, the disease runs its course within one year in 95% of the cases. The risk of acute infection developing into chronic liver disease is overestimated in the United States. According to the German journal Infection 20 (1992, No. 4), the Center for Virakl \hepatitis in Athens, Greece, published their third study showing that acute hepatitis B very rarely progresses to chronic liver disease.

*The risk of vaccine complications in a 12-hour-old newborn remain to be seen. The Vaccine Adverfse Events Reporting System (VAERS) operated by the Food and Drug Administration has received a number of reports of infants dying within the first two weeks to two months of life. As of May 1995, VAERS has received a total of 9,509 reports with 171 deaths following hepatitis B vaccine. I hope that in your consideration of this matter you will investigate these deaths further and look at the range of ages and the circumstances surrounding their deaths. Many of these deaths are in infants who are too young to be considered SIDS. The FDA admits that they are only receiving 10% of all adverse events, including deaths, which occur following vaccination.

In your deliberations of this matter, please consider taking a more conservative approach. We would urge you to resist the temptation to vaccinate healthy newborns simply because they are an available population. We hope you will consider other ways of fighting hepatitis B in Washington, such as (1) screening pregnant mothers for hepatitis B disease; (2) having doctors question their adult and teenage patients about sexual activity, orientation or drug use; and (3) educating the public about the disease and how to avoid it.

Please carefully consider whether it is wise to vaccinate healthy newborns for a disease which is primarily a risk for adults, not infants. Thank you for the opportunity to submit these comments for your consideration.

Sincerely,
Kathi Williams
Director

we must have the freedom to choose and respect everyone's choice.

Karin schumacher
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FYI DC

Subj: **Hepatitis B Vaccine Linked to Autoimmune Rheumatoid Diseases**
Date: 11/9/98 11:53:35 AM Eastern Standard Time
From: AOL News
BCC: TKOREN1

Hepatitis B Vaccine Linked to Autoimmune Rheumatoid Diseases

SAN DIEGO, Nov. 9 /PRNewswire/ -- Data from France released at the 62nd Annual Meeting of the American College of Rheumatology, held November 8-12, 1998, in San Diego, California links immunization against hepatitis B to the development of autoimmune rheumatoid diseases such as lupus and rheumatoid arthritis. The rise of autoimmunity following hepatitis B immunization in school children and adults has become a major public health concern. In October, the Ministry of Health in France suspended routine hepatitis B immunization of school children while continuing hepatitis B immunization at birth. The reason for this decision was reportedly the increased risk of autoimmune diseases that has been associated with the vaccine when it is given starting at school age or later.

end M.S.

The data from France links hepatitis B immunization to both the development of newly diagnosed cases of autoimmune rheumatoid diseases as well as the exacerbation of previously diagnosed cases that were in remission. This finding is supported by data from Canada published in September which linked immunization against hepatitis B to the development of autoimmune rheumatoid diseases in firefighters.

John B. Classen, M.D. an immunologist at Classen Immunotherapies published papers linking the immunization against hepatitis B and other diseases to the development of insulin dependent diabetes, an autoimmune disease. Dr. Classen's work found that immunization starting after 2 months of life was associated with an increased risk of autoimmunity compared to starting at birth. Data from a small study published by the US government appears to support his data and showed that when hepatitis B immunization was given starting after 2 months of life it was associated with an almost doubling of the risk of diabetes.

"The data from humans and animals is very clear, when you stimulate the immune system with vaccines you increase the risk of autoimmunity and exacerbate smoldering inflammatory conditions. Vaccine induced autoimmunity is a major public health problem because of the number of vaccine doses given and the large percentage of people with undiagnosed inflammatory conditions. We need to develop ways of giving vaccines without increasing the risk of autoimmune diseases" states Classen.

"The French decision to continue hepatitis B immunization at birth while discontinuing immunization starting at school age suggests the French Ministry of Health may believe that they can decrease vaccine induced autoimmunity by giving vaccines starting in the first month of life. They appear to be accepting our findings" adds Classen.

Dr. Classen's research has been published in numerous journals and featured in national news reports. For the latest information on the effects of vaccines on insulin dependent diabetes and other autoimmune diseases visit the Vaccine Safety Website (http://vaccines.net).

For more information contact:

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http://vaccines.net

SOURCE Classen Immunotherapies, Inc.

CO: Classen Immunotherapies, Inc.

ST: California

From: Vaccination, Social Violence and Criminality, The Medical Assault on the American Brain by Harris L. Coulter, Ph D, Center for Empitical Medicine, Washington, D.C. 1990

"Activity-limiting Chronic Conditions" in Children

By Harris L. Coulter, Ph D

"The vaccination program was given a boost in 1965 when Congress passed the Immunization Assistance Act. In the following years more and more states extended their vaccination programs and made them obligatory.

"Four or five years thereafter physicians encountered a whole new group of neurologically defective four- and five-year-olds. A 1986 National Health Interview survey found that between 1969 and 1981 the prevalence of "activity-limiting chronic conditions" in persons younger than seventeen increased by an explicable forty-four percent - from 2,680/100,000 to 3,848/100,000, almost all the increases occurred between 1969 and 1975.

"Most of these "activity-limiting chronic conditions" are readily seen to be associated with the post-encephalitic syndrome. Childhood "respiratory diseases" increased forty-seven percent, childhood asthma sixty-five percent, and deaths from asthma in children aged five and older also increased, "mental and nervous system disorders" increased eighty percent, personality and other nonpsychotic mental disorders (including behavioral disorders, drug abuse, and hyperactivity) went up 300 percent, and diseases of the eyes and ears - especially otitis media - 120 percent, reported cases of hearing loss in both ears rose 129 percent.

"The increase was virtually identical in high-income and low-income families, excluding poverty as a major cause.

"Conditions not associated with vaccine damage - injuries, genitourinary disorders, diseases of the circulatory system, infective or parasitic diseases, and deformities - remained stationary during this time or actually declined.

"By 1980 the overall number of disabled children (many, of course, with multiple conditions) had more than doubled. Over two million children in the U.S. had some 'limitation of activity', up from one million in 1960."

From Dawbars:

Japanese findings indicate that adverse reactions to these types of MMR vaccine were up to 78 times as frequent as the UK's Chief Medical Officer of Health has Admitted (7.1/1000 = 78.1/1000). (1) If those figures are correct, then the vaccine is more dangerous than the illness. There have been reports of subacute sclerosing panencephalitis (SSPE) in children who did not have a history of natural measles but did receive measles vaccine.

Clients (and those who have contacted us) have reported to us a number of problems with the vaccine. To date we are aware of more than 600 instances of side effects following the MMR and MR vaccines. The figures in (brackets)...side effects as of January 1997.

Autism (202)
Crohn's disease and other serious chronic stomach problems (110)
Epilepsy (97)
Hearing and vision problems (40)
Arthritis and arthralgia (including juvenile rheumatoid arthritis) (42)
Behavior and learning problems (in older children) (41)
Myalgic encephalomyelitis (ME) and chronic fatigue (24)
Diabetes (9)
Guillain - Barre syndrome (9)
Idiopathic thrombocytopaenic purpura (and other purpuras) (5)
Subacute sclerosing Panencephalitis (SSPE) (3)
Wegener's Granulamatosis (2)
Multiple Sclerosis (1)
Death (14)

References

(1) A prefecture-wide survey of mumps meningitis associated with measles, mumps and rubella vaccine. Takashi Fujinaga, MD, Youichi Motegi, MD, Hiroshi Tamura, MD and Takayoshi Kuroume, MD. Ped Infec Dis J, March 1991 Vol. 10, No. 3.

Crib Death...or Vaccine Death?

Tedd Koren, D C

The mother places her smiling baby in the cradle Exhausted after a long day she begins to nod off herself But something isn't right The baby is silent–the baby isn't breathing! She rushes to the crib, picks up the still infant and gives a shake The baby gasps and cries–blessed crying The terror subsides into relief, "my baby is all right, my baby is all right " Ten thousand times a year she doesn't reach her baby in time

It's called crib death or sudden infant death syndrome (SIDS) and it's the second largest cause of infant deaths in the U S (congenital malformations are first)

Although the cause of crib death is officially classed as "unknown" disturbing reports have emerged over the years challenging that position Independent researchers from different countries noticed that babies die of crib death during that period when they receive DPT shots The reports, buried in journals and ultimately ignored, were termed "coincidence" by medical authorities

And then in 1985, in Australia, Viera Scheibner, Ph.D , a researcher with over 90 published scientific papers in refereed journals to her credit, was using a computerized breathing monitor to study babyies breathing patterns She discovered "babies' breathing was affected in a certain characteristic manner and over a long period of time [40-65 days] following DPT injections We also learned from the parents of crib death infants that most commonly the child had died after DPT injection," said Dr Scheibner

When the local medical groups reacted angrily to Dr Scheibner's discovery she was shocked "We realized that we had touched a very serious and contentious issue The resistance we encountered became the best and most effective goad to us to continue So I wish to thank those who would not speak out against the silent killer of babies," said Dr Scheibner

Is crib death the same as vaccine death? According to medical historian Harris Coulter, Ph D , it is impossible to tell the difference between the two As Dr Coulter says, "At a vaccination committee meeting in Washington, D C where they had a panel of people from about ten countries. I asked, 'How can you tell the difference between sudden infant death syndrome and death from vaccination?'"

"The Americans simply could not answer the question, but the European representatives were more honest and said, 'Indeed, there is no way in the world that we can tell the difference between them and it is a very big problem for us ' It appears that M D s invented the term sudden infant death syndrome to explain away the 'coincidence' that babies die about the same time they receive vaccines," says Dr Coulter

As if on cue, news arrived from an unexpected quarter Along with many European countries, Australia made childhood vaccination non-mandatory When half of the families opted out of the vaccine programs SIDS (crib death) dropped by 50%!

Searching the literature, Dr Scheibner discovered that when Japan moved the vaccination age to two years in 1975 crib death and infantile convulsions virtually disappeared! Japan then recorded the lowest incidence of infant mortality in the world (American babies receive their first shot at two months)

Recently the Japanese government made vaccination under the age of two years an option. Many parents took that option, had their child vaccinated at age 2 months, and crib death is now increasing

Dr Coulter is known to many in this field as the co-author (with Barbara Loe Fisher) of DPT. A Shot in the Dark, the first major work revealing the damaging effects of childhood vaccinations The book is credited with launching the modern anti-vaccination movement His more recent book, Vaccination, Social Violence and Criminality, studies the long-term effects of vaccination and its relationship to conditions such as autism, dyslexia, attention deficit disorder, and other conditions that barely existed before the advent of mass vaccination programs

Dr Coulter claims that vaccines cause encephalitis, or brain inflammation When it damages the nerves that control breathing crib death results--but not always If the damage is more mild the child may develop asthma, which along with the above mentioned conditions of childhood, is also increasing dramatically

Although long denied by medical groups the vaccination-crib death link has been recognized by the National Vaccine Compensation Office in Washington So far about $500 million has already been awarded to families of vaccine damaged children with about half the money to the parents of children killed by shots Their death certificates were originally labeled "sudden infant death syndrome of unknown origin" since doctors are loathe to write "vaccine death " (There are about 4,000 more cases in the pipeline with total compensation in the several billions of dollars Right now no more money can be awarded, the compensation office is presently bankrupt)

Realizing that the public and many health professionals are simply not given the larger picture of vaccine damage, Dr Scheibner studied thousands of journal articles to produce Vaccination, The Medical Assault on the Immune System This book describes how vaccines are much more dangerous to children than we've been led to believe "Immunisations, including those practised on babies, not only did not prevent any infectious diseases, they caused more suffering and more deaths than has any other human activity in the entire history of medical intervention All vaccination should cease forthwith and all victims of their side-effects should be appropriately compensated " says Dr Scheibner

In an interview with Dr Coulter, this author asked him how, in light of the present findings, the denial of the crib death-vaccine death connection persists He responded "I believe that this information will eventually come out, it can't be denied much longer It's just a matter of time"

The above mentioned books are available from Koren Publications, 2026 Chestnut Street, Philadelphia, PA 19103, 1-800-537-3001 Vaccination, The Medical Assault on the Immune System by Dr Scheibner is $26 00 or if ordering two or more, $24 50 each Vaccination, Social Violence and Criminality by Dr Coulter is $14.95 A Shot in the Dark by Fisher and Coulter is $9 95 Please add $4 50 shipping and handling per total order

Mindless Vaccination Bureaucracy

My daughter Lyla Rose Belkin died on September 16, 1998 at the age of five weeks, shortly after receiving a Hepatitis B vaccine booster shot. The following comments are intended to be a heads up to parents and potential parents about the risks of the Hepatitis B vaccine (HBV), and a firsthand report questioning the scientific legitimacy of the vaccine industry, which provides $800 million of annual revenue to Merck – the company which makes the Hepatitis B vaccine distributed in the US. Lyla Rose Belkin was a lively, alert five-week-old baby when I last held her in my arms. Little did I imagine as she gazed intently into my eyes with all the innocence and wonder of a newborn child that she would die that night. She was never ill before receiving the Hepatitis B shot that afternoon. At her final feeding that night, she was agitated and feisty -- and then fell asleep and didn't wake up. The autopsy ruled out choking. A swollen brain was the only abnormal finding. Most doctors I spoke to at the time said it must have been Sudden Infant Death Syndrome (SIDS), a catch-all diagnosis for unexplainable childhood mortality. The first instinctive reaction in such a situation is for parents to blame themselves. For many weeks, my wife and I agonized over what we might have missed or could have done differently.

In the US, the Hepatitis B disease mainly infects intravenous drug users, homosexuals, prostitutes and promiscuous heterosexuals. The disease is transmitted by blood, through sex or dirty needles. How could a newborn baby possibly get Hepatitis B if the mother was screened and tested negative, as my wife was? So then why are most US babies inoculated at birth by their Hospital or Pediatrician with the Hepatitis B vaccine? I've discovered the answer is -- an unrestrained health bureaucracy decided it couldn't get junkies, gays, prostitutes and promiscuous heterosexuals to take the Hepatitis B vaccine -- so they mandated that all babies must be vaccinated at birth. Drug companies such as Merck (reaching for new markets) were instrumental in pushing government scientists to adopt an at-birth Hepatitis B vaccination policy, although the vaccine was never tested in newborns and no vaccines had ever been mandated at birth before. It is widely recognized that newborns have under-developed immune systems, which can be overwhelmed or shocked.

The presentations included a study of Animal Models of Newborn Response to Antigen Presentation, which showed that newborn immune systems were undeveloped and strikingly different than those of adults. The message I received was that immune response in a newborn to shocks such as being injected with a vaccine was potentially unknown, since newborn T-Cells have a radically different behavior then those of adults. Another presentation was Strategies for Evaluating the Biologic Mechanisms of Hepatitis B Vaccine Reactions, in which vaccine researcher Dr. Bonnie Dunbar of Baylor College related numerous Hepatitis B-vaccine related cases of nervous system damage in adults, such as Multiple Sclerosis, seizures and blindness.

On the more positive side, the FDA presented a seemingly reassuring study from its Vaccine Adverse Effects Reporting System (VAERS), which showed only 19 neonatal deaths reported since 1991 related to Hepatitis B vaccination. I found the VAERS study data to be completely deceptive. Since I was sitting in that room and my daughter had died during their sample period and wasn't counted -- I wondered why. In fact, the New York City Coroner called VAERS to report my daughter's Hepatitis B Vaccine-related infant death and no one ever returned their call! What kind of reporting system doesn't return the calls of the NY City Medical Examiner -- and how many other reports were ignored? This is supposed to be the emergency 911 number for disasters such as bad lots of vaccine that could poison thousands of other babies. With the personal knowledge that the VAERS data was completely flawed, I sat in that room and listened in amazement as CDC officials and Dr. Sharrar of Merck (their head of vaccine safety) made disparaging comments about any possible risk from Hepatitis B vaccination, despite the evidence just presented by impartial scientists.

I studied statistics and econometrics at UC Berkeley and have developed innovative methods of applying probability to financial and economic data in my consulting business with some of the largest financial institutions in the world. That training and experience qualifies me to criticize the statistical legitimacy of the VAERS study, on which Sharrar of Merck and the CDC pseudo-scientists based their pro-vaccination stance. Their comments were scathingly dismissive of any possible risk from the vaccine. But that VAERS study is not a legitimate sample of a data set from which any conclusions about the larger population can be made. VAERS doesn't return coroner's calls, leading to the suspicion that deaths and adverse effects from

vaccination are woefully under-reported. To conclude that the Hepatitis B vaccine is safe because VAERS only reports 19 deaths is scientific fraud. In fact, I obtained the raw data from the VAERS system and found 54 reported SIDS cases after Hepatitis B vaccination in just the 18 months from January 1996 -- May 1997. That's almost 15 times as many deaths per year as their own flawed study reported. There are 17,000 reports of adverse reactions to Hepatitis B vaccine in the 1996-97 raw data. Clearly something is fishy about VAERS. VAERS was set up by the FDA and CDC and is supposed to be monitored by vaccine manufacturers. If there are 17,000 reports and VAERS doesn't even return the NY Medical Examiner's call, how many other deaths and injuries go unreported? I came away from that NAS workshop with the distinctimpression that Merck and the CDC didn't know and didn't really want to know how many babies are being killed or injured by Hepatitis B vaccination.

This is a bureaucratic vaccination program that is on auto-pilot flying into a mountain. The CDC bureaucrats have a vested interest in the status quo. If there were 17,000 reports of a dangerous disease in a 18 month period, the CDC would be all over the case. But when there are 17,000 reports of adverse reactions to a vaccine the CDC advocates for "public health" -- the CDC dismisses it as a coincidence. Merck makes $50 a shot from the three-shot series. Where do you think the allegiance of their vaccine safety official Dr. Sharrar lies? He was by far the most arrogant character at the workshop. Merck has sales of upwards of $800 million a year from vaccines.

Vaccination can be a lifesaver if an epidemic is raging, but in this case the risk of vaccination outweighs the risk of infants getting the disease. Surely, the hepatitis B vaccine doesn't injure every child that gets it, but in some unknown number of cases, it appears to be a death sentence and/or a nervous system toxin to innocent children who are at no risk of getting the disease the vaccine is supposed to protect against. My observations of Merck and CDC scientists at the Vaccine Safety Forum left me with the distinct impression that they had absolutely no idea which babies might be killed or injured by this vaccine. Furthermore, they used obviously flawed scientific data to arrogantly steamroller any opposition to their power. Parents should be aware that the Hepatitis B vaccine is not administered for the well-being of their child. Rather, it is delivered by the long arm of some incompetent and mindless bureaucracy in the name of stamping out a disease most babies can't possibly get. The Drug Company/CDC/FDA alliance has really pulled the wool over the medical profession's eyes with the Hepatitis B vaccine. The American Pediatric Society bought the alliance's sales pitch and now recommends that all infants get this vaccine at birth.

So now the first thing most babies get in life is a shock to their immune system from a vaccine against a non-existent risk of contracting Hepatitis B. Clearly, the interests of newborn babies were not represented on the original panel that created this vaccination policy in 1991. This vaccine has no benefit whatsoever for newborns, in fact it wears off and they will need booster shots later in life when they actually could get exposed to the disease. This is simply a case of ravenous corporate greed and mindless bureaucracy teaming up to overwhelm common sense. Merck in particular has gone way over the edge with this vaccination program. Ignoring and suppressing reports of adverse reactions to their profitable Hepatitis B vaccine verges on criminal conduct. A major media organization will soon present an investigative report on the issues discussed here. Nothing will ever bring my lovely daughter Lyla back, but other needless deaths and injuries can be prevented if this senseless Hepatitis B newborn vaccination program is halted.

Kelly Larsen, Kedo@phnx.uswest.net, Adverse Vaccine Information Network of Arizona
Rose Of Sharon Childbirth Supplies, http://www.workingonline.com/birthkits/BirthHome.html

APRIL 3, 1995

DEAR MR TED KOREN,

I AM WRITING YOU THIS LETTER IN REGARDS TO YOUR ARTICLE IN THE MAGAZINE "TODAYS CHIROPRACTIC" DATED JULY/AUGUST 1994, TITLED "CRIB DEATH OR VACCINE DEATH". I AM WRITING YOU THIS LETTER BECAUSE I TRULY BELIEVE THAT IF MY SON DID NOT HAVE HIS FIRST VACCINE SHOT, HE WOULD STILL BE ALIVE TODAY. MY SON WAS BORN MARCH 18, 1994, HE WAS TWO MONTHS PREMATURE. WHEN I TOOK HIM HOME FROM THE HOSPITAL, TOO MONTHS LATER, HE WEIGHED JUST OVER FIVE POUNDS. WHEN A PUBLIC HEALTH NURSE CAME TO MY HOUSE ON JUNE 16, 1994 TO GIVE MY SON HIS FIRST VACCINE SHOT, HE WEIGHED JUST OVER NINE POUNDS. I THOUGHT IT WAS TOO SOON TO GIVE MY SON THE SHOT, BUT THE NURSE TOLD ME HE WAS OVER DUE FOR IT. ON JUNE 17, 1994, MY SON HAD HIS MORNING NAP, AT 12 O'CLOCK NOON MY SON WAS NOT BREATHING, NOT EVEN TWENTY-FOUR HOURS AFTER HIS FIRST VACCINE SHOT MY SON PASSED AWAY. THE DOCTORS TOLD ME MY SON DIED FROM S.I.D.S. I DO NOT BELIEVE THIS. I WOULD LIKE TO GET MORE INFORMATION ON VACCINE DEATH AND POSSIBLY TALK TO SOMEONE ABOUT THIS.

V Scheibner

Strains of subtype 1c were associated with more meningitis and less epiglottitis than were strains of subtype 1. Also, children with disease associated with strains of subtype 1c were younger than those with diseases associated with strains of subtype 1

Has the problem of invasive infections of *Hæmophilus influenzæ* been resolved by mass vaccination? As Peltola (1993) says in her article published in the Lancet: not at all. The number of cases of invasive infections (including meningitis) has not diminished, but instead of being associated with capsular Hib, they are now associated with non-capsular Hib in vaccinated children.

Even more interesting is the article by Michaels and Ali (1993) in which they demonstrate a striking decline in the incidence of *Hæmophilus mengitidis* type b cannot be attributed entirely to immunisation. In fact, their figure 1 shows a peak incidence in 1976-77 which was followed by a steady and rapid decline which saw hospital admissions drop to less than half of the peak level before the vaccine was even licensed. The precipitous decline continued between 1985 (the year the vaccines were licensed) and 1990, especially in the age group which was not given the vaccine at all.

These observations indicate the futility of attempting to stop various *Hæmophilus influenzæ* diseases with vaccines based on different strains of the bacterium.

The documented contamination of vaccines by animal viruses is a chapter of its own. The recent article in the March 1992 issue of The Lancet warns about the contaminants in the polio vaccine which are linked to AIDS, leukæmia and cancer [Kyle (1992)].

It has been well documented that injections of foreign proteins, including those in vaccines, do not immunise, rather they sensitise. Instead of protecting against infectious diseases, they increase the recipient's susceptibility to infectious diseases. Moreover, vaccines modify the immunologic response and cause a great variety of autoimmune diseases. This is important to recognise, since many researchers consider infections occurring even shortly after vaccination to be coincidental (that is, completely unrelated to the injection of the foreign antigens).

The time has come to reveal this to the public, and especially to parents of small children. In their efforts to do their absolute best for their children, parents are emotionally vulnerable and an easy target for those selling vaccines.

An extensive study of medical literature reveals that there is no evidence whatsoever of the ability of vaccines to prevent any diseases. To the contrary, there is a great wealth of evidence (direct and indirect) that they cause serious side-effects.

The time has come to press for the removal of PRP and PRP-D (and other Hib) vaccines from use. All are demonstrably ineffective in preventing invasive infections. Australia should seriously consider following the Swedish example and stop vaccinating against pertussis. The whole-cell vaccine was rejected by Sweden in 1979 because of concerns about lack of efficacy to prevent whooping cough and because of serious side-effects including those of a cerebral nature [Storsaeter *et al.* (1988), and Strom (1960)]. The acellular pertussis vaccine was rejected for similar reasons [Anonymous (1989)].

One of the most worrying aspects of the effect of vaccines is that they accentuate susceptibility to a variety of infections, including the invasive types. The Swedish governmental bodies equivalent to our Health Department recognised this quite clearly and acted upon it. The less than reasonable US attitude to continue mandatory vaccination with ineffective and dangerous vaccines in the face of all the evidence [Mortimer (1988)] should not deter others from the correct decisions.

Ultimately, this is an issue dealing with infants' lives and health.

Dr Viera Scheibner
PRINCIPAL RESEARCH SCIENTIST (RETIRED)

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Dr Ted Koren, DC
Fax: (215) 699 0845

Blackheath 22 5. 1995.

Dear Dr Koiren,

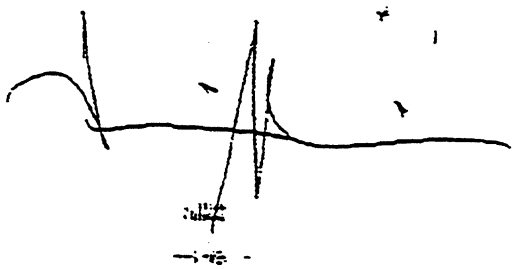
Thank you for faxing me the letter with the question on the dramatic fall in polio incidence after vaccination In 1954, after the mass testing of the Salk polio vaccine, the WHO redefined poliomyelitis as a disease with a residual paralysis lasting more than 60 days. The original definition was a disease with paralysis which resolves within 60 days. So this way they cut out 90% of cases of polio. Also, disease with paralysis lasting less than 60 days is now classified as viral meningitis. As the reported and recognised cases of polio decreased, so did the incidence of viral menigitits increased The same happened with measles: after the introduction of measles vacination the reported numbers of measles dropped dramatically, but the incidence of Rocky Mountains spotty fever increased by some 400%. DPT injections continue causing "provocation" poliomyelitis, but this is only recognised and reported in countries like Rumania. Occasionally an article on provocation polyomyelitis after DPT injections is published in the US.

The product info on polio vaccine contains warning that parents and other contacts of a recently vaccinated child may develop paralytic polio.

All this is mentioned in the chapter on polio in my book You are quite right: the book should have an index. At the time we decided against it because of the size of the book and especially its weight. However, in the second edition which we are working on now we shall use smaller types and save some 20 pages without increasing the size and the weight of the book and the index will be there.

I will send you my cv imminently.

With best regards



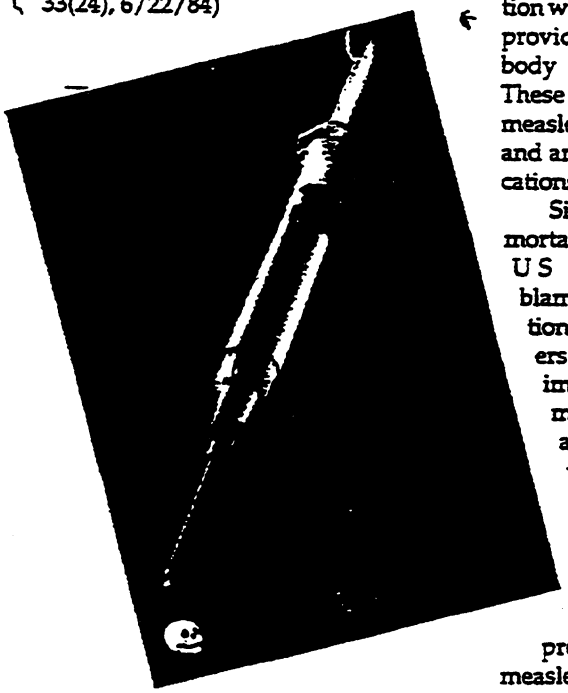
A PHARMACIST QUESTIONS VACCINES

Kristine M Severyn, R.Ph., Ph.D.

During my pharmacy education I believed what I was taught—that vaccines work all the time with extremely rare adverse effects Since then, my extensive research in this area indicates that neither is true

In the government's goal to vaccinate all U S children (and many adults), the medical and public health communities selectively publicize only what they want us to know about vaccines The past three and a half years of my researching state and federal public health information, reading the medical literature, and attending federal vaccine policy-making meetings have caused me to reverse my original trust in vaccines

Ohio Department of Health (ODH) officials often bemoan the 2,720 reports of measles it received in 1989 What the agency fails to mention is that close to three-fourths of the cases occurred in previously vaccinated persons The U S Centers for Disease Control and Prevention (CDC) even reported measles outbreaks in a documented 100 percent vaccinated population (*Morbidity and Mortality Weekly Report* (MMWR), 33(24), 6/22/84)



Five years later the CDC reported: "Among school-aged children, (measles) outbreaks have occurred in schools with vaccination levels of greater than 98 percent These outbreaks have occurred in all parts of the country, including areas that had not reported measles for years " (MMWR, 38 (S-9), 12/29/89)

To combat the resurgence of measles, the CDC and the American Academy of Pediatrics recommended a second dose of the MMR (measles, mumps, rubella) vaccine just before kindergarten, seventh grade, or when entering college This approach has failed to solve the problem, as reported in a recent *Pediatric Infectious Disease Journal* (13(1), 34-38, 1994): "Thus even after the recommended two dose schedule of the current measles vaccine, some adolescents and young adults lack protective titers of measles-specific antibody In addition women lacking protective titers will provide little or no measles-specific antibody transplacentally to their infants These children will be susceptible to measles infection virtually from birth, and are at much higher risk for complications when infected at younger ages "

Significant measles morbidity and mortality in infants during the 1980's U S measles resurgence could be blamed on government mass vaccination programs Since vaccinated mothers possess only short-term measles immunity, and do not pass this immunity to their babies, their infants are left defenseless against measles, which can be quite serious in infancy In past years when women caught measles as children and acquired strong lifelong immunity, they passed measles antibodies to their babies during pregnancy, giving the newborn baby measles immunity for about a year

In late 1993, several U S cities experienced highly publicized pertussis (whooping cough) epidemics, including Cincinnati, St Louis, Chicago, and Philadelphia The July 7, 1994, *New England Journal of Medicine* reported that of the 352 pertussis cases in Cincinnati in 1993, more than 75 percent were vaccinated The authors concluded, "Since the 1993 pertussis epidemic in Cincinnati occurred primarily among children who had been appropriately immunized, it is clear that the whole-cell pertussis vaccine failed to give full protection against the disease "

Similarly, of 186 confirmed pertussis cases in Chicago last fall, the Chicago Department of Health noted, "72 percent were as up to date as possible on their immunizations for their age."

Based on past experience with pertussis vaccine, the above vaccine failures were not unexpected Half of the reported pertussis cases in Ohio from 1987 to 1991 occurred in vaccinated children, in cases where vaccination status was known (source: ODH) One study reported a 55 percent failure rate for pertussis vaccine (*Journal of Pediatrics* 115(5): 686-693, 1989)

However, despite hundreds of pertussis cases in Ohio and Chicago last year, no one died An infectious disease expert from Cincinnati Children's Hospital was even quoted in *The Cincinnati Enquirer*, "The disease was very mild, no one died, and no one went to the intensive care unit "

Mumps vaccine can also be highly ineffective, with outbreaks often occurring in vaccinated preschoolers and school-age children (*Journal of Pediatrics* 119: 187-193, 1991)

Combining poor efficacy of certain vaccines with the risk of vaccine adverse reactions calls into question the ethics of state mandatory vaccination laws, and could explain why some parents delay or do not vaccinate their children

For example, within a 39-month period ending November 1993, the Food and Drug Administration's (FDA) Vaccine Adverse Events Reporting System

collected nearly 32,000 reports of adverse reactions following vaccination, with more than 700 deaths DPT (diphtheria, pertussis, tetanus) vaccine was associated with more than 12,000 of these reports, including 471 deaths The FDA acknowledges that this voluntary reporting underestimates the actual number of reactions

Instead of taking these reports of death and injury seriously, the FDA dismisses them as "coincidental," so nearly all reports languish in a government computer data base FDA's ambivalence toward vaccine adverse reaction reports has caused parents to lose faith in our country's vaccination program

To "compensate' those killed or injured by vaccines, Congress passed the National Childhood Vaccine Injury Act (NCVIA) of 1986 (Public Law 99-660), which established the Vaccine Injury Compensation Program (VICP) As of July 5, 1994, the program has paid $452 5 million for vaccine injury or death, and is backlogged with more than 2,600 cases, all of which will not be adjudicated for several years

Vaccine manufacturers enjoy the enviable position of having their products mandated and their liability costs shouldered by the U S taxpayer Victims of vaccine injury or death are prohibited from suing drug companies until they are denied assistance from the VICP

If victims lose in the compensation program (only one out of three petitioners receives compensation), or find this limited compensation inadequate, state and federal courts tell them that vaccines are "unavoidably unsafe," absolving the drug companies of all responsibility (*White v Wyeth* (1988), No 87-1657, Ohio Supreme Courts *Ackley v Wyeth*, (1990), No 89-3821, U S Court of Appeals, Sixth Circuit, Ohio; *Mazur v Merck*, Third U S Circuit Court of Appeals, No 91-1613, 1992) Financial care for vaccine victims is then assumed by the affected families, or other state and federal programs that assist the handicapped

Congress's stated purpose in passing the NCVIA in 1986 was to give children safer vaccines The only real change since 1986 is that children receive even more vaccines today, often in questionably safe combinations

Although the FDA is charged by Congress to oversee vaccine safety, the agency has caved in to political pressures by not questioning the safety of already licensed vaccines With the President, Congress, the CDC, and medical profession all promoting vaccines, it would be unpopular for the FDA to question vaccine safety issues

The public is repeatedly told that the benefits of vaccines outweigh the risks Yet, we do not know what the risks are because our government is not interested, or perhaps afraid, to find out It's time for the FDA to do its job of properly monitoring safety and efficacy of licensed vaccines Until then, children will continue to suffer needlessly ◆

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Writing extensively on vaccine issues, her work has appeared in the Dayton Daily News, Columbus (Ohio) Dispatch, The Plain Dealer (Cleveland), The Cincinnati Enquirer, Cincinnati Post, The (Akron) Beacon Journal, and The Washington Post

OPVS publishes a quarterly newsletter covering vaccine safety, efficacy, and legislation in Washington, D C , Ohio, and other states To obtain the newsletter write to: Ohio Parents for Vaccine Safety, 251 W Ridgeway Drive Dayton, Ohio 45459 Please include a tax-deductible donation to OPVS for newsletter requests

MEASLES OUTBREAK IN A FULLY IMMUNIZED SECONDARY-SCHOOL POPULATION

TRACY L. GUSTAFSON, M.D., ALAN W. LIEVENS, M.D., PHILIP A. BRUNELL, M.D., RONALD G. MOELLENBERG, B.S., CHRISTOPHER M.G. BUTTERY, M.D., AND LYNNE M. SEHULSTER, PH.D.

Abstract An outbreak of measles occurred among adolescents in Corpus Christi, Texas, in the spring of 1985, even though vaccination requirements for school attendance had been thoroughly enforced. Serum samples from 1806 students at two secondary schools were obtained eight days after the onset of the first case. Only 4.1 percent of these students (74 of 1806) lacked detectable antibody to measles according to enzyme-linked immunosorbent assay, and more than 99 percent had records of vaccination with live measles vaccine. Stratified analysis showed that the number of doses of vaccine received was the most important predictor of antibody response. Ninety-five percent confidence intervals of seronegative rates were 0 to 3.3 percent for students who had received two prior doses of vaccine, as compared with 3.6 to 6.8 percent for students who had received only a single dose. After the survey, none of the 1732 seropositive students contracted measles. Fourteen of 74 seronegative students, all of whom had been vaccinated, contracted measles. In addition, three seronegative students seroconverted without experiencing any symptoms.

We conclude that outbreaks of measles can occur in secondary schools, even when more than 99 percent of the students have been vaccinated and more than 95 percent are immune. (N Engl J Med 1987; 316:771-4.)

THE incidence of measles (rubeola) in the United States is now less than 1 percent of what it was before the introduction of a vaccine. Despite the adoption and enforcement of school immunization requirements in every state, however, outbreaks continue to occur.[1] In Texas, between 1983 and 1985, there were more than a dozen outbreaks among students in junior high and high schools. Examination of school immunization records revealed that more than 95 percent of the students at the schools involved had received live measles vaccine on or after their first birthday and after 1968.

This study was designed to determine why outbreaks occur among adolescent students with immunization records that meet current requirements. During a measles outbreak in 1985 in Corpus Christi, Texas, we studied the proportion of susceptible students required to support an outbreak and the possible reasons for the lack of protection provided by prior vaccination.

BACKGROUND

The incidence of measles declined rapidly in Corpus Christi (Nueces County), Texas, much as it did nationwide, after the introduction of a vaccine in 1963. The incidence fell from 44.1 cases per 1000 persons under 18 years old in 1964 to 0.3 cases per 1000 in 1973. Fewer than 20 cases a year have been reported since 1973.

Under the first school immunization law in Texas (1971), all children in kindergarten through grade six were required to have written evidence of measles vaccination (live or killed vaccine) or of natural measles infection as a condition for school attendance. The regulations were modified in 1978 to require a vaccination on or after the child's first birthday. In 1981, new rules required a record of live measles vaccination for students in all grades (kindergarten through grade 12). In addition, all students vaccinated before 1968 and all students whose histories of natural measles infection could not be verified by physicians' records were required to be revaccinated.

From the Division of Infectious Diseases Epidemiology and the Bureaus of Communicable Disease Service and Epidemiology, Texas Department of Health, Austin; the Department of Pediatrics, University of Texas Health Science Center, San Antonio; and the Corpus Christi–Nueces County Health Department, Corpus Christi, Tex. Address reprint requests to Dr. Gustafson at Infection Control and Prevention Analysts, 1122 N. Alma #234, Richardson, TX 75081.

THE EPIDEMIC

The first reported case of measles in Corpus Christi in 1985 occurred in a 15-year-old student at High School A. Her rash appeared on April 26, but she did not visit a physician until April 30. The diagnosis was confirmed with use of the enzyme-linked immunosorbent assay (ELISA) for measles IgM on May 2, by which time two additional cases had been reported from Junior High B.

In the next three months, 157 cases of measles were reported in Nueces County. The majority (67.5 percent) occurred among children 10 to 19 years of age; 28.7 percent of the patients were under 10 years old, and 3.8 percent were between 20 and 39. The dates of onset clearly indicated that infection occurred first in the adolescent age group and later spread to younger children. The highest attack rate — 3.0 percent (34 of 1122 students) — was observed at a junior high school not included in this study. The attack rate at High School A was 0.3 percent (5 of 1796 students); the rate at Junior High B was 1.8 percent (21 of 1141 students) (Fig. 1). Measles was believed to have been introduced by a traveler from Brownsville, Texas, 140 miles (225 km) to the south, where a high-school–based outbreak began in March.

METHODS

With the cooperation of the local medical society, the school board, the press, and the community at large, a serologic survey was organized two days after the first case of measles was identified. After parental consent was obtained, serum samples were drawn on May 4 from 59 percent of the students (1063 of 1796) at High School A and 65 percent of the students (743 of 1141) at Junior High B. No special immunization clinics were held during the outbreak, but all unimmunized contacts of patients with measles were urged to obtain vaccination.

THE 1993 EPIDEMIC OF PERTUSSIS IN CINCINNATI

Resurgence of Disease in a Highly Immunized Population of Children

CELIA D C CHRISTIE, M D , MARY I MARX, B A , COLIN D MARCHANT, M D , AND SHIRLEY I REISING, PH D

Abstract *Background* In 1993 there was a resurgence of pertussis in the United States Altogether, 6335 cases were reported the most in 26 years

Methods Using active microbiologic surveillance, we investigated the epidemic of pertussis in Greater Cincinnati in 1993 The population of 1 7 million in this area is served by a single children s hospital and pertussis laboratory We prospectively followed patients given a new diagnosis of pertussis in July through September 1993 to determine the characteristics of the epidemic

Results From 1979 to 1992, there was a cumulative total of 542 cases of pertussis In 1993, 352 cases were diagnosed, an increase of 259 percent over the 1992 total Sixty-three percent of the cases had positive cultures for *Bordetella pertussis*, 18 percent were positive on direct fluorescent-antibody testing only, and 19 percent were diagnosed clinically The outbreak began in the suburbs during the summer and spread through Greater Cincinnati Of 255 total cases diagnosed in July through September (195 excess cases over the maximal base-line level of 20 per month in the previous 14 years), 75 percent were in white patients and 67 percent of the patients had private insurance or paid for care out of pocket In 1993, as compared with 1979 through 1992, there was a shift in incidence from younger infants to older children, the percentages of cases according to age group were as follows 0 to 6 months, 53 percent from 1979 through 1992 and 35 percent in 1993 (P<0 001), 7 months to 5 years, 33 percent and 43 percent (P<0 002), 6 to 12 years, 5 percent and 11 percent (P<0 001), and more than 12 years, 5 percent and 11 percent (P<0 003) Immunization records revealed that 74 percent (75 of 101) of the children with pertussis who were 19 months to 12 years old had received four or five doses of the combined diphtheria–pertussis–tetanus (DPT) vaccine, and that 82 percent (103 of 126) of those 7 to 71 months old had received at least three doses of DPT vaccine The whole-cell vaccines used came from both of the major manufacturers (Connaught Laboratories and Lederle Laboratories) Disease was not severe, but 80 of the 255 children (31 percent) given diagnoses during the three epidemic months were hospitalized There were no deaths

Conclusions Since the 1993 pertussis epidemic in Cincinnati occurred primarily among children who had been appropriately immunized, it is clear that the whole-cell pertussis vaccine failed to give full protection against the disease (N Engl J Med 1994,331 16-21)

THROUGHOUT the world, pertussis remains a major cause of morbidity and mortality among infants, it is estimated to account for more than 600,000 deaths annually [1] Whole-cell pertussis vaccines have been effective in controlling the disease but have not eliminated circulation of *Bordetella pertussis* [2 3] Although estimates of the efficacy of the pertussis vaccine vary widely according to the methods used,[4] the efficacy of whole-cell vaccines used in the United States has been substantiated in recent studies of household exposure [3,5 6] Traditionally, pertussis has affected primarily infants and children who are not immunized and children who are incompletely immunized [7 8] Adolescents and adults with waning immunity and mild, atypical disease also have an important role in transmitting *B pertussis* to susceptible infants and children [9-16] During 1993, there was a dramatic resurgence of pertussis in the United States, with 6335 cases eported[17] — the highest number since 1967 [18] Although there has been increased recognition of pertussis in adults[18 19] and new clinical case definitions have been adopted,[18 20] the reason for this resurgence is largely unknown [18]

After two decades during which the incidence of pertussis was stable in Greater Cincinnati (0 4 to 5 8 cases per 100,000 population), an epidemic occurred in 1993 (incidence, 20 7 per 100,000), involving all age groups Nearly all (93 percent) of the first 285 cases reported to the Centers for Disease Control and Prevention (CDC) were identified at the Children's Hospital Medical Center (CHMC) [18] Most disturbing was the number of cases in older children who had been appropriately immunized In this report we describe the clinical epidemiologic features, immunization status, and microbiologic characteristics of pertussis cases that occurred in Cincinnati during 1993

METHODS

Microbiologic Surveillance

The CHMC is a 361-bed university hospital providing regional pediatric services to Greater Cincinnati, defined as an area in southwest Ohio, northern Kentucky, and southeast Indiana with a referral population base of 1 7 million For 15 years, the CHMC has been the only regional microbiology laboratory performing cultures for *B pertussis* and *B parapertussis* and direct fluorescent-antibody (DFA) staining of nasopharyngeal secretions for these pathogens Patients with suspected clinical cases of pertussis in the community are referred directly to our test referral center or to the emergency room Laboratory studies include the examination of specimens by DFA assay and culture for *B pertussis* [21 22] Hospitalized patients with suspected pertussis are routinely placed in

From the Department of Pediatrics University of Cincinnati College of Medicine (C D C C S F R) and the Divisions of Infectious Diseases (C D C C S F R) Epidemiology (C D C C M L M) and Clinical Microbiology (S F R) Children s Hospital Medical Center — both in Cincinnati; and the Department of Pediatrics Tufts University School of Medicine and New England Medical Center and the Massachusetts Public Health Biologic Laboratories Department of Public Health — all in Boston (C D M) Address reprint requests to Dr Christie at the Division of Infectious Diseases Children s Hospital Medical Center 3333 Burnet Ave Cincinnati OH 45229

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NEW BOOK DOCUMENTS IMMUNE SYSTEM DAMAGE TRACED TO WORLDWIDE CHILDHOOD IMMUNIZATION CAMPAIGNS!

VACCINATION: 100 Years of Orthodox Research Shows that Vaccines Represent a Medical Assault on the Immune System

By Viera Scheibner, Ph.D.

Mass immunization campaigns are credited with eradicating smallpox and reducing the incidence of other diseases. Today, the wild polio virus is only found in third world countries. Measles has been nearly eliminated from the developed nations. In 1992, only 4 cases of diphtheria were reported in the United States. By these standards, medical preventative measures seem incredible.

However, according to Viera Scheibner, Ph.D., medical preventative measures are *not* credible. In her new book, ***Vaccination: 100 Years of Orthodox Research Shows that Vaccines Represent a Medical Assault on the Immune System,*** she compiles scientific studies from throughout the world showing how vaccines are often ineffective and can damage the immune system. For example...

* In 1975, when Japan raised the age to receive vaccines from 2 months to 2 years, the incidence of other serious infectious diseases, like meningitis, sharply *increased* in 2 year olds but *decreased* in children below 2 years of age (p. 41).

* During the 1950s and 1960s millions of children were infected with polio vaccines contaminated with dangerous monkey viruses. The most notable of these viruses, SV40, has been associated with increases in cases of childhood leukemia (pp. 152-163).

* In 1982, Dr. William Torch presented a paper at the 34th Annual Meeting of the American Academy of Neurology documenting his research showing a significant correlation between the DPT vaccine and Sudden Infant Death Syndrome (p. 60).

* In 1991, the Institute of Medicine released a report documenting a causal relationship between the rubella vaccine and acute arthritis in adult women. During that same year links were found between this same vaccine and chronic fatigue syndrome (p. 121).

This book is the most well documented indictment of vaccinations to be found anywhere in the world. It is extensively cited with orthodox studies and is **required reading** for anyone seriously investigating this issue.

Viera Scheibner, Ph.D. is a research scientist and the author of numerous published studies. Her most recently conducted study, presented at the 2nd Immunization Conference held in Canberra, Australia (May 1991), and discussed in her book, showed a significant "Association Between Non-Specific Stress Syndrome, DPT Injections and Cot Death."

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Contact Person: Nathan Wright, 505-983-1856

NVIC: the number of adverse events and deaths in children after hepatitis B vaccinations outnumber reported hepatitis B cases in children under 14.

The NVIC took its figures from raw data compiled by the government-operated Vaccine Adverse Event Reporting System (VAERS). The government's requirement that all children be given hepatitis B vaccinations is a "dangerous and scientifically unsubstantiated policy," charges the NVIC. The organization is calling for an end to the mandate, and is demanding that more research be conducted on the vaccine. The CDC questions the NVIC's analysis, however, and maintains that hepatitis B vaccines are safe for infants, children and adults.

The hepatitis B vaccine has caused chronic arthritis, symptoms resembling multiple sclerosis, and in some cases, death.

VAERS from 1990 to 1998 reports

Hepatitis B reactions:

There were 24,775 reports of complications
Of that total, 2,424 children under age 14 experienced adverse events.
1,209 experienced "serious" events
73 deaths

CDC OFFICIAL CLAIMS CHICKENPOX VACCINE CAN CAUSE SHINGLES

Finally, a vaccine that may prevent painful shingles from occurring or recurring. Chicken Pox is a classic childhood ailment that can leave a kid housebound with a sore throat, fever and itchy sores. After two weeks, the chicken pox symptoms usually have vanished, but the varicella-zoster virus lingers behind, hiding in the sensory nerve cells near the spinal cord. It lies dormant through adulthood when, for some reason, it becomes active again, causing another disease - shingles.

An estimated 600,000 to 1.2 million cases of shingles occur every year, in the elderly or in people whose immune systems are compromised. "It can be very painful because it pinches the nerve cells," said DR. ABBAS VAFAI, CHIEF OF BIOLOGICS AT THE CENTERS FOR DISEASE CONTROL AND PREVENTION IN ATLANTA. "The rash area causes excruciating pain. It may last for four weeks or longer." While antiviral drugs can reduce the length of the rash, no drug currently available prevents the disease from occurring or recurring. Dr. Vafai hopes that a vaccine he recently patented will do exactly that.

"THERE IS A VACCINE CURRENTLY AVAILABLE AGAINST CHICKEN POX," DR. VAFAI SAID. "BUT IT USES A LIVE, ATTENUATED VIRUS. WHILE IT IS VERY EFFECTIVE AGAINST CHICKEN POX, THE VACCINE ITSELF BECOMES LATENT AGAIN AND CAN REACTIVATE LATER IN LIFE TO CAUSE SHINGLES."

Instead of using a live virus, Dr. Vafai took a piece of glycoprotein - which attaches to the surface of the varicella-zoster virus – and chopped it off at one end. The remaining part of the glycoprotein stimulates the immune system to produce virus neutralizing antibodies, which when used as a vaccine, Dr. Vafai said, would prevent a dormant virus already in the body from reactivating and causing shingles. So far Dr. Vafai's vaccine has been tested on lab animals. He was granted patent 5,824,319, which has been assigned to Research Corporation Technologies.

NY Times Monday, April 12, 1999 C12
Patents - Teresa Riordan

Chickenpox Shot Said Safe

http://www.suntimes.com:80/output/news/pox13.html

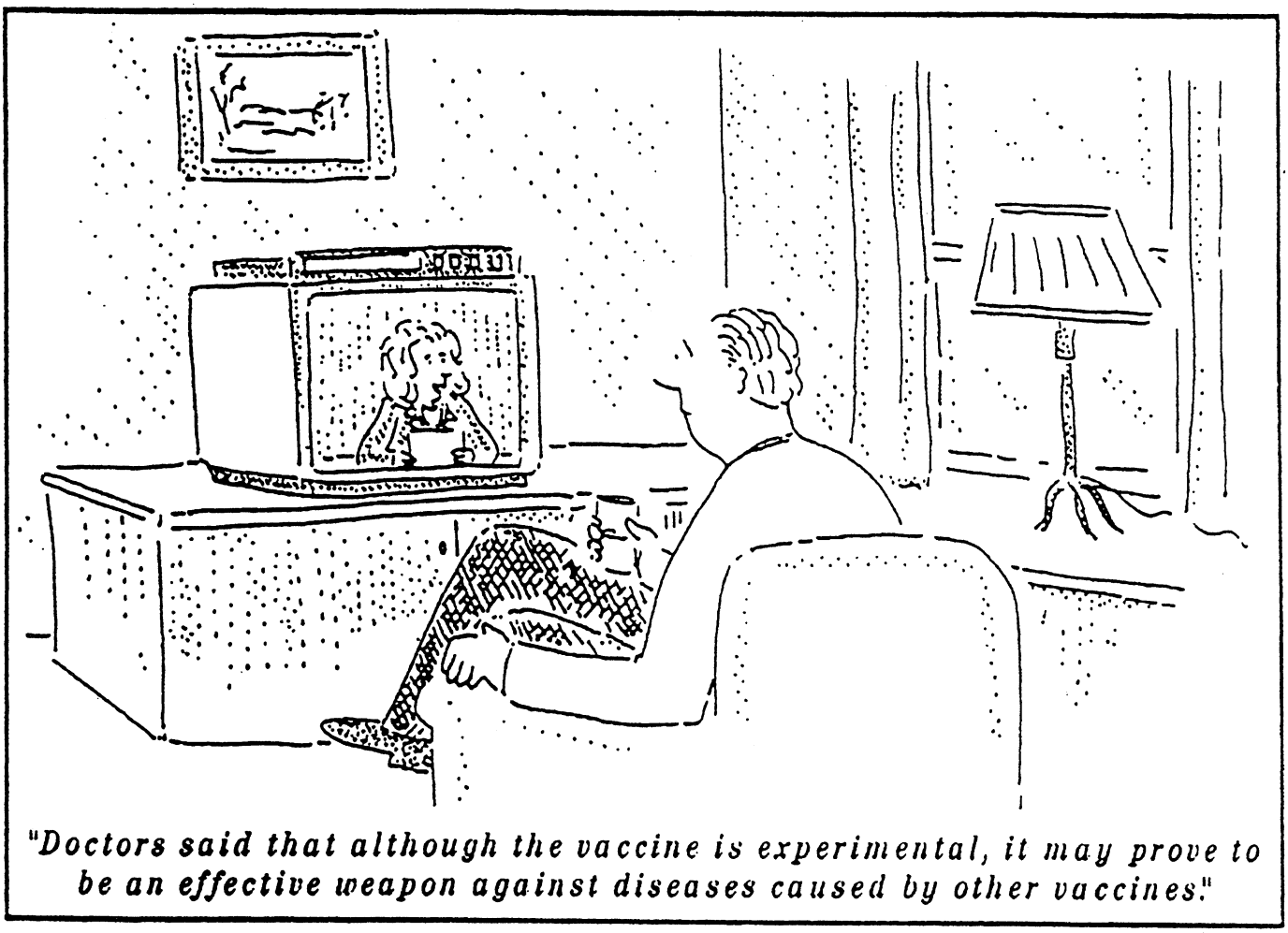
The study analyzed chickenpox data from the U.S. Vaccine Adverse Event Reporting System.

Researchers found 6,574 "adverse events" from March 1995, when the vaccine was approved, to July 1998. This is less than one event per 1,000 shots. (Children under 13 get one shot; those 13 and older get two shots.) About 96 percent of events were minor, including rash, fever and soreness where the shot was given.

Serious events included liver disorders, pneumonia, blood and blood vessel disorders, convulsions, meningitis and anaphylaxis (severe allergic reaction).

Because not all adverse events are reported, the system can understate vaccine problems. Conversely, the system can overstate risks: If something bad happens after a person gets a shot, the vaccine isn't necessarily to blame.

For example, it appears none of the 14 reported deaths was caused by the chickenpox vaccine, said Dr. Robert Wise of the FDA. He was the study's lead author. Investigators found other conditions, such as severe asthma, contributed to the deaths."...



"Doctors said that although the vaccine is experimental, it may prove to be an effective weapon against diseases caused by other vaccines."

Ask The Experts

Experts said DDT is harmless.
Experts said asbestos is safe.
Experts said cigarette smoking is safe.
Experts said formula is just as good as breast milk
Experts said aspirin doesn't cause Reyes syndrome.
Experts said the polio vaccine isn't contaminated with monkey virus.
Experts said it's OK because animal genes can't affect humans (then came mad cow disease).
Experts said thalidomide is safe.
Experts said DES is safe.
Experts said irradiating tonsils and thymus glands is safe (until thyroids became cancerous)
Experts said tonsillectomies are necessary.
Experts said blood-letting is a cure.
Experts said fluoride is safe.
Experts said VBACs should not be done.
Experts said it wasn't necessary to wash hands before delivering babies.
Experts said the swine flu is coming.
Experts said vaccination is safe.

After limes were found to prevent scurvy it took over 60 years before the British Navy's doctors agreed that sailors should have limes.
It was over 30 years from the time PKU screening was developed before the medical profession adopted it.
It was over 20 years from the time an Aussie doc reported that bacteria caused ulcers before the medical profession agreed. Even today, many doctors refuse to accept this knowledge.

"Science advances funeral by funeral."