Spring/Summer 2003

VRAN Newsletter

Vaccination Risk Awareness Network Inc.

REFLECTIONS ON IMMUNITY, VACCINATIONS AND SMALLPOX

By Philip Incao, MD

Part One: The Phenomenon of Immunity

Illness is a process that everyone experiences repeatedly in one's lifetime. Until our modern era, illnesses were classified according to their recognizable signs and symptoms. Today, in addition to the outward appearance of an illness, we also classify it according to its unique features detectable with the microscope and with biochemical tests. Thus many illnesses of similar or identical appearance which were lumped together in the past can now be distinguished from one another based on their microscopic or biochemical features. For example, what for hundreds of years was called influenza is now described as a group of "influenza-like illnesses", each one associated with a different virus.

On the other hand, many diseases known for centuries and recognizable by their typical signs and symptoms have been confirmed by modern science to be distinct entities, i.e. to be associated each with its own particular virus or bacterium and with no other. Measles, chicken pox and scarlet fever are examples of these.

It has long been known that in some illnesses such as these, one experience of the illness usually confers lifelong immunity. A second experience with measles or scarlet fever is extremely rare.

These observations by physicians and patients throughout history, as well as careful observations of the stages in a patient's recovery >from an acute inflammatory illness like measles or scarlet fever, have led to certain basic concepts in medicine.

One of these concepts was formulated as "Hering's Law" in the 19th century, although it was well-recognized and mentioned by the ancient Greek physician Hippocrates. This law states that as an illness resolves, its manifest signs and symptoms travel from the inner vital organs and blood circulation to the outer surface of the body, often visible as a rash or as a discharge of blood, mucus or pus. In this way we "throw off" an illness.

Another basic concept arising from the phenomenology of illness, i.e. from observations of the directly perceptible behavior of human illness, is the concept of immunity to or protection from an illness that one has had before.

This immunity to second episodes of certain illnesses like measles or scarlet fever reveals a knowing function of the human being in relation to illness. This inner knowing allows us, without any conscious knowledge or effort, to recognize an illness we've had before and to thereby resist it or quickly repulse it.

Hering's law on the other hand is evidence of an innate doing function of the human being in healing, i.e. we actively clear the illness from our body, we get it out of our system as we heal.

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DIPTHERIA & TETANUS VACCINATION

By Sherri Tenpenny, DO

Over the last two years, I have invested more than 2000+ hours investigating the truth about vaccines and I have had some "eye-opening" experiences. Some of my biggest revelations came when I began analyzing the CDC's information about the tetanus and diphtheria vaccines. Here is some of what I have learned.

Tetanus – the disease and the vaccine

Tetanus is a disease caused by the Gram-positive bacterium *Clostridium tetani that exists in soil as a spore.*

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VRAN NEWSLETTER

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With thanks to Lisa Farr for the newsletter layout.

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 4 times a year as a means of distributing information to members and the community. Suggested annual membership fees, including quarterly newsletter and your on-going support to the Vaccination Risk Awareness Network:
$25.00—Individual $50.00—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 fax or e-mail, as indicated above.

VRAN website: www.vran.org

VRAN NEWS

Dear Members & Friends,

This issue of the VRAN Newsletter features another wonderful essay by Dr. Philip Incao who inspires us to take a leap forward in consciousness to realize that the immune system "is an aspect of who we are as human beings, and as we learn from experience, our immune system learns too. When children experience their colds and fevers, they are challenging their immune systems and developing an inner strength that will be theirs to draw on throughout life."

As well, we have reprinted a number of excellent articles on tetanus - the disease and the vaccine. We appreciate the research gathered and overview offered by the authors. Many parents still have niggling doubts about tetanus even after researching the vaccine risk/benefit ratio and concluding that the risks associated with many vaccines either outweigh the benefits, or that the disease in question is obscure and no longer poses a danger. We are frequently contacted by people who have rejected all or most vaccines for their children, but who still worry about tetanus and wonder whether they should get the vaccine for their child.

In conversations with our local health unit near Nelson, BC, and vaccine manufacturer Aventis Pasteur, I was informed that tetanus as a single component vaccine is no longer available. Aventis confirmed that they and other vaccine manufacturers in Canada have stopped manufacturing the single component tetanus vaccine on the recommendation of Health Canada. The reason? To insure that all children under age 7 are "protected" from diphtheria, tetanus, pertussis and polio, and that they receive the 4 or 5 component vaccines such as Quadracel (DTaP + Polio) or Pentacel (DTaP + Polio + Hib). In other words, Health Canada has arbitrarily eliminated parental choice in vaccine decision making.

However, the tetanus & diphtheria vaccine (TD-Adsorbed on aluminum phosphate) is available for use in children age 7 and older, and adults not previously vaccinated.

The amount of tetanus antigen is the same as in Quadracel & Pentacel This product also contains the mercury based preservative thimerosal. I asked if parents could order this vaccine for children under age 7, and was told it is not recommended or licensed for use in younger children because their "immature immune system requires a higher amount of antigen" and the diphtheria component in this vaccine is too small to mount an adequate immune response. However, if parents want to order the TD-Adsorbed vaccine for children under age 7, it would hinge on "physician and parental decision".

Health officials have calculated that by removing the availability of single tetanus vaccines, people will be forced to submit to combination products containing multiple vaccines. Their subversive plan may backfire as indicated in a number of conversations with parents in recent months who

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were considering getting the single tetanus vaccine for their children, but discovering they would be forced to accept multiple vaccines, changed their minds. These conversations have turned to an emphasis on wound care, the most essential aspect of tetanus prevention.

VRAN Annual General Meeting

The VRAN AGM was held by telephone conference on April 27, 2003. Participating were Mary James and Frank Luschak (Manitoba), Rita Hoffman (Ontario), Susan Fletcher and Edda West (British Columbia) The following items were discussed:

1. A discussion about VRAN's vision to reform the currently inadequate vaccine adverse events reporting system in Canada and a proposal for a vaccine injury compensation plan with more balance and integrity than the plan issued by the Immunization Safety Meeting in Montreal (report released fall 2001 – available online at: http://www.hc-sc.gc.ca/pphb-dgspsp/publicat/ccdr-rmtc/01vol27/27s4/index.html#contents). Susan Fletcher has drafted a detailed letter expressing our concerns and proposed amendments.

Mary James, Rita Hoffman & Edda volunteered to form a committee to develop a strategy to work with this letter as a basis for initiating communication with health officials who convened the Immunization Safety Meeting. We invite interested VRAN members to join our committee and will gladly forward our draft letter to familiarize you with the issues at hand.

2. A discussion about outreach to renew the vaccine risk issue in Canada. We would like to invite Dr. Sherri Tenpenny to lead a cross-Canada speaking tour to major centres – possibly Vancouver, Calgary, Winnipeg, Toronto, Ottawa. We will approach the Health Action Network and the Consumer Health Association as possible partners in sponsoring this tour.

Edda will contact Dr. Tenpenny to discuss her availability either for the fall of 2003 or early spring 2004. We would need to appeal to the alternative health community – chiropractors, naturopaths, health food stores in the various areas to help with sponsorship.

3. Monthly VRAN press releases. There was enthusiasm to issue press releases on a regular basis. People agreed to take turns (a couple of months each). The wording of press releases will be checked with another VRAN core group or Board member for accuracy before sending to wire services.

4. A discussion regarding the possibility of liaison with the new 'Canadian Partnership for Children's Health and the Environment'.

5. Charitable status for VRAN was carried over from last year's minutes.

A discussion reviewing previous attempts to obtain charitable status. Mary reminded us that our Winnipeg lawyer had initiated an application which was sent to an Ottawa law firm specializing in obtaining charitable status for groups. They felt that we did not have a good chance of succeeding. When the Ottawa law firm informed us that the application cost is $600, and that we would have less than a 50% possibility of obtaining charitable status, it was decided to withdraw the application. Harold and Susan Fletcher have offered to work on the application forms with Edda.

6. Fundraising. Edda expressed a strong wish for a fundraising committee to relieve her of the burden of insuring that VRAN's operating budget of $20,000 is met each year. There ensued a discussion of how to expand our membership/financial base. Approaching the chiropractic and other alternative healing community was suggested. Rita Hoffman offered to help with outreach.

Appreciation goes to Penny Ruvinsky, VRAN auditor for preparing our 2002 financial statement which is included in this issue of the Newsletter.

Vaccine Education and Outreach

Dr. Jason Whittaker has recently presented a number of great seminars in Ontario, **"Vaccinations-Science or Dogma"**. Dr. Whittaker has so generously shared the proceeds from his seminars with us. ***"VRAN is officially my chosen charity or non-profit organization so I will be sending funds every month…..I expect there will be substantial donations this fall. My goal is to put some financial clout (and build membership) to your tireless and outstanding efforts and make VRAN a group to be reckoned with."*** With special recognition to VRAN member Cornelia Manske for her "stellar" efforts in spreading the word and helping organize talks for Dr. Jay.

Upcoming seminar dates of **"Vaccinations-Science or Dogma"**:
August 25 – Chiropractic First Clinic, Oakville, Ont.
To register, 905-827-2444
September 25 – Dufferin Family Chiropractic, Orangeville, Ont.
519-942-1217
October 13 – Vaccine Conference, Rochester N.Y. For details contact conference organizer, Sevaste Spaker (585) 346-0396 or Dr. Whittaker (905) 773-5122

Dr. Whittaker can be contacted by email at: drwhittaker@kingkom.com

History of DPT Vaccines in Canada

Rita Hoffman is researching the history of DPT vaccines in Canada for inclusion on our website. Much appreciation to Rita and her husband John for the many trips to the medical library gathering data from past issues of the CPS (Canadian Compendium of

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Pharmaceuticals). The following excerpt, from the 1982 CPS for DPT vaccine, is from another era, when doctors still exercised common sense and discernment prior to vaccination:

" Only children in good health should be vaccinated. Postpone the vaccination of a child who presents febrile symptoms, who has a respiratory infection, a contagious disease or any other kind or a coryza. Infants suffering from cyanosis should be vaccinated when they are around 6 months old. A child who has acute eczema or an acute dermitis who suffers from cerebral lesions or contusions, or who has had convulsions during the previous 12 months should not be vaccinated. Immunization can be started when the child reaches at least 1 year of age, using fractionated and multiple doses. It is suggested to start the injections with a dose of 0.1 ml to determine the degree of sensitivity of the individual and to gradually increase the dose, according to the response, to reach the ordinary doses. Such immunizations may take from 5 to 8 injections."

New VRAN Website

We are pleased to announce the launch of the new VRAN website at www.vran.org or www.vaccinerisk.org. We have also purchased the following domain names to facilitate ease of access to our website: vaccinerisk.net, vaccinerisk.org, vaccinereaction.org and vaccinereaction.net. With much gratitude to Maggie Teiner who has worked so hard to create the new site, to Scott Hunter for his wonderful design suggestions & input, to Doug Toner who is hosting our new site and who navigated through the complexities of transfer, and to Susan and Harold Fletcher whose generous financial contributions made our new site possible. Many thanks to Daniel Moser for his insight & suggestions and for securing www.vran.ca on VRAN's behalf, which will soon also become an active link to our site. There are still areas of the site that are incomplete which we are continuing to work on. We welcome feedback and suggestions from you, and thank you all for your continuing support of the work we do at VRAN.

Best Wishes to All
Edda West

✣ Protect Children's Health ✣
Support VRAN now

As we approach our fall fundraising drive, please consider donating generously to VRAN to help us continue our work of public education about vaccine risks. We are offering two new wonderful books as this year's fundraising bonus in appreciation for donations of $150 or more. Catherine Diodati's wonderful "Vaccine Guide for Dogs & Cats" as well as "The Vaccination Dilemma", a collection of excellent essays by Dr. Philip Incao and other wholistic physicians.

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These inner activities of doing and knowing work more strongly during illness than in the healthy state, and they were clearly recognized by the ancient physicians. Hippocrates said illness consisted of the active element pónos (labor) as well as the passive element pathos (suffering). Illness is intense inner work. Hippocrates perceived this labor as a cooking and digesting (pepsis) of our inner poisons during an inflammatory illness. Today we regard our inner work as a battle against a hostile virus or bacterium. The all-too-often overlooked point however, is that it is we ourselves who inwardly, unconsciously determine whether or not to engage in the battle. The great medical pioneer Hans Selye, M.D., who introduced and elucidated the role of stress in health and illness explained, "Disease is not mere surrender but also fight for health; unless there is fight there is no disease (emphasis mine)."(1)

The symptoms of an acute inflammatory-infectious illness begin not when we are infected by a virus or bacterium, but when we respond. The magnitude of our response is influenced not only by the magnitude of the infection, but also by the inherent strength of what is responding in us. For the ancient physicians the responder in us was an aspect of our human spirit and our inner vitality; our inner healing force. Today the physical basis of our inner responder is what we call our immune system. The phenomenon of immunity hasn't changed, but our thinking about it has.

The severity of the early symptoms of a particular illness is directly proportional to the vigor of our immune response and indirectly to the burden and noxiousness of the infection to which we are responding. The surprising fact is that most of the symptoms of an infectious disease are caused not by the germs themselves but by our own activity of the immune system in fighting the germs. The germ "invasion" of our body is often silent, and can take place gradually over a long period of time

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without disturbing us. It is only when our immune system decides to do battle with the encroaching germs that we start to feel sick.

The metaphor of battle is a convenient, but not fully accurate description of the relationship between our immune system and the proliferating viruses or bacteria during an acute inflammatory/infectious illness. Pasteur's germ theory assumes that disease germs have a predatory nature: that they prey on our flesh for their own survival, while contributing nothing to us in return. The germ theory further assumes that the harmful or lethal effects of infectious/inflammatory diseases are a direct result of this predation of the human body by germs.

In early microscopic studies of host tissues in acute inflammatory/infectious diseases, Pasteur, Koch and their colleagues repeatedly observed that germs were proliferating while many host cells were dying. They made the critical assumption, upon which all further thinking has been based, that the germs attack and destroy otherwise healthy cells, thus causing direct harm to the human body.

It would have been equally justified by the observable facts to assume that the cells were dying for inapparent biochemical reasons and that the proliferating germs were attracted to the site of increased cell death and decay just as flies, crows and vultures are attracted to death in outer nature. A choice was available early on between regarding germs as predators and regarding them as scavengers. The nineteenth-century thinking of the time was captivated by the Darwinian images of "Nature red in tooth and claw" and the relentless struggle for survival. The decision to see germs as predators was perhaps inevitable, and that has made all the difference in our current thinking about illness and health. That early decision by Pasteur and his followers led to medicine's present nearly-exclusive focus on combating germs, while neglecting all the subtle but far-reaching ways to strengthen the host against lasting harm from inflammatory/infectious illness.

Just as flies, crows and vultures were regarded by the Native Americans as playing a necessary and helpful role in the great chain of Being, so too with germs which scavenge death and decay within our bodies. The true causes of inflammatory/infectious illnesses will ultimately be found to reside not in the germs, but in the various human frailties which allow the forces of death and decay to predominate in us. The scavenging germs are the markers of our waxing and waning states of physiologic imbalance when cell death and decay temporarily exceed their normal limits.

The metaphor of battle between immune system and germs is justified provided we remember that our real enemies are the forces of death and decay. The germs themselves become sacrificial victims marked for destruction by our immune system because their role is to absorb the products of death and decay. Germs become poisonous to us through embodying the poisons we create. In "battling" germs, the real battle is to overcome ourselves and to refine our nature. This concept is implicit in the following discussion of how our immune system does battle with germs.

Using battle as our metaphor, we can imagine three possible scenarios. In the first, the attacking army is not strong, but the defenders are, and the attackers are routed from the field in a bloody but one-sided and brief battle in which the defenders suffer no casualties. This describes a typical case of a benign but acute inflammatory-infectious illness like roseola which usually expresses itself in a very high fever of 105° or 106°F and an extensive rash despite being no threat whatsoever to the host.

A second scenario would be when the opposing armies are evenly matched and there is a fierce battle with many casualties on both sides. This could describe an acute life-threatening inflammatory illness like septicemia or an overwhelming pneumonia, in which recovery or death is equally likely.

In the third scenario, the war reporter arrives late at the battlefield and finds no carnage, in fact little or no evidence of any previous battle. The defending army is quiet and no attackers can be seen. The reporter at first concludes that it was a very quick and easy victory for the defenders and the attackers have fled. On closer investigation, however, he finds that no battle took place because the defenders were unable or unwilling to fight.

What our reporter at first thought was the defending army in reality consists of non-combatant defenders who have been quietly and massively infiltrated by the attackers. The attackers blend in, occupying the defenders' homeland, and any defenders who would fight them have gone underground where they intermittently harass and provoke the occupying enemy.

The point of this elaborate metaphor is to demonstrate by analogy that the absence of fevers and other symptoms and signs of inflammatory illness (the absence of a battle) does not always mean that our immune system (the defending army) has been victorious!

Today it is more often the case that when we don't fight our battles vigorously and often enough, i.e. when our fevers and discharging inflammations are very seldom and mild, then we are liable to be infiltrated by the enemy in disguise and suffer from chronic allergic or autoimmune disorders. This concept today is called the hygiene hypothesis. In the 1920's Rudolf Steiner expounded essentially the same concept as a mutual interplay between

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opposing forces of inflammation and of sclerosis, in which the healthy state is a dynamic balance between the two.

Returning to our third scenario, there are of course times when the absence of a battle, i.e. absence of obvious disease symptoms, indeed does mean that the defending army has easily routed the enemy and is truly immune from further attack. Thus we see that two entirely opposite outcomes, 1. Immunity from attack and 2. quiet infiltration by the attackers into the defenders' homeland (the host body) can have the exact same appearance superficially. This analogy applies precisely to another pair of similar-appearing but inwardly opposite states, i.e. the true immunity conferred by overcoming illness as opposed to the apparent immunity conferred by vaccination. In both cases the host appears to be healthy due to the absence of illness, but true health is much more than the absence of overt illness. We will illustrate this point further when we discuss smallpox in part 3.

To complete our phenomenological description of immunity, we must note that in addition to the functions of clearing illnesses from the body and of recognizing the illnesses it has previously encountered, the immune system has another cognitive or knowing capacity. This is the discrimination of self from non-self and the ability to "tolerate", i.e. to not treat as foreign and to not react to, any elements of self. This remarkable knowing of the immune system also extends to its ability to tolerate, in pregnancy, a massive foreign presence in the body, the fetus, without reacting to it at all.

Thus we see the incredible skill and apparent purposefulness of doing and the discriminating capacity of knowing possessed by the immune system. Although modern science rarely uses the words "knowing" and "doing" in its descriptions of the immune system, nevertheless distinct knowing and doing functions are very clearly and unavoidably implied in all scientific writing on immunology. Science prefers to focus on the molecular level, hoping to find in molecular events the elusive key to understanding, if not why, at least how the immune system does what it does.

Today the immune system is most often described in articles and textbooks as comprising those bodily organs, cells and functions which discriminate between self and non-self. The molecules of self or non-self which the immune system can recognize are called antigens. One branch of the immune system, called the humoral immune system, consists primarily of antibodies which are protein molecules made by the body to specifically interact with foreign antigens. Antibodies attach themselves to any foreign antigens like bacteria or parasites which may exist in blood or body fluids outside of the body's cells. Antibodies are attracted to such extracellular antigens and usually coat these antigens as one step in the complex process of the destruction, digestion and elimination of foreign matter in us by our immune system.

We come now to a beginner's question, one seldom or never asked in the science of immunology. It is, why does our immune system work in such an inconsistent way, providing for permanent immunity from recurrence only after certain illnesses and not after others? A "why" question such as this is usually considered irrelevant in modern science, while the equivalent "how" question is actively pursued. In the case of immunity to illness, it is the "how" questions that have led science to the idea and the practice of vaccination.

For science the pertinent question is, how can we imitate nature and bring about lifelong immunity to an infectious-inflammatory illness, but without having to experience the illness first? The first task would be to learn exactly how nature itself manages to maintain permanent immunity in us after a first experience of illness. What is this process of lifelong maintenance of resistance to a particular illness? Can science duplicate it?

Part Two: How Do Vaccinations Work?

It is an interesting fact that sometimes a practical scientific breakthrough happens out of an intuition, a hunch, long before the discoverer or anyone else is able to explain just how and why this particular breakthrough works. This is true of the work of Jenner and Pasteur, the great initiators of the practice of vaccination. Astoundingly, in our modern era when vaccinations are so widely acclaimed and practiced, science still cannot explain how they work.

In the New Scientist magazine of May 27, 2000, an article on AIDS vaccine research quotes the following from two scientists: "I'm amazed by the amount of basic science we don't know," and "the assumption that successful vaccines work by simply producing antibodies is almost certainly wrong." The article then describes how one vaccine researcher found that in a certain viral disease of horses, vaccination was successful in inducing antibodies against the virus, nevertheless the vaccinated horses died faster than the unvaccinated ones! Referring to our present ignorance as to just why these vaccinated horses would succumb, he stated, "It's an issue people haven't wanted to think about, but we might have to."

Vaccine science and practice have always been based on certain assumptions, which we are only now beginning to examine. One of these is that antibodies in the blood (humoral immunity) confer protection against an illness, and that the level of antibodies correlates with the degree of protection. This relationship between mea-

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surable antibodies in the blood and apparent protection from illness has been observed for decades in many types of infectious diseases. It is not known however whether the antibodies persisting in the blood for months or years after an infectious disease are themselves responsible for protecting us from recurrences of that disease or whether they are merely markers of a protection that is accomplished by another part of the immune system. It is also not known whether the apparent protection associated with vaccination-induced antibodies is a benefit pure and simple or whether a hidden cost to the immune system is involved. The idea of a hidden cost is considered unthinkable by vaccine researchers for obvious practical reasons, yet it continues to be a nagging doubt among an ever-widening circle of parents, consumer advocates, chiropractors, holistic physicians and other discerning people.

The AIDS research quoted at the beginning of this article suggests that it's not the antibodies which protect us, but rather it's the cellular immune system. Also called the cell-mediated immune system, it comprises the white blood cells, all the lymph nodes and lymphatic tissue throughout the body and is concentrated in the thymus, tonsils, adenoids, spleen and bone marrow. It is generally agreed that the primary function of the cellular immune system is to destroy foreign intracellular antigens like viruses and some bacteria as well as the cells that harbor them. This is accomplished by the various white blood cells which are able to move inside, outside and through the walls of our blood vessels and to access every part of the body.

In the past I have been tempted to assign the immune system's doing function to the cell-mediated branch and its knowing function to the humoral antibody-mediated branch. This neat division of function is not borne out by the facts. Research shows us that each branch participates in functions of both knowing and doing, although most of the immune system's muscle to destroy, digest and drive out intruders is flexed by its cell-mediated branch. Thus, while immune system functions of knowing and doing may be conceptually distinct, in the physical reality they are overlapping in an exceedingly complex orchestration of organs, cells, molecules, hormones and chemical messengers.

There are also other aspects of the immune system which are beyond the scope of this article. Reading a modern textbook of immunology can be frustrating as one finds a bewildering array of cellular, molecular and antibody-mediated processes which science has discovered without knowing how they all fit together and manage to cooperate in health and in illness in the human being. It's something like hoping to find an understanding of how an automobile performs by studying its disassembled parts in an auto parts shop.

At the present time, it is thought that the encounter between self and non-self, that is, between the immune system and a foreign "invader" like a virus or bacterium begins in the domain of the cellular immune system with a cell called the antigen-presenting cell. If the foreign guests are not great in number or in their noxiousness, the cellular immune system is able to dispatch them, digest them and clear them from the body without ever calling into action its coworker the humoral or antibody-mediated immune system. This explains the very important fact that without our awareness we are continually infected with many small numbers of different germs in our body, some of them nasty, and the cells of our immune system continually shepherd them and keep them in check without the assistance of antibodies.

Like dust and other unseen debris, these microorganisms enter our bodies as we breathe, eat and drink. Only when the number or rate of growth of germs exceeds a certain threshold are they then recognized by the humoral immune system, resulting in the formation of antibodies specific to the particular provocative bug. At this stage we may have only mild fleeting symptoms or none whatsoever. This explains how we may be found to have antibodies against illnesses we don't remember ever having had! This is called "subclinical infection", i.e. infection without symptoms, and it happens commonly.

Thus science has discerned three levels of infection. The lowest level is our steady-state equilibrium of everyday life in which we peacefully co-exist with our inner menagerie of germs without needing to form detectable antibodies against them. At this lowest level our cellular immune system is quietly busy keeping our bugs in line and when necessary pruning the flock. Thus, although small numbers of disease agents are within us, our cellular immune system sees to it that we remain well and free of disease symptoms, and that our germs are under control.

At the second level of infection, we temporarily relax our vigilance and allow a certain group of germs to begin rapidly multiplying to the point where the humoral immune system is alerted and begins to produce antibodies against the offending bugs. This sets off a cascade of immune system functions which succeed in fairly quickly quelling our rebelling germs, so quickly that the person hosting all these inner happenings is unaware of having just gone through a subclinical illness. The identity of the wayward germ can afterwards be diagnosed by the presence in the blood serum of the specific antibodies produced against it by the humoral immune system.

At the third level of infection things

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get seriously out of control and all our inner alarm bells go off as a tribe of germs proliferates wildly and provokes the full defensive reaction of our immune system. This is called the "acute inflammatory response", which usually includes fever, release of stress hormones by the adrenal glands, increased flow of blood, lymph, mucus, and a streaming of white blood cells to the inflamed area. The human host of these wisdom-filled events now feels sick and may experience pain, nausea, vomiting, diarrhea, weakness, chills and fever. We have now emerged from the realm of the subclinical to a full-blown clinical illness, with all of its intense and often frightening symptoms. It is critical to a healthy understanding of these things to realize that we never merely suffer through an illness in a passive, one-dimensional way. In an acute illness, parts of us that in health are most active, like our mind and our muscles, are subdued, while other parts like our blood, glands and immune system are much more active than normal. Thus every illness rouses us to become more inwardly active than usual, and this inner activity of ours is the cooking through, the sweating out and the throwing off of the illness. This is hard work, and every illness calls upon and exercises capacities in us which otherwise would have remained dormant. Adults often notice these new capacities as a change in attitude or outlook after an illness. Children often manifest positive changes in their behavior or development after overcoming an acute inflammation or fever.

Having successfully passed the challenge of a particular illness, we may not need to experience it again. Something about the illness and our response to it has made us immune to its recurrence. If we knew what that something was, perhaps we could learn how to use it to create health and prevent illness. Of course, this is the basic concept of vaccination, but the all-important question is, does vaccination accomplish what we think it does?

We've already suggested that it's probably the cellular immune system, and not antibodies, which protect us against illness. Surely antibodies can have no role in either preventing or overcoming first bouts of infectious-inflammatory illness, because they are formed only after the illness has peaked. It must be the cellular immune system which confers the resistance to, as well as the capacity to overcome, both first episodes and

subsequent episodes of infectious disease. To understand how this might happen, it is helpful to examine more closely the very illness and its vaccination which started the whole debate: smallpox.

Part Three: Smallpox And Its Vaccination

That vaccines can confer a degree of protection from certain infectious-inflammatory illnesses is clear. What is not clear, as mentioned earlier, is exactly what vaccinations do to the immune system to bring about their protective effect. Researchers generally agree that vaccines do not prevent the particular virus or bacterium from entering the body nor from beginning to multiply within it. It is thought instead that the vaccines stimulate or "prime" the immune system to quickly eradicate the offending germ soon after it begins to infect the host.

Let us consider how this process might work in the case of smallpox. Our knowledge about smallpox and its vaccination is based on over 200 years of study of this dramatic and much-feared illness by physicians in many countries.

The natural course of the illness begins when one "catches" smallpox from someone with a smallpox rash or from the mucus or pus of smallpox on a patient's bedclothes or dressings. For the next twelve days there are no signs or symptoms at all and the new patient is not contagious even though the smallpox virus is multiplying within the body. On or about the twelfth day large numbers of smallpox virus enter the blood (viremia) and the "toxemic" phase of the illness begins, meaning a poisoning or contamination of the blood circulation. This blood poisoning of smallpox is the beginning of the overt illness, with symptoms of fever, prostration, severe headache, backache, limb pains and sometimes vomiting. After three or four days of these symptoms the typical smallpox rash begins to erupt and in the next one to two days the fever falls to almost normal and the patient feels much better.

The skin eruption begins as red spots which over the next few days evolve into raised pimples, which then change to blisters which then become pus-filled (pustules). On the 11th to 13th day of the illness the pustules begin to dry up and form crusts or scabs which then fall off by the end of the third week of the illness. The fever usually returns, less severely, after the pustules appear and then becomes normal as the crusts and scabs form. If one dies from smallpox, it may be in the first week of the illness if the toxemia is very severe, but most smallpox deaths have occurred toward the end of the second week after the pustules appear.

The majority of smallpox patients survive, and the falling away of the dried-up scabs from the skin signifies the final stage of healing, approximately 33 days after catching the infection. The dramatic course of smallpox illustrates very well some of the concepts discussed earlier in this article. The twelve-day incubation period during which the smallpox virus actively multiplies in the body without provoking the slightest symptom confirms the point that it is our response to infection, not the infection itself, which causes the typical disease symptoms of

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fever, aches and pains and extreme weakness.

The fact that the fever drops and the patient feels much better after the rash breaks out illustrates Hering's Law. The poisons circulating in the blood during the toxemic phase cause the most severe symptoms of smallpox. These symptoms improve considerably once the blood clears out its poisons by discharging them through the skin, producing the typical pus-filled blisters of smallpox. The chief danger of smallpox consists in the degree of blood poisoning and in the huge and exhausting effort required for the immune system to push the poisons out of the blood and through the skin. When the toxemia, the poisons, are overwhelming and the patient lacks the strength to discharge them out of the body, then the patient may die in the effort, either before the eruption ever appears or else, utterly spent, afterwards.

The patients who survive smallpox will have lifelong neutralizing antibodies to smallpox virus in their blood and permanent immunity to a second episode of the illness. What does this mean?

Using the battle metaphor from part one, we could say that the victorious defending army has acquired much valuable skill, know-how, and confidence through its combat experience as well as certain medals awarded to acknowledge their participation in combat. The first three attributes are comparable to the inner strengthening of the cellular immune system which is attained through overcoming an illness like smallpox. The medals as visible tokens of achievement are roughly comparable to the antibodies visible on simple blood tests indicating that the host has already won that battle and is likely to be immune to future attacks of the same illness.

If a foolish general were under the illusion that merely wearing a combat medal actually conferred the know-how, skill and confidence gained in battle, then he might propose pinning medals on soldiers with no combat experience to make them immune to dangerous future battles. That would bestow the same outward appearance to the seasoned and unseasoned soldiers alike, belying their experience.

In the same way, science bestows antibodies through vaccination and mistakenly assumes that it is bestowing the immune strength that can only be developed through the experience of illness. In equating the significance of vaccine-induced antibodies with that of illness-induced antibodies, science confuses the outer sign of the battle experience with the experience itself. Antibodies arising through illness are markers of immunity and (unlike the medals in our battle metaphor) also contribute to immunity, but antibodies alone are not sufficient to confer lasting immunity to a particular illness. There are several diseases which may recur repeatedly, such as herpes outbreaks, despite high antibody levels. The evidence suggests that it is our cellular immune system which confers lasting immunity, with antibodies playing a secondary role in the process.

Immunity is really the result of our experience, of having gone through, along with our cellular immune system, an active process (the combat in the metaphor) of learning and strengthening. The immune system is a limb of us, and it learns from experience just as we do. Antibodies signify that we've had experience of illness, often repeatedly, but not necessarily that we've gained anything from the experience. When on some level we respond with greater initiative to our experience of illness, actively processing, digesting and ultimately learning from such experience, then we are usually immune from having to repeat it. In such cases our cellular immune system has strengthened itself through its active encounter with, and overcoming of, the illness. In this view, immunity is the result of having successfully met the challenge of a particular illness and having gained mastery over it. It is like learning a particular skill, such as riding a horse, which is then usually retained for life. On the physiologic level, the skill and mastery we gain in overcoming illness accrue to our cellular immune system.

This active process of acquiring mastery cannot be replaced by a vaccination unless the host's immune response to the vaccination is essentially identical to its response to the illness itself, even though reduced in intensity. This would mean that in order to produce genuine cellular immunity, a vaccination would have to reproduce the experience of the illness, causing some of the same signs and symptoms, though milder, that are caused by the illness. To see if this is true, let us look at smallpox vaccination.

The vaccination consists of introducing live cowpox (vaccinia) virus into the skin by multiple superficial punctures in a small area about 1/8 inch diameter on the upper arm. The vaccination site is then inspected twice after 3 and 9 days to determine if the vaccination "takes" or not. A primary reaction or "take" evolves as follows: for three days after the vaccination there is no reaction whatsoever. On the fourth day a small red pimple appears which gradually grows into a blister which becomes pus-filled, surrounded by a zone of redness and often with tender, swollen glands in the armpit and mild fever. This reaction peaks on the 8th to 10th day, after which the pustule gradually dries up and forms a scab which eventually falls off leaving a scar.

Clearly the primary "take" reproduces the experience of smallpox itself described earlier, but of course in a very limited way so as to generate only one pock rather than many dozens of them. The cellular immunity produced by smallpox vaccination is also limit-

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ed, lasting from six months to three years. This immunity probably coincides with the length of time that the exercised "muscle" of the cellular immune system remains strengthened from its labor of discharging the single cow pock resulting from the vaccination. The antibodies appearing in the blood after primary smallpox vaccination may remain for over ten years, but these antibodies cannot be taken as a trustworthy sign of immunity. The official description of the currently available smallpox vaccine in the U.S., which was manufactured by Wyeth Laboratories, states vaguely "the level of antibody that protects against smallpox infection is unknown"(2) If we can state blandly that the protective level of antibody is still unknown after having assumed for several decades that protection is directly correlated with antibody level, then surely it is time to rethink that assumption.

In practice antibody levels were seldom used in the smallpox era as a measure of immunity. Anyone not vaccinated in the previous three years was considered to be susceptible to smallpox, regardless of their antibody level.

The all-important question is how to interpret the meaning of reactions to smallpox vaccination which are milder and briefer than the primary "take" which peaks in ten days, and which does result in a genuine though short-lived immunity of the cell-mediated system.

Since the early 1970's only two types of reactions to smallpox vaccination have been officially recognized, as recommended by the World Health Organization (WHO). For purposes of greater clarity, in this discussion I will be referring to the older classification which recognized three types of normal reactions to smallpox vaccination.

The second type of normal skin reaction to smallpox vaccination was called the accelerated or vaccinoid reaction, usually in people who had some immunity to smallpox at the time of vaccination, either from a previous experience of the disease or from a previous smallpox vaccination. In the accelerated reaction, the skin blister which forms is smaller and reaches its maximum size and intensity between the 3rd and 7th day after the vaccination. This reaction works in exactly the same way as the primary reaction but to a lesser degree, boosting the cell-mediated immunity that is already present, but waning, from the previous vaccination.

It is the third type of reaction to smallpox vaccination that in my opinion has created all the problems, that has been at the root of a 200 year old controversy over the usefulness of smallpox vaccination. This stems from the fact that this reaction for years was interpreted as indicating immunity to smallpox, when it often meant exactly the opposite. In many cases the bearers of this reaction may have had a suppressed cellular immunity, making them on repeated revaccination more susceptible to smallpox than an unvaccinated person!

This third type of reaction to smallpox vaccination was originally called an immune reaction, then later renamed an early or immediate reaction. A small pimple forms at the vaccination site which may evolve into a tiny blister, peaking on the second or third day and diminishing thereafter. An earlier textbook of viral diseases from the smallpox era states the following: "The early or immediate reaction is an indication of sensitivity to the virus and may be given by persons who are either susceptible or immune to smallpox. It cannot be regarded as a successful result and cannot be guaranteed to induce or increase the person's resistance to smallpox. (3) This is a typical scientific understatement that glosses over years of devastating results of smallpox vaccination in which thousands of vaccinated people who were thought to be immune based on their so-called "immune reaction" to vaccination later caught smallpox and died.

Ian Sinclair, writing on the history of smallpox, states:

"After an intensive four-year effort to vaccinate the entire population between the ages of 2 and 50, the Chief Medical Officer of England announced in May 1871 that 97.5% had been vaccinated. In the following year, 1872, England experienced its worst ever smallpox epidemic which claimed 44,840 lives.In the Philippines, prior to U.S. takeover in 1905, case mortality [death rate] from smallpox was about 10%.In 1918-1919, with over 95% of the population vaccinated, the worst epidemic in the Philippines' history occurred resulting in a case mortality of 65%.The 1920 Report of the Philippines Health Service [stated] 'hundreds of thousands of people were yearly vaccinated with the most unfortunate result that the 1918 epidemic looks prima facie as a flagrant failure of the classic immunization toward future epidemics.'" (4)

How can this be? How can these historical facts be reconciled with my earlier statement that a primary take in response to a first smallpox vaccination results in genuine cellular immunity for up to three years? The usual explanation offered is that the vaccine used was inactive due to loss of potency in storage, but this clearly cannot be the whole answer to the many documented instances of failure of smallpox vaccination to protect from smallpox.

The answer is an open secret which has been very well known for years, but never fully understood: that many first recipients of smallpox vaccine fail to produce a take (primary reaction) and continue to fail to do so even when revaccinated many times. The textbook states,

"Easton (1945) records of one man who died of confluent smallpox that vaccination had been attempted at

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birth, again in 1941 and ten times in 1943 without a take, thus emphasizing the danger of accepting even repeated unsuccessful vaccination as evidence of insusceptibility to smallpox.."(5)

This is an excellent example of a vitally important observation leading to an irrelevant, though not incorrect, conclusion. This example begs the question: how many repeated failures to react does it take to justify the concern that continuing to revaccinate may be doing more harm than good?

The relevant conclusion, in my opinion, is that due to differences in immune response capability among individual human beings at the time of first vaccination, in some individuals the cellular immune system lacks the muscle to push out the single pock eruption that is the primary take. The scratching of the virus into the skin of the arm is a strong challenge to the immune system. A successful take depends on the ability of the cellular immune system to respond to that challenge in an equally vigorous way, to push the intruding virus right back out of the body. It is a simple matter of action and reaction, of challenge and response. If Charles Atlas challenges a 97-pound weakling to arm wrestling and his opponent's arm immediately collapses, we would not think that the challenge ought to be repeated indefinitely if the weak condition of the responder had no means of improving! Yet in thousands of individuals in the last 200 years who may have been weakened through stress, poor nutrition and poverty, whose cellular immune systems were not vigorous enough to respond to smallpox vaccination with a take, the effect of repeated revaccination, which was commonly practiced, was to weaken these individuals' immune systems still further, making them no doubt more vulnerable to smallpox than they had been before vaccination! This would explain the disastrous results of the above-mentioned smallpox vaccination campaigns in England, the Philippines and in many other countries as well.

The ambivalent nature of the early reaction to smallpox vaccination is analogous to the third battle scenario mentioned in part one of this article. When little or no signs of battle (reaction) are visible, it may mean that the defenders were easily victorious (the host is immune) or contrariwise it may mean that the defenders lacked the strength to fight and their homeland was subsequently quietly infiltrated by the attackers. When a smallpox vaccine recipient lacks the immune muscle to respond to the viral intrusion of his or her body with a vigorous pock-forming discharge, then we might expect that most of the intruding virus has remained in the body. With each revaccination the burden of vaccinia virus in the body increases, and the suppressive effect of this viral burden on the cellular immune system also increases, eventually resulting in a dangerous state of immunosuppresion. This may also explain the occasional catastrophic effects that were observed resulting from a brief medical fad in the 1970's: treating recurrent herpes infections with repeated smallpox vaccinations.

The disease smallpox and its vaccination are fruitful subjects to study in order to understand how the immune system works, because we can observe what happens on the skin as vital clues to what might be happening inside the body. The main lesson from this study is the exceedingly important fact that a lack of a vaccine reaction, and by extension a lack of illness symptoms, can by no means be taken as a sign of immunity or of health.

The other critical fact confirmed by our historical experience with smallpox vaccination is that individual differences in response to vaccination are extremely important. One size most definitely does not fit all. It is clear that although the smallpox vaccine was effective in conferring a temporary immunity in some individuals, an unknown number of other individuals were probably harmed by the vaccine. With the smallpox vaccination the adverse effects were fairly obvious, they often appeared on the skin. With other vaccines in use today the adverse effects may not be so obvious. We've seen with smallpox that the same vaccination procedure which temporarily strengthened the cellular immune system in some individuals probably weakened it in others, especially upon repeated revaccination.

The possibility, that the up to 39 doses of 12 different vaccines which children today receive by school entry may be impacting the cellular immune systems of many individual children in a negative way, suggests itself to the open mind. Science has most of the knowledge and the tools it needs to investigate and to find answers to these unanswered questions. All it needs now is the will. May it come soon, for our children's sake.

Note: *We appreciate the opportunity to reprint Dr. Incao's excellent essay, which is also published in a new book entitled "The Vaccination Dilemma", published by Lantern Books, New York, N.Y. Dr. Incao has practiced family medicine for over 25 years and is one of only a handful of American physicians who practice anthroposophic medicine. Dr. Incao has studied vaccinations and their effects first-hand and has lectured and written extensively on the topic. He has a medical practice in Denver and Boulder, Colorado.*

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Diptheria & Tetanus cont. from page 1

High concentrations can be present if the soil has been contaminated with animal or human feces. In the presence of anaerobic (low oxygen) conditions, the spores can germinate and release a potent neurotoxin, called tetanospasmin, into the bloodstream. Dirty, deep puncture wounds that are contaminated with soil are at greatest risk for infection. Wounds that are gangrenous, or injuries caused by frostbite, crush injuries, and burns are also at increased risk.

The incubation period prior to the onset of tetanus symptoms can take several days to several months, depending on the location of the inoculation. Once the spores germinate, the toxin is released into the bloodstream and travels to peripheral nerves, eventually attaching to receptor sites at the nerve endplates. The result is unrelenting, painful muscle spasm.

The four clinical types of tetanus are generalized, local, cephalic, and neonatal, with generalized tetanus being the most common. This form manifests as the classic spasms which can last from seconds to minutes. Death from tetanus is due to spasm of the vocal cords and spasm of the respiratory muscles, leading to respiratory failure. The highest mortality rate for tetanus is seen in the very old and the very young, but on average, it is generally reported in most literature that the mortality rate is approximately 30%. Recovery can take months **but is usually complete,** unless unforeseen complications occur (1).

Yes, you read it right, **complete recovery.**

It is an article of faith, widely accepted by doctors and patients alike, that tetanus is almost invariably fatal, especially if the person is not vaccinated. This fear is so deeply entrenched that I have personally seen patients dutifully wait in a busy emergency department for hours to get a tetanus shot because they had sustained a superficial cut while washing dishes. Before I knew better, and because the "standard of care" dictates that every cut gets a tetanus shot, I handed these shots out like candy, believing it was better to "over protect" than to risk the development of a "fatal" case of tetanus.

Discovering that most people recover from an acute bout of tetanus was unexpected, but it was disconcerting to find that many of the reported cases of tetanus were in "fully vaccinated" people. A review of the Morbidity and Mortality Weekly Report (MMWR) from the CDC called "Tetanus Surveillance—United States, 1995-1997" (2) revealed unexpected information and facts. However, because this report is bogged down with complicated statistics that must be methodically disentangled, it is no wonder that few are aware of its contents.

The document discusses 124 cases of tetanus reported between 1995 and 1997. Here is what was reported (3):

TABLE 1. Tetanus toxoid vaccination status and deaths among persons with reported tetanus, by vaccination status -- United States, 1995-1997

Vaccination Status	Number	%	# deaths
Unknown	66	53.7	9
0 doses	27	21.5	4
1 dose	11	9.1	0
2 doses	4	3.3	1
3 doses	4	3.3	0
>= 4 doses	12	9.1	0
Total	124*	100.0	14
*Outcome was unknown for two patients.			

Note that nearly twenty-five percent (24.8%) of those who contracted acute tetanus had at least one dose of the vaccine and *more than twelve percent (12.4%) of the patients were fully vaccinated*, with three or more doses of tetanus. Of the 66 (53.7%) people who had an "unknown vaccination status," it could reasonably be assumed that a portion of those had had one or more tetanus shots at some point in their lives. Therefore, statement made by the CDC that "the disease continues to occur almost exclusively among persons who are unvaccinated, inadequately vaccinated or whose vaccination histories are unknown or uncertain" (4) is simply not true.

The "rationale" for getting a tetanus shot is that milder cases will result among the vaccinated (5). This is an argument used with all the mandated the vaccines. Yet, given that the fatality rate (11.2%) is lower than reported and the apparently low incidence overall, the following questions should be asked:

1) What is the real risk of getting a severe case of tetanus if you are unvaccinated?

2) How many cases of serious tetanus would occur were all wounds cared for properly?

3) What antibody level actually confers protection from a serious case of tetanus?

The truth is, the antibody level required to be universally protective is unknown. The "generally accepted" protective level for tetanus antibody > 0.15 IU/mL. This level was proposed by Snead in1937, and has been the accepted "standard" since that time. However, the number is arbitrary and not guaranteed to protect from infection (6). Therefore, routinely vaccinating every 10 years, as the journal article suggests, simply to maintain "adequate antibody levels" is uncalled for and may not only provide the person with a false sense of security, it may actually cause harm.

Tetanus vaccines haven't gotten the "bad press" many of the other vaccines have recently received. In the zeal to protect from this "deadly disease," it is imagined that the risk of infection

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far exceeds the potential risk of the vaccine. What harm could it do? I thought the vaccine only contained inactivated tetanus toxin and sterile water. I am convinced that is the perception of nearly all physicians. It was disturbing to learn of the other ingredients that are in the tetanus toxoid vaccine: formaldehyde; sodium phosphate monobasic; sodium phophate dibasic, [an eye and skin irritant that may be harmful if ingested]; glycine, aluminum, and 25 ug. of thimerosal (mercury). There is obviously more to the tetanus vaccine than inactivated toxoid!

In the Emergency Department, if the tetanus status of a patient is "unknown," an additional shot is routinely given, because it is thought to be harmless. However, this is simply bad medicine. If the person doesn't need the tetanus booster, the vaccine can cause a severe allergic reaction referred to as an Arthus type, Type III hypersensitivity reaction. This side effect is defined as "an acute inflammatory reaction caused by deposition of antigen-antibody complexes into the tissues (7)." The "Arthus type" variation classically causes a reaction only at the injection site, but the result is an acute necrotizing vasculitis and localized necrosis (death) of the tissues. The reaction starts 2-8 hours after a tetanus toxiod injection and occurs if the person has very high serum antitoxin antibodies due to overly frequent injections (8).

In addition to the local reaction, severe systemic reactions can occur. A partial list of adverse events includes headache; nausea; vomiting; arthralgias; tachycardia; syncope (fainting); cranial nerve paralysis; and a variety of neurological complications including EEG disturbances, seizures and encephalopathy; anaphylaxis and Gullian-Barre' syndrome (9). Recommending "routine" tetanus boosters based on mathematical models of antibody degradation can result in severe complications and is risky business, indeed.

Diphtheria

But what about diphtheria? Do we need to keep our guard up about this infection?

Diphtheria is an infection caused by the gram-positive bacteria, *Corynebacterium diphtheriae*, its name derived from a Greek work meaning "leather hide." Early symptoms include sore throat, malaise, and a low-grade fever. Although cutaneous diphtheria infections occur, the most common form of the infection occurs in the tonsils and pharynx. If not treated early, a grayish-green membrane develops in the back of the throat which may lead to respiratory obstruction.

Similar to tetanus, the complications from diphtheria are caused by a toxin released from the infecting bacteria. The severity of the disease is related to the amount of toxin that is absorbed systemically from the infection site. The most frequent complications caused by the toxin include cardiac arrhythmias and nerve paralysis involving the palate, eyes, limbs and diaphragm. Even with these extensive complications, **complete recovery** usually occurs within five weeks of onset (10). Death occurs without medical support for the complications.

Complete recovery? Here we go again…

There are many different species of *Corynebacterium* commonly found in soil, dust and contaminated water and most do not result in serious infection. In fact, most strains of C. diphthereae do not produce the disease-causing toxin! Only when the bacteria has been infected by a specific virus, called a B phage, will the toxin be produced. The B phage contains the specific genetic information to code for the toxin, therefore, *only strains infected with the virus cause severe disease* (11). The important question, then, is, how often such an event occurs.

The article refers to a "recent outbreak" of diphtheria in the former Soviet Union as the primary reason to revaccinate. It is assumed that a decrease in vaccination rate was the most significant cause for the 1990-1995 diphtheria outbreak in the Newly Independent States (NIS). This epidemic is often cited as the reason to maintain high vaccination rates.

Let's take a closer look at what was happening in the Soviet Union at that time. In 1991, fifteen new countries had just become independent with the dissolution of the USSR and shortly thereafter, the infrastructure of the region completely collapsed. Garbage piled up in the streets of Moscow and other cities. Large refugee and migrant camps descended upon the major urban areas. Health care services, including disposable syringes and needles, were virtually non-existent.

By 1995, Russia's annual health care budget was slightly less than 1 percent, about the same as the poorest African nations. Half of the country's 21,000 hospitals had no hot water, a quarter had no sewage systems, and several thousand had no water at all. In the operating rooms, truly sterile instruments were rare and blood was being washed off the hospital floor with a garden hose (12).

More than 150,000 acute infections and nearly 5,000 deaths from diphtheria were estimated to have occurred between 1990 and 1998. However, even with the initiation of widespread immunization campaigns by the World Health Organization in 1994, more than 2,700 cases were still reported in 1998 (13).

Comparing what happened in the NIS to what might happen if antibody levels fall in the US, without taking into account the living conditions in each country, is an invalid comparison.

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What about the vaccines?

There are several available vaccine choices: tetanus toxoid (TT); adult diphtheria toxoid plus tetanus toxoid (dT); pediatric diphtheria toxiod plus tetanus toxoid (DT) and tetanus immune globulin (TIG). The diphtheria vaccine is not obtainable separately

Like the tetanus vaccine, the diphtheria vaccine is made from the toxin of C. diphtheriae. The bacteria is grown in a casein medium and the final product contains ammonium sulfate, residual formaldehyde, sodium bicarbonate, 0.3 mg aluminum phosphate and 25ug thimerosal.

The tetanus toxoid vaccine (TT) was discussed previously and is the vaccine most commonly given. There are two forms of diphtheria vaccine, pediatric (D) and adult (d) and this vaccine is always given in combination with tetanus toxoid. Therefore, the pediatric vaccine is DT and the adult vaccine is dT. The distinction is made because the DT form contains *8 times more diphtheria toxoid* than the dT form.

It is contraindicated to give the pediatric vaccine, DT, to adults or to children over the age of 7 years because of the increased the likelihood of side effects. Infants are given 4 doses of the DT form (as DTP or DTaP) during the first 12 months of life. The result is that infants receive 32 times the dose of diphtheria toxin from the DT form than they would receive if the dT form was used. The reason the higher concentration is "safe" for smaller, younger children is unclear.

Tetanus Immune Globulin (TIG) is a vaccine that contains tetanus toxin antibodies derived from the plasma of donors previously vaccinated with tetanus toxoid. This vaccine is considered to give "passive immunization," meaning that the antibodies are supplied at the time of immediate need. Peak antibody blood levels from this vaccine are obtained approximately 2 days after the injection and remain in circulation for approximately 23 days. TIG can be used following an acute injury in patients whose immunization status is unknown or incomplete.

What are the other treatment choices?

Although proper hygiene has been known since the 1940s to be the best way to prevent infection, it tends to be overlooked as the best way to prevent tetanus. Regardless of immunization status, dirty wounds should be properly cleaned and crushed tissue should be surgically removed.

Diphtheria infections can be prevented by thorough hand washing and good nutrition.

Antibiotic regimens are available for the treatment of both tetanus and diphtheria infections. The Red Book™, published by the American Academy of Pediatrics makes a suggestion for an alternative treatment for tetanus. The antibiotic, metronidazole (30 mg/kg/day) given at 6-hour intervals is effective in reducing the bacterial count in a wound. Metronidazole is the antibiotic of choice for dirty wounds. Another choice is injectible penicillin G (100 000 U/kg/day), given at 4- to 6-hour intervals. These therapies should be continued for 10 to 14 days (14). It appears that a prophylactic course of antibiotics would be prudent for dirty wounds to prevent the possibility of C. tetani germination and toxin production.

Additionally, there is an antibiotic treatment available for diphtheria infections. Erythromycin orally or by injection (40 mg/kg/day; maximum, 2 gm/day) or procaine penicillin G daily, intramuscularly (300,000 U/day for those weighing 10 kg or less and 600,000 U/day for those weighing more than 10 kg) can be given for 14 days. The disease is usually not contagious 48 hours after antibiotics are instituted. Elimination of the organism should be documented by two consecutive negative throat cultures after therapy is completed (15). Indeed, since nearly every sore throat is treated by conventional medicine with an antibiotic, perhaps this is the reason for the decreased the incidence of diphtheria, and not the vaccine.

A third option is to use the TIG vaccine at the time of acute injury. It appears that treatment with TIG is an adequate form of treatment. The package insert states the following:

"If a contraindication to using tetanus toxoid preparations exists for a person who has not completed a primary series of tetanus toxoid immunization and that person has a wound that is neither clean nor minor, only passive immunization should be given using tetanus immune globulin (16)."

With all of these options available, routinely vaccinating adults to maintain an arbitrary antibody level should be considered inappropriate healthcare. In addition, knowing the real facts about these infections and being aware of the available treatment options should be a comfort to parents who choose not to vaccine.

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This article was originally published on the Dr. Mercola website where references can be found :
http://www.mercola.com/

Adults Need Booster Shot of Diphtheria, Tetanus

A recent journal article states that only 60% of American adults have adequate antibody protection to ward off diphtheria infections and only 72% are protected against tetanus.

Tetanus, a sometimes-fatal illness, is caused by toxin-producing bacteria that usually starts after acquiring a dirty cut or wound. The disease is characterized by painful muscle spasms or contractions.

Diphtheria is caused by another type of bacteria that primarily attack the larynx, tonsils and throat. The toxin produced by the bug can damage the nerves and heart.

While most US children receive immunization for diphtheria and tetanus, many adults may not realize that over time the protection provided by the shots can wane.

In the study, 18,045 people aged 6 years and older were tested for the presence of diphtheria and tetanus antibodies in their blood between 1988 and 1994.

The researchers found that **91% of children aged 6 to 11 years were found to have protective levels of diphtheria and tetanus antibodies**. However, the number of adults found to have protective levels was another story altogether.

Overall, **only about 50% of adults had protective antibodies to both diseases**, and among those 70 years and older, only about 30% had protective levels against either of the two illnesses.

Although diphtheria and tetanus occur only rarely in the US, a recent outbreak of diphtheria in the former Soviet Union is a reminder that even a well-controlled infection can re-emerge when population immunity is not maintained.

Since immunity to diphtheria and tetanus decreases with age, doctors should re-immunize patients at 11 to 12 years of age and every 10 years thereafter, as recommended by the US Advisory Committee on Immunization Practices.

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TETANUS

By Magda Taylor

April, 2003 - The Informed Parent Newsletter, UK

The following article is an amalgamation of papers written on tetanus, surrounding the disease, the vaccine, and the host response. Once again it is apparent that there are many uncertainties, lack of understanding, and indeed lack of acknowledging findings that do not support vaccination as regards to tetanus and the cause. It must be stressed that the likelihood of developing tetanus is extremely rare, particularly in young infants in the UK and other developed countries.

Tetanus is unique among the so-called vaccine-preventable diseases as it is not communicable and therefore the 'herd immunity' argument is not applicable. Tetanus as a clinical entity is linked to the bacterium Clostridium tetani, however this bacterium is recovered from a wound in only 30% of cases, and is often isolated from patients who have not developed tetanus.

Soil is not the only reservoir, the organism lives as a harmless commensal in the gut of many animals, in addition to humans (rural residents tend to have higher rates of intestinal carriage than city dwellers). Spores have also been detected in street dust and the dust and air of surgical operating theatres.

It is not the bacterium itself that causes the development of tetanus but the toxins it produces under anaerobic conditions. "Under normal conditions, no disease will occur if spores are introduced into a wound."(J. Ark Med Soc Vol 80, No 3 p134) and "It is the compromised host, or traumatised patient, either by surgery or accident, who is most apt to develop tetanus." (J Foot Surgery Vol 23, No 3 p235). When the conditions are right, an exotoxin (called tetanospasmin) is released from the localised area and transported into the central nervous system. The incubation period has been reported to vary from 1 day to several months, but the majority of cases occur within 3-21 days following inoculation of spores.

In 'Vaccines' by Plotkin & Mortimer, it states that 'Incubation periods of 10 days or more tend to result in mild cases whereas persons who develop illness within 7 days of injury tend to have more severe disease.' However it is admitted in the same text that 'For the most recent few years, no such relationship is observed."

The geographical distribution of tetanus across the globe generally follows the areas of moist, warm climate and fertile soil - the highest rates occur in the developing world, particularly in countries near the equator.

Most people associate tetanus with the wound from a rusty nail or deep puncture wound where it is diffi-

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cult for oxygen to reach. These kind of wounds account for just over half of the cases in the developed countries, as other causes have been observed, ie middle-ear infection, tonsillitis, appendicitis, dental infection, abortions and in some cases there is neither a history of injury, nor a detectable wound! Also laboratory investigations frequently produce negative results.

Tetanus is extremely rare in the developed world, and according to the UK Dept of Health book 'Immunisation Against Infectious Disease' (1996): 'Between 1984 and 1995 there were 145 cases of tetanus in England and Wales. 75% occurred in individuals over 45 years, and of the remainder, 16% were in individuals from 25-44 years.' It also concludes that the highest risk group is the elderly, with women being at greater risk than men.

At the beginning of the 1900s the annual death-rate was 7 per million population compared to, for example, whooping cough death-rate, which was 1000 per million children, so even then it was relatively rare considering the living conditions and the deposits by horse-drawn transport still in use.

Tetanus neonatorum is the most common form of tetanus in developing countries. This form of generalised tetanus occurring in the new-born infants is often as a result of an infected umbilical cord stump due to poor hygiene and the use of dirty, rusty scissors when cutting the cord. In the United States, the occurrence of neonatal tetanus was falling before the use of tetanus toxoid became widespread in women, due to improved birth practice.

Natural Immunity

Why debate continues over whether humans can develop circulating antitoxin against tetanus in the absence of vaccination or disease is a mystery, since evidence of natural immunity has been observed. Although there have been conflicting results, some studies in Brazil, China, Ethiopia, India, Italy, Israel, Spain and the USSR have shown substantial proportions of unimmunised populations with detectable levels of antitoxin. Specifically, up to 80% of persons in India and up to 95% of persons in a group of Ethiopian refugees had levels of antitoxin suggestive of protection. It is admitted by medical experts that this phenomenon has not been adequately studied, and yet it is apparent that when unexpected or undesirable findings emerge, rather than acknowledging the results, it is presented as an ongoing debate!

The development of tetanus by a deep puncture injury is known not to induce any subsequent immunity, which then raises the serious question - how is a vaccine able to produce any long-term immunity? Proper and natural immunity is achieved by the ingestion of tetanus spores through natural entry, stimulating the immune system at all levels in an appropriate way. Critics of vaccination often highlight the fact that injecting foreign antigen into the body by-passes a branch of the immune system leading to a compromised host. Dr Viera Scheibner, a researcher on the ineffectiveness and dangers of vaccination, points out that any injection is a deep-puncture wound, so that is why contracting tetanus through a wound does not produce any long-term proper immunity because of the similar action to a vaccination, ie the by-passing of our multi-levelled immune system due to unnatural entry.

With an obvious lack of under - standing on this aspect, from the world health 'experts' of the day, it is surprising that their general conclusion is that 'even if natural immunity occurs in some populations, it can not be relied on to control tetanus.' In 1973, of the estimated one million tetanus deaths throughout the world, 60 to 90% were due to neonatals (in otherwords most tetanus cases). Clearly the most simple and effective way to reduce this problem would be improved hygiene in childbirth practices, along side obvious health improvements for the population at large.

Symptoms of Tetanus

Irritability, restlessness, headaches/ muscle twitching and spasms, progressing to pain and stiffness in jaw , abdomen or back. This can lead to 'lockjaw' and in severe cases may cause the difficulty in swallowing, spasm of the respiratory muscles necessitating artificial ventilation, and in some cases, death. Characteristically the symptoms worsen for three days, remain stable for the next 5-7 days and by two weeks may have disappeared all together. Most survivors recover completely in 4 weeks, and all the effects appear to be self-limiting because those who recover from the disease have no residual defect.

Early medical literature shows clearly that the treatment of choice was vitamin C in all toxin-mediated diseases. Vitamin C in large enough doses to enter the bloodstream will start neutralising the toxins present in the bloodstream, although this will not neutralise any toxins already in the central nervous system. Also studies have shown B vitamins can also reduce the intensity of spasms, which also confirms that diet has a profound effect on the ability of the immune system.

The most common homeopathic remedies for suspected cases of tetanus are ledum and hypericum, which have proven to be of great value in the prevention of the disease for more than a century. However it is strongly advisable to seek advice from a qualified practitioner for individualised, preventative and remedial treatments.

It appears that prompt and ade-

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quate care of wounds is of major importance in preventing tetanus disease. Profound wound cleansing is an important measure and the wound should be allowed to bleed freely, since this eliminates bacteria and infected matter from the wound and supplies oxygen through the blood stream. Wounds should be left open to the air, until completely clean, which also allows them to heal from the base up, before stitched. Application of hydrogen peroxide (3%) is very useful as it releases oxygen in high concentration.

The Vaccine

The vaccine is made from the tetanus toxoid inactivated with formaldehyde. To produce the toxoid the bacterium is cultured in liquid medium in large-capacity fermenters. The medium consists of digestive enzymes of milk protein, allegedly free of contaminants, which is harvested by filtration, purified and detoxified. The vaccine also contains aluminium hydroxide or phosphate, which acts as an adjuvant (any substance used in conjunction with another to enhance its activity), and thimerorsal, a mercury-containing compound, which prevents bacterial contaminant overgrowth.

In 1979, the WHO attempted to standardise the content of tetanus toxoid preparations. However, immune responses varied in laboratory animals e.g. the response in mice varies greatly depending on the mouse strain used..... so the response in humans can vary greatly, therefore an international standard has not been adopted.

According to medical literature, tetanus toxoid is one of the most potent immunising agents used routinely in children with protective levels being obtained with schedules that start in the newborn period. Apparently in contrast to the diphtheria toxoid, which is clearly impeded in the presence of passively transferred maternal anti-toxin, the tetanus toxoid has been considered to be minimally inhibited by maternal antitoxin. However, interestingly enough, studies in US have shown that infants have high levels of circulating tetanus antitoxin, well above the protective level, at 2 months of age before beginning immunisation. (Barkin RM et al. DTP reactions and serologic response with a reduced dose schedule, J Pediatr 105: 189-94, 1984. - Barkin RM et al Pediatric diphtheria and tetanus toxoids vaccine. J Pediatr 106: 779-81, 1985).

Better vaccination coverage of target populations is the main focus for future tetanus control by the medical establishment. However, they state that 'a sense of diligence' must remain in investigating the apparent failure of the tetanus toxoid in preventing disease. A case-control study in Bangladesh, conducted in 1990, estimated the efficacy of a 2-dose regime to be below 50%. Other studies have been consistent with these findings and further examinations of the potency of tetanus toxoid in other nations is under way. No doubt it will be a lengthy process with further on-going debate.

Some researchers have apparently suggested that active immunisation of foetuses can occur as a consequence of the vaccination of mothers during pregnancy, and this research has opened up numerous possibilities into the prevention of other diseases and new vaccine regimes.

Vaccines containing tetanus are the Td, DTP, DTaP, Hib/DTaP, Hib/DTwP. Single tetanus has recently been replaced by the Td, this is apparently being done due to the concern of low levels of diphtheria immunity in older people.

The Dept of Health recommend five doses of Td during a lifetime- 3 doses in first year, followed by boosters at pre-school and school leaving age, since they admit that further boosters have been shown to be unnecessary and can cause considerable local reactions.

Regarding vaccine side-effects, apart from the general - redness, swelling/pain at the site, fever, headache etc there have been numerous side-effects published in medical literature over the years. Conditions, such as, allergic, neurological, cardiac, rheumatic, gastro-intestinal reactions have been well documented. In one study 11 healthy subjects receiving the tetanus toxoid produced a lowering of the t-lymphocyte helpers/suppressor ratio such as might be seen in patients with AIDS. (NEJM,1984, 310:198-9. Eibi MM et al Abnormal T-lymphocyte subpopulations in healthy subjects after tetanus booster.)

In an article on tetanus by Kris Gaublomme, MD, a medically qualified homeopath and vaccine researcher, he concludes with:

'The overwhelming amount of literature on tetanus toxoid vaccine adverse side-effects and the severity of those complications make it absolutely impossible to ridicule them as rare and benign. Doing so could only demonstrate a profound lack of knowledge of the literature concerned. Some medical professionals insist on having adrenalin readily available when tetanus toxoid is administered, thus admitting that the vaccination is in fact a life-threatening medical intervention, even in apparently healthy individuals. This speaks for itself. Risking one's life by an intervention which is probably ineffective, to avoid a disease which will probably never occur, is not sound medical practice. All it takes, on a world scale, to avoid the majority of tetanus cases is clean scissors to cut the newborn's cord. Information, soap and peroxide might do a far better job than tetanus vaccine.'
http://www.whale.to/v/tetanus.html

And of course it should go without saying, that the promotion of a

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healthy and balanced lifestyle, physically and emotionally, is the absolute best way to prevent yourself and your family creating the right internal environment for rare conditions such as tetanus to develop in the first place!!

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Tetanus - Question & Answer

The late Dr Robert Mendelsohn became an outspoken critic of vaccination programmes, and ran a popular medical column - The People's Doctor, in US national newspapers (published between 1976-88).

Reproduced here are some of his comments in response to a question on tetanus. Taken from 'The People's Doctor,' Vol 8 No. 12, it reads:

Q Ever since my daughter was born almost three years ago, I have been compiling an extensive file on the pros and cons of vaccinations. So far, she remains unimmunised, but one serious worry remains in my mind. Should she be immunised against tetanus? Most anti-vaccination people seem to feel that the tetanus shot is the lesser of two evils -- I am told that tetanus germs are everywhere.

I realise you have changed your advice from pro-tetanus for everyone to only for farm dwellers, and we do not live on a farm. If I choose not to vaccinate my child , what if she winds up in a hospital emergency room badly cut or with a puncture wound?--M H

A You have every right to closely question me on the tetanus vaccine, since that was the last vaccine I abandoned. It wasn't hard for me to give up vaccines for whooping cough, measles, and rubella because of their disabling and sometimes deadly side-effects. The mumps vaccine, a high-risk low-benefit product, struck me and plenty of other doctors as silly from the moment it was introduced.

Arguments for the diphtheria vaccine were vitiated by epidemics during the past 15 years which showed the same death rate and the same severity of illness in those who were vaccinated vs. those who were not vaccinated. As for smallpox, even the government finally gave up that vaccine in 1970, and I gave up on the polio vaccine when Jonas Salk showed that the best way to catch polio in the United States was to be near a child who recently had taken the Sabin vaccine. But the tetanus vaccine exercised a hold on me for a much longer time.

As you point out, I gave up belief in this vaccine in stages. For a while, I still held onto the notion that farm families and people who work around stables should continue to take tetanus shots. But in spite of my early indoctrination with fear of "rusty nails," in recent years, I have developed a greater fear of the hypodermic needle. My reasons are:

1. Scientific evidence shows that too-frequent tetanus boosters actually may interfere with the immune reaction.

2. There has been a gradual retreat of even the most conservative authorities from giving tetanus boosters every one year to every two years to every five years to every 10 years (as now recommended by the American Academy of Pediatrics), and according to some, every 20 years. All these numbers are based on guesses rather than on hard scientific evidence.

3. There has been a growing recognition that no controlled scientific study (in which half the patients were given the vaccine and the other half were given injections of sterile water) has ever been carried out to prove the safety and effectiveness of the tetanus vaccine. Evidence for the vaccine comes from epidemiologic studies which are by nature controversial and which do not satisfy the criteria for scientific proof.

4. The tetanus vaccine over the decades has been progressively weakened in order to reduce the considerable reaction (fever and swelling) it used to cause. Accompanying this reduction in reactivity has been a concomitant reduction in antigenicity (the ability to confer protection).

5. Until the last few years, government statistics admitted that 40% of the child population of the US was not immunised. For all those decades, where were the tetanus cases from all those rusty nails?

6. There now exists a growing theoretical concern which links immunisations to the huge increase in recent decades of auto-immune diseases, eg rheumatoid arthritis, multiple sclerosis, lupus erythematosus, lymphoma, and leukaemia. In one case, Guillain-Barre paralysis from swine flu vaccine, the relationship turned out to be more than just theoretical.

Risks of tetanus vaccine

In preparing my courtroom testimony on behalf of a child who allegedly was brain-damaged as a result of the DPT vaccine, I reviewed the package insert for the Connaught Laboratories product which was administered to this child. The 1975 and 1977 package insert information which measured seven-and-a-half inches long, listed 3 scientific references in support of the indications, contra-indications, warnings, cautions, and adverse reactions to

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this vaccine. By 1978, the length of the insert had grown to 13.5 inches, and the number of scientific references had increased to 11. By 1980, the insert was 18 inches long, and the references numbered 14. Of those newly-added references, seven dealt specifically with reactions to the tetanus DPT portion of the toxoid vaccine.

An article in the Archives of Neurology (1972) described brachial plexus neuropathy (which can lead to paralysis of the arm) from tetanus toxoid. 4 patients who received only tetanus toxoid noticed the onset of limb weakness from six to 21 days after the inoculation. A 1966 article published in the JAMA reports the first case of "Perepheral Neuropathy following Tetanus Toxoid Administration." A 23-year-old white medical student received an injection of tetanus toxoid into the right upper arm after an abrasion of the right knee while playing tennis. Several hours later, he developed a wrist drop of his right hand. He later suffered from complete motor and sensory paralysis over the distribution of the right radial nerve (one of the major nerves innervating the arm and hand). One month later, no residual motor or sensory deficit could be found.

Reference is made to an article in the Journal of Neurology, 1977, entitled "Unusual Neurological Complication following Tetanus Toxoid Administration." The author reports a 36-year-old female who received tetanus toxoid in her left upper arm following a wound to her finger. Five days later, she noticed a weakness first of the right, and then of the left arm and later of both legs. She complained of dizziness, instability, lethargy, chest discomfort, difficulty in swallowing, and inarticulate speech. She staggered when she walked, and she could take only a few steps. Her EEG showed some abnormalities. After a month, she was discharged without neurological disturbance, but she continued to feel weak and anxious.

Examinations during the next 11 months showed continued emotional instability and paresthesias (numbness and tingling) in the extremities. The medical diagnosis was "a rapidly progressing neuropathy with involvement of cranial nerves, myelopathy, and encephalopathy."

The Journal of Allergy and Clinical Immunology, 1973, carried an article entitled "Hypersensitivity to Tetanus Toxoid," and in a volume entitled "Proceedings of the II International Conference on Tetanus" (1967), an article appeared entitled "Clinical Reactions to Tetanus Toxoid."

A 44-year-old article in the JAMA (1940) was entitled "Allergy Induced by Immunisation with Tetanus Toxoid." That same year, an article in the BMJ reported on "Anaphylaxis following Administration of Tetanus Toxoid." In 1969, a German medical journal reported a case of paralysis of the recurrent laryngeal nerve (nerve to voice box) after a booster injection of tetanus toxoid. The patient developed hoarseness and was unable to speak loudly, but the nerve paralysis subsided completely after approximately 2 months.

Should your doctor reassure you that tetanus vaccine is completely safe, or that "the benefits outweigh the risks," or that you should have the shot "just in case," why not share these citations with him?

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Tetanus - one naturopath's view

Extract from: Tetanus by Dr Alec Burton, ND, DO, DC. Republished in The Hygienist, BNHS, Autumn 1995.

It is popularly believed that tetanus is caused by a germ, clostridium tetani, which gains entry to the tissues through a wound. That is, tetanus results from an "infected" injury which may be of a minor nature. "Pathology" edited by Dr Anderson, 5th edition, 1966, states: "The site of local infection may be quite inconspicuous, and in an appreciable number of cases it cannot be demonstrated at all." How virulent is the germ? Just how does it damage the tissues and cause tetanus? The clostridium tetani is relatively innocuous but it elaborates a certain toxin, tetanospasmin, the effects of which are hard to determine. Drs. Cecil and Loeb, in their Textbook of Medicine, say "Tetanus toxin fails to produce any recognisable pathological lesions in the tissues it affects, nor do any specific changes occur at the site of infection by the clostridium tetani." But in "Pathology" a different view is expressed. "Tetanus is primarily a disease of nervous tissue, the result of injury by tetanus toxin."

The tetanus bacterium is ubiquitous. It is not here today gone tomorrow. It is found on the surface of the body, in the mouth, in the gastro-intestinal tract, in house dust and clothing. It occurs extensively in cultivated soils. In spite of the ubiquity of the so-called cause, the incidence of tetanus is significantly low.

"The disease proper is unquestionably caused by the tetanus toxin....." state Drs Cecil and Loeb, and then they proceed to tell us "....but the mechanisms whereby it is absorbed and produces its effects are still largely unknown." Yet we read a little later that "The mode of action of the tetanus toxin is entirely unknown." Is it "largely" or "entirely" unknown? Is it "questionably" or "unquestionably" caused by the tetanus toxin? How confused these authors are is clearly demonstrated by their self-contradictions and uncertainty. Such comments as "led to the theory," "it was assumed," "it was also assumed," "additional support for both points of view," and "convincingly shown the probable correctness of the first theory" all tend to confirm that they do

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not know the cause of tetanus.

The idea of a specific cause dies hard. It is so easy to believe that a germ or a virus has "invaded" the tissues and for this reason we are sick. It is plausible and at least saves us the trouble of thinking. Louis Pasteur was the architect of the "Germ Theory" but he soon realised that his theory raised more problems than it solved. When he announced, after his early enthusiasm had matured. "The soil is all" no one was interested in what he had to say, it was not commercially exploitable.

Let us carefully consider some of the facts reported in the medical literature in 1920, Sir Leonard Hill said in a report to the Medical Research Committee, "Tetanus and gas gangrene bacilli washed clean and injected are innocuous." In 'A System of Bacteriology' Vol III, page 307, Drs Bosanquet and Eyre say "The bacilli are in pure culture incapable of vegetating in viro," ie of multiplying in the body. Furthermore, in the Official History of the War, Pathology 1923, it is stated "Tetanus bacilli have been found in 20% of war wounds although no symptoms of tetanus were present, " and "in 50% of undoubted tetanus cases the bacilli have been undiscoverable." In the same volume also appears clostridium tetani has been "cultivated from the wound of a man showing no evidence of tetanus, 882 days after it had been inflicted," and "it has been realised during the war that the tetanus bacillus or its spores may be present in vast numbers of wounds without producing tetanus."

We may deduce from the above facts that we have, as the cause of tetanus, a bacterium which is (a) harmless in pure culture (b) incapable of multiplying in the body (c) absent in 50% of cases of undoubted tetanus (d) present in 20% of cases where no tetanus symptoms appeared and often remaining in the body for months or years without producing symptoms. This is certainly a peculiar cause.

It is thought that whilst the bacteria themselves are somewhat feeble, their spores may remain dormant in the tissues for lengthy periods. If this is so, what are the factors which enable the spores to develop into bacteria and elaborate their toxins? What causes them to become active? Why do they remain dormant for long periods? As yet the answers to these questions are not forthcoming. They could supply the answer to the cause of the disease, in fact, all disease, for these questions obviously concern the host rather than the bacteria, and it is to the host that we must look for causes. Here we will find the cause of tetanus, not in some microscopic piece of protoplasm which we endow with almost omnipotent properties. Bacterial diseases, so-called, have a biochemical basis. The tetanus bacteria may be a factor in tetanus. The toxin may be involved in some way but that these are fundamental causes is nonsense, otherwise the disease would be more common, in view of the fact that the bacteria is so frequently found on and in our bodies.

Tetanus is a rare disease considering the probable number of wounds which must be "infected" with the germ, yet it is sufficiently serious to necessitate the employment of preventative measures. Medically, it is claimed that an anti-toxin serum is successful in preventing tetanus and is helpful in treating the disease. Hygienists contravert this popular dogma that disease may be prevented or "cured" by the introduction of foreign organic substances into the body, and I shall attempt to show that the anti-toxin serum and toxoid employed to prevent and treat tetanus are of no value.

Horse serum (clear part of blood) is used against tetanus and has the reputation of producing "anaphylactic reactions," more commonly than the other sera. The "preventative" toxoid consists of cultured and killed "causal" germs. Do these "immunising" agents prevent the development of tetanus? Do they have any influence upon the disease once symptoms are evident? Is there any statistical evidence to show that the incidence of the disease is influenced by the employment of anti-toxin or toxoid?

The following is taken from the Medical Press, Nov 3, 1948. "The not infrequent failure of tetanus anti-toxin prophylactically is indicated by the fact that deaths from tetanus occur in 7% of civilian cases and 50% of military cases, in spite of its use." From the Medical History of the Second World War, Medicine and Pathology, we note, "It is disappointing to find that the case mortality is the same as in 1914-18. There is still no convincing evidence that anti-tetanic serum possesses curative value." Many more such statements from strictly "orthodox" sources could be quoted to consolidate our claim that the serum is incapable of affording any protection against tetanus. However, we must now turn to another important aspect concerning the employment of the serum.

Is there any danger associated with the injection of sera, and if there is, does any test exist which can show the probability of the development of "allergic reactions" in a particular patient. There can be serious effects following the introduction of tetanus anti-toxin into the body and there is no valid method of revealing the possibility of these side effects beforehand. Most textbooks on bacteriology point out the 'fallibility of the intradermal sensitivity test." The so-called allergic manifestations may appear immediately following the injection or they may be delayed for 1-14 days. Early "reactions" to toxoid include anaphylactic shock, unconsciousness and death. The later reactions may be chills, fever, urticaria, angioneurotic oedema, swollen lymph glands, pains in the muscles and joints. The anti-toxin may

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prove fatal but there is also another hazard associated with the dangerous yet dramatic practice of transfusing blood. Dr Meyer in his book "Side Effects of Drugs," has this to say: "Six cases of transfusion reactions occurred in 8 recipients with blood of O donors previously vaccinated with anti-toxins (diphtheria and tetanus anti-toxins)."

I think it is desirable and necessary to discuss briefly the problems of "hypersensitivity" which medical men are frequently mentioning. They refuse to blame the drugs, vaccine and sera for the "reactions" which follow their administration, but assert that the patient was "sensitive". All this means is that the drug was not to blame. The blame was the patient's. He or she was "sensitive". To a greater or lesser degree, we are all sensitive to poisons, that is, when poisons are taken into the body through any channel, an attempt is made to resist these poisons, to expel them or to neutralise them, to get rid of them, to destroy them. In the process of neutralising, expelling and resisting the poisons acute symptoms are the actions of the body, not the drug or serum, actions of the body defending itself against the poison.

Finally what is the real cause of tetanus? How may it be prevented, and how may a patient recover once tetanus has developed? The real cause of tetanus is not a germ, but dirt and filth. The bacteria are harmless when placed into a surgically clean wound. Tetanus develops when drainage of a wound is checked and dirt is retained in the tissues. The bacilli do not circulate in the blood. They remain at the point of entry and produce toxins. One of these poisons, tetanospasmin, is one of the most dangerous poisons known to man which occasions vigorous activity in the nervous tissues. The other toxin, tetano-lycin, occasions a breakdown of the blood cells. If good drainage is facilitated from the beginning, tetanus will not result from a wound. If tetanus has developed, an incision should be made to afford drainage, removing the foreign matter, and once the wound is drained and cleaned, the bacteria will not be able to elaborate the powerful toxins which are poison in the body. Once the poisoning ceases, the patient will start to recover. The ability to combat, destroy and eliminate the toxins will depend on the health and vigour of the patient. The patient suffering from tetanus should be put to bed, permitted to rest, kept warm and fasting should be immediately instituted. They should receive all the salubrious hygienic influences and the fasting should be continued until all symptoms have disappeared. Wounds should never be permitted to become pent-up. Drainage must be afforded, and if this is done, there is no danger. Drugs, anti-toxins, are a hazard to health. The sick cannot be poisoned into good health.

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Editor's note: We appreciate the kind consideration of The Informed Parent, Britain's leading vaccine risk awareness newsletter for permission to reprint the foregoing informative articles on tetanus and tetanus vaccine. www.informedparent.co.uk

Magnesium as first line therapy in the management of tetanus: a prospective study of 40 patients.

Anaesthesia 2002 Aug;57(8):778-817

Attygalle D, Rodrigo N.

A prospective observational study was conducted to examine the efficacy and safety of magnesium sulphate for control of spasms and autonomic dysfunction in 40 patients with tetanus. Magnesium was infused intravenously, aiming to control spasms despite suppression of patellar reflex or respiratory insufficiency. Spasms were controlled in 38 of the 40 patients within a serum Mg2+ range of 2-4 mmol.l-1 with only two patients needing additional neuromuscular blocking drugs. Seventeen of 24 patients (< 60 years) and six of 16 patients (>/= 60 years) did not require ventilatory support. Thirty-six patients were conscious and co-operative throughout their management. Sympathetic over-activity was controlled without supplementary sedation. Overall mortality was 12%; all five deaths were in patients >/= 60 years and no deaths were due to autonomic dysfunction. We recommend magnesium as possible first line therapy in the routine management of tetanus.

HUMAN CANCERS & CONTAMINATED POLIO VACCINES

Letter to demand a Congressional Investigation on the introduction of Simian Virus 40 (SV40), a cancer-causing monkey virus, into the American population from contaminated polio vaccines.

Dear Representative Burton,

I am writing this letter on June 7, 2003. Exactly seven years ago, on June 7, 1996, my son Alexander was born. He would die in my arms 30 months later in a little motel room in Houston, Texas as we, his parents, tried desperately to safe his life. This letter is written in commemoration of Alexander's short life and the injustice that befell him and the cause of the brain tumor (medulloblastoma) that killed him.

This letter is also the result of four long years of struggle by myself and my husband to find out why our beautiful healthy young son would be stricken by cancer. Now, our lawsuit against the manufacturer of the oral polio vaccine, American Home Products, (i.e. Lederle), has come to a close. As a result, much of the information that has been under a protective order for over three years has been entered into the public record through our legal documents filed with the Federal Court for the Central District of California in Los Angeles. What happened to Alexander is not an isolated event. We contend that his death was caused by a Public Health Disaster that has befallen others and will continue to kill children until it is addressed.

On August 12, 1999, we wrote you when you where Chairman of the Committee on House Government Reform in support of your investigations into pediatric vaccines - Vaccines; Finding the Balance Between Public Safety and Personal Choice. In this letter we described how various childhood vaccines contain known carcinogens and yet not a single vaccine is tested for carcinogenicity. While shampoos and cosmetics are tested to see if they cause cancer, incredibly, biological substances that are squirted or injected into healthy infants and children have never been tested.

On June 7, 2000, My husband and I also appeared before your Committee to discuss the FDA's control of effective non-toxic pediatric cancer therapies in Cancer Care for The New Millenium - Integrative Oncology. During our sworn testimony we described how Alexander suffered enormously and unnecessarily as a result of the administration of four toxic but ineffective chemotherapy drugs (vincristine, cytoxan, etoposide, and cisplatin - Protocol CCG 9921). We described how the FDA would not allow our son to have access to a non-toxic cancer therapy that offered him the best chance of saving his life. We presented photographs to your Committee that demonstrated how Alexander struggled to stay alive and then suffered a horrific death.

From your own considerable effort in investigating vaccine production, testing, and safety you know that childhood vaccines contain formaldehyde (i.e. formalin), mercury (i.e. thimerosal), aluminum, and other toxic substances. In addition, vaccines can also contain animal viruses - contaminants from the animal substrates upon which the vaccines are manufactured. One of these viruses, a monkey virus called Simian Virus 40 is carcinogenic and found its way into the oral polio vaccine (OPV) and the inactivated polio vaccine (IPV) in the late 1950's and early 1960's. Such an event was not surprising because monkey kidneys contain a multitude of simian viruses and the polio vaccine is grown on monkey kidney cells.

The oral polio vaccine is a "live" trivalent vaccine which means that it contains three strains of poliovirus - Types I, II, and III, and each strain is attenuated (i.e. weakened). Dr. Albert Sabin, who was responsible for the creation of the licensed OPV, had to passage his poliovirus strains through a myriad of animals and animal host cells in order to attain the right virulence-strong enough to illicit an immune response, but sufficiently attenuated so as to not cause polio in the recipient. For example, Type I has the following lineage:

In 1941, Drs. Francis and Mack isolated the Mahoney poliovirus "from the pooled feces of three healthy children in Cleveland." Dr. Salk then passed this strain through fourteen living monkeys and two cultures of monkey testicular cultures. In 1954, the strain (now called Monk14 T2) was given to Drs. Li and Schaeffer who subjected the virus to nine more passages through monkey testicular cultures. Next, the strain (now called Monk14 T11) underwent fifteen more passages in monkey testicular cultures, eighteen passages in monkey kidney cells, two passages through living rhesus monkeys skin, and additional passages through African Green monkey skin and monkey kidney cell cultures. This strain was now called MS10 T43 and LS-c. In 1956, Dr. Sabin took this virus and passaged it through seven cultures of African Green Monkey kidney cells. That same year, the pharmaceutical company, Merck, Sharp & Dohme, passed the strain (now called LS-c, 2ab/KP2) through a rhesus monkey kidney cell culture. The resulting material was called Sabin Original Merck (SOM) and was provided to Lederle in 1960 as the seed material to manufacture its polio vaccine.

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Types II and III were created in a similar fashion.

Once the strains were isolated, the pharmaceutical companies needed a method to propagate the viruses in order to produce the vast quantities of vaccine needed for nation-wide immunization campaigns. This required a substrate upon which the poliovirus could be efficiently grown and harvested. Kidney cells from rhesus monkeys were chosen because they were found to be an effective growth medium. A small quantity of poliovirus could be added to the minced kidneys removed from these monkeys and within a few days, large quantities of poliovirus could then be harvested from these same monkey cells.

Between 1959 and 1960, Bernice Eddy, Ph.D., of the National Institute of Health (NIH) examined minced rhesus monkey kidney cells under a microscope. These were the cells of the same species of monkeys used to create and produce the oral polio vaccine. Dr. Eddy discovered that the cells would die without any apparent cause. She then took suspensions of the cellular material from these kidney cell cultures and injected them into hamsters. Cancers grew in the hamsters. Within a few months, the virus responsible for creating these cancers would be isolated and identified by Dr. Eddy and other scientists. Because it was the 40th simian virus found it was named simian virus 40 (SV40).

According to the FDA:

The discovery in 1960 that a DNA tumor virus, designated simian virus 40 (SV40), was an inadvertent contaminant of rhesus monkey cells, and consequently the poliovirus and adenovirus vaccines that were made in these cells, was a watershed event in vaccine development."

By 1960, the Salk injectable polio vaccine (IPV) had been administered to about 98 million American children and adults, and Sabin's oral polio vaccine (OPV) had been administered to about 10,000 Americans and millions in the USSR where the clinical trials had been conducted. It was estimated that 10% to 30% of the vaccines contained live SV40. The federal agency in charge of vaccine licensing and safety at the time was the Division of Biologics Standards (DBS) of the National Institute of Health (NIH). Incredibly, this agency did not order a recall of any of the SV40-contaminated vaccines. The tainted vaccines continued to be administered until 1963 when they were all used and replaced by allegedly SV40-free vaccines as required by the new federal regulations promulgated in 1961.

In 1961, federal regulations were implemented to ensure that SV40 would no longer contaminate the polio vaccine. Despite these regulations, we contend that the OPV has been sporadically contaminated with SV40 for the last four decades. As a result, we allege that some of the children who have been administered the contaminated vaccines have been stricken with cancer and others are at risk. The main points are summarized below:

1) SV40 (Simian Virus Number 40) is a cancer causing monkey virus found in the kidney cells of Rhesus and African Green Monkeys. The kidney cells of these two species of monkeys comprise the substrate that has been used to create poliovirus strains and manufacture the oral polio vaccine for four decades.
2) SV40 is a human carcinogen for brain cancer and mesothelioma and it is a suspected carcinogen in osteosarcomas (bone cancers) and Non-Hodgkin's Lymphomas.
3) Alexander was administered the OPV in November 1997. He was diagnosed with a brain tumor in August 1998. Alexander died on January 31, 1999.
4) Four independent laboratories using DNA testing and laser micro-dissection found SV40 in Alexander's brain tumor.
5) SV40 has been found in the cancers of many other children. Pediatric brain tumors and other childhood cancers including osteosarcomas (bone cancer) and Non-Hodgkins Lymphomas have been found to contain SV40.
6) When Alexander was born on June 7th, 1996, I had his cord blood saved and stored by a private laboratory. The cord blood was the blood shared by Alexander and myself at the time of Alexander's birth. We had this blood tested for SV40. This marked the very first time the cord blood of a child with an SV40 positive brain tumor would be tested for SV40. To the astonishment of the scientists it was negative for SV40. This suggested that at the time Alexander was born he had not been exposed to SV40.
7) It is known that SV40 can be spread through contaminated blood so my husband and myself underwent a battery of tests from 2000 to 2001. Using a variety of sophisticated DNA tests to isolate the genetic fingerprint of the SV40 virus including Polymerase Chain Reaction (PCR), the scientists checked blood, urine and semen multiple times looking for any trace of SV40 (even antibodies). The scientists were once again surprised. Despite the repeated tests by leading SV40 laboratories both in the United States and Europe, we had absolutely no trace of SV40.
8) The scientists concluded that Alexander did not get SV40 from his parents, nor did he give SV40 to us.
9) The original oral polio vaccine (OPV) seed stocks created by Dr. Albert Sabin and used to make OPV since 1961 were known to be contaminated with SV40. In fact, SV40 was isolated from Sabin's OPV seeds - the original material used to make OPV for four decades.
10) Dr. Sabin had admitted that OPV

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seeds were contaminated with SV40 in a peer-reviewed scientific publication. Dr. Sabin wrote, "The three types of the large lots produced by Merck, Sharp and Dohme in rhesus monkey kidney cell cultures contained SV40."
11) Lederle, the sole American manufacturer of OPV for many years, received their OPV seeds from Merck, Sharp and Dohme. There is no evidence that Lederle ever tested their seeds for SV40 nor discarded their presumably contaminated seed stocks.
12) There are Lederle documents (not under a protective order) that demonstrate that their early OPV vaccines were contaminated with SV40.
13) Lederle did not use the SV40-neutralization procedures recommended by Dr. Sabin.
14) Monkeys used to produce OPV were not tested for SV40 by Lederle because of economic considerations.
15) After reviewing all of the Lederle records and the Lederle systems in place, our expert concluded that the contamination detected in the OPV material ultimately administered to Alexander was SV40.
16) The medical literature is unequivocal - the pediatric brain cancer rate in the U.S. has been climbing at a rate of approximately 3% for the last four decades.
17) A recent study has demonstrated that 11% of Americans are currently infected or have been infected with SV40.

SV40 is not only responsible for causing the cancer, but also for making these particular cancers incurable. Orthodox cancer therapies such as chemotherapy and radiation can not cure an SV40 positive cancer. Pediatric brain cancers and other solid cancers have been found to contain SV40. SV40 binds with the tumor suppressor genes p53 and RB and stops tumor cells from undergoing apoptosis (programmed cell death). Apoptosis is what radiation and chemo depend on to work in order to trigger the cancer cell to die. Exposing SV40 positive cancer cells to chemo and radiation does not kill the cells but simply creates more genetic mutations - making the cancer more aggressive. The bottom-line is that SV40 causes human cancer, stops orthodox cancer therapies (i.e. chemo and radiation) from providing any benefit, and can make the cancer even more aggressive.

Despite these facts, children diagnosed with cancer are not given a choice of whether they should undergo debilitating and toxic chemo and radiation. Alexander should have been tested for SV40 upon his diagnosis, not after he died. He should not have been administered ineffective and unnecessary chemotherapy which provided no benefit and only made him suffer. Children with SV40 positive cancers (or p53 mutations) should not be used as guinea pigs and profit centers for pediatric oncologists, hospitals, and pharmaceutical companies.

A Congressional Hearing should be immediately convened to examine how a federally policed vaccine program has introduced a deadly monkey virus into countless American men, women and children for the past 45 years and what the public health consequences have been of this tragedy.

This government investigation should demand to know:

-Why a vaccine manufacturer was allowed to use vaccine seed stocks for four decades that came from a source contaminated with SV40?

-Why did this manufacturer violate federal regulations and allowed contaminated vaccines to be released?

-Why weren't sophisticated tests to detect SV40 during OPV production and to eliminate the virus ever required by the federal government?

-Why aren't children with cancer tested for SV40 when they are diagnosed, not when they are dead, because an SV40 positive cancer means that chemo and radiation will be ineffective?

"... a federally policed vaccine program has introduced a deadly monkey virus into countless American men, women and children for the past 45 years..."

-Why is there a significant percentage of Americans (children and adults) walking around with evidence of having had an SV40 infection and what does that mean for their risk of cancer and chances for a successful treatment?

Like our son, many children are already dead, victims of this virus, and many adults will be stricken later. Time is of the essence, not for our beloved Alexander anymore, but for other children who are infected with this cancer causing virus.

Sincerely,

Raphaele Moreau-Horwin M.A., M.F.S.
Michael Horwin, M.A., J.D.

Editor's note: The Horwin's appeal letter was sent to U.S. Congressman Dan Burton who has convened numerous Congressional Hearings to investigate vaccine safety issues and the link between vaccines and the autism epidemic stalking children today. Please refer to http://www.ouralexander.org to read the tragic story of little Alexander Horwin.

LETTERS

April was National Autism Awareness Month. In a letter to the President of the Windsor Essex county Autism Society, Deana Poole wrote the following:

I had the good fortune to be at my daughters school while the President of the Windsor Essex County was there to collect funds raised by our daughters school (they raised $500.00!) A short video on Autism was presented to the student body & the parents present. It inspired me to write the following letter to her. I am recommending we all do this for Autism Awareness.

Hello Ms. Golocevac,

I was one of the parents sitting in the audience this morning at Anderdon P.S. Good presentation on the video about Autism. I was in tears watching it. It also made me laugh, remembering our trapeze in our basement, and our trampoline. I wish there had been such awareness amongst my son's peers when he attended Anderdon years ago. He's 20 now.

However, as a parent of a young man afflicted with Autism, I am troubled by what you speak of regarding fundraising - searching for a cure for Autism. How about prevention? I am one of those parents (there are a large & growing number of us) who watched it happen before my very eyes. My breastfed son, (I say breastfed, because he should have had immunity from my breast milk - not a toxic vaccine) nearly died during routine vaccinations. My medicine cupboard overflowed with various drugs to make him better. Antibiotics, antifungals, penicillin, cough syrup, ear drops etc... etc...

Here in Canada, there are regions that are already immunizing infants (needlessly) for a sexually transmitted illness - Hepatitis B. There is virtually no risk to newborns, and mothers can be screened to pre-determine if an infant will be at risk during birth. Unless,(forgive me for saying this) the child is going home with it's pimp, this is a careless & frivolous assault on a tiny infant's developing immunity. It is routinely done throughout the U.S & the results have been catastrophic. Infant mortality in hospitals there has risen, thanks to this vaccine. Something has to be done to stop it. Many vaccines that are administered today, are for illnesses that have been long eradicated, or unnecessary - for the convenience of the working parent, should the child become ill.

> *"... infants at risk of vaccine injury can be identified prior to vaccination..."*

What needs to be done for Autism Awareness, is for funds to be raised to make screening available so that infants at risk of vaccine injury can be identified prior to vaccination, including newborns vaccinated with hepatitis B before leaving the hospital, as well as babies started on the vaccine schedule at 2 months of age. My son reacted the very first time - at 2 months of age. It is known that a percentage of 2 month old infants also have hyper IgE. Had there been a test then to determine if an infant is at risk, would my son be in the same condition that he is today? I think not!

Voices of Safety International (VOSI) published the results of a recent 1623 sample study which showed that approximately 5% of newborns have hyper IgE. The conclusion of the V50.3A research report was that approximately 5% of newborns should not be vaccinated until their immune system meets the minimum IgE. The most recent standard, V50.3A, "Standard to Delay Vaccinating Newborns", is the first standard for screening the strength of a newborn's immune system (IgE) before giving the Hep B shot.

I am not just another parent looking to blame someone for my son's condition. It took me literally thousands of hours of research to be convinced that my pediatrician was wrong - it went against everything I had been taught. Today, I don't just "think" that vaccines injured my son - I know it.

I have two other children. My son had all of his shots right up to kindergarten entry, against my protests. My second child had 3 vaccines before I realized what was happening with my son, was beginning to repeat with my her. I stopped anymore vaccines. She has ADD, though only mildly. She struggles in school, but manages to get by. She has allergies to dairy, as does our son, which is common in Autistic children. Our third child is completely unvaccinated. We were at the school today to witness her, in grade 6, receive yet another honour role award. She has never missed getting honours yet, and is in a class for gifted children. She has robust good health, and very rarely even catches a cold. So I can very clearly see the contrast between all 3 of my children. I chalk it up to, vaccinated/unvaccinated, and I have lots of "what if's" & "if only's..."

I am in contact with many other mothers who can all say without a doubt, our children are vaccine injured. Some of the mom's on my list, have lost infants within hours of a vaccine...

I believe that Autism could be avoided in most instances. When the Foundation begins working towards prevention, rather than a "cure" I will be happy to send in my toonie for Toonie for Autism Day. I'll send in a hundred toonies!

Deana Poole

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Autism Resources:
Autism Canada Foundation: www.autismcanada.org
ATEDM – Montreal Autism Society: http://iquebec.ifrance.com/autismemtl/2002/program_en.html
Childscreen- Working to reduce childhood neurological problems by: Newborn screening to detect signs of immune, metabolic, and neurological vulnerability before vaccinating. Recommendations for improved birthing procedures and wellness practices for healthier children. http://www.childscreen.org/
Voices of Safety International (VOSI) http://www.voicesofsafety.com, the Public Health page contains Standards and Research Reports that define the major cause of the current autism epidemic.
Moms On A Mission:U.S. Autism Links: http://momsonamissionforautism.org/Links.shtml
Directory of autism societies by province: http://www.autismsocietycanada.ca/en/index.html

* *

Dear VRAN, (May, 2003)

My mother directed my attention to this month's issue of Alive magazine and I was very interested in Christel Taylor's letter regarding the hurdles faced by parents making the decision not to vaccinate their children. My son will be 4 months old on May 28th and we will not be vaccinating him.

I too have faced the 'speech' from the doctor, nurses, and even some teachers about how Thomas will not be able to attend school, how by NOT vaccinating children increases the risk of these illnesses coming back and even playing on my emotions by asking me how I would feel if Thomas became ill from not having the vaccine. If it wasn't for the fact that I had an excellent support system within my immediate family and that I did some research on the subject I would have easily caved under the pressure.

I strongly agree with Lana Belvis (VRAN member) when she says that "a support network must be established with other like-minded parents, a supportive doctor, as well as other health-care professionals who will stand with you in your decision." I have the book "How to Raise a Healthy Child in Spite of your Doctor" and in it Dr. Mendelsohn admits that there are some doctors that have not vaccinated their children because of the risks involved. When I discussed this subject with Thomas' doctor and informed him of my hesitation because of the risks of adverse reactions he informed me that in all his years of caring for children he had never seen an adverse reaction to a vaccination.

"... a support network must be established with other like-minded parents..."

My gut reaction to that response was "he is not telling me the truth". I also told him that IF we decided to vaccinate Thomas he would NOT be getting the shot late on a Friday afternoon before the weekend and I would have his home number, pager number and cell phone number. He looked at me like I was a mad-woman. The doctor did tell me that if our decision was not to vaccinate Thomas it would not compromise his care with the doctor. Thomas and I are also under the care of a wonderful doctor of Naturopathic Medicine here in Peterborough. I told the Paediatrician that I did not agree with the "well-baby" visits and if I was doing my job as a Mother properly that he should not be seeing much of Thomas at all! I would also like to find out exactly what is in the MMR vaccines.

My sister first turned me onto the VRAN site and it has been a wealth of information...thanks for all the hard work keeping us informed with what is going on.

Heather Zischler
Peterborough, ON

* *

Too Many Vaccines

I am a 35 year old woman, who recently learned that I was over vaccinated for both Measles and Rubella as a child. I received six vaccinations of Measles - some live/dead. As a child I was chronically ill - fevers, swollen glands, aching joints, learning problems. As a teenager I had arthritic symptoms, swollen joints and auto-immune problems. I was diagnosed with rheumatoid arthritis at 16, and then was told I could have Lupus. I also now have endometriosis, which could be related to Auto-Immune.

I am now CONVINCED that the negligence of government and health officials in the province I live in Canada, led to the error in giving me too much vaccination. They have sent me a letter indicating WHY I was given more than the routine recommended amount. The letter basically indicates that policies with vaccinations changed and every time the government changed vaccination policies/schedules, I just got a shot.

No one BOTHERED to look up my records, which in those days were non-computerized, to see what I had. Because the majority of shots were given by travelling nurses and in schools, my mother had no clue as to how much I was getting. She said that when a nurse showed up, she trusted that the nurse knew just how much I was getting. When vaccination day came around in the schools, my mom assumed someone would have records on what I had been given.

I was given my first Measles at six months and NOT at 12 months. Between 1968-1969 I was given 4 more shots, and then again given shots in 1974 and 1985. I am a health care professional and now have just received my first HepB shot - I feel as if I do not want to go in and have the second/booster series after reading others' stories. Can someone lead me in the right direction on information on adults who have received TOO much vaccination - it seems that having ONE dose causes all kinds of trouble in some cases, what happens when you have TOO MUCH???????

Note: *This letter was posted on a vaccine injury list and forwarded to us by Rita Hoffman*

* *

In response to the "Vaccine Lottery" in Ontario (see newsclips for details)

July 23, 2003

Please do not enter my son in your vaccine lottery. He has already experienced significant neurological and immunological damage from his DPT-P shot at five months of age and as a result has an uncontrolled seizure disorder. The thousands of seizures my son has experienced has now resulted in severe intellectual impairment as well.

I hope you are advising your lottery winners that no vaccine has successfully passed a double blind longitudinal study with a control group to prove that vaccines are safe and effective. Being vaccinated is truly a lottery and my son has already lost.

Sincerely,
Ted Kuntz

BOOK REVIEW

Vaccine Guide for Dogs & Cats: What Every Pet Lover Should Know by Catherine J.M. Diodati, MA, is a comprehensive vaccine resource that will enable concerned animal lovers to make an informed decision when considering pet vaccination. Once again Catherine Diodati has mobilized her impressive research skills to shed light on the growing body of evidence linking veterinary vaccines to debilitating and often fatal autoimmune and neurological disorders suffered by our beloved animal friends.

Says Veterinarian Dr. Richard Pitcairn PhD, Director of the Animal Natural Health Center (www.drpitcairn.htm) and long time practitioner of wholistic and homeopathic medicine, "Vaccines are more of a factor in the production of chronic disease in our animals than we have ever anticipated. Veterinarians and pet lovers alike have long needed the information that Catherine Diodati has gathered for us in this book. It is a real gift. Diodati provides us with a comprehensive picture of vaccines – their development and use – enabling us to think seriously about this practice. Before this book, we did not know the facts. Ms. Diodati has given us the tools we need to consider this issue intelligently."

We appreciate the kind permission of the author to reprint the following excerpt from the introduction to the ***Vaccine Guide for Dogs & Cats*** – pges. 24-26:

Vaccine Ingredients

Vaccines can be dangerous; it makes sense that the risks increase when an animal is over-vaccinated. All vaccines contain antigens (i.e., viruses, bacteria, or toxins secreted by bacteria), relevant to the disease they are meant to prevent. A parvovirus vaccine, for example, will contain parvovirus. Antigens are generally grown and propagated in a feasible culture media, such as bovine fetal serum or upon host tissues derived from certain animals. The antigen is either weakened or killed by the use of heat, serial passages through various cells, or by disinfectants. Vaccine antigens are not supposed to be able to cause disease, but as repeated experience has shown, they can remain virulent in the final preparation. They *are* capable of causing disease both in the vaccinee and in contacts.

One disinfectant that is commonly used to kill vaccine antigens is formaldehyde (formalin). The use of this extremely toxic and carcinogenic chemical has persisted despite many historical lessons demonstrating its inadequacy. Simply put, it does not always work. Instead of inactivating the antigens, the formaldehyde may instead harden the outer gelatinous debris of clumped proteins, leaving the antigens inside untouched. When this unnatural chemical amalgam enters the body, enzymes digest the hardened outer portion, freeing the fully virulent particles to enter cells, replicate and cause disease.

Dr. Harash Narang, a clinical virologist, noted another problem associated with formalin-use in vaccines. The "concentration [of formalin] used is so low [that it does] not kill all of the [pathogens, but]...heating the same vaccine preparation would make it completely safe [and]...it would only take minutes." Formalin-inactivated vaccines have caused numerous outbreaks of various diseases. In fact, improperly inactivated vaccines have been at the root of a number of the foot-and-mouth disease epidemics in Europe over the past two decades and of the 1969-1972 Venezuelan equine encephalitis pandemic.

Vaccines also contain a variety of chemicals intended to prevent contamination by extraneous microorganisms. They may include antibiotics and other additives such as mercury or phenol. Adjuvants such as aluminum salts or gel may be used to prolong the

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immune response. Although these substances may appear in vaccines in small quantities, their consequences can be great. They can have significant detrimental effects on immune cells, on the brain and central nervous system, and on organs. For example, one distraught family noted that Kelly, their German shepherd, began experiencing seizures, and Tom, their cat, developed leukemia and died, within four weeks of vaccination. The vaccine antigens and chemicals clearly had adverse effects on these previously healthy animals.

Despite the use of preservatives, vaccines can become contaminated with undetected extraneous microorganisms. In 1994, for example, a combination canine vaccine was contaminated with a bluetongue virus which caused abortion in, and subsequently killed, a number of pregnant bitches. Although not scientifically confirmed, this vaccine was also believed to have caused decreased reproduction in some vaccinates and diminished endurance in Alaskan sled dogs. Bluetongue is typically a disease found in sheep and occasionally in cattle. It logically had been assumed that the bovine fetal serum used during production was at fault but a variety of tests performed on the serum were negative for the virus. The definitive source of the contamination was never discovered.

Another concern has recently arisen over the use of bovine fetal serum in vaccine production: the transmission of Bovine Spongiform Encephalopathy (BSE, also known as Mad Cow Disease). BSE causes vacuoles (small spaces) in the brain which gives the appearance of sponginess. Those affected will exhibit trembling and ataxia (physical incoordination). It was believed that BSE was transmitted primarily through the ingestion of infected meat and bone meal, which were frequently fed to cattle and other animals before bans were imposed on the practice. It was asserted, without proper investigation, that calves less than 30 months were safe because signs of the disease were not apparent before that time, so it was also assumed that fetal calf serum was safe. However, recent studies have demonstrated that the disease can be transmitted even if there are no signs, and it can be transmitted in utero. BSE is heat resistant, with boiling having no apparent effect. When the causative agent is heated at 250" Farenheit (121" Celsius) for 15 hours, it still remains at least partially infective. Thus, the use of bovine fetal serum in vaccines provides a potentially significant means of transmission both to animals and humans.

BSE may have emerged in cattle due to a laboratory accident or from a vaccine. Sheep spleens, brains and spinal cords were used to prepare a vaccine against Louping-ill virus in Britain during the 1930s. Sheep vaccinated with this vaccine developed scrapie. BSE appears to have originated from Type II scrapie. Vaccines always carry a risk of contamination from a variety of pathogens that may lurk in the host tissues, media culture, or may be present in the manufacturing laboratory.

Veterinary vaccines, like their human counterparts, require careful consideration. Even if a vaccine is relatively free of extraneous microorganisms, it still contains its own pathogens, plus toxic and carcinogenic chemicals, which can cause devastating and irreversible effects. In many cases, the risks associated with vaccines are simply not warranted because the disease in question may be mild or virtually absent. In other cases, the risk is not warranted because the vaccine is not effective. Each animal should be assessed individually based upon health status, family medical history, environment, stress, and whether the disease in question will pose an actual risk to your pet.

Vaccine Guide for Dogs & Cats is published by New Atlantean Press http:..www.thinktwice.com/ani.htm

NEWS CLIPS

Antibiotics & Asthma Is There A Link?

From April 30/2003 Armand Rossie newsletter

Antibiotics given to a child during their first year of life is linked to a 400% greater risk of developing asthma. Children suffering from asthma is at epidemic proportions. Research indicates that in the U.S. over 3 million children suffer an asthma attack each year.

Results of a study published in the Journal of Clinical and Experimental Allergy (1999: Vol. 29, pp766-71) showed that children given antibiotics in their first year of life were over four times more likely to develop asthma symptoms than children who had never taken antibiotics. This increased risk was evident even after the researchers accounted for potential variables such as gender, ethnicity, family size, family history of asthma and parents' smoking habits. If asthma is linked to antibiotics, then it's just another of many risk factors associated with antibiotic use. As a parent, you may want to think twice before giving antibiotics to your children, especially if they're not specifically required. Always find out why your doctor is prescribing a particular medication, and ask if there are acceptable non-pharmacological alternatives available.

Editor's note: *Multiple vaccinations starting at birth and early infancy deplete children's immune systems and pave the way for ear infections, respiratory illnesses and repeated courses of antibiotics.*

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Simian virus 40 in human cancers

The American Journal of Medicine Volume 114, Issue 8 , 1 June 2003, Pages 675-684 published a report which analyzed studies reporting the

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presence of simian virus 40 (SV40) deoxyribonucleic acid (DNA) or protein in human brain tumors and bone cancers, malignant mesothelioma, and non-Hodgkin's lymphoma from 1975-2002.

Thirteen studies fulfilled the criteria for the investigation of primary brain cancers (661 tumors and 482 control samples). Specimens from patients with brain tumors were almost four times more likely to have evidence of SV40 infection than were those from controls. The conclusion reached is that "These results establish that SV40 is associated significantly with brain tumors, bone cancers, malignant mesothelioma, and non-Hodgkin's lymphoma. Studies are needed to assess current prevalence of SV40 infections.

For history of SV40 contaminating polio vaccine - see Sheri Nakken's website: http://www.nccn.net/~wwithin/polio.htm and http://www.whale.to/v/sv40.htm

* *

SARS forced suspension of food safety and immunization programs

Canadian Press - Jun. 12, 2003

TORONTO (CP) - The SARS outbreak forced public health units to scrap compulsory programs like food safety and immunization tracking, says a document presented to the cabinet of Ontario's Conservative government earlier this year.

"Public health programs across the province do not have staff in place to provide programs mandatory under the Health Promotion and Protection Act," reads the document, a "plan of action" for SARS and infectious disease control.

"All food safety, immunization tracking and health (sic) babies programs have been suspended."

Even prior to the SARS outbreak, public health units have complained that provincial downloading has left them **badly underfunded.**

A Health Ministry spokesman was not immediately available to comment on whether the programs are back on track.

http://www.vaccinationnews.com/DailyNews/2003/May/15/default.htm

* *

WHO backs death in the virtual hospital

20th May by Jon Rappoport

Yesterday, WHO held its annual general assembly in Geneva. 192 nations were represented. So this was no small conference. The major announcement? "There will be more outbreaks like SARS," said David Heymann, point man for the WHO communicable diseases unit.. You have to realize that despite appearances, this was a statement of intention, not a prediction about natural events. Heymann himself does not know this. He is just a front man. But behind him are men who understand the game.

THE INVENTION OF DISEASE

http://www.sarstravel.com/

* *

Child develops Rett syndrome after pertussis vaccine reaction

Journal of Child Neurology- 2002 Sep;17(9):700-2

Department of Pediatrics, University of Catania, Italy.

Rett syndrome is a progressive neurodevelopmental disorder with a well-defined clinical spectrum and course. We report on a girl who, at age 2 months, developed an acute encephalopathy with destructive brain damage 12 hours after acellular pertussis vaccination. Peripheral lymphocyte subset analysis revealed the existence of T lymphocytes double positive for CD4 and CD8 markers. This pattern normalized over the following 3 months. Months later, the girl manifested a Rett syndrome phenotype. DNA screening of the MECP2 gene was unrevealing in the child and her parents. This previously unreported association emphasizes the notion that Rett syndrome phenotypes can result from different (either genetic or environmental) causes.

http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=12503649&dopt=Abstract

* *

More vaccines creeping into the schedule – our health care dollars at work!

The Ontario Government is spending $5.6 million on two new vaccines designated for 100,000 children and teenagers to combat so called "re-emerging diseases". Adacel is a new tetanus, diphtheria & acellular pertussis vaccine booster for youth between the ages of 14 and 16 years. This new 3 in 1 vaccine will replace the current teenage booster shot of diphtheria and tetanus.

Whooping cough is re-emerging around the world even in highly vaccinated populations, with the most rapid increase in teens. "Protection" from vaccines injected in infancy and early childhood wanes over the years, and mutant strains of the organism are reported to be appearing. Rationale for vaccinating teens and adults with pertussis vaccine is to prevent transmission of the bacteria to infants.

And Prevnar, the new controversial pneumococcal vaccine will be available for children under 2 years who are considered at "high risk" due to underlying medical conditions. The Haliburton & Kawartha health districts in Ontario have dreamed up a novel vaccine promotion and are currently running a "vaccine lottery" at a cost of $50,000. The winners, 400 lucky children will be injected with Prevnar and Menigococcal C conjugate vaccines. Unbelievable the deviousness with which they are trying to create a demand for these two expensive vaccines! Read the press release at:

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http://www.hkpr.on.ca/news.asp?id=616

Meanwhile, British Columbia, following Alberta's lead where these vaccines were added to the childhood vaccine schedule in the fall of 2002, has committed $15 million in 2003/04 and $18.3 million the following year to initiate a complex schedule of the new Meninogococcal conjugate C vaccine and Prevnar to "high risk infants and children" ages 2 – 59 months, to **all Aboriginal infants** and to "high risk individuals" of all ages. The plan is to phase both Prevnar and the Meningogoccal conjugate C vaccines into the regular infant and young child vaccine schedule by July 1, 2003. Meningococcal C vaccine will also be provided to all grade 6 students. **Expect provincial governments across Canada to commit to these additional vaccines.**

For detailed critiques of Prevnar go to: http://64.41.99.118/vran/vaccines/pneumococcal/vaccine_pne.htm
Read up on these vaccines at our new website at: www.vran.org or www.vaccinerisk.org

* *

FDA approves sale of nasal mist flu vaccine

Dow Jones Newswires – June 17, 2003 – excerpt from AP Washington

FluMist, a nasal spray flu vaccine manufactured by MedImmune Vaccines Inc. of Gaithersburg, Md., is the first to be delivered by a squirt up the nose instead of a needle in the arm has been approved by the Food and Drug Administration for healthy people from five to 49. At about $46 a dose, it is twice the typical cost of injected flu vaccine. An advisory panel said the drug would not be appropriate for toddlers, the elderly and people with other chronic disease. Safety and effectiveness has not been proven for people over 50.

FluMist was not approved for children under five, because in clinical trials researchers found that **young children treated with the nasal mist vaccine had a higher rate of asthma attacks and wheezing within 42 days of the vaccination, compared to children who received a placebo.**

An FDA statement said FluMist should not be given to persons with compromised immune systems, such as patients with AIDS, cancer or organ transplants. The agency also said that the safety of the nasal vaccine has not been demonstrated for patients with asthma or some other reactive breathing diseases.

* *

Bell palsy following intranasal vaccination
GACVS - Global Advisory Committee on Vaccine Safety, 20-21 June 2002
http://www.sabin.org/news_nov22_02.htm

Results from a case-control study and a case-series analysis indicate a **significantly increased risk** of Bell palsy developing following intranasal immunization with a new vaccine. This inactivated influenza vaccine, composed of influenza antigens in a virosomal formulation with E. coli derived LT adjuvant, was licensed in Switzerland in October 2000.

Following spontaneous reports of Bell palsy, the company decided not to market the vaccine during the following season. In general, the etiology and pathogenesis of Bell palsy remain inadequately understood. The greater risk of Bell palsy following immunization with this vaccine may be due to specific vaccine components such as LT toxin, influenza antigens or virosomes, or simply to use of the intranasal administration route. It is possible that such complications of vaccine administration may also apply to other nasal vaccines.

The average time to onset of Bell palsy following intranasal immunization with this new vaccine was as much as 60-90 days.

Note: *Bell Palsy is a facial paresis involving the facial nerve attributed to an inflammatory reaction involving pain around the ear, restriction of eye closure and difficulty with eating and facial movements.*

* *

Aids vaccine worse than useless?

Alliance For Human Research Protection (AHRP) June 25, 2003
http://www.ahrp.org/infomail/0603/25.html

An article published by the Institute of Science and Society (ISS located in the UK) cautions that experience thus far with 51 NIH-sponsored AIDS vaccine trials (Phase I and II) belie the claimed positive findings made in an article in the current issue of Vaccine, which concluded that there were no adverse effects in 3189 HIV uninfected, healthy volunteers who were enrolled.

"The only AIDS vaccine to have progressed past phase 3 trial, made by VaxGen, took 5 years and involved 5108 gay men and 309 women. Unfortunately, it proved ineffective, and may even be harmful" noted Dr. Mae-Wan Ho.

"In the 3003 white and Hispanic volunteers who received VaxGen's vaccine, a higher proportion suffered breakthrough infections than in the 1508 controls: 6% vs 5%. Although the difference is not significant, it could indicate a dangerous trend. But the company is not releasing further details on the trial results."

"Unfortunately, the key information - comparison of the health status between breakthrough infected vaccinated volunteers and control subjects who participated in these trials - was not reported, just as it was not reported by VaxGen in the results of their Phase III clinical trial" said AIDS scientist, Dr. Veljko Veljkovic.

"Unless this information is reported, says Veljkovic, the companies and institutions that organized these clini-

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cal trials are in danger of committing a scientific and ethical misconduct."

Dr. Veljkovic and colleagues have repeated their call for an immediate moratorium on the current clinical trials of HIV-1 gp120/160 vaccines. For full article by Dr. Mae-Wan Ho and indepth commentary by Dr. Veljkovic go to the **Institute of Science in Society** website: http://www.i-sis.org.uk/AVWTU.php

* *

Does West Nile imperil your children? Maybe not

Excerpted from The Globe & Mail, May 12, 2003

By Stephen Straus & Gloria Galloway

Health professionals in Ontario have been debating a deeply subversive proposition as to how to deal with children and their risks from mosquito-borne West Nile virus. "It has been suggested at a couple of meetings that I was at: 'Forget the kids. If they get infected earlier, if they get sick, they are not likely to have serious consequences, and they are protected for the rest of their life.' This has been the experiences of the endemic countries," said Colin D'Cunha, Ontario's chief medical officer of health.

It is not as if children never come down with West Nile disease, but rather that they hardly ever do. In November, 2002, the Centers for Disease Control and Prevention (USA) reported that children under 9 made up only about 1 per cent of the 2,354 cases in which there was any kind of serious infection.

Last year, of the 400 people in Ontario who came down with a serious form of West Nile disease, only six were younger than 20. All of which leads to the argument that it could be better to be infected early with a mild case of the illness -- especially if that protection will last you for life. It is a way of thinking, point out experts, that often prevailed before vaccines were available. At measles or mumps "parties," parents tried to expose their children to these illnesses.

Rita Shahin, an associate medical officer of health in Toronto, said she agrees that a West Nile infection is not as serious in children as it is in adults. "The younger you are, the milder the illness," she said yesterday. But Dr. Shahin's department is still warning parents to take precautions such as reducing standing water on their property "so that the whole family doesn't get exposed."

No one, in fact, is quite willing at present to tell people to let the mosquitoes do their damnedest to their kids. Part of this has to do with the still unknown nature of the illness.

In the Middle East, where it is endemic, the effects are quite mild. In North America, the effects are more dire. Maybe a natural immunity has developed in the Middle East, or maybe the virus has mutated and become more virulent here, says Dr. Brown, professor of virology at the University of Ottawa.

When asked about the wisdom of letting nature take its biting course, Andrew Simor, head of microbiology at Sunnybrook and Women's College Health Sciences Centre in Toronto, first answered: "Good question. I don't have an answer to that one." Then he backed up a bit. "I don't think parents should deliberately go out and infect their children -- that would be rash -- but I don't think that parents should be overconcerned because the risk is so small for children developing serious forms of the disease."

"If only two nine-year-olds in the entire province become ill, their parents would say, 'You said it was 100 per cent safe and it wasn't.' You understand my challenge. What I am supposed to say to them?" Dr. D'Cunha said.

http://www.globeandmail.com/servlet/ArticleNews/TPStory/LAC/20030512/UNILEN/TPHealth

MOSQUITO REPELLANTS

By Susan Fletcher

Health authorities recommend using repellants containing the chemical DEET, although **Health Canada has recently banned products with more than 30% DEET**. After numerous studies of the effects of this chemical on rats, Duke University pharmacologist, Mohamed Abou-Donia Ph.D, says **"frequent and heavy use of DEET, especially in combination with other chemicals or medications, could cause brain deficits in vulnerable populations."** He warns that **children's skin absorbs such chemicals more readily than adult's and they may affect their developing nervous systems to the extent that muscle weakness, fatigue or memory lapses occur.**

Abou-Donia has called for further testing of short-term and occasional use of DEET. He says " The take-home message is to be safe and cautious when using insecticides. Never use insect repellants on infants, and be wary of using them on children in general. Never combine insecticides with each other or use them with other medications. Even so simple a drug as an antihistamine could interact with DEET to cause toxic side effects….Until we have more data on potential interactions in humans, safe is better than sorry." (see http://www.dukenews.edu/med/deet.htm)

Considering the above and that DEET has been known to dissolve plastic, it might be wise to consider an alternate repellant. **There are numerous non-toxic products on the market that contain insect repelling ingredients.** One example is 'Buzz Away' which contains essential oils of citronella, cedarwood, eucalyptus, lemongrass, and peppermint and contains no petrochemicals or preservatives. Several tests have shown it to be equally effective to DEET and it been awarded the National Parenting Association Seal of Approval.

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IMMUNIZATION INFORMATION ON THE INTERNET

Compiled by: VRAN (web site hosted by Freedom of Choice in Health Care: <http://www.freedomofchoice.org>)

Eagle Foundation
http://www.eaglefoundation.org
Canadian organization in support of vaccine injured families.

WHALE Vaccination Resource
http://www.whaleto.freeserve.co.uk/vaccines.html
Excellent site.

New Atlantean Immunisation Resources
http://www.new-atlantean.com/global/vaccine.html
A good list of resources; global pro-choice vaccine groups books, tapes and videos.

Vaccination Information Paradigm
http://www.cco.net/~trufax/vaccine/vacindex.html
Very good information, updated regularly.

Sebastiana's Medical Journal listings of vaccine risks
http://www.omen.net.au/~pienaar/index.html

National Vaccine Information Center
http://www.909shot.com
Excellent site run by the largest N.A. group.

Attachment Parenting & Natural Nurturing & Vaccine Links
www.geocities.com/Heartland/Fields/2460
Excellent site offering concepts that create health in the family and access to Vaccination OneList network.

Natural Immunity Network
http://www.i-wayco.com/niin/index.html

Concerned Parents for Vaccine Safety
http://home.sprynet.com/sprynet/Gyrene/Home.htm
Excellent site—links to many others.

Informed Parents Home Page
http://www.unc.edu/~aphillip/www/vaccine/informed.htm
Excellent site—well researched.

Immunisation Awareness Society
http://www.ias.org.nz
Excellent site—offers international research.

FEAT (Families for Early Autism Treatment)
http://www.feat.org

Dr. Harris Coulter's Website
http://home.earthlink.net/~emptherapies/

Leading edge Research Group: The Biological Manipulation of Human Populations
http://www.trufax.org/menu/bio.html

Center For Complex Infectious Diseases— info re. stealth viruses & Dr. John Martin's research
http://www.ccid.org

Tetrahedron — AIDS, Ebola, vaccines, Gulf War Syndrome
http://tetrahedron.org/

International Advocates for Health Freedom — John Hammell
http://www.iahf.com/index1.html
Networking between health freedom activists

Health World Online- Discussion Forums on Vaccines
http://www.healthy.net/

Vaccination Information & Awareness— Links to many sites
http://www.access1.net/via

Vaccine Safety Website—Dr. B. Classen
http://vaccines.net/risks.htm

Australian Vaccination Network
http://www.avn.org.au/
This group is forging ahead with legal actions challenging government violation of informed consent laws.

MEDICAL INFORMATION & PRO-VACCINE LINKS:

WHO & Communicable Diseases Surveillance
http://www.who.int/emc/

Vaccine News Updates— Immunization Briefs
www.infoinc.com/imnews2

Vaccine Weekly Magazine—For the medical world
http://www.holonet.net/homepage/1v.htm
Covers new vaccines.

Infectious Diseases in Children
http://www.slackinc.com/child/idc/199805/vaccine.htm#speclink

Immunization Action Coalition— Pro-Vaccine site
http://www.immunize.org/

Achoo & MD
http://www.achoo.com
Consultation source for travel vaccines

Medscape—Online medical info
http://www.medscape.com √

DID YOU KNOW ?

There is no law that can force you to vaccinate your children. The only laws relating to vaccination govern school pupils, not infants, and these can be waived through available exemptions. If your child has exhibited any of the following adverse reactions or conditions, you may wish to defer from continuing the course of vaccinations.

- If your child is ill or running a fever.
- If the child collapses or goes into a shock-like state following a vaccine.
- If the child has high pitched screaming for several hours; and cannot be comforted
- If the child has a temperature of 38° C or higher after vaccination.
- If the child develops pain, redness, swelling, lump at the needle site
- If the child develops severe diarrhea and/or vomiting
- If the child has one or more convulsions or has a family history of convulsive disorders (eg. epilepsy); if the child has an evolving neurological condition.
- If there is a family history of severe allergies and/or history of vaccine reactions.
- If the child has signs of brain injury such as a bulge in the soft spots of the head or a severe change of consciousness.
- If the child is receiving treatments that suppress the immune system
- If the child has a widespread allergic reaction, rashes, hives, wheezing, trouble breathing.
- If the child develops swollen joints/arthritis like symptoms
- If the child has an irregular heartbeat within several hours after vaccination.
- If the child is excessively sleepy following vaccination.
- If the child has an episode of sleep apnoea (stops breathing during sleep)

SIX REASONS TO QUESTION VACCINATION

By Walene James

1. Vaccinations are forced. For example, there are compulsory vaccination laws in every state. If something is good it doesn't have to be forced*.
2. Vaccinations are toxins by definition.
3. Vaccinations are indigenous to only one model of healthcare—the allopathic medical model—and its practitioner's particular understanding of disease phenomena.
4. Vaccinations are promoted by fear, guilt, and 'creative' statistics.
5. Vaccinations are represented as safe and effective when evidence suggests they are neither.
6. Vaccinations are aggressively pushed by public health departments and other government agencies as though they were a public health issue when they are not. This is done to insure a high rate of compliance.

*Vaccination is not mandatory anywhere in Canada.

TEN REASONS TO JUST SAY 'NO' TO VACCINATIONS

By Walene James

1. Vaccinations are toxins by definition.
2. Vaccinations are aggressively promoted by those who have a financial stake in their consumption.
3. Vaccinations are promoted using fear, intimidation, and coercion.
4. Vaccinations are big business.
5. Vaccine manufacturers are nearly liability proof for their products.
6. Vaccinations are not only forced upon us, but those who deny us the exercise of our free will refuse to take responsibility for the consequences of their actions.
7. Evidence suggests that vaccinations damage the immune system, the nervous system and the spirit-mind-body connection.
8. Compulsory vaccinations ignore biochemical and psychospiritual individuality.
9. Vaccinations are misrepresented by government agencies as a public health issue which they are not.
10. Vaccinations are heavily subsidized, heavily propagandized and can be seen as a wake-up call for us to see how we allow ourselves to be programmed by huge vested interests.

Philosophical questions:

"Perhaps more important than anything else is for our group to consider the larger picture: What lessons do we need to learn trying to stem the tide of coercion from an out-of-control medical-pharmaceutical industry and the Mass Mind that allows this? How does understanding and working with the vaccination issue contribute to our maturation as spiritually aware and fully alive human beings?"

~Walene James

Walene James has authored an exceptional book that is a must read for everyone involved in educating themselves, their families and communities about vaccine risks and health creating alternatives to vaccination. She helps us take a quatum leap out of the fear-based vaccine paradigm. Walene's insightful analysis of the history of vaccines and infectious disease is complemented by a thorough investigation of the factors that create health in human populations, and what we all need to do to create health in our families. For more information, contact Ingri Cassel at Vaccination Liberation in Idaho: 208-267-8037

RESOURCE & INFORMATION LIST

Immunization: History, Ethics, Law & Health
by Catherine Diodati. Best new book about vaccines. Please order from VRAN
Cost: $35 + $5 postage

Immunization—The Reality Behind The Myth
by Walene James.

What Every Parent Should Know About Childhood Immunization
by Jamie Murphy

Vaccinations: Are They Really Safe and Effective?
by Neil Z. Miller

How To Raise a Healthy Child In Spite of Your Doctor
by Robert Mendelsohn, M.D.

Universal Immunization — Medical Miracle or Masterful Mirage?
by Dr. Raymond Obomsawin available from Health Action Network - (604) 435-0512

A Shot in The Dark
by Dr. Harris L. Coulter & Barbara Loe Fisher

Vaccination, Social Violence, Criminality: The Medical Assault on The American Brain
by Dr. Harris L. Coulter

Vaccination—Medical Assault on the Immune System
by Viera Scheibner Ph.D.
to order: (204) 895-9192

The Immune Trio
by Dr. Harold Buttram
To order call 215-536-5168

Every Second Child
by Dr. Archie Kalokerinos (204) 895-9192

Vaccinations and Immunization: Dangers, Delusions and Alternatives
by Dr. Leon Chaitow.

What About Immunizations? Exposing the Vaccine Philosophy
by Cynthia Cournoyer Nelson's Books, Box 2302 Santa Cruz, CA, 95063

Vaccinations—The Rest of the Story
published by Mothering Magazine. P.O. Box 1690-Santa Fe, N.M. 87504.

The Immunization Decision—A Guide for Parents
by Dr. Randal Neustaedter.

The **Case Against Immunizations**
by Richard Moscovitch M.D.
available from American Institute of Homeopathy, 1500 Massachusetts Ave. N.W. Washington, D.C. 20005.

The Immunization Resource Guide
by Dr. Zoltan Rona, M.D.
to order call:
1-877-920-8887

Natural Alternatives to Vaccination
by Diane Rozario
available from Vaccine Policy Institute
(937) 435-4750

Vaccination—The Hidden Truth
New Video. Five medical doctors speak out about vaccine risks.
Order from VRAN
Cost—$40 + $5 postage

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