VRANewsletter

Vaccination Risk Awareness Network Inc.

Spring 2011

The Chickenpox Vaccine

By F. Edward Yazbak, MD, FAAP

January 13, 2011

Of all pediatric mandated vaccination programs, two seem to make even less sense than others. The first is the universal hepatitis B vaccination program, starting shortly after birth and intended to decrease the risk and incidence of primary liver cancer. The second is the universal pediatric chickenpox vaccination program, the subject of this report.

¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤

My good friend Julienne has been suffering for over 3 months with shingles, a viral illness related to an old chickenpox infection and post-herpetic neuralgia, its most dreaded complication. The term "suffering" hardly describes the excruciating pain she has been experiencing. At times, she has even needed narcotic analgesics to bring down the torture to the "Awful" level on the Richter scale of pain. To make things worse, her left-handed eighty-year-old husband fell and broke his left shoulder. In just three weeks, this very happy and active couple was seriously sidelined and suffering… together.

When Julienne asked me when or where she could have "caught" shingles, I told her as gently as possible that it was probably a gift from her 14-month-old granddaughter who had recently received her MMR and chickenpox vaccines and who comes to visit on Sundays. Her first reaction was a long sad look as if I had stabbed her, a look every grandparent would have easily recognized. Words were not needed, her face said it all: "What nonsense is that and how dare you blame my baby?" After she counted to ten, she asked defensively: "But shingles happen to old people, anyway… right?" I agreed. This was definitely not the time to explain to her the recent United States shingles epidemic.

As the visit went on, I could see the wheels turning as she was thinking about what I had said, still bewildered. She knew I loved to tease but she also knew that I would have never dared under the circumstances. I dropped the subject, she was hurting enough…

When I saw my friends a couple of weeks later, they were still suffering, maybe a little less but still considerably, at times.

Until the mid-nineties, everyone thought that chickenpox was a mild childhood illness that was catchy and made children itch for a few days. It rated somewhere between an inconvenience and a mild nuisance but it was a good excuse for mothers to stay home from work and "bond" for a while. The best part of the day for the poor itchy toddler was bath time when a tubful of tepid Aveeno seemed like heaven and where he could splash and giggle and sing "If you're happy, and you know it, clap your hands."

For the longest time, mothers were delighted when their children developed chicken pox because they knew that the disease was so much more severe among adults. In fact, in spite of their doctors' admonition, mothers sometimes chose to expose their toddlers to chickenpox in order "to be done with it."

Pediatricians knew that the infection was caused by the varicella zoster virus (VZV) and that children very rarely developed serious complications, unless they were immune-compromised.

It was also well-known that the elderly developed shingles, a late complication caused by a reactivation of the chickenpox virus. It was postulated that particles of VZV migrated from the chickenpox blisters and moved to the nervous system where they laid dormant for years because of the repeated exposure to chickenpox in the community that boosted the individual's immunity. If an individual was compromised for any reason, such as by

The Chickenpox Vaccine cont. on page 4

INSIDE THIS ISSUE

Vaccine Injury Compensation—A Quagmire of Injustice

By Edda West

It's ironic that just as a recent Canadian Medical Association Journal article informed us of a new study recommending that Canada adopt a no-fault compensation plan for vaccine injury victims, our neighbours to the south were shocked to discover that the U.S. Supreme Court "slammed the door shut" on the right of

Editorial cont. on page 3

VRAN NEWSLETTER
Vaccination Risk Awareness Network Inc.
P.O. Box 169, Winlaw, B.C. V0G 2J0
Coordinator and newsletter editor: Edda West
info@vran.org 250-355-2525

Statement of Purpose:

- VRAN was formed in October of 1992 in response to growing parental concern regarding the safety of current vaccination programs in use in Canada.
- VRAN continues the work of the Committee Against Compulsory Vaccination, who in 1982, challenged Ontario's compulsory "Immunization of School Pupils Act", which resulted in amendment of the Act, and guarantees an exemption of conscience from any 'required' vaccine.
- VRAN forwards the belief that all people have the right to draw on a broad information base when deciding on drugs offered themselves and/or their children and in particular drugs associated with potentially serious health risks, injury and death. VACCINES ARE SUCH DRUGS.
- VRAN is committed to gathering and distributing information and resources that contribute to the creation of health and well being in our families and communities.

VRAN's Mandate is:

- To empower parents to make an informed decision when considering vaccines for their children.
- To educate and inform parents about the risks, adverse reactions, and contraindications of vaccinations.
- To respect parental choice in deciding whether or not to vaccinate their child.
- To provide support to parents whose children have suffered adverse reactions and health injuries as a result of childhood vaccinations.
- To promote a multi-disciplinary approach to child and family health utilizing the following modalities: herbalist, chiropractor, naturopath, homeopath, reflexologist, allopath (regular doctor), etc.
- To empower women to reclaim their position as primary healers in the family.
- To maintain links with consumer groups similar to ours around the world through an exchange of information, research and analysis, thereby enabling parents to reclaim health care choices for their families.
- To support people in their fight for health freedom and to maintain and further the individual's freedom from enforced medication.

VRAN publishes a newsletter 2 to 3 times a year as a means of distributing information to members and the community. Suggested annual membership fees, including quarterly newsletter and your ongoing support to the Vaccination Risk Awareness Network: $35.00—Individual $75.00—Professional
We would like to share the personal stories of our membership. If you would like to submit your story, please contact Edda West by phone or e-mail,as indicated above.

VRAN website: www.vran.org √

VRANews

We wish to thank all VRAN members who responded so generously to our fundraising appeal in the Fall 2010 newsletter. We also thank those who have renewed their membership, and remind everyone that memberships are due at the beginning of each calendar year.

We appeal to those of you who have not yet renewed your 2011 membership to please do so. It's easy to donate by credit card on our secure PayPal account on the VRAN website, or simply mail us a cheque or money order Your ongoing support is our lifeline enabling us to maintain the VRAN website, phone line in our small office, co-ordinator's modest salary and publish our acclaimed newsletter.

One of VRAN's greatest needs is a fundraising co-ordinator. From time to time we have asked for help in this challenging area and are putting out a plea again. If you have any fundraising ideas or experience and wish to assist in this area, please contact Edda West at: 250-355-2525 or email: info@vran.org

VRAN Annual General Meeting

VRAN's AGM will be held via telephone conference in mid June, 2011. If you wish to participate in the AGM, please contact Edda West for specific date and time.

Shots in the Dark

Lina Moreco's acclaimed film *Shots in the Dark* has been pulled out of circulation by the National Film Board. The issue seems to be the Wakefield factor. An interview with Dr. Andrew Wakefield was included as a segment in the film. Last fall when we tried to purchase more copies of the film to be included in the VRAN fundraising drive, we were told the film was not available at the time as it was being re-edited. A disclaimer was being added because Dr. Wakefield's medical license had been revoked. A few months later, the film was available for purchase for a short time, but then disappeared again from the NFB online store when the latest round of Wakefield media attacks erupted in January.

The long arm of vaccine industry malfeasance strikes again, this time in the form of censorship of a film which tells the story of vaccine damage, the children and their families, and courageous medical doctors and researchers in North America and Europe who dared stick their necks out to speak the truth about the link between vaccine injuries, brain damage and autism. The film is a classic —an important piece of the dark history surrounding this controversial issue.

A conversation with a sales rep at the NFB didn't leave me hopeful that NFB would be releasing the film any time soon, if ever. We had hoped to be able to acquire some copies of the film directly from Lina Moreco, but have not yet had a confirmation.

Fundraising

VRAN fundraising is an ongoing effort. VRAN is solely supported by the generosity of our members and receives no corporate or government funding. Thus, we are able to offer you an honest commentary on this issue. Unhampered by the constraints of government/corporate policy makers, we have the intellectual freedom to explore emerging research on the effect of vaccine policies on human health

For a donation of $150, please select *one* of the four fundraising bonuses listed below. Please send your donations to: VRAN Fundraising, P.O. Box 169, Winlaw, BC, V0G 2J0

Please note: Donations are in addition to annual membership.

Bonus Items:

- **Vaccine Epidemic**, a new book edited by Louise Kuo Habakus & Mary Holland. A powerful new book that "exposes the bitter truth about vaccination mandates." The contributing authors explore how corporate greed, biased science and coercive government threaten our human rights, our health, and our children.
- **Vaccine Safety Manual**, by Neil Miller
- **Immunization: History, Ethics, Law and Health**, by Catherine Diodati
- **Jabs, Jenner & Juggernauts**, by Jennifer Craig
- Please note, we will have Heather Fraser's **The History of the Peanut Allergy Epidemic** available as a fundraising bonus later this year when the second edition is published. √

Editorial cont. from page 1
vaccine injury claimants denied compensation in 'vaccine court' to pursue litigation through the regular courts.

Unlike our friends in the U.S., Canadians have never had access to any form of government compensation for vaccine injuries, except in the province of Quebec. We're told that Canada and Russia are the only G8 nations without national no-fault compensation programs for people injured by vaccines, and according to Canadian vaccine experts, "it is high time Canada made its exit from that short but inglorious list."

Theoretically, a compensation plan may seem to have merit, but viewed through the cynical lens of history, it may be safe to predict that the proposed compensation plan would be subject to the kind of dysfunction that has haunted the U.S. vaccine injury compensation system. That is because the motivation behind the government compensation plan is rooted NOT in altruistic concern for vaccine injury victims, but protectionism of the almighty vaccine program and liability protection for the vaccine industry.

Because vaccines are admitted to be "unavoidably unsafe", an impossible tension is created between medical policies that insist all children must be injected with complex biological products known to carry a risk of injury and death, and parents who want to protect their children from diseases but worry that the risk of vaccine injuries outweighs disease risks.

Because the medical industry has never honestly evaluated the true background rates of health injuries precipitated by vaccination nor calculated the real costs to society, such as the parallel rise of debilitating chronic illnesses in highly vaccinated populations, a growing mistrust of vaccine programs has crept into the public perception. The real motivation behind the proposed compensation program has little to do with compassion for vaccine victims, but has everything to do with bolstering blind faith in the vaccine paradigm—a kind of pre-emptive damage control.

When the U.S. Congress passed the National Childhood Vaccine Injury Act in 1986, it absolved vaccine manufacturers from liability for injuries caused by vaccines, and instructed the government to set up a special 'no-fault', non-adversarial vaccine court to adjudicate vaccine injury claims. To date, approximately $2 billion has been paid to vaccine victims. The compensation program has been a "dismal failure", says Mary Holland, co-author of Vaccine Epidemic. What was meant to be a petitioner-friendly administrative forum, is instead "exceptionally hostile and adversarial—the exact opposite of what Congress intended."

The Vaccine Injury Table defining the types of injuries eligible for compensation has been systematically gutted by the government with the result that few compensable injuries remain...

The Vaccine Injury Table defining the types of injuries eligible for compensation has been systematically gutted by the government with the result that few compensable injuries remain on the Table. The no-fault compensation system has devolved into a "kangaroo court" that denies compensation to nearly 4 out of 5 vaccine injury claimants. With the gutting of the Injury Table, the majority of cases which would previously have qualified for compensation are now denied, making it appear that vaccine damage is rare. The fewer claims that are compensated, the less evidence of the true extent of vaccine damage.

Congress also gave vaccine injury claimants the right to litigation through the regular court system if compensation was denied by the vaccine court. But a recent decision by the U.S. Supreme Court decision in the case of Bruesewitz vs. Wyeth has now taken that right away, effectively blocking all avenues of appeal to the regular court system. American vaccine victims and their families are now on their own, just like in Canada.

Barbara Loe Fisher expressed her sense of betrayal, saying, "Parents of vaccine injured children, who worked in good faith with Congress in the early 1980's on the 1986 law, have been betrayed by six American judges, who ignored congressional intent and threw victims of vaccine injury under the bus in order to give complete liability protection to a wealthy industry with a long history of hiding their products' risks. They have removed the safety net we were promised. If we had known this day would come, we would have vigorously opposed any federal legislation that limited civil liability for drug corporations now making substantial profits from vaccines mandated by government."

The following excerpt from What Bruesewitz v. Wyeth Means for American Families ,written by Vaccine Epidemic editors Louise Kuo Habakus and Mary Holland, captures the essence of the tragedy suffered by tens of thousands of vaccine damaged families in North America.

"Imagine your child was hit by a reckless driver and catastrophically injured. Cognitive impairments, seizures, problems with walking, eating, talking – you name it. You find out who the driver was, and you sue the driver for damages – but you can only sue in a "special driving court." Cases in this court usually take years, sometimes more than a decade. For ten years, you and your child struggle to make ends meet to pay for all the healthcare bills. Finally, the special court issues a ruling. Against the weight of the evidence, without affording you discovery or a jury of your peers, you lose. You're out on your ear, even though the driver has a massive insurance policy for just such accidents.

"You dust yourself off and sue the driver in a regular court, because you have that right by statute – and the regular court says, "No, the special court is good enough for you; no regular courts for those injured by reckless drivers." So you appeal that decision to the court of appeals, and you lose; and then you appeal again to the U.S. Supreme Court, and you lose again. For almost twenty years, you've been fighting just to get fair compensation, only to learn that the Supreme Court would rather protect reckless drivers than your innocent child.

"If you re-write the first sentence to 'imagine that your child was injured by a badly designed, federally-recommended vaccine', you have the essence of the *Bruesewitz v. Wyeth* decision that the U.S. Supreme Court handed down last month.

"Hannah Bruesewitz, as an infant, suffered catastrophic seizures and brain injury within hours of a diphtheria-pertussis-tetanus vaccine that was pulled from the market several years after her injury because it was insufficiently safe. Hannah has devastating injuries from which she will never recover. Her family had no choice but to go to the Vaccine Injury Compensation Program, a very "special court" if ever there was one. The family litigated there for ten years, losing a case that common sense, science, and decency say they should have won. Now the U.S. Supreme Court told them that there is no court—**no court in the land**—that may hear their case.

"This Supreme Court decision is a betrayal", say Habakus and Holland. "No

Editorial cont. on page 8

The Chickenpox Vaccine cont. from page 1

lack of immune competence or stress, the VZV reactivated, moved back through the nerve fibers and invaded the sensory cell bodies in the neighboring skin, eventually causing the typical rash of shingles. Because that last event took a little while, skin sensitivity and pain often preceded the skin eruptions.

Some fifteen years ago, suddenly and out of the blue, chickenpox became a very serious disease and there were multiple TV and press reports about children dying from chickenpox all over the country. Economists weighed in and ominous warnings filled the air: Chickenpox was not only killing kids and adults, it was a national economic disaster that was eventually ultimately going to collapse the United States economy because it kept mothers at home caring for their children instead of at work.

Merck and the CDC joint efforts had succeeded in creating "a need", a vaccine for chickenpox was developed and the FDA quickly licensed it. After all, our children's lives and our national economy depended on it.

VARIVAX® was launched to the cheers of the Merck stockholders in 1995 [i] Within less than a year spent figuring out reimbursement, it caught on in a grand way. With time, it became apparent that *two doses* were required to protect susceptible children and adults and … in 2006, a second dose of VARIVAX® was recommended. The children were not too happy; the stockholders were jubilant and it is rumored that at Merck, people were heard humming: "Double the shots! Double the Fun." The vaccine is *still* selling well at $83.77 per dose.

Pediatricians were first told that the vaccine, because it was another attenuated live virus vaccine, had to be administered one month after the MMR vaccine, between 12 and 15 months of age.

This was soon changed!

It was acceptable to give VARIVAX® and MMR on the same day at different sites but… if we did not give them *on the same day*, then *we had to wait a month*. This was certainly peculiar but then preventing chickenpox, most often a mild illness in children, did not make much sense either!

Evidently forgetting the uproar about the MMR vaccine, some bright people at Merck met with friends in Atlanta, and decided to *combine* VARIVAX® with the MMR vaccine. The new vaccine MMRV was licensed in 2005 and marketed under the name PROQUAD®. I thought the name was as strange as the idea. [ii]

In early 2008, the FDA announced that the incidence of febrile seizures had increased with the use of PROQUAD® at age 12–15 months and that some reports of encephalitis following vaccination had been filed. [iii] The Agency then immediately explained that this did not mean that the encephalitis was caused by the vaccine, a standard argument with vaccine adverse events. If one takes an arthritis or an anti-diabetic drug and gets a reaction, the drug is immediately blamed, the lawyers take over and the company suspends or stops manufacturing the problem drug. On the other hand, **if someone has a serious reaction shortly after a vaccination, such as an encephalopathy or encephalitis, it is almost always considered a *coincidence*.** No matter the number of reports of vaccine-related adverse events, the verdict is the same: They are all *anecdotal* and nothing but unscientific observations by nervous parents.

To deal with the increased risk of febrile seizures following the first dose of PROQUAD® (MMRV), the CDC published a long and hard to understand Morbidity and Mortality Weekly Report (MMWR) [iv] on May 7, 2010 that included the following recommendations:

- The routinely recommended ages for measles, mumps, rubella and varicella vaccination continue to be age 12–15 months for the first dose and age 4–6 years for the second dose.
- For the first dose of measles, mumps, rubella, and varicella vaccines at age 12–47 months, either measles, mumps, and rubella (MMR) vaccine and varicella vaccine or MMRV vaccine may be used. Providers who are considering administering MMRV vaccine should discuss the benefits and risks of both vaccination options with the parents or caregivers. Unless the parent or caregiver expresses a preference for MMRV vaccine, CDC recommends that MMR vaccine and varicella vaccine should be administered for the first dose in this age group.
- For the second dose of measles, mumps, rubella, and varicella vaccines at any age (15 months–12 years) and for the first dose at age 48 months, use of MMRV vaccine generally is preferred over separate injections of its equivalent component vaccines (i.e., MMR vaccine and varicella vaccine). Considerations should include provider assessment, patient preference, and the potential for adverse events.
- A personal or family (i.e., sibling or parent) history of seizures of any etiology is a precaution for MMRV vaccination. Children with a personal or family history of seizures of any etiology generally should be vaccinated with MMR vaccine and varicella vaccine.

The 25 page *current* PROQUAD® product insert [v] dated September 2010, that doctors and their nurses are supposed to read only includes the following recommendations: FOR SUBCUTANEOUS ADMINISTRATION ONLY

Each 0.5-mL dose of ProQuad is administered subcutaneously.

The first dose is usually administered at 12 to 15 months of age but may be given anytime through 12 years of age.

If a second dose of measles, mumps, rubella, and varicella vaccine is needed, ProQuad may be used. This dose is usually administered at 4 to 6 years of age. At least 1 month should elapse between a dose of a measles-containing vaccine such as M-M-R II (measles, mumps, and rubella virus vaccine live) and a dose of ProQuad. At least 3 months should elapse between a dose of varicella-containing vaccine and ProQuad.

The difference between the two sets of recommendations is at the very least concerning.

After VARIVAX® was introduced, we all expected a decrease in the number of cases of chickenpox among children and an increase in the disease incidence among adults, who were likely to be much sicker. That all happened!

As uptake of VARIVAX® increased, the incidence of chickenpox decreased and by 2002, verified pediatric chicken pox cases had dropped by 85% in certain surveillance sites. Unfortunately, that brilliant result came with a price: **The all important chickenpox immunological boosting that had occurred since time immemorial because of continued exposure to wild-type VZV was quickly disappearing and with it all the protection it provided.**

The Australians are well known for adopting new vaccination initiatives rather promptly but for some reason they dragged their feet with the varicella vaccine. The Australian health authorities eventually surrendered, and the vaccine was licensed in 2000. On October 18, 2010, the Medi-

The Chickenpox Vaccine cont. on page 5

The Chickenpox Vaccine cont. from page 4
cal Journal of Australia, the official journal of the Australian Medical Association published an article conceding that since the introduction of the varicella vaccine in 2000 "…there has been a decrease in varicella cases and a rise in HZ (herpes zoster or shingles) cases in Australian general practice consultations". [vi]

This was absolutely the first time that I had personally seen or heard that very disturbing fact so bluntly stated. The authors' statistics were very sobering too: The number of general practice consultations for shingles in Australia had increased by 100% in 10 years from 1.7/1000 consultations in 2000 to 3.4/1000 consultations for the first half of 2010. The increase in shingles-related consultations among patients older than 70 during the same period was simply described as *substantial*.

The fact that the incidence of shingles had increased after the introduction of VARIVAX® has been known for sometime. It was in fact in 2002 that my good friend Gary S. Goldman, Ph.D., had first warned about the recent sudden increase in the incidence of shingles. Goldman, a quiet, soft-spoken and meticulous scientist remains almost apologetic about his discovery; a flashback seems essential to show its brilliance and importance.

The project easily confirmed that the incidence of chickenpox (varicella) among children was decreasing. Even though everyone knew that the absence of natural disease was likely to compromise the immune boosting that was essential to suppress shingles (herpes zoster) due to the reactivation of varicella zoster virus, the declaration by Dr. Goldman that cases of shingles were much more numerous than expected was still met with denial.

Three Varicella Active Surveillance Projects (VASP) were created to monitor trends of varicella (chickenpox) as VARIVAX® was launched. Dr. Goldman worked in the California VASP, located in Antelope Valley, an area of around 300,000 residents. The project easily confirmed that the incidence of chickenpox (varicella) among children was decreasing. Even though everyone knew that the absence of natural disease was likely to compromise the immune boosting that was essential to suppress shingles (herpes zoster) due to the reactivation of varicella zoster virus, the declaration by Dr. Goldman that cases of shingles were much more numerous than expected was still met with denial. No one apparently wanted to concede that, what was logically expected but shamefully overlooked by the vaccine developers was indeed happening. Dr. Goldman begged the principal investigators to address the problem; instead of thanking and praising him, they fought him all the way, ignoring the evidence.

History was repeating itself! This was certainly not the first time that people who had discovered important medical facts were marginalized and persecuted.

It was only after the horse was way out of the barn, that surveillance sites started monitoring shingles trends, some five years after the varicella vaccine had been introduced.

Even then, the pro-vaccine forces still remained in solid denial and persistently downgraded the risk; after all, "their serious disease called chickenpox that had killed people" had been wiped out. So what if there was some "collateral damage".

True to form, the CDC is still not mentioning shingles as a complication of chickenpox vaccination. On October 23, 2010, I reviewed the current Vaccine Information Statement (VIS) for VARIVAX®, [vii] the official information pamphlet that a parent is supposed to read before signing the permission slip allowing the administration of the vaccine.

The document, dated 3/13/2008 only stated that: "A person who has had chickenpox can get a painful rash called shingles years later". It also still asserts that before the vaccine, about 11,000 people were hospitalized and about 100 died each year in the United States, as a result of chickenpox."

It did not say that the vaccine can double the incidence of shingles among contacts and it certainly did not say how frequently people all over the United States now suffered from the complication. Nor did it allude to the vastly under-represented 45,000 + chickenpox vaccine-associated reactions so far reported to VAERS. (Vaccine Adverse Events Reporting System in the U.S.)

The "11,000 hospitalizations" attributed to chickenpox are impossible to confirm or deny. What is easier to do is to compare them with other inflated CDC statistics such as influeza-associated hospitalizations[viii] that averaged over 200,000 per year during the 1990s with individual seasons ranging from a low of 157,911 in 1990–91 to a high of 430,960 in 1997–98.

According to information published by the CDC, varicella was the underlying cause of death on average of around 43 children aged less than 15 years, each year from 1990 to 1994, just before VARIVAX® was introduced.[ix] Because the vaccine is primarily intended for children, wouldn't it have been more honest for the CDC to just mention the number of *pediatric* deaths in its Vaccine Information Statement instead of inflating the statistics to include the approximately 100 *children plus adult deaths*. In any case, to help put things in perspective, 82 individuals were killed by lightning strikes,[x] on average, each year from 1980 through 1995 (range: 53–100).

Is VARIVAX® still very effective?

In the early years of administration of the vaccine, immunity of vaccinated individuals was still being boosted by other children with wild type varicella. Because of that *exogenous* boosting, the reports on varicella vaccine efficacy were biased upwards, with levels above 90% sometimes reported. When exogenous boosting became rare in most communities after 2000, varicella vaccine efficacy declined in certain areas to under 60%.[xi]

According to a 2004 report by the CDC and the Oregon Department of Human Services about a chickenpox outbreak in a highly vaccinated pediatric population, [xii] "Of 422 students, 218 (52%) had no prior chickenpox. Of these, 211 (97%) had been vaccinated before the outbreak. Twenty-one cases occurred in 9 of 16 classrooms. In these 9 classrooms, 18 of 152 (12%) vaccinated students developed chickenpox, compared with 3 of 7 (43%) unvaccinated students. Vaccine effectiveness was 72% (95% confidence interval: 3%–87%)."

What did Merck do?

Responding to the waves of Shingles nationwide and well immune (if you forgive the pun) from litigation because of the National Vaccine Injury Compensation Program, Merck did again what was best for Merck: It invented ZOSTAVAX® to boost the immune system of adults and help suppress or postpone the onset of shingles. That vaccine, essentially a much stronger VARIVAX®, is effective in preventing shingles in about 50% of those individuals receiving it, according

The Chickenpox Vaccine cont. on page 6

The Chickenpox Vaccine cont. from page 5
to the CDC's Vaccine Information Statement [xiii] published 10/6/2009.

A single dose is recommended but those in the know quickly add that "it is possible a second dose will be recommended in the future." Why not?

If one considers that VARIVAX® doubled the incidence of shingles in the United States and that ZOSTAVAX® can only prevent 50% of the augmented cases, then the U.S. Government and the good people of this country who paid millions for these achievements got NOTHING for their money, except pain and grief.

According to the CDC October 6, 2010 vaccine price list,[xiv] a single dose of ZOSTAVAX® costs doctors $161.50 and costs the CDC $116.70.

Merck's chickenpox vaccine had truly become for shareholders the gift that keeps on giving.

For the rest of us, it has just afflicted us with more shingles and with the increased risk of getting chickenpox as adults, when the disease is usually much more serious.

What the varicella vaccination program did to the U.S. Economy was no less unfortunate. Originally, one dose of varicella vaccine was supposed to provide lifetime immunity and supposedly save an estimated $70 million per year—primarily in societal costs associated with a parent staying home from work to care for a child with chickenpox. Instead, the present epidemic of shingles and complications has caused a surcharge of several hundred million dollars that no one anticipated. Added to that is the cost of the now required second dose of VARIVAX®, also a non-anticipated expenditure.

It has been proposed that around 25% of medical costs of VZV disease are due to chickenpox and 75% are due to shingles. A relatively small increase in shingles cases can therefore quickly offset any cost-benefit previously expected from universal chickenpox vaccination.

It is interesting that pediatricians, who were now administering VARIVAX® because it was recommended and in places required, had quite a bit to lose… personally.

There was a little secret we had known for sometime but did not discuss too much, may be to ward off the evil eye: We pediatricians, as a group, were less likely than others to get shingles as we aged.

In 1998, Solomon, Kaporis et al[xv], State University of New York Health Science Center, Brooklyn confirmed that fact statistically… at last. They conducted a study of physicians and found that pediatricians, because they were constantly exposed to Varicella-Zoster Virus, had distinctly lower rates of shingles than psychiatrists who were rarely exposed to the virus and the disease in their practice.

Obviously that is now changing and the thought is depressing!

Shingles, the clinical picture

Some prevalence reviews suggest that women may be more susceptible to shingles than men.

Usually the first manifestation of the disease is pain that can be severe and may represent early on a diagnostic challenge. Many sufferers have been needlessly exposed to X-rays and even CT-scans before the typical rash appeared and the diagnosis became evident.

The rash starts as a crop of contiguous red blind pimples in a dermatome, the area of skin where sensations from a single nerve root in the spinal cord ultimately end. As new crops develop, the previous lesions start blistering then become pustular and ultimately crust over.

The skin eruption is painful and itchy and can involve any dermatome and sometimes more than one. The rash, often in linear bands, very rarely crosses the midline and is most commonly located on the side of the torso, affecting a nerve root between the third thoracic and the third lumbar roots.

Ophthalmic Zoster affects the distribution area of the ophthalmic branch of the trigeminal nerve, a truly scary presentation. Other sites such as the face are more rarely involved.

Postherpetic neuralgia is the most dreaded complication of the disease. It is essentially an excruciating and almost unbearable constant burning and tingling pain that follows the rash and may last for weeks, months or longer.

In the debilitated elderly patients the blisters may be very deep and may result in severe scarring. Around 5% of the affected elderly develop muscle weakness.

Early treatment of shingles—within 72 hours of the onset of the rash—with antiviral drugs such as Acyclovir can shorten viral replication and reduce complications. Success has also been achieved recently with the use of intravenous vitamin C.[xvi] Large scale studies are needed to confirm the findings. Oral vitamin C has been used by some.[xvii]

Anticonvulsants have been used for the symptomatic treatment of postherpetic neuralgia; Neurontin (Gabapentin) in particular appears to have had more success than others. Antidepressants help sometimes. Recently, Lyrica (Pregabalin) has been tried with good results. All these medications require attentive medical supervision.

Over-the-counter painkillers are helpful in mild cases of neuralgia. More often, physicians have to resort to opioids that carry a distinct risk of addiction.

Application of anesthetic creams for local relief is another option for those patients who are reluctant to take drugs.

Thoughts and Reflections

Twenty-first century mainstream medical professionals insist that a vaccine is needed for every acute illness. However, until and unless we do studies comparing the vaccinated to the never-vaccinated, we will never know what is really best for us and for our children.

Honest efforts to study both the long and short-term effects of each vaccination are urgently needed otherwise we are fooling ourselves and just whistling in the dark when we enumerate the alleged benefits of a vaccination.

Honest efforts to study both the long and short-term effects of each vaccination are urgently needed otherwise we are fooling ourselves and just whistling in the dark when we enumerate the alleged benefits of a vaccination.

In years past, people felt that children were actually stronger and healthier after they recovered from certain contagious diseases. At least one California study seems to support that old belief.

Glioma is an aggressive malignant tumor of the nervous system. Wrensch, Weinberg et al conducted a large adult glioma study in the San Francisco Bay Area from 1997 to 2000 and evaluated associations of immunoglobulin G antibodies to varicella-zoster virus and three other herpesviruses among 229 adults with the disease and 289 controls. They found that patients with glioma were less likely to report a history of chickenpox than controls. Testing also revealed an inverse association with anti-varicella-zoster virus immunoglobulin G, more so in glioblastoma multiforme cases, a sub-

The Chickenpox Vaccine cont. on page 7

The Chickenpox Vaccine cont. from page 6
class. In the case of chicken pox, could we have traded a nuisance of an illness for brain tumors or whatever else may be lurking, unexamined and/or ignored?

Conclusion

Prior to the introduction of the universal varicella vaccination program in the United States, almost 95% of adults experienced natural chickenpox, usually as school age children. These cases were usually benign and resulted in long term immunity because of constant boosting due to repeated exposures to other children and adults with the disease.

This large reservoir of individuals having long term immunity has been seriously compromised by the mass vaccination of children that provides at best 70 to 90% immunity. The vaccine-acquired immunity is of unknown duration and only causes the shifting of chickenpox to the more vulnerable adults. To arrive to the bottom line, one needs to now add the adverse effects of the required two doses of chickenpox vaccine and the distinct potential for increased risk of shingles for an estimated 30 to 50 years among adults.

One must also keep in mind that regardless of the number of boosters, the acquired immunity from vaccination will never equal the strong constantly-boosted natural immunity we all had in the past, before the Universal Varicella Vaccination program was launched.

Varicella vaccination was a mistake.

Mandating it as a universal vaccination program for every child was an even bigger mistake.

Dr. Gary Goldman's assistance was very much appreciated.

¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤

Note: *We are grateful to Dr. Yazbak for permitting us to reprint this article and deep appreciation goes to Sandy Gottstein at Vaccination News for posting this and many other important articles authored by Dr. Yazbak:* http://www.vaccinationnews.com/20110113ChickenpoxVaccineYazbakFE

References

[i]http://www.fda.gov/BiologicsBloodVaccines/Vaccines/ApprovedProducts/ucm142828.htm (Accessed 10/20/10)
[ii] http://www.vaccinationnews.com/node/19913 (Accessed 10/24/10)
[iii]http://www.fda.gov/BiologicsBloodVaccines/Vaccines/ApprovedProducts/ucm123798.htm (Accessed 10/24/10)
[iv] http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5903a1.htm#box (Accessed 10/24/10)
[v] http://www.merck.com/product/usa/pi_circulars/p/proquad/proquad_pi.pdf (Accessed 10/24/10)
[vi] Grant KA, Carville KS, Kelly HA. Evidence of increasing frequency of herpes zoster management in Australian general practice since the introduction of a varicella vaccine. Med J Aust. 2010 Oct 18;193(8):483
[vii] http://www.cdc.gov/vaccines/pubs/vis/downloads/vis-varicella.pdf (Accessed 10/24/10)
[viii] http://www.cdc.gov/flu/about/qa/hospital.htm (Accessed 10/25/10)
[ix] http://www.cdc.gov/mmwr/preview/mmwrhtml/00052600.htm (Accessed 10/25/10)
[x] http://wonder.cdc.gov/wonder/prevguid/m0052833/m0052833.asp (Accessed 10/25/10)
[xi] Goldman GS. Universal varicella vaccination: Efficacy trends and effect on herpes-zoster. International Journal of Toxicology, 2005 July-Aug.;24(4):205–13.]
[xii] http://pediatrics.aappublications.org/cgi/content/abstract/113/3/455 (Accessed 10/25/10)
[xiii] http://www.cdc.gov/vaccines/pubs/vis/downloads/vis-shingles.pdf (Accessed 10/23/10)
[xiv] http://www.cdc.gov/vaccines/programs/vfc/cdc-vac-price-list.htm (Accessed 10/23/10)
[xv] Solomon BA, Kaporis AG, Glass AT, Simon SI, Baldwin HE. Lasting immunity to varicella in doctors study (L.I.V.I.D. study). J Am Acad Dermatol. 1998 May;38(5 Pt 1):763-5).
[xvi] www.jpands.org/vol11no1/orient.pdf (Accessed 10/23/10)
[xvii] http://www.orthomolecular.org/resources/omns/v01n05.shtml (Accessed 10/23/10)

Vaccine-related Literature

[1] Braun MM, Mootrey GT, Seward JF, Rider LG, Krause PR. Postlicensure safety surveillance for varicella vaccine. JAMA 2000;284:1271–9.
[2] Ravkina LI, Matsevich GR. Morphological changes in the central nervous system in post-vaccinalZh Nevropatol Psikhiatr Im S SKorsakova, 1970; 70(10):1465–71. encephalomyelitis developing after chickenpox vaccination in children.
[3] Poser CM. Neurological Complications of Vaccinations. Mealey's Litigation Report, ThimerosalApr.;Volume 1, Issue #10. & Vaccines, 2003
[4] Sunaga Y, Hikima A, Ostuka T, Morikawa A. Acute cerebellar ataxia with abnormal MRI lesions after varicella vaccination. Pediatr Neurol. 1995 Nov; 13(4):340–2. [2 year old boy with staggering gait and difficulty speaking.]
[5] Singer S, Johnson CE, Mohr R, Holowecky C. Urticaria following varicella vaccine associated with gelatin allergy. Vaccine 1999 Jan 28; 17(4):327–9.
[6] Gerecitano J, Friedman-Kien A, Chazen GD. Allergic reaction to varicella vaccine. Ann Intern Med. 1997 May 15; 126(10):833–4.
[7] Sakaguchi M, Yamanaka T, Ikeda K, Sano Y, Fujita H, Miura T, Inouye S. IgE-mediated systemic reactions to gelatin included in the varicella vaccine. J Allergy Clin Immonol. 1997 Feb; 99(2):263–4.
[8] Naruse H, Miwata H, Ozaki T, Asano Y, Namazue J, Yamanishi K. Varicella infection complicated with meningitis after immunization. Acta Paediatr Jpn 1993 Aug;35(4):345–7.
[9] Lee SY, Komp DM, Andiman W. Thrombocytopenic Purpura following varicella-zoster vaccination. Am J Pediatr Hematol Oncol, 1986 Spring; 8(1):78–80.
[10] Matsubara K, Nigami H, Harigaya H, Baba K. Herpes zoster in a normal child after varicella vaccination. Acta Paediatr Jpn 1995 Oct; 37(5):648–50.
[11] Hammerschlag MR, Gershon AA, Steinberg SP, Clarke L, Gelb LD. Herpes zoster in an adult recipient of live attenuated varicella vaccine. J Infect Dis, 1989 Sept; 160(3):535–7.
[12] Esmaeli-Gutstein B, Winkelman JZ. Uveitis associated with varicella virus vaccine. Am J Ophthalmol, 1999 Jun; 127(6):733–4.
[13] Wrensch M., Weinberg A, Wiencke J, Miike R., Barger G, Kelsey K. Prevalence of Antibodies to Four Herpesviruses among Adults with Glioma [Brain Tumor] and Controls. Am J of Epidem, 2001; 154(2):161–5.
[14] Uebe B, Sauerbrei A, Burdach S, Horneff G. Herpes zoster by reactivated vaccine varicella zoster virus in a healthy child. Eur J Pediatr, 2002 Aug; 161(8):442–4.
[15] Naseri A, Good WV, Cunningham ET Jr. Herpes zoster virus sclerokeratitis and anterior uveitis in a child following varicella vaccination. Am J Ophthalmol, 2003 Mar; 135(3):415–7.
[16] Schwab J, Ryan M. Varicella zoster virus meningitis in a previously immunized child. Pediatrics, 2004 Aug;114(2):e273–4.
[17] Wirrell E, Hill MD, Jadavji T, Kirton A, Barlow K. Stroke after varicella vaccination. J Pediatr, 2004 Dec; 146(6):845–7.
[18] Bronstein DE, Cotliar J, Votava-Smith JK, Powell MZ, Miller MJ, Cherry JD. Recurrent papular urticaria after varicella immunization in a 15-month-old girl. Pediatr Infect Dis J. 2005 Mar;24(3):269–70.
[19] Binder NR, Holland GN, Hosea S, Silverberg ML. Herpes zoster ophthalmicus in an otherwise-healthy child. J AAPOS, 2005 Dec; 9(6):597–8.
[20] Grossberg R, Harpaz R, Rubtcova E, Loparev V, Seward JF, Schmid DS. Secondary transmission of varicella vaccine virus in a chronic care facility for children. J. Pediatr. 2006 Jun;148(6):842–4.
[21] Lohiya GS, Tan-Figueroa L, Reddy S, Marshall S. Chickenpox and pneumonia following varicella vaccine. Infect. Control Hosp. Epidemiol. 2004 July;25(7):530.
[22] Levitsky J, Te HS, Faust TW, Cohen SM. Varicella infection following varicella vaccination in a liver transplant recipient. Am. J. Transplant. 2002 Oct;2(9):880–2.
[23] Huang W, Hussey M, Michel F. Transmission of varicella to a gravida via close contacts immunized with varicella-zoster vaccine. A case report. J. Reprod. Med. 1999 Oct; 44(10):905–7.
[24] Kohl S. Rapp J, La Russa P, Gershon AA, Steinberg SP. Natural varicella-zoster virus reactivation shortly after varicella immu-

The Chickenpox Vaccine cont. on page 8

The Chickenpox Vaccine cont. from page 7
nization in a child. Pediatr. Infect. Dis J. 1999 Dec;18(12):1112–3.
[25] Salzman MB, Sharrar RG, Steinberg S, LaRussa P. Transmission of varicella-vaccine virus from a healthy 12-month-old child to his pregnant mother. J. Pediatr. 1997 Jul;131(1 Pt 1):151–4.
[26] Plotkin SA, Starr SE, Connor K, Morton D. Zoster in normal children after varicella vaccine. [Case Report; Letter] J Infect. Dis., 1989 May; 159(5):1000–1.
[27] Levin MJ, Dahl KM, Weinberg A, Giller R, Patel A, Krause PR. Development of resistance to acyclovir during chronic infection with the Oka vaccine strain of varicella-zoster virus, in an immunosuppressed child. J Infect Dis. 2003 Oct 1;188(7):954–9.
[28] Ludwig B, Kraus FB, Allwinn R, Keim S, Doerr HW, Buxbaum S. Loss of varicella zoster virus antibodies despite detectable cell mediated immunity after vaccination. Infection 2006 Aug;34(4):222–6.
[29] Quinlivan ML, Gershon AA, AlBassam MM, Steinberg SP, La Russa P, Nichols RA, Breuer J. Natural selection for rash-forming genotypes of the varicella-zoster vaccine virus detected with immunized human hosts. Proc Natl Acad Sci USA, 2007 Jan 2;104(1):7–8.
[30] Apuzzio J, Ganesh V, Iffy L, Al-Khan A. Varicella vaccination during early pregnancy: a cause of in utero miliary fetal tissue calcifications and hydrops? Infect Dis Obstet Gynecol. 2002; 10(3):159–60.
[31] Wrensch M, Weinberg A, Wiencke J, Miike R, Sison J, Wiemels J, Barger G, DeLorenze G, Aldape K, Kelsey K. History of Chickenpox and Shingles and Prevalence of Antibodies to Varicella-Zoster Virus and Three Other Herpesviruses among Adults with Glioma and Controls. Am J Epidemiol 2005;161(10):929–38.
[32] Schrauder A, Henke-Gendo C, Seidemann K, Sasse M, Cario G, Moericke A, Schrappe M, Heim A, Wessel A. Varicella vaccination in a child with acute lymphoblastic leukaemia. Lancet 2007 April 7;369:1232.
[33] Bayero O, Heininger U, Heiligensetzer C, von Kries R. Metaanalysis of vaccine effectiveness in varicella outbreaks. Vaccine 2007 Sept. 17; 25(37-38):6655–60. Epub 2007 Jul 27.
[34] Cornelissen M, Koster-Kamphuis L, Melchers WJ, Galama JM. Breakthrough VZV infection after immunization, presenting as herpes zoster. Scand J Infect Dis. 2008;40(5):428-30.
[35] Ota K, Kim V, Lavi S, Ford-Jones EL, Tipples G, Scolnik D, Tellier R. Vaccine-Strain Varicella Zoster Virus Causing Recurrent Herpes Zoster in an Immunocompetent 2-Year-Old. Pediatr Infect Dis J. 2008 Jul 25.
[36] Fine HF, Kim E, Flynn TE, Gomes NL, Chang S. Acute posterior multifocal placoid pigment epitheliopathy following varicella vaccine. Br J Ophthalmol. 2008 Aug 26. [Epub ahead of print]
[37] Walter EB, Snyder MA, Clements DA, Katz SL. Large injection site reactions after a second dose of varicella vaccine. Pediatr Infect Dis J. 2008 Aug;27(8):757–9.
[38] Ota K, Kim V, Lavi S, Ford-Jones EL, Tipples G, Scolnik D, Tellier R. Vaccine-strain varicella zoster virus causing recurrent herpes zoster in an immunocompetent 2-year-old. Pediatr Infect Dis J. 2008 Sep;27(9):847–8.
[39] Levin MJ, Debiasi RL, Bostik V, Schmid DS. Herpes Zoster with Skin Lesions and Meningitis Caused by 2 Different Genotypes of the Oka Varicella-Zoster Virus Vaccine. J Infect Dis. 2008 Sep 30.
[40] Iyer S, Mittal MK, Hodinka RL.Herpes Zoster and Meningitis Resulting From Reactivation of Varicella Vaccine Virus in an Immunocompetent Child. Ann Emerg Med. 2008 Nov 22.
[41] Nagpal A, Vora R, Margolis TP, Acharya NR. Interstitial keratitis following varicella vaccination. Arch.Ophthalmol, 2009 Feb; 127(2):222–3.
[42] Lin P, Yoon MK, Chiu CS. Herpes zoster keratouveitis and inflammatory ocular hypertension 8 years after varicella vaccination. Ocul Immunol Inflamm. 2009 Jan-Feb;17(1):33-5.
[43] Italiano CM, Toi CS, Chan SP, Dwyer DE. Prolonged varicella viraemia and streptococcal toxic shock syndrome following varicella vaccination of a health care worker. Medical Journal of Australia (MJA) 2009; 190 (8): 451-453.
[44] Gould PL, Leung J, Scott C, Schmid DS, Deng H, Lopez A, Chaves SS, Reynolds M, Gladden L, Harpaz R, Snow S.
[45] Angelini P, Kavadas F, Sharma N, Richardson SE, Tipples G, Roifman C, Dror Y, Nofech-Mozes Y. Aplastic Anemia Following Varicella Vaccine. Pediatr. Infect. Dis. J. 2009 Aug;28(8):746–8.
[46] Spackova M, Wiese-Posselt M, Dehnert M, Matysiak-Klose D, Heininger U, Siedler A. Comparative varicella vaccine effectiveness during outbreaks in day-care centres. Vaccine 2009, Oct.
[47] Chouliaras G, Spoulou V, Quinlivan M, Breuer J, Theodoridou M. Vaccine-associated Herpes Zoster Opthalmicus and Encephalitis in an Immunocompetent Child. Pediatrics. 2010 Mar 1. [Epub ahead of print]
[48] Fusco D, Krawitz P, Larussa P, Steinberg S, Gershon A, Jacobs J. VZV meningitis following varicella vaccine. J Clin Virol. 2010 Jun 11.
[49] Khalifa YM, Jacoby RM, Margolis TP. Exacerbation of zoster interstitial keratitis after zoster vaccination in an adult.Arch Ophthalmol. 2010 Aug;128(8):1079-80.
[50] Han JY, Hanson DC, Way SS. Herpes zoster and meningitis due to reactivation of varicella vaccine virus in an immunocompetent child. Pediatr Infect Dis J. 2010 Sep 14.

Note: Additional references entitled "Immunity-related Literature" accompanied this article. Due to space constraints, these additional references have not been reprinted in this issue of the VRAN newsletter, but are available on request. √

Editorial cont. from page 3
parents should be compelled to subject their children to "unavoidably unsafe" medical interventions, which are mandated by every state in the country as a requirement for school admission, and then have no direct recourse against the manufacturers when the products could have been made far safer.

This is like the doctrine of *caveat emptor*, buyer beware, only infinitely harsher." Because parents have very little choice when it comes to vaccines, it's not just buyer beware, it's "families have no civil rights when it comes to childhood vaccines." Habakus and Holland say the Supreme Court has "violated the social contract" and urge Congress to step in and "overrule Supreme Court's misguided decision, and restore the right of civil suit."

In Canada (except for the province of Quebec), no one has ever been compensated by the government for vaccine injuries, nor won a civil suit in a Canadian court. In this country, the plight of vaccine victims has always languished in obscurity. Beginning with the medical profession's acute allergy to acknowledging vaccine reactions, to doctors' refusal to report vaccine reactions, to the absence of legal requirements that doctors report suspected vaccine adverse events, to inaccessibility to justice in the court system, the government with its partners in the medical industry have succeeded in keeping a tight lid on the issue of vaccine damage in Canada.

The 'tight lid' has also shielded the government from having to disclose the data on vaccine adverse events. Without a publicly accessible vaccine reaction reporting data base such as VAERS in the U.S., Canadian parents can't find out which vaccines are hurting children.

With access to legal recourse effectively barred for vaccine injury victims, the government has been able to get away with mass experimentation on Canadian children with vaccines such as PENTA, the first 5 in 1 vaccine that was never licensed and for which no product monograph has ever been found. Canadian children served as guinea pigs for this first generation 5 in 1 vaccine which then morphed into Pentacel and Pediacel, the second generation of 5 in 1 vaccines injected in a series of 4 shots beginning in early infancy. This paved the way for these vaccines to be licensed in many other countries with great financial benefit to the vaccine industry.

Editorial cont. on page 9

Editorial cont. from page 8

Author Heather Fraser writes about the experimental PENTA vaccine in her forthcoming second edition of the History of the Peanut Allergy Epidemic, "In less than three years, there were more than 5,000 adverse events reported – and reports of this nature are typically 10% of what actually occur. A Canadian Dept. of Pediatrics information sheet stated: 'Significant side effects were observed after Penta vaccination, commonly blamed on the whole cell pertussis component.' Penta was also only about 60-80% effective against pertussis."

These side effects included mineingoencephalomyelitis (brain inflammation), convulsions, anorexia, infections, anaphylaxis, inconsolable screaming and death according to Health Canada records. Such was the speed at which this 5 in 1 combination vaccine was delivered to market. There were no follow up studies on these children. Ensuing damage that anecdotally included both autism and food anaphyaxis was not investigated by Health Canada."

For decades, Canadian health officials have remained aloof to the plight of the vaccine injured. Their denial of the pervasiveness of vaccine injuries has been aided and abetted by a court system whose insurmountable legal rules insure that vaccine injury lawsuits are denied. A compensation program designed along the American model?? Why would we expect any kind of justice from these people?

VRAN science analyst, Susan Fletcher has written a probing analysis of the proposed compensation system in which she challenges the many questionable assumptions made by the authors. "Reading the Keelan/Wilson report, one gets the impression that the main reason it's been written is to assist in a process which could help bolster vaccine uptake." Susan's excellent critique, entitled Compensation Plan Rebuffed is posted on the main page of the VRAN website in our In The News column at www.vran.org

¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤

Note: The excerpt from Bruesewitz vs. Wyeth was reprinted from the Age of Autism blog: http://www.ageofautism.com/2011/03/what-bruesewitz-v-wyeth-means-for-american-families.html#more

Mary Holland and Luuise Kuo Habakus are co-editors of *Vaccine Epidemic: How Corporate Greed, Biased Science, and Coercive Government Threaten Our Human Rights, Our Health, and Our Children*. √

Preventing Autism—An Emerging Hypothesis

By J.B. Handley, April 2011

My second child's autism diagnosis put the plans my wife and I had for at least three kids on potentially permanent hold. Three years later, we are the proud parents of a beautiful baby girl, and we feel well-armed with the wisdom of other parents and many doctors to prevent her from the same fate her brother experienced.

What? We're planning to prevent her from developing autism? The notion of being able to prevent autism is a highly controversial idea, and one sure to make many sentences in this entry blogger-fodder. So be it.

It's probably worth taking a quick step back. The Generation Rescue website spells out pretty accurately how we feel about the cause of autism:

We believe these neurological disorders ("NDs") are environmental illnesses caused by an overload of heavy metals, live viruses, and bacteria. Proper treatment of our children, known as "biomedical intervention", is leading to recovery for thousands.

The cause of this epidemic of NDs is extremely controversial. We believe the primary causes include the tripling of vaccines given to children in the last 15 years (mercury, aluminum and live viruses); maternal toxic load and prenatal vaccines; heavy metals like mercury in our air, water, and food; and the overuse of antibiotics.

As we began to think about child number three, and armed with this general point of view above, my wife and I began to network with other parents who were in similar situations. Specifically, parents with an autistic child who had decided to have an additional child after becoming biomedical experts.

Through all of these conversations and time spent with many great doctors, we began to develop a plan to prepare for life before and after birth that we believed would reduce the chances for another autistic child. The complete list of ideas, from which we chose the right plan for us, included:

Early Preparation for Mom (prior to conception):

- Switching to a gluten/casein free diet
- Eating organic foods and avoiding all artificial colors, flavors, and preservatives
- Limitingsugar
- Focusing on gut health through a combination of anti-fungal treatment, beneficial bacteria repopulation, and digestive enzymes Detoxifying the body through a combination of chelation and natural detoxification techniques like FIR sauna, NDF Plus, Zeolites, etc.
- Adding a pre-natal vitamin and B-12

During pregnancy:

- Maintaining all dietary approaches listed above
- Avoiding all vaccines
- Avoiding any environmental risks like lead paint, home construction, cleaners and solvents, chemicals, etc.
- Avoiding antibiotics except in life-or-death situations
- Avoiding x-rays and sonograms, unless high-risk birth issues exist
- Continuing supplementation of prenatal vitamins, probiotics, digestive enzymes, and B-12
- Proper supplementation of mom's methylation cycle based on genetics

After birth:

- Maintaining all dietary approaches and supplements listed above while breastfeeding
- Holding off on introducing solid-foods until at least 6 months
- Avoiding antibiotics for breastfeeding mom and baby except in life-or-death situations
- Avoiding any environmental risks like lead paint, home construction, cleaners and solvents, chemicals, etc.
- Supplementing baby with infant-safe probiotics
- Avoiding all vaccines for at least the first 2 years of life, and then taking extraordinary caution

Preventing Autism cont. on page 10

Preventing Autism from page 9

- At the right time (typically 6 months or older), adding proper methylation cycle support
- At the right time, proper supplementation of Omega3-6-9
- Providing natural detoxification through things like Epsom salt baths

On the one hand, it's been "painful" to watch my daughter develop through seven months now without the eczema, ear infections, severe bowel problems, or sleepless nights her older brother experienced as his body slowly stopped functioning properly. "Painful" because I feel like so much of his suffering was preventable. On the other hand, we are grateful every day for the wisdom our son has given us about how to reduce the risks of autism for his new sister.

Are we out of the woods yet? Not remotely, we worry about autism for our daughter every day. Part of me was too superstitious to put these words on paper, but I hope other parents considering another child may benefit from the insight we feel helped us.

One final word on vaccines. Some have wondered whether or not we would consider vaccinating our daughter. Not anytime soon. Aside from the fact that the vaccine schedule has not been proven to be safe and that testing for it is grossly inadequate, we also feel that for whatever reason we produce children who react poorly to vaccines, based on the experience with both of our boys. As free citizens, we are exercising our rights to decide which medical procedures are safe for our children, and vaccines do not meet our standards. Might we change our minds as she gets older? Maybe, particularly for diseases like Rubella that can cause real problems for girls.

Is autism preventable? We believe it is. A radical concept several years ago, we feel it's a topic that deserves a lot more airtime today. Even mainstream scientists are now acknowledging the role "the environment" is playing in autism. What if you could modify that "environment" to reduce the risks?

Note: J.B. Handley is co-founder of Generation Rescue, a website dedicated to recovery from autism through biomedical treatments. http://www.ageofautism.com/2011/04/best-of-aofa-preventing-autism-an-emerging-hypothesis.html#more Generation Rescue is co-sponsor of the Autism One Conference, an annual meeting of parents and leading experts who are successfully guiding families in the recovery of children on the autism spectrum. The Autism One Conference will be convened May 25-29 in Lombard, Illinois. For conference particulars and list of speakers go to: http://www.autismone.org/content/autismonegeneration-rescue-2011-conference √

A Few Things I Know

February 5, 2011

By Suzanne Humphries, MD

I am a Medical Doctor with credentials in internal medicine and nephrology (kidneys). I received a bachelor's degree in theoretical physics in 1987 from Rutgers University. I mention the college degree in case any doubtful readers question my mental prowess. One can doubt my intellectual ability less if they first realize that I know how to figure out difficult things. I know how to look at something in depth for many hours or days until I understand the inner workings of it. This is what I learned to do in college. In fact the strenuous mind-bending exercise that was part of the physics curriculum made medical school easy. I found the study of the human body, chemistry and biology to be in comparison quite shallow, simple and easy to comprehend.

I also spent two years working in a biochemistry lab as the head technician. There I learned many things that at the time I didn't think would ever serve any purpose in my life. But in fact, as our destinies are often predetermined, the lab experience did indeed come around to serve me. In the recent days of vaccine debates, need for scientific proof, evidence of harm, I have found that knowledge of the technical aspects of animal studies and cell cultures are very good things to understand.

I have spent four years teaching internal medicine and nephrology to medical students, residents and advanced fellows in training at a university hospital as an assistant professor. During that time, reading over and critiquing dozens of journal articles was a part of everyday life. Suffice it to say, my past experiences have put me in good standing to look into the problems with vaccines and make certain determinations.

Like most doctors, I held a blind belief for many years, that vaccines were necessary, safe and effective. Like most doctors, I never lifted a page to seek out any other truth for myself. But unlike most doctors, I have no stake in upholding false paradigms and I am no longer indebted to the government for hundreds of thousands of dollars. Unlike most doctors, I have the means to survive with or without my medical license because I have sought out another education to support myself in case of worst case scenario. I do not feel fearful to speak the plain truth as it sits on the pages in front of me. Thousands of pages and hundreds of hours have led me to see the horrifying truth of what is being done to people and animals all over the world under the false pretense of "health".

I started to study vaccines, their components, and the science behind the statements of safety and effectiveness. From there an avalanche of truth collapsed upon me and I will never be the same. In fact, nothing I look at will ever be the same.

I am of sound mind, on no pharmaceutical drugs, carry no medical diagnosis and am unusually fit for my 47 years. I am happy, and have no grudge against any particular party. Up until 2 years ago I was content to work as a medical doctor caring for very sick people with kidney failure. Two years ago, everything changed. With several undeniable cases of kidney-associated vaccine injury in previously healthy people, I started to look deeper into the information that I had previously held as factual and not worthy of debate. I started to study vaccines, their components, and the science behind the statements of safety and effectiveness. From there an avalanche of truth collapsed upon me and I will never be the same. In fact, nothing I look at will ever be the same. Chronic degenerative diseases, kidney failure, autoimmune diseases and powers of authority will never look the same to me again. There are certain things that I can now say with no uncertainty.

Vaccines did not save humanity and never will.

Vaccines have never been proven truly safe except for perhaps the parameters of immediate death or some specific adverse events within up to 4 weeks.

Smallpox was not eradicated by vaccines as many doctors readily say it was. They say this out of conditioning rather than out of understanding the history or science.

Polio virus was not responsible for the

A Few Things I Know cont. on page 11

A Few Things I Know from page 10

paralysis in the first part of the 20th century. Polio vaccine research, development, testing and distribution has committed atrocities upon primates and humanity. Bill Gates is not a humanitarian.

Vaccines are dangerous and should never be injected into anyone for any reason. They are not the answer to infectious diseases. There are many more sustainable and benevolent solutions than vaccines.

Medical authorities should not have the final word on how doctors treat individual patients in the privacy of their own offices and should not be able to dictate injections into our private hospital patients.

The list goes on, but with this introduction I challenge health care practitioners to look into the topic of vaccines with an open mind, on their own. I implore them to read books and alternative literature sources. I ask that they understand that the peer review process has censored intelligent doubt on vaccine safety and driven it into the alternative press. I beg that all health care practitioners place their egos beside them and be ready for what will happen when the truth is visible. You may not want to go back to work. You may not be able to follow the recommendations that are being ever more heavy handedly given to you. I ask this for the good of humanity.

Please, parents and health care practitioners do your homework. The minds and bodies of future generations depend upon it.

With each passing moment more and more money and power is being handed to the powers that be and the end result is a barrage of vaccines starting at the first hours of every life that is born in a conventional manner. The injections pile up and the new illnesses appear shortly thereafter more and more every year. The degree of illness in such an advanced society should not be accepted as normal or just environmental. Please, parents and health care practitioners do your homework. The minds and bodies of future generations depend upon it.

Note: Appreciation goes to the International Medical Council on Vaccination, for providing an online forum in which health practitioners present their views on the topic of vaccination http://www.vaccinationcouncil.org/2011/02/06/a-few-things-i-know/#comment-752 √

Wakefield Has Company

by Judy Converse, MPH RD LD

Is there a vaccine-autism link? Is Andy Wakefield a crazy man? The gap I see, as a nutrition professional who has worked with children with autism for twelve years, is in a willingness to open our minds, to consider studies that corroborate Wakefield's work. I am weary of doing the literature search over and over, handing out these links (below) again and again—the ones the media ignore so handily. Your pediatrician likely doesn't know that Wakefield is not alone. I challenge physicians out there to pause, breathe, read the studies, and wonder. Think it through: What if he's right?

I notice that most doctors, parents, journalists and bloggers who are shouting about what a fraud Dr. Wakefield is are more voyeurs on the autism controversy than anything else. Most often, they don't see many patients with autism, don't treat them for anything beyond prescribing Miralax or Abilify, or aren't raising children with autism themselves. Or maybe I should say, they don't see their poop, their growth charts, endoscopy reports, stool cultures, or food intakes.

They don't see how physically ill these children are, up close. How many autism diapers have they changed? You know, the ones with the explosive gold lumpy liquid that soars up the child's neck and seeps down to his knees, six or eight times a day? How many toilets have they unclogged or replaced, after one too many enormous, stone-hard stools filled it? How many impacted colons have they cleared in young children with autism? How many failure to thrive children with autism have they worked with, to restore normal nutrition status and good health? This is what I'm mucking through at work on a regular basis as I provide nutrition care. Either in a child's history, parent interview, or in a kid's pants right in my office. Do I want to see it, mom asks? Why, yes I do, I always answer. And I want to culture it too. So off we go collecting that stool sample, right then and there. Let's do something about it.

Let's do something about the myths relentlessly repeated now about measles and Andrew Wakefield too.

First, there are fewer, not more, children getting measles in the UK since Andrew Wakefield voiced his concerns for the bundled MMR vaccine. In his detailed analysis, *Dr. Yazbak shows "There were 188,483 reported measles cases in the ten years preceding the Wakefield paper compared to 28,289 cases in the following ten years, an 85% decrease."

And, no, your child is not certain to die from measles if unvaccinated against it, unless he happens to be in profoundly weak status for vitamin A, iron, protein, and body mass index. Those nutrition parameters are strong predictors of how children manage most any infectious disease, and measles in particular. They are so strong, in fact, that protocols for using vitamin A to prevent and treat measles have long existed for UNICEF and the World Health Organization. A child in strong nutrition status typically passes through measles quickly with no lasting ill effect, and then has permanent immunity. This does not mean children never catch or die of measles. It does mean that measles is a highly survivable routine illness that healthy, well-nourished children overwhelmingly survived in the pre-vaccine era—just as my siblings did, who passed immunity to me.

Thirdly, I would also point out (groan, again) that Wakefield's infamous original

Wakefield cont. on page 12

Dr. Wakefield cont. from page 11

Lancet article was a case series. Which means, it did not test a hypothesis that MMR causes autism, nor did it intend to. It did not state this at all, as the media relentlessly hypes. I wonder how many MDs have actually read this original article, or even know the findings published there. The real tragedy is that the message of that original case series has been long lost in the sensationalist media cacophony. Again, think: **What if he's right?** Would Pharma, CDC, FDA, AAP, ACIP, UK GMC, and NIH stand up and say—"Oops. We're sorry." Would the US go into even greater financial arrears, to pay the hundreds of thousands of injured families the billions they would be due?

These are colossally powerful, profitable entities. If there is trouble with bundled vaccines like MMR, what a tidy solution if Wakefiled is indeed a monster and a fraud. But I don't think he is, after reviewing food intakes, GI sx, growth patterns, medical histories, and developmental histories on hundreds of children with autism.

Enough lamenting. I'm always asked, so here are some citations for the uninitiated. Wakefield has company. Can all these journals and authors be wrong as well? Here's one that I can't link to because it has vanished from PubMed (hmmm it was there two days ago), so here is the full citation:

Sheils O, Smyth P, Martin C, O'Leary JJ. Development of an 'allelic discrimination' type assay to differentiate between the strain origins of measles virus detected in intestinal tissue of children with ileocolonic lymphonodular hyperplasia and concomitant developmental disorder. J Pathol 2002; 198 (suppl): 5A.

Wakefield's company includes other researchers, and other vaccines beyond the MMR. For example, hepatitis B vaccine at birth was found to triple risk for autism in this retrospective study: http://bit.ly/rKeth

A horrifying vindication for a book I published in 2002 *When Your Doctor Is Wrong: Hepatitis B Vaccine & Autism.* This one shows a "hyperimmune" response to MMR in children with autism: http://bit.ly/fXmchZ

Oh alright, I will keep going…

Here's a 2010 chart review finding ileal or colonic lymphonodular hyperplasia in 73% of subjects with autism http://bit.ly/cr0HAL and this one saw a strong association between MMR vaccination and CNS autoimmunity in children with autism http://bit.ly/eTH7Vg and this one documents intestinal permeability ("leaky gut") occuring 7x more frequently in subjects with autism compared to controls http://bit.ly/aYirdO…

Here's a page with over twenty citations and analysis collected in one spot for MMR-autism: http://www.jabs.org.uk/pages/thrower.asp

Okay I'll stop. There is more, you can keep going down this rabbit hole if you like. You'll find Wakefield has plenty of company.

Lastly, we never hear much about this study, perhaps the most chilling of all. It is the only one to date that reviews the immunization schedule as it is given to human infants—something the FDA never required anybody to do before allowing our children to be given dozens of vaccines in a short time span, as many as twelve or fifteen in one day, as I have seen on my patients' vaccine records. It was a prospective case controlled study with primates, the closest animal model to humans that we can use. Do you know the outcome? Read it and weep, for our children.

http://www.ncbi.nlm.nih.gov/pubmed/20628439

They are not victims of Wakefield. They are victims of ignorance and greed. We owe them more research, solutions to the neurodevelopmental disorders and autism they now suffer in unprecedented numbers, and truth.

Note: *Measles in the United Kingdom, The "Wakefield Factor" by F. Edward Yazbak MD. http://www.vaccinationnews.com/measles-united-kingdom-wakefield-factor

Article reprinted from Vaccination News: With appreciation to Sandy Gottstein for her dedication in presenting exceptionally high quality content on her website, Vaccination News: http://www.vaccinationnews.com/wakefield-has-company √

Book Reviews

Vaccine Epidemic: How Corporate Greed, Biased Science, and Coercive Government Threaten Our Human Rights, Our Health, and Our Children

By Louise Kuo Habakus and Mary Holland

Editor's note: When I started reading this book, I couldn't put it down. It is brilliantly inspired! I predict Vaccine Epidemic will accelerate the collective consciousness to a heightened awareness of the health destruction caused by forced mass vaccination policies.

"Vaccines are safe and effective" is the mantra public health officials want you to believe. This book delves into the many areas of knowledge that challenge and refute the medical industry's simplistic and deceptive mantra. Polls in the U.S. show that parents are increasingly concerned about vaccine safety and the right to make individual, informed choices.

Vaccine Epidemic features essays by more than twenty experts from the fields of ethics, law, science, medicine, business, and history. Their collective voices urgently call for reform. It is a book about the most basic human right—the right to self determination when considering an invasive medical procedure that carries a risk of injury and death. **Coercive vaccination policies deprive people of free and informed consent—the hallmark of ethical medicine.**

It is a book about the erosion of medical rights and ethics and the disastrous outcome to human health when we allow the government and the medical industry to decide what is best for our health. William Wagner, JD, one of the contributing authors eloquently reminds us that, "The sacred and legal underpinnings of parents' unalienable right to direct the upbringing of their children are embedded in deeply rooted divine, natural, and common law traditions. Parents, not the state, have responsibility for and authority over decisions concerning the raising of their children—including vaccination choices." Wagner reiterates, "Replacing the sacred parental right to responsibly determine a child's medical treatment with dictatorial government mandates inevitably erodes a country's essential foundations."

Vaccine Epidemic is the essential

Book Reviews cont. on page 13

Book Reviews cont. from page 12
handbook for the vaccination choice movement and required reading for all people concerned about this issue. The editors, Louise Kuo Habakus and Mary Holland introduce a diverse array of interrelated topics concerning the explosive vaccine controversy, including:

- The human right to vaccination choice
- The ethics and constitutionality of vaccination mandates
- Personal narratives of parents, children, and soldiers who have suffered vaccine injury
- Vaccine safety science and evidence-based medicine
- Corrupting conflicts of interest in the national vaccine program

Vaccine Epidemic—A review by Judy Converse, MPH, RD, LD, Colorado

After I spoke at the May 2010 rally for vaccine choice in Chicago, requests for chapters for *Vaccine Epidemic* went to speakers. I understood this was going to be a book like no other. And, I cringed. I figured long ago that if parents want to pay attention to vaccine safety, they have ample resources to do so now that didn't exist for me in 1996, when my son was born. Access to information about vaccine choice was limited then to say the least. Even with a master's degree in public health, I knew nothing then about vaccine injuries, deaths, or the right to defer. That's all changed now that this information is a click or two away.

When I received my copy this week, I was wowed. We need this book. I have hung around this issue for fourteen years. I helplessly watched as vaccines nearly shook the life out of my son. I've read countless books and articles, talked to hundreds of parents and many physicians and scientists, and struggled to do my best to intervene on the lasting effects of vaccine injury for my child and hundreds of others. I've been around this block. And I will say this truly is a book like no other; the [North]American public is ready for it now like they never have been before.

Its chill tone lays the bare truth at your feet, from several vantage points: Vaccines are possibly causing more harm than good for our country now, because it's profitable. Vaccines are like oil, coal, or any other lucrative commodity. They make colossal, unthinkable sums of money that spout on universities, government entities, individuals (Paul Offit, for one), shareholders, and corporations. The stakes are astronomically high. The health and well being of your baby is no longer near the top of the list of priorities for vaccine manufacturers. The belief that you think it is, is. In the meantime, you might spare one more child the agonies of these conditions by exercising your right to choose how or if you vaccinate, after you read Vaccine Epidemic

¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤

Vaccine Epidemic—A review by Judith Jolly, Texas

When I started the book last week, I was not expecting it to be one that I could not put down. But I carried it with me, and read it whenever I had a moment.

This is a MUST READ! I am a pediatric nurse, and I was really blown away by the FACTS in this book. Vaccines are not adequately studied for safety, and they can clearly cause a great deal of injury. I knew that the idea that it was a 1 in a million chance of getting an injury was false, because I have cared for several vaccine injured children who were left severely brain damaged from seizures, only hours after receiving their vaccines.

No doctor I have EVER been in contact with goes over the risks of vaccines, the side effects (other than soreness at the site, mild fever) and I have never seen a consent form for a vaccine. Not to mention, no doctor ever reviews the ingredients. I guess if you tell a parent that you are about to inject their day old baby with Aluminum Hydroxyphosphate Sulfate, Amino Acids, Dextrose, Formaldehyde or Formalin, Mineral Salts, Potassium Aluminum Sulfate, Soy Peptone, and Yeast Protein, they will snatch their child and run for their lives!!!

I have now changed my wording in my nursing assessments. When I ask about vaccines, as required by the medical paperwork, I now ask if the family has CHOSEN to vaccinate their child. Because parents need to know that vaccinations are a choice. And if you are being bullied about vaccines by your child's doctor, you need to FIRE THEM! The Supreme Court Ruling today just made me even more convinced that vaccines are a huge danger to people, especially since you have NO LEGAL recourse when you get injured. I'm going to pass this book around, and I am going to see if my book club will want to discuss it! Great job!

¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤

Shaken Baby Syndrome or Vaccine Induced Encephalitis—Are Parents Being Falsely Accused?

By Harold Buttram M.D. and Christina England

Shaken Baby Syndrome – A review by Sandy Lunoe, Oslo, Norway,

Thousands of parents and caretakers are being accused of shaking their babies to death without establishment of a thorough differential diagnosis and ruling out possible causes of the findings. Many children are being unjustly removed from their parents and caretakers and placed in foster homes, "something that will come to be looked upon as legalized kidnapping in future and wiser times".

There is fathomless sorrow and suffering of parents who are falsely accused of murdering their children and those who have wrongly had children taken away from them.

Dr. Harold Buttram, an expert regarding the shaken baby syndrome (SBS), has been involved as a defense witness in many SBS cases. Infants who are violently shaken should present symptoms of neck or spinal injuries; the vast majority of the children who die or suffer brain injuries thought to be due to SBS do not present these injuries, but they may present brain damage and brain hemorrhages, which are known to be related to vaccines.

Dr. Buttram describes, in addition to other relevant issues, biomechanical research findings, giving credible and comprehensible explanations. The following eye-opener is convincingly deduced: "The Shaken Baby Syndrome theory defies both reason and common observation. As a simple statement, it is physiologically impossible".

Co-author Christina England is a journalist whose work is read internationally and who speaks at seminars worldwide. Her main area of expertise is in researching the areas surrounding false allegations of child abuse. She has spent many years researching vaccines and adverse reactions.

In the chapter "A Dangerous Combination" Ms. England discusses vaccines, relating to numerous studies, with special reference to the five-in-

Book Reviews cont. on page 15

Gardasil Sterilized My Daughter—A Mother's Testimony

Testimony by Roberta Boyce to FDA Vaccines and Related Biological Products Advisory Committee - November 17, 2010

I just want to start by saying I have no conflict of interest. In fact I sold all my Merck stock when I found out what it had done to my daughter. I am here today because my daughter was harmed by the Gardasil vaccine. My daughter was actually sterilized by the vaccine.

I don't have a medical degree but consider myself pretty well educated. I've spent the past two years researching medical papers so I could understand why my daughter had such debilitating side effects post-Gardasil, and I read hundreds of medical papers from various sources. There is a lot of misinformation out there about what causes HPV, in my opinion.

I presented information last September against the vaccine at a similar FDA meeting when you were considering extending the vaccine to boys and older women. At that time I told the advisory panel that many of the Gardasil girls were showing symptoms of severe vitamin deficiencies, specifically niacin. That in turn causes pyruvate kinase deficiency, something critical to the Krebs cycle. For those of you in the audience here that don't know, the Krebs cycle is a vital function in the body that provides nutrients for new red blood cells, energy, and glucose, and repairs cell damage during periods of stress.

If the person has severe pyruvate kinase deficiencies, the person exhibits a myriad of symptoms and can never recover unless they take supplements. If they don't get supplements, they continue to deteriorate. That is what is happening with many of the Gardasil girls. The symptoms are slightly different because of individual genetic makeup; however, all the side effects exhibited are caused by the same PK deficiency.

Unfortunately, since PK deficiency is a relatively new finding, only discovered in 1996, the majority of doctors have never heard of it. I am certain they don't understand that the Gardasil vaccine would have catastrophic implications for these individuals.

Since PK deficiency or hemochromatosis is the most prevalent genetic trait in the United States, any individual having it would have a difficult time recovering from a vaccine. But my daughter was never tested for this prior to vaccination, even though your charts show that you do not include people with those autoimmune disorders in your studies.

Does this mean that each person getting the Gardasil vaccine will actually get cancer from the vaccine if they have PK deficiency? I don't know, but certainly there are those with genetic deficiencies that will have issues with it.

Already the May 2006 FDA VRBPAC reports that if a woman has HPV and receives Gardasil, her chances of getting cervical cancer increase by 44.6 percent after inoculation.

Already the May 2006 FDA VRBPAC reports that if a woman has HPV and receives Gardasil, her chances of getting cervical cancer increase by 44.6 percent after inoculation. Is it just possible that HPV is caused by PK deficiencies? I believe so. Shouldn't patients be tested for the most prevalent genetic trait prior to vaccination if this vaccine would be so dangerous to them? And what about the test studies? Were individuals with PK studied, a predominantly Northern European trait included in the test studies? Right now today you showed they were not.

In my opinion there were not parallel populations put in these studies, unless the study that was included from Costa Rica, they were expecting to market this vaccine to Hispanics, which I doubt, since it's the most expensive vaccine ever produced.

The Merck Manual clearly cites several types of PK deficiencies and even suggests that individuals with these inherited disorders would not be candidates for vaccines. A few types of PK deficiencies I would specifically point out are G6PD, a traditionally Jewish trait, sickle cell anemia, and thalassemia. There are many other names for the same deficiency, such as Celtic Curse, HH, HFE, and iron overload, but they are all the same PK deficiency.

In fact most if not all of us have a slight form of PK deficiency because of several issues, including toxins in our environment, in our homes, excess minerals in our drinking water and foods, alcohol consumption, and a gamut of other factors, including stress and exercise. I don't believe scientists developing this vaccine had access to all the information they should have. I want to believe that they did not understand that PK deficiency is also environmentally caused. Everyone here needs to understand that PK deficiency is no longer just a genetic trait.

The effect of a live vaccine like Gardasil has tremendous implications for all of us because we all have some form of this deficiency. We will not be able to recover from this vaccine and, perhaps slowly, will continue to exhibit debilitating side effects post-vaccine.

In April 2008 the FDA sent a warning letter to Merck citing two lot numbers, X and U, that had extra yeast. I believe these lots exacerbated the problems of the vaccine, and the side effects that normally would have taken years to show up became obvious almost immediately. Some side effects that normally might have been mild have now exploded. Today there have been 84 deaths and over 20,000 severe side effects documented in our government VAERS system, and now Gardasil makes up more than 65 percent of the entire VAERS database. The vast number of side effects that have been reported are from lots X and U that have the extra yeast.

India has already outlawed this vaccine because of what they have seen post-vaccination. Many of you are aware that there is currently a lawsuit in the Supreme Court that will decide on certain vaccines having design flaws. Gardasil, in my opinion, should be considered one of those vaccines.

First, the test trials never had a true placebo but instead used an aluminum adjuvant as the placebo. Second, the vaccine was marketed as a vaccine to prevent cervical cancer, and yet the HPV virus has never proven to positively cause cervical cancer. I would strongly argue that it is caused by genetic and environmentally caused PK deficiency. Third, the long-term side effects of polysorbates, which can also cross the blood-brain barrier, were never thoroughly explored.

There are many medical papers documenting fertility issues in mice that have been administered polysorbates, and yet the long-term implications of these were never tested. Merck has come right out

Gardasil cont. on page 15

Gardasil cont. from page 14
and said they do not know if fertility will be an issue for these vaccinated children in the future. This is a critical issue. Could Merck have known that this vaccine would cause fertility issues in women wanting to conceive in the future?

Last year I stumbled upon a World Intellectual Property Organization paper which discussed pyruvate kinase deficiency in animals. This was many of the "God moments" that I've had in the past two years since I found out my daughter was injured. I know that's not a popular stance to take in a government meeting, that I've had all these "God moments," but let me tell you, it happens when you know your daughter is dying after a vaccine.

The paper I read talks about fertility impairment of cats and dogs. The vaccine was administered in three doses over a 6-month period, and one of the main ingredients was polysorbates, also in Gardasil. What was interesting about the paper was the animals with PK deficiencies did not sustain any cessation of menses post-vaccination—very interesting and very scary, because it was exactly what I was seeing in my daughter post-Gardasil.

My daughter recently tested sterile at age 21, although she is still getting a relatively normal period. Could it be that Merck intentionally developed this vaccine thinking it would affect a small number of individuals with PK deficiencies? Is this what their intent was when they developed their recently approved fertility drug Aleva, which was just passed for European use? I wonder if Merck and other big pharmas have intentionally taken advantage of genetic deficiencies. I believe they have, and I believe this is what has happened many, many times over. In fact today's presentation by Dr. Garner clearly stated that DNA extractions were performed in their tests.

I was distraught knowing my daughter would likely be sterilized from the vaccine and it was my fault.

Imagine how a mother who wanted her daughter to have a vaccine would feel after learning all this information. I was distraught knowing my daughter would likely be sterilized from the vaccine and it was my fault. In my eyes, it seemed certain that my daughter had either a genetic or environmentally caused PK deficiency, since she had been exhibiting menopausal symptoms for several months and erratic periods, sometimes very heavy, usually coming every two weeks. She complained of hair loss, experienced severe PMS symptoms and mood swings, and those were the more mild symptoms.

After recent tests my daughter had done, I can now positively confirm that my daughter tested post-menopausal as it relates to her hormone levels, with no family history of early menopause. She is no longer ovulating and she has hormone levels of a 50-plus-year-old woman. My worst nightmares have come true.

Because I am privy to information about the health of other girls through support groups that I am involved with —two of them are truthaboutgardasil.org and sanevax.org—I know there are many other girls who are also experiencing similar testing and their results are comparable to my daughter's.

I am grateful to God for guiding me to the Gardasil groups I belong to. Both are very large and have hundreds of members like me, desperately trying to stop the HPV vaccine and find answers to help their daughters. The sanevax.org group, which is a spinoff of truthaboutgardasil web site, now has 69 countries spanning the globe using their resources.

God made us all slightly different, and we all have subtle genetic imperfections. That is what makes us unique. Unfortunately, I believe unethical people in big pharma have figured out how to take advantage of these imperfections. That's how they've made money in the past, and that's how they intend to continue making money in the future, because they are beholden to their stockholders to bring in profits no matter what the cost, even if it means harming children to get their money.

I must reiterate that I honestly doubt they took into account PK deficiencies were environmentally caused. In my opinion, they didn't know the damage done would be so astronomical. But so far they have taken no action to help those harmed. When families call Merck trying to get help, they will not even return phone calls. Doctors don't know how to correct the damage done and throw up their arms, saying the CDC and FDA say it's safe. These cases seem so complex, but clearly this vaccine is not safe.

I am pretty certain doctors aren't even aware of the myriad of side effects they are saying are caused by PK deficiency. Remember, it's relatively new, only discovered in 1996. It is horrifying to see previously perfectly healthy children now having seizures, migraines, pneumonias, personality disorders, fatigue, menstrual issues, vomiting, diarrhea, and the list goes on, post-Gardasil. This vaccine needs to be pulled immediately. Over 20,000 families are now begging for help, and no one is answering their desperate pleas.

I am begging you, do not expand this vaccine until there are answers to the problems that have already arisen. How many children will have to die because this vaccine was a mistake of crazy proportions? How many will be sterilized? Imagine if our entire world were vaccinated with Gardasil. Will we all be sterilized? The truth needs to be told.

Source: Food and Drug Administration
Center for Biologics Evaluation and Research
Vaccines and Related Biological Products
Advisory Committee Meeting – Nov. 17, 2010
http://www.fda.gov/AdvisoryCommittees/CommitteesMeetingMaterials/BloodVaccinesandOtherBiologics/VaccinesandRelatedBiologicalProductsAdvisoryCommittee/ucm241266.htm √

Book Reviews cont. from page 13
one vaccines (DTaP/HIB/IPV or DTaP/HIB/HepB): "Taking the history of each vaccine in turn, we can quickly establish that each of these vaccines has a tainted history, with many adverse reactions. Is it a wise move to put all these highly toxic and potentially dangerous vaccines into one syringe? Surely as a result, we should not be surprised to see adverse reactions soar. Only time will tell, but how many precious lives will be lost and how many more parents will be falsely accused of shaken baby syndrome as the world embarks on yet another "government vaccine experiment?"

This book refers to many relevant studies, is reasonably priced and can be read within just a few hours. It should be widely distributed, included in medical libraries and in the curriculum for medical and law studies, in order to contribute towards increased awareness of the alleged shaken baby syndrome.

Note: Both Vaccine Epidemic and Shaken Baby Syndrome are available from Amazon. As well, VRAN plans to offer these books as fundraising bonus items for donations of $150 or more. √

Prevnar is the value standard, but who captures the value?

By Mark Blaxill, January 5, 2011

The Offit Index* gave me an opportunity to reflect a bit on the dissonances that can emerge between private and public value. The case for the public value of Prevnar relies on its ability to prevent several form of invasive pneumococcal diseases (IPD), especially pneumonia and meningitis, caused by *streptococcus pneumoniae*. IPD is a serious and occasionally fatal disease, more common in children than adults, but more dangerous for the elderly. Before Prevnar was introduced in the US, CDC surveillance estimated that IPD occurred at a rate of 9.5 per 10,000 in children under five, with a mortality rate of about 1%; among adults over 65 years old, IPD rates were 6.2 per 10,000 but with a mortality rate of 23%. (Hicks et al 07) The case for Wyeth and Pfizer to reap billions in profit from this vaccine rests exclusively on Prevnar's success in reducing the human toll of IPD.

From a public health perspective, the early returns on Prevnar were full of hope and optimism. After just a few years in the American market, initial studies of Prevnar's impact (see Hicks et al 2007 and Hsu et al 2005) reported reductions of more than 60% in IPD cases and hospitalizations in children by 2004. But even though most studies emphasized Prevnar's successes, this early optimism was tempered in the most comprehensive investigation, one that covered a population of 19 million people in and around 8 major cities. The study found that "the overall mortality rate among children did not change during the study period" (remaining constant at about six deaths per million children) and adult mortality decreased only slightly (Hicks et al, 2007).

The reason? Wyeth's vaccine was proving effective at reducing IPD and associated mortality from the 7 strains of bacteria in Prevnar, but because *streptococcus pneumoniae* comes in many different forms, it appeared that suppression of the strains in Prevnar 7 might be promoting the survival of different pneumococcal strains. **Even worse, these surviving strains might prove to be more virulent than the strains they replaced.**

Sadly, recent studies in Dallas (Techasaensiri et al, 2010), Cleveland (Jacobs et al, 2008) and Massachusetts (Hsu et al, 2010) have shown that this is exactly what happened. Dallas rates of IPD in children fell by more than half from 1998 to 2003, but as the non-vaccine strains emerged, the overall IPD rate began increasing and reached three quarters of the pre-Prevnar rate by 2008. The Cleveland study showed explosive growth rates, from 100% to as high as 900%, in the non-vaccine strains over a seven year period. In Massachusetts, the increase in IPD from non-vaccine strains completely cancelled out the reduction in IPD from vaccine strains between 2001 and 2007, with eight deaths resulting from these non-vaccine strains (which were often antibiotic resistant) and a case fatality rate of over 3% in infants.

The remarkable conclusion of these studies was never to question the wisdom of the policy to begin with... but rather to increase the number of the streptococcus pneumonia strains contained in the vaccine. Instead of seven strains, a larger combination of "serotypes" would be needed...

The remarkable conclusion of these studies was never to question the wisdom of the policy to begin with (did we really need to spend billions on a Wyeth vaccine that didn't reduce deaths in children and only temporarily reduced IPD cases?), but rather to increase the number of the *streptococcus pneumonia* strains contained in the vaccine. Instead of seven strains, a larger combination of "serotypes" would be needed: maybe ten, maybe thirteen, maybe more, out of a population of as many as forty known varieties.

So now we have Prevnar 13, approved by the FDA in February 24, 2010. And despite the marginal public value of the original vaccine, Wyeth's commercial momentum never skipped a beat. From 2000 through 2010, Wyeth's sales of Prevnar 7 added up to over $15 billion. This success paid huge dividends to Wyeth's shareholders. When Pfizer acquired Wyeth in late 2009, they paid $68 billion.

A large portion of that acquisition price was due to Prevnar, Wyeth's #3 brand behind Effexor and Enbrel. In early 2010, Pfizer launched the new Prevnar 13 vaccine and it appears that the Prevnar brand is on track for its biggest year ever, easily topping $3 billion in sales. After fourth quarter results are in, it seems likely that Prevnar 13 will garner over $2 billion in revenue in its first year as Pfizer phases out Prevnar 7.

For a vaccine that one large population study showed had no life-saving benefits for children, isn't that a lot of money to provide to a private corporation in a mandated government program? No one in the public health establishment seems to have asked that question.

¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤

*Note: * The "Offit Index" refers to the observation that Dr. Paul Offit, Chief of Infectious Diseases at the Philadelphia Children's Hospital is also America's leading vaccine proponent and the beneficiary of lucrative remuneration from his rotavirus vaccine patent. He is renowned for having postulated that babies can withstand up to 100,000 vaccine antigens given at the same time.*

Mark Blaxill is Editor-at-Large of Age of Autism and co-author with Dan Olmsted of the new book, *The Age of Autism: Mercury, Medicine and a Manmade Epidemic. The article segment reprinted here is excerpted with appreciation from:* http://www.ageofautism.com/2011/01/the-offit-index-tracking-a-patent-owners-ongoing-financial-interest-in-one-vaccines-sales.html#more

References:

1. 1. Hicks LA, Harrison LH, Flannery B, Hadler JL, Schaffner W, Craig AS, Jackson D, Thomas A, Beall B, Lynfield R, Reingold A, Farley MM, Whitney CG. Incidence of pneumococcal disease due to non-pneumococcal conjugate vaccine (PCV7) serotypes in the United States during the era of widespread PCV7 vaccination, 1998-2004. *J Infect Dis*. 2007;196(9):1346-54.
2. 2. Hsu K, Pelton S, Karumuri S, Heisey-Grove D, Klein J; Massachusetts Department of Public Health Epidemiologists. Population-based surveillance for childhood invasive pneumococcal disease in the era of conjugate vaccine. *Pediatr Infect Dis J*. 2005;24(1):17-23.
3. 3. Jacobs MR, Good CE, Bajaksouzian S, Windau AR. Emergence of Streptococcus pneumoniae serotypes 19A, 6C, and 22F and serogroup 15 in Cleveland, Ohio, in relation to introduction of the protein-conjugated pneumococcal vaccine. *Clin Infect Dis*. 2008;47(11):1388-95.
4. 4. Hsu KK, Shea KM, Stevenson AE, Pelton SI; Massachusetts Department of Public Health. Changing serotypes causing childhood invasive pneumococcal disease: Massachusetts, 2001-2007. *Pediatr Infect Dis J*. 2010;29(4):289-93.

√

Meningococcal Diseases and Vaccine

By Susan Fletcher

Meningococcal Diseases are associated with the bacterium, Neisseria meningitidis, also referred to as meningococcus, and include the invasive diseases, meningitis and blood poisoning, both of which can also be caused by other pathogens. Currently, there are five major serogroups of meningococcus. According to the 2006 Canadian Immunization Guide, serogroups B and C were predominant at that time; serogroup Y, which mainly occured in older adults,was less prevalent; and serogroups W135 and A were even rarer in Canada. However, even B and C cases were so rare that they were almost non-existent. Statistics from the years 2000-2003 show the average yearly total of meningococcal C cases in infants and children up to four yrs old was 4 to 9 for the whole country.

The US Centers for Disease Control (CDC) tells us that, "High fever, headache, and stiff neck are common symptoms of meningitis in anyone over the age of two years. These symptoms can develop over several hours, or they may take one to two days. Other symptoms may include nausea, vomiting, discomfort looking into bright lights, confusion, and sleepiness. In newborns and small infants, the classic symptoms of fever, headache, and neck stiffness may be absent or difficult to detect, and the infant may only appear slow or inactive, or be irritable, have vomiting, or be feeding poorly. As the disease progresses, patients of any age may have seizures."

Regarding transmission, the CDC explains, "The bacteria are spread through the exchange of respiratory and throat secretions (i.e., coughing, kissing). Fortunately, none of the bacteria that cause meningitis are as contagious as things like the common cold or the flu, and they are not spread by casual contact or by simply breathing the air where a person with meningitis has been." In 2002, Health Canada's website described meningococcal disease as "not very contagious".

In a paper published in the Medical Journal of Australia, epidemiologist Dr Mahomed Patel noted that introduction of vaccines against two other bacterial infections, those of pneumococci and Haemophilus influenzae type b, were followed by increases in bacterial strains not included in the vaccines. He commented, "It's not unlikely that this may occur with the meningococcal vaccines". In fact, it appears his prediction was correct.

A winter, 2010 cross-Canada study has shown that, since 2006, the meningococcal C vaccine introduced in 2003 has been largely ineffective for prevention of invasive meningoccal disease (IMD) in children. In children, but not adults, the incidence of serogroup B has become greater than that of C; from 2006 to 2009, the incidence of B was 69% whereas that of C was 5%. Accounting for all five serogroups and all regions, the study found serogroup B associated with 74% of IMD in Newfoundland, 71% in Quebec and 41% in the other provinces.

So, we have the vaccines, Menjugate® and Menactra® to cover all the less numerous serogroups but no vaccine for the most predominant one. Discussing the Quebec preponderance of B, the National Advisory Committee on Immunization (NACI) has stated: "The increase in serogroup B IMD two years after the introduction of a mass meningococcal vaccination program using conjugate C meningococcal vaccine for individuals 2 months to 20 years of age raises the possibility of serogroup replacement." Similar to the universal and frequent use of antibiotics, the universal and frequent use of vaccines may cause as much infectious disease as it prevents.

But, even if this were not so, the NACI has also stated that although, "vaccination with conjugate meningococcal vaccine primes the immune system for memory and induces good anamnestic [antibody memory] responses after challenges with meningococcal C polysaccharide or conjugate vaccines…because of the short incubation period of IMD (range two to 10 days, commonly three to four days) it is now generally accepted that the anamnestic response cannot be relied upon to prevent disease and that circulating antibodies [from previous infection or repeated recent vaccination] are necessary for protection."

Citing UK studies which showed numerous vaccine failures, the NACI acknowledged, "These data suggest that [vaccine-derived] immunity wanes over time, and that immunization after one year of age provided longer term protection against IMD than immunization in infancy." But, taking their pro-vaccine stance to the extreme and as if to justify injecting infants with risky meningococcal vaccines, they added, "Auckland et al. were…able to demonstrate that vaccine failures with IMD mounted a memory response to disease…". And why was this any more beneficient than a memory response mounted as a result of IMD in the unvaccinated? It was because, during their convalescence, the failed vaccine group had higher antibody levels than convalescing unvaccinated controls. Evidence that this higher level was maintained beyond convalescence wasn't provided.

The 2006 monograph for Menjugate® vaccine tells us that, like the pneumococcal vaccine, Prevnar®, it is a conjugate vaccine; it contains a portion of the meningococcal C bacterium joined to a protein carrier which is a non-toxic mutant of diphtheria toxin. Menjugate® also contains mannitol, sodium phosphate monobasic monohydrate, sodium phosphate dibasic heptahydrate, aluminum hydroxide, and sodium chloride.

The monograph states, "No pharmacodynamic or pharmacokinetic studies have been conducted with Menjugate®, in accordance with its status as a vaccine." Presumably this means that, because vaccines are assumed to be effective if they elicit a significant production of antibodies, that effect should be sufficient evidence to convince us that further study of their action in the body is unnecessary.

The monograph instructs those who administer the vaccine that "Precautions such as the use of antipyretic measures should be relayed to the parent or guardian". But, while lowering body temperature with the use of drugs may make the vaccine recipient feel better and parents less anxious, it could also possibly reduce immune response. In the case of a meningococcal infection, fever suppression is especially risky since reduced immune response may mask tell-tale symptoms of rapidly progressing meningococcal disease.

Because, during trials, other vaccines were injected along with Menjugate®, a convenient loophole was available regarding adverse event reporting. The monograph states: "In infants and toddlers symptoms including crying, irritability, drowsiness, impaired sleeping, anorexia, diarrhea and vomiting were common after vaccination but there was no evidence that these were related to Menjugate® rather than concomitant vaccines, particularly

Meningoccocal Diseases cont. on page 18

Meningoccocal Diseases cont. from page 17

DPT." Note that there was also no evidence that they were related to concomitant vaccines rather than Menjugate®. This points to the fallacy of co-administering other vaccines with trial vaccines and using vaccines as controls.

The monograph further states: "Although symptoms of meningism such as neck pain/stiffness or photophobia have been reported, there is no evidence that the vaccine causes meningococcal C meningitis. Clinical alertness to the possibility of coincidental meningitis should therefore be maintained." Does this mean that Novartis made every attempt to find evidence that these symptoms were caused by their vaccine and found none, or does it mean they made every attempt to avoid looking for evidence?

Sanofi Pasteur's Menactra®, another 'subunit vaccine', contains parts of meningococcal serogroups A, C, Y and W-135. Its approval for use anytime between 2 yrs and 55 yrs allows for repeated booster shots (as usual with new vaccines, "the duration of protection is unknown").

The Menactra® monograph warns, "persons previously diagnosed with GBS [a type of paralysis] should not receive Menactra®." since, "Based on evaluation of post-marketing adverse events, a slight increase in the number of GBS reports was observed following administration of Menactra®." The monograph also warns, "There are no data on the use of this vaccine in pregnant women." and, "the effect on breast-fed infants of the administration of Menactra® to their mothers has not been studied."

Safety trials of Menactra® used Menomune®, a similar meningococcal vaccine, as the placebo. This means that the data generated are mostly useful to compare the types and rates of adverse events from the two vaccines, not to discover the extent of risk from Menactra®. Only if a true (non-reactive) placebo such as saline solution had been used could this have been accurately accomplished. The comparison between the two vaccines shows that in children 2 to 10 yrs old, Menactra® produced local reactions more often. In adolescents and adults it produced more local reactions, especially pain, and more systemic reactions, with headache, fatigue and malaise topping the list.

References:
- Mosby Medical Encyclopedia; Signet; 1996.
- National Advisory Committee on Immunization; 'Vaccine-Preventable Diseases: Meningococcal'.
- Centers for Disease Control and Prevention; 'Meningococcal Disease: Frequently Asked Questions'.
- 'Meningococcal Vaccine'; Health Canada; Dec 16, 2002.
- 'Call for further study on meningococcal vaccine'; Feb 14, 2007.
- 'The epidemiology of serogroup B meningococcal invasive infections in Canada, IMPACT 2002-2009; Canadian Journal of Infectious Diseases & Medical Microbiology; Vol 21, No 24; Winter 2010 / 9th Canadian Immunization Conference Abstract 010. (LINK TO http://www.pulsus.com/journals/abstract.jsp?HCtype=Physician&sCurrPg=abstract&jnlKy=3&atlKy=9831&isuKy=950&isArt=t&fromfold=Current%20Issue&)
- 'Update on the Invasive Meningococcal Disease and Meningococcal Vaccine Conjugate Recommendations; CCDR; Vol 35; ACS-3; April, 2009. (LINK TO http://www.phac-aspc.gc.ca/naci-ccni/recs-eng.php)
- Menjugate® Product Monograph; Novartis Vaccines and Diagnostics; Sept 6, 2006.
- Menactra® Product Monograph; Sanofi Pasteur Ltd; Toronto, Canada; Sept 2008. (LINK TO http://www.menactra.ca/index.cfm?fa=view.show&cname=MEN_Mono)

√

Tracking the 'herd'

By Susan Fletcher, April, 2011

Heralding in 2011, the Canadian Medical Association Journal (CMAJ) advised us that, "The Canadian Public Health Association and leading paediatricians and immunologists are calling for a national immunization registry and harmonized vaccination schedules **so no one risks missing a vaccine because of where they live."** (emphasis mine) Of course, we've known for some time that these "stakeholders"—more than 50 of them according to CMAJ—have been chomping at the bit to increase vaccine uptake. No doubt their stakes are well worth cultivating.

The CMAJ reminds us that, "Deputy ministers of health across Canada originally approved a national immunization strategy that was funded through a $45 million contribution over five years in the 2003 federal budget. A national immunization trust subsequently provided $300 milion to help the provinces make four additional vaccines—acellular pertussis, meningococcal C conjugate, pneumococcal conjugate and varicella—available."

The original impetus for such generosity with taxpayer's money dates back to 1996 when, according to the Public Health Agency of Canada, attendees at the Canadian Immunization Conference recommended an "urgently needed" immunization tracking system. In 1998 at a conference convened by Health Canada, it was decided that the goal of a National Immunization Records Network would be: "To ensure every province and territory will have a comprehensive electronic immunization registry capable of participating in a national immunization records network by 2003."

However, implementing the goal has been hit and miss. "For example," notes the CMAJ, "Canada Health Infoway was charged, in the wake of the SARS crisis, with developing a single public health information system for Canada, which would include a national vaccination registry. But the system, called Panorama, has not yet been rolled out in any Canadian jurisdiction....It's behind schedule and over budget...".

A CMAJ news article of June 19 2007 noted the comment of one vaccination expert that the main outcome of the National Immunization Strategy [NIS] exercise was "the creation of a massive intergovernmental vaccination bureaucracy." The article illuminates: "After a vaccine is approved as safe and effective by Health Canada, it is subject to the scrutiny of the National Advisory Committee on Immunization [NACI], a group of pediatric and adult immunization experts who essentially volunteer to study and recommend whether a vaccine should be made available for routine use among specific population groups. In turn, the advisory committee's recommendations are scrutinized by the Canadian Immunization Committee, a 19-member committee comprised primarily of provincial public health officials… the Canadian Immunization Committee is responsible for developing the operational plans by which the vaccines recommended by the National Committee on Immunization might be made available to the public. It reports **confidentially** to the Communicable Disease Control Expert Group, which in turn reports to a 14-member federal/provincial body called The Council

Tracking the Herd cont. on page 19

Trackiing the Herd cont. from page 18

(typically, provincial medical officers of health). [emphasis mine] All, and various other expert and issue groups, are collectively known as the Public Health Network, which reports to the Federal/ Provincial/Territorial Conference of Deputy ministers of Health." Notwithstanding the "essentially volunteer" NACI, obviously, the cost of the vaccines alone – as high as it is—is a minor expense compared to the total cost to arrive at the point of injection. It boggles the mind to think of the additional costs of over a decade of planning for an NIS.

According to Ian Gemmill, MOH for Kingston Frontenac Lanark and area, one of the advantages of a national registry would be that, "Monitoring uptake on immunizations could also allow public health officials to target educational campaigns at regions in which antivaccination advocates have been active... **'If we're not there to provide the information that people need, and to answer their questions truthfully, then the only source of information those people will have is the anti-vaccination people.'** Obviously, "the information that people need" is the 'truth' that vaccines are harmless and will undoubtedly protect them from horrendous diseases and early death.

Monika Naus, medical director of immunization programs for the BC Centre for Disease Control (BCCDC), likes the fact that, "Registries would also provide better surveillance information, so Canada could evaluate and assess its immunization programs to see what proportion of the population is actually protected against particular diseases...'We know that in some countries where vaccination levels have slipped, there have been epidemics or outbreaks of these diseases.' I wonder if Dr Naus remembers that during outbreaks of measles in vaccinated children, BCCDC acknowledges that it's the older generations who've never been vaccinated against measles that are "actually protected".

It's considerate of the "stakeholders" to want to ensure nationwide equality of vaccine availability. **But nowhere in the January 2011 CMAJ article is tracking of adverse events mentioned. Is this surprising?**

References:
http://www.cmaj.ca/earlyreleases/11jan11-experts-call-for-national-immunization-registry-coordinated-schedules.dtl
http://www.phac-aspc.gc.ca/im/cirn-rcri/index-eng.php http://www.cmaj.ca/cgi/content/full/176/13/1811 √

British Medical Journal in Partnership with Merck

An investigative piece at the Alliance for Human Research Protection (AHRP) website offers a glimpse of medical industry malfeasance operative behind the Wakefield saga. We are informed that the British Medical Journal (BMJ) has partnered with Merck, world's largest producer of MMR—the vaccine at the centre of the Wakefield controversy.

AHRP director, Vera Hassner Sharav asks, "Why did the BMJ fail to disclose its partnership agreement with Merck, major vaccine manufacturer—13 vaccines, including the controversial MMR vaccine?

"Why did the BMJ fail to disclose its partnership agreement with Merck, major vaccine manufacturer—13 vaccines, including the controversial MMR vaccine?"
AHRP director, Vera Hassner Sharav

"Is it just conceivably possible, that the BMJ's decision to commission and publish Brian Deer's series of articles attacking Dr. Andrew Wakefield's personal and scientific integrity—and lend its unwavering editorial endorsement—without giving him an opportunity to defend himself—might be influenced by a SIGNIFICANT financial conflict of interest ?"

In 2008, Merck, using its trade name MSD signed a partnership agreement with the BMJ group which gave the pharmaceutical giant control of 350 continuing medical education courses in over 20 medical therapy areas. The stated purpose of the Merck / BMJ/ Lancet partnerships that remained hidden from view, is to 'change the face of medical education in Europe and beyond'.

As well, in 2009, Univadis®, another Merck trademark entered into partnership with The Lancet, providing medical education and an information website. Doctors registered at Univadis® will receive free access to recently published articles at The Lancet, inevitably linking them to Univadis®/Merck with the BMJ and The Lancet to Merck's VIS (Vaccine Information Service) online—"a comprehensive source of information, especially designed to provide healthcare professionals with the answers to their questions on vaccines."

"The fact that BMJ and The Lancet—two of the most prestigious international medical journals would enter into a medical education partnership with the drug manufacturer whose staff drew up a "doctor hit list" to intimidate doctors who dared to discuss the lethal cardiac risks linked to Vioxx—is in itself a betrayal of trust of the worst sort", writes Sharav.

Remember Vioxx, the drug Merck marketed for arthritis and the scandal that erupted over the injuries and deaths it caused? According to estimates provided to Congress by non-conflicted FDA personnel some 57,000 Americans lost their lives to Vioxx.

The Australian class action suit brought to light the "doctor hit list" containing words such as "neutralize" and "discredit" written next to the names of doctors speaking out against Vioxx. "We may need to seek them out and destroy them where they live," a Merck employee wrote, according to an email excerpt read to the Australian court. Merck staff are also alleged to have used other tactics, such as trying to interfere with academic appointments, and dropping hints about how funding to institutions might dry up.

The Australian class action suit brought to light the "doctor hit list" containing words such as "neutralize" and "discredit" written next to the names of doctors speaking out against Vioxx. "We may need to seek them out and destroy them where they live," a Merck employee wrote...

Was Andrew Wakefield put on an industry "hit list" when he got too close to the truth of the inadequacies of MMR vaccine safety science? Is it too much of a stretch to speculate that powerful forces in Big Pharma colluding with government insiders decided to annihilate both the man and the science that threatened to reveal their complicity in the autism epidemic ?

Perhaps we're a little closer now to understanding why The Lancet retracted Wakefield's paper last year, 12 years after its publication. Not because it had technical or scientific errors, but because The Lancet, like the British Medical Journal and others have sold out to the pharmaceutical industry, who now calls the shots.

Reference: Alliance for Human Research Protection http://www.ahrp.org/cms/content/view/766/149/ √

Outbreaks Proof That Whooping Cough Vaccine Doesn't Work

Dr. Sherri Tenpenny, DO, January 11, 2011

This past summer, newspapers throughout North America announced an epidemic of whooping cough, caused by the bacterium Bordetella pertussis, in California that health officials predicted would spread throughout the country. From January, 2010 through the end of November, California's state epidemiologist reported 2,625 pertussis cases including ten infant deaths while the Center for Disease Control and Prevention (CDC) reported 18,586 cases nationwide. [1] The reports have speculated that the outbreaks have been caused by the large number of unvaccinated children throughout the state. What these reports fail to mention is that most of the children who contracted pertussis had been vaccinated against whooping cough.

In response to the outbreaks, the California state legislature passed a law in September, 2010. Starting with the 2012-13 school year, parents have been told that incoming seventh graders will need to provide proof of vaccination. [2] This has lead to some confusion because California law allows the execution of personal belief exemptions, or PBEs, giving parents the right to refuse vaccines. Officials believe that vaccination rates of at least 93 percent are needed to ensure so-called herd immunity against pertussis. With 98 percent of California's children receiving all of the CDC recommended vaccines, herd immunity should be maintained and blaming the unvaccinated for the outbreak is not logical.

Vaccine failures

The push for children of all ages and even their adult family members to get their DTaP shot is certainly questionable when one looks at a sampling of the well-documented cases of vaccine failure in communities with large numbers of whooping cough cases. In 1996, a statewide outbreak of pertussis occurred in Vermont, a state where vaccination rates were among the highest in the country. Of those children, 19 to 35 months of age who contracted whooping cough, 97 percent had received all doses of the recommended DTaP vaccines.

In 2006, British Medical Journal reported on a study showing that a substantial proportion of immunized children of school age who have a persistent cough may have had a recent infection with Bordetella pertussis. Harnden and colleagues recruited 172 children aged 5 to 16 years (from 18 U.K. general practices) who had been coughing for two weeks or more. Serological evidence of a recent pertussis infection was found in 64 of the children, and 55 of these children had been fully vaccinated. They went on to say, "Making a secure diagnosis of whooping cough may reassure the parents and prevent inappropriate investigations and treatment, conclude the authors." [5]

More recently, *The Star-Ledger* reported on February 11, 2009 of a pertussis outbreak in 21 fully vaccinated children in Hunterdon County, New Jersey. [6] Even in Canada, a laboratory-confirmed pertussis outbreak occurred among preschool children in Toronto where greater than 90 percent of the kids were up-to-date with pertussis immunization. [7]

The Watchdog Institute, an investigative journalism center based in San Diego, recently teamed up with local San Diego television station, KPBS, to research the actual number of families affected by the whooping cough outbreak to determine how many children had been fully vaccinated against pertussis. The four-month investigation culminated in the airing of a documentary on December 16, 2010. Their research was revealing: In the nine California counties most affected, 44 to 83 percent of those contracting the infection had been fully vaccinated. In Ohio and Texas, two states also having record numbers of whooping cough cases, 75 and 67.5 percent respectively had been vaccinated. [8]

Dr. Fritz Mooi, a respected Dutch scientist who has been studying pertussis bacteria mutations for 15 years, claims **a more virulent strain is the cause of recent outbreaks**. Mooi says the international Global Pertussis Initiative has ignored his theories about a new, more toxic strain of the disease. "They just don't want to listen," he said. "They have kept it out of their articles, and it's a kind of censorship." **Much money has been invested in the current vaccine, Mooi said, and if he is right about a new strain, a different vaccine would need to be developed.** [9]

Conflicts of interest

The Watchdog Institute and KPBS further found that the two leading global makers of pertussis vaccines, Sanofi Pasteur and GlaxoSmith Kline, have funded expert groups that recommend vaccine policy on the disease to government agencies. Sanofi Pasteur funds the most influential group, the Global Pertussis Initiative, which is made up of 35 medical experts from 16 countries. The Watchdog Institute and KPBS found that 24 of the group's members have received funding from Sanofi Pasteur, its parent company Sanofi-Aventis, and/or GlaxoSmithKline (GSK). [10]

The CDC cites the Global Pertussis Initiative in its publications and the World Health Organization had four members of the Initiative on their pertussis vaccine advisory committee. This conflict of interest translates to countries spending millions on pertussis vaccines that have a long history of not being protective, with the manufacturers unwilling to spend any of their revenue on research into emerging strains of pertussis. Globally, vaccines were a $22 billion industry last year and according to one forecast, sales are expected to top $34 billion by 2012. In just the state of California, health departments spent $207 million on pertussis vaccines since 2007 with a whopping $59.6 million spent in 2010. [11]

Vaccinated as Silent Carriers

Vaccine-induced immunity to pertussis is measured by a blood test, called a titer test, which measures the presence of specific antibodies thought to be protective. It is recognized that these antibodies wane over time. The incidence of B. pertussis infection in adolescents and adults appears to be approximately one percent per year. Infection is most likely to be pertussis among those with a cough that has lasted more than 21 days. Officials believe infections in adolescents caused by "waning immunity" to be a source of transmission in the community, particularly for young infants.

As a result, new vaccines such as Boostrix, for children 11 to 18 years of age, and Adacel, for adults 19 to 64 years of age, have been developed and licensed for use in the U.S. [12] Public health officials hope that by vaccinating teens and adults there will be fewer cases of pertussis overall.

Oubreaks Proof cont. on page 21

Outbreaks Proof cont. from page 20

The rush to revaccinate the entire population and all age groups against pertussis has had little effect on lowering the incidence of whooping cough overall.

The rush to revaccinate the entire population and all age groups against pertussis has had little effect on lowering the incidence of whooping cough overall.

Pertussis-containing vaccines seem to have little effect on the overall incidence of the infection. Instead of focusing on the fear of whooping cough, it is obvious we need to focus on strengthening the immune system naturally and simple public health measure that work. Health aids such as hand washing, getting eight hours of sleep per night, taking vitamin C and maintaining a high blood level of Vitamin D are foundational in the prevention of all infectious diseases, including pertussis. Clearly, public health officials need to embrace these non-toxic, non-invasive methods over injections that don't work and can cause serious harm.

Footnotes:

1. MMWR. Pertussis Weekly Update. Week 48
2. "New California Law Mandates Whooping Cough Booster Shot for Teens," Jan 3, 2011
3. National Vaccine Information Center documentation.
4. Whooping Cough in California Worries Officials. ABC Healthnews. June 24, 2010.
5. Ibid
6. "Whooping Cough returns to Hunterdon County" by Mike Frasinelli, The Star-Ledger, February 11, 2009 .
7. Waters, Valerie et al. "Outbreak of Atypical Pertussis Detected by Polymerase Chain Reaction in Immunized Preschool-Aged Children." Pediatric Infectious Disease Journal. 28(7):582-587, July 2009.
8. "Many whooping cough victims have been immunized; Experts spar over prospects of new disease strain," by Kevin Crowe. Published December 13, 2010
9. "Blurred lines of Influence," by Kevin Crowe and Roxanna Popescu. Published December 14, 2010.
10. Ibid. "Blurred lines of influence."
11. Ibid. "Blurred lines of influence."
12. National Network for Immunization Information. "Adolescent and Adult Pertussis Vaccines." December, 2006.
13. Dr. Sherri Tenpenny, D.O. is a knowledgeable and outspoken physician on the negative impact vaccines can have on health. She is a contributing columnist to the International Medical Council on Vaccination, source of this article: http://www.vaccinationcouncil.org/2011/01/11/2377/

√

Whooping Cough Vaccine Promotes the Rise of B. Parapertussis Organism

Recent studies suggest that the acellular pertussis vaccine in widespread use today may be creating an ideal climate for the proliferation of another pertussis organism known as B. parapertussis. The authors of one study show that the acellular pertussis vaccine "impedes host immunity against B.parapertussis". In other words, the vaccine impairs immunity against this related pertussis organism.

"Despite widespread vaccination, whooping cough incidence is on the rise worldwide, making it the only vaccine-preventable disease associated with increasing deaths in the United States" says the Center for Infectious Disease Dynamics. Although this disease is most often attributed to Bordetella pertussis infection, it is also caused by the closely related pathogen, B. parapertussis. However, Bordetella pertussis has remained the center of attention, whereas **B. parapertussis** has been greatly overlooked in the development of whooping cough vaccines."

While the study found that acellular pertussis vaccines were effective in preventing colonization by Bordetella pertussis, **"in contrast, vaccination led to a 40-fold enhancement of B. parapertussis** colonization in the lungs of mice. Though the mechanism behind this increased colonization was not specifically elucidated, it is speculated to involve specific immune responses skewed or dampened by the acellular vaccine, including cytokine and antibody production during infection. Overall, these data suggest that the vaccine may be contributing to the observed rise in whooping cough incidence over the last decade by promoting B. parapertussis infection." Ofcourse the researchers are calling for pertussis vaccines of the future to target B.parapertussis as a means of controlling whooping cough.

http://www.cidd.psu.edu/research/synopses/acellular-vaccine-enhancement-b.-parapertussis

Homeopathic remedies suggested for whooping cough

- **Aconitum napellus** for sudden attacks of croupy coughs at the beginning stages of illness and cough
- **Antimonium tartaricum** for rattling in the chest with a strong, loose cough when **chest feels full of mucus**
- **Bryonia alba** for dry, racking, painful cough in chest and head, made worse by motion and better by being still
- **Coccus cacti** for winter coughs with tickling in the throat, and strong fits of coughing that end in choking or vomiting
- **Cuprum metallicum (Cuprum)** for spasmodic coughing fits
- **Drosera** for violent coughing spells ending in choking, gagging, or vomiting. Sometimes these coughs are so strong that the child can hardly catch her breath. Drosera is indicated for barking coughs, whooping cough, croup, and coughs that are worse after midnight, commonly accompanied by a bloody nose and a hoarse voice.
- **Hepar sulphuris calcareum** for croup that is worse in the morning and evening (until midnight); indicated following Aconitum napellus, especially with croup with rattling mucus in chest that is worse in the morning
- **Ipecacuanha** for whooping cough and other severe suffocative coughs that end in retching, vomiting, or cyanosis, with stiffness in the body; the child feels nauseated and has an aversion to food (including the smell of food)
- **Pulsatilla** for coughs with yellow-green mucus; cough is worse at night and interferes with sleep
- **Spongia tosta** for dry coughs that sound like a saw going through wood; often used for croup. Useful for croupy coughs that are worse before midnight, accompanied by a dry, barking cough that can sound like a seal.

Note: Homeopathic remedies suggested by Lauren Feder, MD, "Straight Talk on the 100 Day Cough", Mothering Magazine, Jan/Feb, 2011 http://drfeder.com/files/42/Mothering-Whooping_Cough%20january%202011.pdf

√

Federal Court Compensated 83 Vaccine-Injured Autistic Children—Tuesday, 10 May 2011

by Vera Hassner Sharav

A new study uncovered 83 federal-court- adjudicated cases of autism linked to vaccine-induced injury—thereby unmasking government duplicity.

For over 20 years, the federal government has vehemently denied a vaccine-autism link. But a new study, the first to examine the successfully adjudicated cases of vaccine-induced brain injury by the federal Vaccine Injury Compensation Program (VICP), uncovered 83 cases of autism among those who have been compensated for vaccine-induced brain damage—most notably, "encephalopathy," "residual seizure disorder," "developmental regression."

The evidence uncovered by this study, clearly belies public pronouncements by government officials who have for decades misled the public by claiming emphatically that "no evidence exists linking autism to vaccines" and "no case of vaccine-induced autism has ever been compensated."

The peer-reviewed study by Mary Holland, Research Scholar and Director of the Graduate Legal Skills Program, NYU School of Law; Louis Conte, Robert Krakow, and Lisa Colin, was published in the *Pace Environmental Law Review* .

The authors relied on evidence recorded in VICP court documents. Their review of 170 adjudicated cases, found that 83 children with autism received compensation for vaccine-induced injury. That number, the authors note, is probably the tip of an iceberg.

The overwhelming majority of petitioners in the VICP have not received compensation.

Of the 13,755 claims filed in the VICP to date, 2,621 awards have been paid, or less than 1 in 5 ofthe total number of claims filed. So far, 5,277 claims have been dismissed and 5,857 claims are pending. In all, 2,500 cases have been compensated by VICP.

The 83 cases of children diagnosed with autism who were compensated for vaccine-induced brain damage, demonstrate that the VICP court has quietly, though inconsistently, compensated some children who suffered vaccine-induced neurological damage associated with autism—since the inception of the VICP program in 1986.

The study is likely to ignite the acrimonious debate about vaccine-induced autism. **The findings raise serious questions about the unfair, inconsistent, inequitable treatment the VICP has applied to thousands of similar cases that have been brought before it.**

How do the 5,000 cases of "autism" that the VICP rejected in the Omnibus Autism Proceeding (2010) differ from the cases of "encephalopathy" and "seizure disorder" that the VICP has compensated before and since?

The catalyst for this Pace law review of VICP published compensated cases, was the case of Hannah Poling. In a 2008 report submitted to the VICP (which was leaked to the press) the Health and Human Services administration "conceded" that vaccines had triggered Hannah Poling's encephalopathy and subsequent developmental regression. HHS's description of the child's condition implied a distinction between "autism-like symptoms" and "autism," although there was no ambiguity that Hannah Poling in fact had autism.

In 2010, the VICP court award Poling $1.5 million, while denying other similarly injured children compensation. Nevertheless, in March 3, 2011, HHS baldly disclaimed its own 2008 "concession" document, stating in its Statistics Report: "HHS has never concluded in any case that autism was caused by vaccination."

What will it take for government to acknowledge a link between vaccines and autism?

Of note, **a key similarity among the 83 successful claims, including the Poling case, claims which produced more than $96.7 million in settlements and awards, is semantics not evidence of injuries: the families who were successful in their claims did not assert that autism was their child's primary injury.**

The authors call for Congressional hearings to examine the lack of fairness and inconsistency in VICP compensation determinations.

Reprinted with appreciation from Alliance For Human Research Protection: http://www.ahrp.org/cms/content/view/804/9/ √

LETTERS

International Vaccine Reaction Reporting

Dear VRAN,

I am a homeopath and naturopathic physician in Switzerland. I have been managing the biggest german language vaccine critical website for almost 10 years now. The main focus of the website is vaccine damages, which can be reported by individuals of which there are hundreds of reports.

I'm glad to inform you that we now have an English version of the site. Previously, I only received vaccine damage reports from Germany, Austria and Switzerland. Due to a donation I received I was able to translate the site into English and now, all the vaccine damage reports we have gathered are translated into English.

I feel it is important, that as many people as possible from all over the world become aware of vaccine dangers, and urge you to report your experiences to our data base. We also have a reporting form for parents to recount the health of their unvaccinated children. I really would appreciate if you could put a link on your site. You can link to our reporting form, and read about the many cases we have gathered since 2003 by linking to: www.vaccineinjury.info/

Thank you very much
Andreas Bachmair

¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤

Vaccine injury: no record, no risk?

Dec. 30, 2010

A fitness trainer was diagnosed with Guillaine-Barré ("polio" renamed) 13 days after receiving a flu shot but, according to the Dec 24 Oak Bay News and Vancouver Island Health Authority, no report has been filed. Vaccine adverse event reporting in Canada is a farce. Even in regions where reporting is "required" (in BC it isn't), it's not enforced. Even if it were enforced, acknowledgement that vaccination may have caused an adverse event usually depends on the whims of those whose reputations and earnings are upheld by the belief that vaccines are safe. Recall the dearth of reports during last year's "pandemic" except from unofficial sources. The latter encompass reports of miscarriage, stillbirths and in-

Letters cont. on page 23

Letters cont. from page 22
jury to children including a Sechelt boy and an Edmonton child whose mother was repeatedly misdirected as she tried to submit a report to Health Canada (see *h1n1 side effects, Canadians for Health Freedom blog*).

While the main topic for discussion at a recent national immunization conference was a perceived need to increase vaccine uptake, little if anything was discussed about bolstering adverse event reporting. One would think that the former would necessitate the latter.

An article in the Dec 21, 2010 *Montreal Gazette* informs us of the 2008 bathtub drowning of a teen 15 days after receiving the second of two doses of HPV vaccine. Her emergency hospital visit due to headaches, confusion and vomiting 17 days after her first dose, apparently wasn't considered significant. It's been suggested that the Yasmin she was taking for acne triggered her death, but this drug's product monograph doesn't list loss of consciousness or death as possible adverse events. If the teen had died in USA, the presiding coroner and the girl's mother, both of whom suspected a vaccine adverse event, could have reported it at the VAERS website, easily accessible to anyone seeking such information. But unless the media dare inform us, we Canadians are kept in the dark. To date in USA, 85 deaths and several times more life threatening cases have been reported as possible HPV vaccine adverse events (and only 1-10% are reported). How many have there been in Canada?

To report a suspected vaccine adverse event, fill out a Public Health Agency of Canada form, accessible at http://vran.org/report-a-reaction/. Whether or not your report will be filed is unknown, but you may have some satisfaction knowing you've done your bit to help wither the stonewalling.

Susan Fletcher - Sechelt, B.C.

¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤

Ad hominem attacks on those who question vaccine safety

Christopher A. Shaw, Professor University of British Columbia, February 9, 2011

The recent BMJ editorial, along with several recent publications, have made extremely serious allegations of scientific fraud against Dr. Wakefield and his colleagues in regard to the 1998 Lancet study that supposedly linked the MMR vaccine to gastrointestinal disorders and autism. Even assuming that such fraud was committed -and there is abundant countervailing evidence to suggest that such did not occur—does the use of the term 'fraud' invalidate a legitimate scientific question? The answer is that it does not.

The autism spectrum disorders incidence levels have grown explosively since 1992. Claims that such rising levels are due to changes in the gene pool have no scientific validity. Similar claims that changes in diagnostic criteria for ASD are to blame, while partially true, cannot account for the 2000 to 3000% change in ASD. This observation leads inevitably to one remaining conclusion, namely that something in the human environment is the culprit. There are many possible factors that may have increased leading to rising ASD levels. One of these is the significantly increased vaccine schedule for children. Any a priori exclusion of possible factors based on belief rather than evidence is not scientific, but rather reflects a disturbing trend to view anything associated with vaccines and vaccine policy as sacred and beyond scientific scrutiny.

Indeed, some who appear to take this view frame their arguments less as scientific critiques and more as ad hominem attacks on the credibility, expertise, or scientific training of any who do what scientists are trained to do: ask questions and seek answers. Assertions that those who do so in respect to any aspect of vaccine safety must therefore be "anti vaccine" and hence not to be taken seriously belies a belief system that is profoundly unscientific.

As most readers will know, an ad hominem attack on an opponent's character or credibility is a tacit admission that the logical argument is lost. Such comments have occurred in some letters to the editor on the issue of the Wakefield editorial and have attempted to portray those scientists who attended the recent Vaccine Safety Conference in Jamaica as unreliable because of some alleged bias against vaccines. As one of the organizers of the conference, let me state that an anti-vaccine bias was not the agenda of the meeting. Rather, a number of highly qualified scientists from different fields gathered for an open examination of the issue and in so doing simply fulfilled their fiduciary duties as scientists to seeking the truth.

Competing interests: None declared

Source: BMJ Rapid Responses http://www.bmj.com/content/342/bmj.c7452/reply#bmj_el_250543

¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤

The Never-Vaccinated

Sandy L. Gottstein

Until and unless we compare the vaccinated to the never vaccinated, we will never know if vaccines, whether in general or specifically, result in better health outcomes for those who are administered them. And forget the argument that people who don't vaccinate might be different and that might affect the results: If the never-vaccinated are healthier than the vaccinated, wouldn't we want to know it? We could then go about trying to understand why. The failure to do such studies speaks volumes.

As far as using the excuse that there are limitations and difficulties with conducting such studies, fine. Don't do them. But stop pretending you know that the benefits of vaccines (far) outweigh the risks.

Finally, the hue and cry over the Wakefield paper is so out of proportion to the alleged wrongdoings, one has to wonder who's behind it and why it is happening. If those who are claiming such egregious flaws really cared whether or not the Wakefield paper was fatally in err, they would do a properly designed and conducted retrospective study comparing those who have only gotten the MMR to those who have never been vaccinated at all. Only then might we get closer to the truth. But that isn't going to happen, because there is no official interest in really knowing it.

So instead we get a smoke-screen designed to quell further debate and put the fear of God (or something) in anyone contemplating challenging the status quo.

Competing interests: I am President of Vaccination News, the only website on the Internet that goes to great effort to publish all sides of the vaccination controversy.

Source: BMJ Rapid Responses, January 8, 2011 http://www.bmj.com/content/342/bmj.c7452/reply#bmj_el_250543

¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤

Letters cont. on page 24

Letters cont. from page 23

A Simple Study Could Settle This

Jaquelyn B. McCandless, MD, Physician Sole Practitioner

I am a physician board-certified by American Board of Psychiatry & Neurology who has specialized in autism for the last 13 years. I have trained hundreds of other physicians in the biomedical treatment of autism, and regularly mentor actively practicing physicians. I and other physicians with whom I work have had many children in our practices with history of Hep B vaccine at birth followed by regression into autism after the live triple MMR vaccine. Almost every patient with autism has some degree of gut disorder, and those with high rubeola (measles) antibody titers often have had the most intractable gut inflammation conditions in my practice.

I have never questioned Dr. Wakefield's association between MMR, autism and what is aptly named autistic enterocolitis and personally do not believe he has acted fraudulently. Along with hundreds of other physicians with waiting lists trying to help these suffering children I believe this uproar could be easily settled by a good study comparing autistic children who received Hep B at birth and then MMR with neurotypical children who have never been vaccinated (who are plentiful). Maybe a physician who has made millions off of vaccines and is a highly vocal vaccine proponent would propose/conduct such a study; it is obvious why vaccine makers would not like to do so.

Jaquelyn McCandless MD (author, "Children With Starving Brains, A Medical Treatment Guide for Autism Spectrum Disorder)

Source: BMJ Rapid Responses, January 8, 2011

¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤

To the President of Sick Kids Foundation—Toronto

December 18, 2010

I just watched a heart wrenching segment on "Sick Kids" television with a young child dying of cancer. Then the plea came to donate. Perhaps you should look into getting government or pharmaceutical companies to test their vaccinations for the potential to cause cancer. With infants getting as many as 8 vaccines at a time, and with pregnant women getting vaccinated for flu I think this would be a worthwhile situation to put research dollars into. Isn't prevention better than cure?

If you don't believe me, here is a sample product monograph:

"Carcinogenesis, Mutagenesis, Impairment of Fertility. Prevnar has not been evaluated for its carcinogenic or mutagenic potential, or impairment of fertility". http://www.wyeth.ca/en/products/Product%20Monographs%20PDFs/Prevnar_PM_Dec_22_2008_sub_Jan_8_2009.pdf

Interestingly, Sanofi Pasteur seems to have taken out the Carcinogenesis, Mutagenesis, Impairment of Fertility section on some of the 2010 product monographs I have looked for. Perhaps too many people are asking questions.

Rita Hoffman, Stirling, Ontario

¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤

Letter from VRAN to CBC The Sunday Edition, Feb. 20, 2011

I was very disappointed with your one -sided interview with journalist Brian Deer this morning. For the sake of balanced journalism, you owe it to Canadian parents to interview Dr. Andrew Wakefield.

Our daughter Katie died 27 years ago, at the age of five months after contracting polio from the Sabin oral polio vaccine. At that time, Manitoba was the only province in Canada that still administered the oral polio vaccine to babies despite the fact that it was well known in the medical community that the Sabin polio vaccine caused paralysis & death in recipients. Quietly, with no fanfare, the Sabin vaccine was taken off the market in North America in the late 1980' Shockingly, the Sabin polio vaccine is still used in third world countries.

Health Canada's "Report of a Vaccine - Associated Adverse Event" form lists 26 serious reactions following childhood immunization. Reaction such as, encephalopathy, (permanent brain damage), meningitis, encephalitis, anaphylaxis, seizures and death.

Dr. Wakefield acknowledged publicly that more studies must be done to examine the link between the meteoric rise of autism in the past 25 years with the sheer volume of vaccinations infants now receive. Infants in Canada presently receive 41 doses of 13 vaccines by 18 months. There has never been any studies to prove that it is safe to administer so many vaccines, so close together to infants with immature neurological & immunological systems. We simply do not know the long term consequences of injecting so many vaccines into the bodies of our children.

Interestingly, the Courts in the USA have awarded compensation to parents who children developed autism spectrun disorders following the MMR vaccine. Actually over two billion dollars has been awarded to vaccine injured children in the USA. Vaccine damage is not a myth. Many countries throughout the world support a compensation system to address vaccine-related illnesses and injury.

The medical profession will not support mandatory reporting of vaccine reaction, so we do not have any idea of the true number of vaccine injured children or the number of baby deaths due to childhood vaccination programs,

Why is there any doubt that a pharmacuetical product that contains adjuvants like thimersol, aluminum, killed & live attenuated bacteria and viruses, toxins and known carcinogens administered to infants with immature neurological and immunological systems cannot possibly harm a baby?

I sincerely believe that we will one day regard vaccines the same way that we regard smoking. Big pharma is using the same deceitful tactics that the tobacco companies used to convince the public that smoking was safe and did not cause cancer.

Michael Enright, do the right thing and interview Dr. Wakefield and let Canadian parents make an informed decision in choosing to vaccinate or not to vaccinate their babies. We all have the right to decide what products we put in our bodies and the bodies of our children.

I also suggest you read Dr. Wakefield's book Callous Disregard.

Sincerely,
Mary James
Vaccination Risk Awareness Network (VRAN)
www.vran.org √

My Brush With Tetanus

Archie Kalokerinos MD

In 1964 I was young enough and foolish enough to love fast cars. Nothing but the most powerful and attractive satisfied my craving. That is; until I saw someone riding a new breed of motor bike. Its mechanical perfection overcame me. One of these I had to have—and I wasted no time purchasing one of these wonderful creatures. It lived in the house with me—not in a dirty garage.

It did not take me long to discover another thrill—riding a motor bike without a shirt to cover me. And that is how the inevitable happened. One day while riding on a bush track the bike decided that it wanted to go its own way while I decided to go in another direction. We parted company. The result? I lost a lot of skin, broke a few bones, and partially destroyed the bike.

Unknown to me a mob of sheep had just crossed the track. They had recently had their tails cut off—a procedure that helped prevent their rear ends becoming fly blown. And a number of these sheep had developed tetanus—and later died.

So, my torn skin became infected with tetanus spores—in great numbers. This did not bother me, because, during my student days I had been taught that fully vaccinated individuals could not get tetanus. I went home and had a bath, gave myself a tetanus booster, and some antibiotics. According to the rules of that time I was fully protected. Furthermore, I had been taught that during the second world war, no soldiers had suffered from tetanus because they were fully vaccinated. Later, I met doctors who had cared for soldiers during the war, who told me a completely different story. Fully vaccinated soldiers had indeed, got tetanus, but they were told not to report it. In other words, what I was taught and what was true were two different things.

A few weeks after the accident, I awoke one morning feeling strangely ill. When I tried to get up, I collapsed onto a portable radio and re-broke several ribs that were still not fully healed.

The pain was strange. Attempts to move caused painful spasms. After a few hours the spasms appeared spontaneously. At that stage the senior hospital nurse insisted that I placed myself in the hands of another doctor. It was a painful journey, of over a hundred miles of unsealed roads to a hospital where three doctors who were greatly respected worked as a team.

They were mystified. So entrenched was the myth of total vaccine protection against tetanus, that the diagnosis was not even considered. That night I slept on and off in a hospital bed while a nurse sat by my side. Sometime after midnight the truth could no longer be hidden. I knew that I had tetanus.

So entrenched was the myth of total vaccine protection against tetanus, that the diagnosis was not even considered.

A huge air-force plane flew me to Sydney. I remember awaking for a short time as I was carried l on board. Already loaded was a great mass of equipment that had been hastily assembled—together with specialist doctors. I was, to state the obvious—deeply moved by all this attention.

Two other patients suffering from tetanus were in the same hospital. The nurses did not know that I was partially awake when I heard one say to her assistant, 'The other two have died and we don't think that this one has much chance either'. But I did survive. In fact, the disease did not pass onto the stage that I was dreading. I did not need to be artificially ventilated.

What I did not like was the huge volume of anti-tetanus serum that was forced into my veins. For weeks I smelt like a horse—and I hate the damn things!

James, one of my older brothers, was the senior radiologist in the hospital.

Because of this I was frequently visited by specialists of all sorts. One relatively young man had a bee in his bonnet—he did not believe that I had tetanus. How he accounted for the spasms was never explained. Many years later I was provided with the answer. I certainly had tetanus – but there was more than one variety; the sceptic was partially right.

Tetanus occurs when a wound become infected with tetanus spores from bacteria that live in the soil, dust or animal waste. The spores become active and produce a powerful toxin—that is responsible for the deadly spasms.. There are four forms of the disease:

1. Generalized tetanus—the severe form with a very high mortality rate.
2. Local tetanus that has a low mortality rate of 1 to 2 percent. This is obviously what I had.
3. Cephalic tetanus that affects the face.
4. Neonatal tetanus that is similar to generalized tetanus except that it affects neonates. This is rare in developed countries.

Why it took so long for these forms to become recognized is a mystery. Obviously, there remains much to be learned.

During my wanderings in the hospital wards I came across a young Greek who was quadriplegic. He had been an opal miner in Coober Pedy in Central Australia. This involved sinking shafts up to 80 feet through rock in the hope of finding opal. In those days this was dangerous because while the shaft was being dug the miner below was faced with the possibility of a bucket full of rock falling off a hook and crushing the man below. So various hooks were designed in the hope of preventing this. The miner under discussion had 'invented' a fool-proof hook… which came off and crushed him —hence the paralyses.

After I recovered from tetanus I ceased practising medicine for three years, and became an opal miner in Coober Pedy. Some of the equipment used by the unfortunate miner was purchased by me. The fatal hook rested on a nail above my bed—just to remind me not to take many risks.

¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤

Note: Dr. Kalokerinos is the author of Every Second Child as well as many scientific papers. In his book, Dr. Kalokerinos recounts his experience as a physician working in aboriginal communities in Australia where children suffered significant levels of malnutrition. He pinpointed the increase in vaccination campaigns as the reason why, at a certain point, up to half of the vaccinated Aboriginal infants died, obviously from an acute vitamin C deficiency provoked by the vaccination. Read an interview with Dr. Kalokerinos at: http://www.whale.to/v/kalokerinos.html

¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤

Veteran vaccine researcher, Hilary Butler has written an excellent review of the medical history of tetanus prevention and treatment options. "Magnesium should be a first line treatment for tetanus. Magnesium stabilizes the heart and reduces blood pressure; reduces the need for sedation, and also makes nursing simpler."
http://www.beyondconformity.org.nz/resources/tetanus √

Tetanus cont. on page 25

NEWSCLIPS

Autism: a disease of many causes?

Helen Ratajczak, a former senior scientist at a drug firm, has used her freedom from censorship and retirement spare time to review the autism science published since 1943 when the disease was first identified. In her article, 'Theoretical aspects of autism: Causes—A review', published in the Journal of Immunotoxicology she states: "Documented cases of autism include genetic mutations and/or deletions, viral infections, and encephalitis following vaccination. Therefore, autism is the result of genetic defects and/or inflammation of the brain." In an interview for CBS News she noted that autism had increased when human DNA (from aborted foetal tissue) was used in vaccines. This, she said, could combine with DNA of a vaccine recipient to produce mutated genes and subsequent chronic brain inflammation. She further contends there are many vaccine –associated effects which could cause autism, including the large number of vaccines given within a short period of time.

http://www.ncbi.nlm.nih.gov/pubmed/21299355 ; http://www.cbsnews.com/8301-31727_162-20049118-10391695.html

¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤

Warning moms-to-be

The Dec 17 issue of Science reveals a startling discovery. It was assumed that the foetal immune system is simply an immature version of the adult's. But a study has found the two arise from different types of stem cells, resulting in a foetal immune system which is more sensitive than but also more tolerant than that of the adult

The change to reduced sensitivity and increased reactivity appears to occur during the third trimester. According to preventdisease.com, Dr Dave Mihalovic rationalized, "The fact that a fetus must tolerate toxins ingested or injected into its mother, it gives us a new outlook on why it may be especially dangerous to vaccinate a woman during her pregnancy…

We know that vaccines often contain dangerous levels of excipients, preservatives and adjuvants, many of which have never been tested in any known infant study, let alone fetal study….We simply do not have enough evidence on the fetal immune system to vaccinate pregnant women."

http://preventdisease.com/news/10/121710_vaccines_dangerous_baby_immune_system.shtml

¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤

Milk allergy + pertussis vaccine = anaphylaxis?

The Journal of Allergy and Clinical Immunology has published an abstract which finds anaphylaxis a possible adverse event in highly milk-allergic children vaccinated with primary or booster doses of the DTaP vaccine, Adacel. The study reviewed charts of patients at Mt Sinai School of Medicine who'd reported allergic reactions following injections of the vaccine; 7 children had severe anaphylaxis post-vaccination. Subsequent testing of the vaccine found casamino acids from cow's milk, a contaminant from culture medium.

Following is an excerpt from the DTP section of VRAN'S website: "A 1982 study by Steinman which suggested a link between a history of allergies, either in the child or his/her family, and risk for pertussis vaccine reactions, noted that milk allergy may be especially conducive. Anecdotal reports of parents agree. A recommendation by Drs. Gloecker and Gobel in 'A Guide to Child Health', Floris Books, 2002 points to a possible connection between poor milk digestion and complications of pertussis disease. They recommend that babies under 1 yr. with pertussis be examined for rickets or a lack of calcium in their diet since these can make pertussis much more dangerous." The monograph for the DTaP-containing vaccine, Infanrix hexa™ lists lactose as an ingredient; that for Pediacel® lists bovine serum albumen.

http://www.medpagetoday.com/MeetingCoverage/AAAAI/25520

¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤

Meningococcal madness in Alberta

On Jan 31st, the Edmonton Journal announced the Feb 1st initiation of a $2 million program to vaccinate Alberta's Grade 9s with the latest version of meningococcal vaccine, the 4-valent Menactra®. (Note the 'surprise attack' strategy.) A previous article had discussed diagnosis of viral meningitis in 90 Edmontonians. (No matter it wasn't bacterial; few would know there's a difference.) Just one week prior to the announcement, a New Jersey 17 yr old who'd been vaccinated with Menactra® had succumbed to meningitis. (Did the Alberta PHNs warn parents about this?) What the Edmonton Journal didn't say is that a winter, 2010 cross-Canada study published in the Canadian Journal of Infectious Diseases & Medical Microbiology showed that, "Due to the reduction in serogroup C invasive meningococcal disease (IMD), serogroup B now causes the majority of IMD in Canada." It also didn't say that serogroup B isn't represented in any vaccine currently available.

http://www.edmontonjournal.com/health/Meningitis+program+vaccinate+Alberta+Grade/4196863/story.html#ixzz1CfUPrtge

¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤

Shingles from live virus shedding and other horror stories

In March, 2011, Catherine M. DiGiorgio of the U of Texas center for clinical studies told a meeting of the American Academy of Dermatology that, up to 28 days post-injection, the chickenpox/shingles virus, Varicella zoster, from Zostavax shingles vaccine was detected in the saliva of elderly vaccinees. This means the vaccine might transmit shingles or chickenpox to individuals in whom it is ineffective (as well as to those no longer immune via vaccine-derived or natural immunity)—a curious twist which could further devalue the 'herd immunity' theory. In fact, such transmission seems likely since it's been documented that Merck's chicken pox vaccine can do the same and their Zostavax monograph warns newly vaccinated individuals to avoid contact with infants, immunosuppressed individuals, and pregnant women who haven't had chickenpox or been vaccinated against it.

Dr DiGeorgio, who works on studies sponsored by companies making shingles-related antivirals and pain killers, wasn't completely upset by the finding. She suggested, "It could possibly have use in clinical practice, allowing detection of shingles prior to development of the rash, enabling an earlier start of antiviral therapy and decreasing the…pain of postherpetic neuralgia." The latter, she said, is a condition which allows viral shedding in the saliva not just for one month but for

Newsclips cont. on page 27

Newsclips cont. from page 26
years. Meanwhile, in March, CBC News reported that PEI's chief health officer, Heather Morrison, commented, "Because of breakthrough cases of chickenpox… across the country, all of the provinces are looking at introducing a booster dose of varicella." She said this would likely happen within next year.

http://www.internalmedicinenews.com/news/infectious-diseases/single-article/varicella-shedding-detected-up-to-month-after-zoster-vaccination/8f6b51d39f.html ; http://www.cbc.ca/news/canada/prince-edward-island/story/2011/03/10/pei-chicken-pox-cases-584.html

¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤

Breastmilk bad for business

An Oct, 2010 study in Pediatric Infectious Disease Journal concludes the fact that live virus rotavirus vaccines have been less effective in poor countries than wealthier ones "could be explained, in part, by higher titers of IgA and neutralizing activity in breast milk consumed by their infants at the time of immunization that could effectively reduce the potency of the vaccine. Strategies to overcome this negative effect, such as delaying breast-feeding at the time of immunization, should be evaluated." In a similar vein, a March, 2011 study in Blood has found that maternal antibodies block an immune response to measles vaccine. This study holds hope for manipulating the antibodies so that vaccines could be made effective despite their presence. The Medical News Today report about this remarks, "The antibodies protect infants against disease in the first months of life, but that protection comes at a cost…".

http://journals.lww.com/pidj/Abstract/2010/10000/Inhibitory_Effect_of_Breast_Milk_on_Infectivity_of.7.aspx ;http://www.medicalnewstoday.com/articles/217739.php

¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤

Developed Nations Requiring the Most Vaccines Tend to Have the Highest Infant Death Rates

May 4, 2011 — A new study, published in Human and Experimental Toxicology, a prestigious journal indexed by the National Library of Medicine, found that developed nations with higher (worse) infant mortality rates tend to give their infants more vaccine doses. For example, the United States requires infants in first 12 months of life to receive 26 vaccines (the most in the world) yet more than 6 U.S. infants die per every 1000 live births. In contrast, Sweden and Japan administer 12 vaccines to infants, the least amount, and report less than 3 deaths per 1000 live births. Canada gives 24 vaccine doses in the first year and infant mortality rate is 5.05 per 1000 live births.

The current study by Miller and Goldman, Infant Mortality rates Regressed Against Number of Vaccine Doses Routinely Given: Is There a Biochemical or Synergistic Toxicity? found "a high statistically significant correlation between increasing number of vaccine doses and increasing infant mortality rates." This raises an important question: Would fewer vaccines administered to infants reduce the number of infant deaths? The authors concluded that "closer inspection of correlations between vaccine doses, biochemical or synergistic toxicity, and infant mortality rates, is essential. All nations—rich and poor, advanced and developing—have an obligation to determine whether their immunization schedules are achieving their desired goals."

Other study findings:

The United States spends more per capita on healthcare than any other country yet 33 nations have better infant mortality rates.

Some infant deaths attributed to sudden infant death syndrome (SIDS) may be vaccine-related, perhaps due to over-vaccination.

Progress on reducing infant deaths should include monitoring immunization schedules and official causes of death (to determine if vaccine-related infant deaths are being reclassified).Infant mortality rates will remain high in developing nations that cannot provide clean water, proper nutrition, improved sanitation, and better access to health care.

To read the study & interesting graphs, go to: http://www.thinktwice.com/miller-goldman-study.htm

¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤ ¤

UN Wants Billions for STD Vaccination Scheme

May 5— The UN will be asking governments to fund the vaccination of every girl in the world against the sexually transmitted disease HPV, human papillomavirus and could cost as much as $300 per person, totaling billions.

The campaign was launched by leaders from the UN Population Fund (UNFPA), the American Cancer Society, and the contraceptives manufacturer PATH and a prominent African first lady. Three shots are required over a period of six months, totaling $42, and the treatment is only good for five years. Seven treatments would be required to cover each woman's reproductive lifetime.

Advocates anticipate the idea would be contentious. When American local governments tried to mandate inoculation of school girls against HPV several years ago, popular outcry quashed the initiatives. Casting the campaign as an effort to eradicate cervical cancer rather than a massive vaccination program against a sexually transmitted disease will help steer clear of political resistance, they said.

A dramatic increase of cervical cancer in the developing world translates into half the patients dying of the disease because they did not have access to regular cervical cancer preventive screening.

The UN Population Fund would spearhead the campaign. If approved by UN member states, UNFPA stands to receive a significant boost in funding, given the fact that there are billions of women and girls who would require the $42 treatment every five years.

Critics are concerned that the vaccination scheme will subsume the fight against cancer into the already well-funded reproductive rights agenda at the UN. They warn that because UNFPA aggressively promotes "sexual rights" for minors, the effort will not address sexual behavior or parental rights regarding medical decisions and could lead to an increase of the disease rather than its cure.

UN member states will deliberate the issue September 19th and 20th at the UN High Level Meeting on Non-communicable Diseases.

Excerpt from: http://www.c-fam.org/publications/id.1847/pub_detail.asp

Note: Vaccine critics warn that since the HPV vaccine may be causing infertility in up to 1/3 of recipients, a global initiative to vaccinate every girl on the planet up to 7 times in her reproductive life, may be part of a larger "depopulation" agenda. √

VRAN Membership and Order Form

Suggested Annual Membership—$35 or $75 professional
Includes Newsletter 3X a year & ongoing support of vaccination risk education
P.O. Box 169, Winlaw, BC, V0G 2J0—phone: 250-355-2525, E-mail: info@vran.org
VRAN website: www.vran.org

Name/Organization:_____

Address: _____

Telephone: _____ Fax: _____ E-mail:_____

Reason for Interest:

_____

_____

Your Questions, Personal Stories:

_____

_____

_____

Please photocopy this form from back cover of newsletter and use the back side of the sheet to write your own vaccine story.

**** New Members receive a comprehensive information package totaling over 100 pages. ****

Please note: Annual membership is renewed in January of each year.
People joining VRAN at any point in the year will receive all newsletters published during that calendar year.

INFORMATION PACKAGES, & RESOURCES (Please allow 3-4 weeks for delivery)

____**VRAN Membership**—suggested donation—$35.00 (family) or $75.00 (Professional) _____
(membership discounted if newsletter is sent via email rather than by post)

____**New Parent information package**—(over 50 pages of articles)…… $10.00 + $3.00 (postage) _____
(If ordering both packages, cost is $25.00—postage included)

____**"Vaccination: What You Need to Know"**—Excellent intro to the vaccine issue _____
$1.50 each + $1.50 postage. Bulk orders of 12 or more—$1.00 each +$5 (postage each dozen)

____**"Five Vaccines in One: Your Baby's first Shot"**– Overview of the vaccines & diseases _____
$1.50 each & $1.50 postage. Bulk orders of 12 or more—$1.00 each + $5 (postage each dozen)

____**Back Issues of the VRAN Newsletter**– Members can obtain a password from the VRAN _____
administrator to access all previous issues online at our website. Printed copies can be
purchased for $8.00 each - postage included. Issues Available from 1994-2011

____Video/DVD—**"What The CDC's Own Documents Reveal"**…….$30.00 + 6.00 (postage) _____
Dr. Sherri Tenpenny exposes the deceptions of vaccine policies

____**Vaccinations: Science or Dogma**—audio CD…….. (postage incl.$20.00) _____
Dr. Jason Whittaker's highly informative vaccine lecture

____**Immunization: History, Ethics, Law and Health**…….. $35.00 + 9.00 (postage) _____
By Canadian author, Catherine Diodati M.A "A must read for those who wish
to be aware, responsible and informed" Dr. E.S. Anderson-Peacock

TOTAL: _____