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Wednesday, 12 July 2006
Rev. Sunday, 30 July 2006

To Whom It May Concern:

The review that follows this introductory letter is a critical assessment of the article, "**Arsenel of immunizations With resurgent diseases, doctors urge parents to have children inoculated**," written by Meg H. Partington, published on-line by the Herald-Mail at:

http://www.herald-mail.com/?module=displaystory&story_id=141599&edition_id=0&format=html

on 3 July 2006, which I visited as a part of my research in this area on 4 July 2006.

In general, to clearly differentiate between my assessment comments and those of the article, the article's printed statements are quoted in a "Times New Roman" font followed by this reviewer's remarks in indented text written in a "News Gothic MT" font, the font used in this cover letter.

Quotes from general reference articles and documents will be presented in an "Arial" font; and federal laws and statutes will be quoted in a "Lydian" font.

For those who have access to a color printer, this reviewer's comments are made in a blue color with existing text corrections in **red**.

Should anyone find any factual misrepresentations in this reviewer's remarks, then this reviewer requests that you submit the factual error(s) found along with the scientifically sound and appropriate documents that prove your point to this reviewer so that this reviewer can learn from you, incorporate that new knowledge into his understanding, and, where indicated, appropriately correct this document.

Respectfully,

Paul G. King, PhD, MS, BA
Founder, **F.A.M.E. Systems**

In-depth Assessment Of: "Arsenal of immunizations With resurgent diseases, doctors urge parents to have children inoculated by MEG H. PARTINGTON megp@herald-mail.com"

[**Note:** This reviewer noted and corrected two obvious typographical errors, "**Arsenel**" (sic; Arsenal) and "**childre**" (sic; children), in the title lines that were somehow missed when the article was posted.]

"While health officials worldwide strategize ways to prevent a bird-flu pandemic, the average person might not worry about the threat that childhood diseases pose to their families and society as a whole.

Immunizations have eliminated diseases such as polio from the U.S. and made others that once commonly killed children rare. But there is no room for complacency in public health, says Dr. Greg Lyon-Loftus with Mont Alto (Pa.) Family Practice."

Factually,

- Better hygiene,
- Clean water,
- Improved environmental conditions and housing, and
- Starvation reduction (improved access to basic foodstuffs)

have done more to reduce the rates of most all diseases than vaccines have done.

Moreover, *contrary to the writer's apparently myopic views*, "polio" (as that disease was defined in the early 1950s) has *not* been "eliminated."

At best, vaccination for childhood diseases:

- Has only "temporarily" reduced the incidence rates, and
- *Compared to the immunity provided by having these childhood diseases and developing "natural" immunity*, only provides:
  - shorter-term and,
  - less-complete immunity (*because of the mode of administration and/or the immunity-inducing components used)*,

  than contracting these diseases in childhood (where, *historically*, complete "lifetime" (greater than 60-year) immunity is acquired and, *during nursing*, the mothers' antibodies to these diseases are initially passed on in the colostrum and milk consumed by the nursing neonates and, *for the period while the babies are nursing*, generally protect babies from contracting these diseases).

  [**Note:** The recent measles and mumps outbreaks in those who were fully vaccinated as young children but are now contracting these diseases in their teens, twenties and thirties seem to have again shown the difference in the degree and/or duration of immunity provided by vaccination vis-à-vis the "natural" immunity acquired by having these childhood diseases.]

In addition, vaccines can have other deleterious side effects (besides, *for live-virus vaccines*, giving those vaccinated a case of the viral disease or diseases contained in the vaccine dose, *including, in some cases, adventitious foreign viruses introduced when the vaccine viruses are grown in biological cell-culture systems (using, for example, eggs [influenza], mouse brains [Japanese encephalitis], and primate kidneys [polio])*.

This is the case because today's vaccines contain formulation additives (like, aluminum salts used as immune-system "stimulants" [adjuvants]) that:

a. are *not* normally self-injected by humans, **and**

b. are highly toxic (*e.g.*, Thimerosal) **or**

c. *in some cases*, are known to be "allergy"-inducing (*e.g.*, Neomycin and Thimerosal).

Among other things, these vaccine additives increase the risk of immune system dysfunction, including an increased risk of vaccine-induced autoimmune disease.

Finally, there is a large, and growing, body of scientifically sound experimental research that

clearly indicates that repeatedly injecting Thimerosal-preserved[1] vaccines into humans mercury poisons all so treated to some degree.

The clear evidence is that, *in developing children (fetus through 17 years of age)*, more than 15% of those so treated exhibit one, or more, of the clinical symptoms of sub-acute mercury poisoning.

Further, *given a peak asthma incidence of 1 in 4 in the early 2000s* (up from a 1 in 500 rate in the 1970s), Thimerosal also seem to be a strong general contributing factor in creating long-term dysfunction in the human immune systems.

"'We take it for granted that these things aren't going to happen today,' Lyon-Loftus says.

Yet there's a resurgence in mumps in Pennsylvania, he says."

Mumps cases were found in doubly vaccinated (2 doses of the MMR vaccine) "children" mostly in their late teens to early 20s (those 18-24 years of age) indicating that the vaccine-provided mumps immunity is *not* long-term but probably not longer than "10–15" years for a significant portion of those vaccinated. [**Note:** Perhaps this is the reason the Japanese do *not* recommend universal childhood vaccination for mumps though they do recommend it for measles and for rubella – using separate monovalent vaccines for each.]

In contrast, **almost all of those who have childhood mumps** have a relatively mild disease from which they fully recover and, *except in rare cases*, then **have "lifetime" immunity**.

Based on a simple cost-benefit basis, it would seem that a few days in bed at home as a child in exchange for lifetime immunity is much more cost effective than what is now 2-plus doses of an ever-more-expensive "MMR" or "MMRV" vaccine that:

- Only provides somewhat-limited-duration immunity;
- Seriously harms a small percentage of those simultaneously infected with the measles, mumps, rubella, and, *for those vaccinated with Merck's ProQuad®*, chickenpox viruses (because vaccination with a live-virus vaccine infects almost all of the recipient with all the diseases contained in the vaccine).
- *For a significant percentage of the population*, provides limited immunity to mumps; and,
- *For young adults,* apparently only delays the risk of contracting mumps further into "adulthood," where mumps is an even more serious disease – one that significantly interrupts their ability to work and threatens not only their livelihoods but also, *for males*, may render them permanently sterile.

Source: ***MMWR***. 26 May 2006; **55**(20): 559-563 [with **bolding** added for emphasis]
[(http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5520a4.htm)
"**Editorial Note:**

In the United States, the reported incidence of mumps* declined after introduction of mumps vaccine in 1967 and the recommendation for its routine use in 1977 (3). After expanded recommendations for a 2-dose MMR vaccine schedule for measles control in 1989 (3), mumps cases declined further (Figure 4). During 2001–2003, fewer than 300 mumps cases were reported each year, a 99% decline from the 185,691 cases reported in 1968 (2).

The current multistate mumps outbreak, with 2,597 cases reported through May 2, 2006, is the largest number of mumps cases reported to CDC in a single year since 1991, when 4,264 cases were reported (2). The first cases in the current outbreak were detected on a college campus in eastern Iowa in December 2005; the source of these initial cases is unknown (1). Although the age group most affected (38% of cases) has been young adults aged 18–24 years, many of whom are college students, the outbreak has spread to all age groups (1).

Multiple factors might have contributed to the spread of mumps in this outbreak and on college campuses. First, the college campus environment (e.g., living in dormitories with frequent and extended close contact

[1] Thimerosal-preserved vaccines nominally contain Thimerosal levels of 0.003% to 0.01% (30 to 100 ppm).

with other students) facilitates transmission of mumps and other illnesses that are spread through respiratory and oral secretions. Second, only 25 states** and the District of Columbia report a college admission requirement of 2 doses of MMR vaccine, including three of the 11 states with outbreak-associated cases of mumps; no data on implementation and evaluation of the 2-dose college admission requirement are available (CDC, unpublished data, 2006). Thus, 2-dose coverage with mumps-containing vaccine among college students likely is lower than the median 97% (range: 57%–99%) coverage for measles-containing vaccine (almost exclusively administered as MMR vaccine) for students entering elementary school and the median 98% (range: 62%–99%) coverage for students entering middle school reported in 2000 from 38 and 25 states, respectively (4). Third, delayed recognition and diagnosis of mumps cases might have contributed to the spread in this outbreak; younger physicians in the United States likely have not seen mumps, and physicians might not consider the diagnosis in vaccinated persons. Fourth, 2 doses of MMR vaccine are not 100% effective in preventing disease, and accumulation of susceptible persons who were not successfully immunized might be sufficient to sustain transmission in certain settings. In addition, the vaccine might be less effective in preventing asymptomatic infection or atypical mumps than in preventing parotitis, and persons with asymptomatic infection or mild disease might contribute to transmission. **Finally, waning immunity has been postulated as a contributing factor in this outbreak. Young adults aged 18–24 years would most commonly have received their most recent dose of mumps-containing vaccine (i.e., MMR vaccine) 6–17 years ago.**

High vaccination coverage with 2 doses of MMR vaccine, especially in school-aged populations in the United States, likely prevented thousands of additional cases of mumps in this outbreak. **Postlicensure studies conducted in the United States during 1973–1989 determined that 1 dose of mumps or MMR vaccine was 75%–91% effective in preventing mumps with parotitis that lasts >2 days** (5). **Although fewer data are available on the effectiveness of 2 doses of MMR vaccine against mumps, one study from the United Kingdom documented vaccine effectiveness of 88% with 2 doses** (6). In a mumps outbreak in a high school in Kansas, students vaccinated with 1 dose of MMR vaccine had an attack rate five times that of students vaccinated with 2 doses (7). In a mumps outbreak in a middle school in 1982, before mumps vaccination became widespread, attack rates of 25%–49% occurred among unvaccinated students, depending on how cases were ascertained (8). During 1986–1990, after widespread implementation of a 1-dose mumps vaccination policy, attack rates of 2%–18% (most >6%) were documented in mumps outbreaks among junior high and high school students with vaccination coverage of >95% (7,9). **In contrast, preliminary data from two colleges in Iowa during the current outbreak identified attack rates of 2.0% and 3.8%, respectively, with the lower attack rate in the college with higher 2-dose vaccination coverage**.

To prevent mumps, the Advisory Committee on Immunization Practices (ACIP) recommends a 2-dose MMR vaccination series for all children, with the first dose administered at ages 12–15 months and the second dose at ages 4–6 years (3). Two doses of MMR vaccine are recommended for school and college entry unless the student has other evidence of immunity (3). In a specially convened meeting on May 17, 2006, ACIP redefined evidence of immunity to mumps through vaccination as follows: 1 dose of a live mumps virus vaccine*** for preschool children and adults not at high risk; 2 doses for children in grades K–12 and adults at high risk (i.e., persons who work in health-care facilities, international travelers, and students at post-high school educational institutions). Other criteria for evidence of immunity (i.e., birth before 1957, documentation of physician-diagnosed mumps, or laboratory evidence of immunity) are unchanged. Furthermore, health-care facilities should consider recommending 1 dose of MMR vaccine to unvaccinated health-care workers born before 1957 who do not have other evidence of mumps immunity.

During an outbreak and depending on the epidemiology of the outbreak (e.g., the age groups and/or institutions involved), a second dose of vaccine should be considered for adults and for children aged 1–4 years who have received 1 dose. The second dose should be administered as early as 28 days after the first dose, the minimum recommended interval between 2 MMR vaccine doses. In addition, during an outbreak, health-care facilities should strongly consider recommending 2 doses of MMR vaccine to unvaccinated workers born before 1957 who do not have other evidence of mumps immunity. An MMWR Notice to Readers will be published, summarizing these interim recommendations in more detail.

Additional means to decrease transmission in outbreak settings include exclusion of persons without evidence of immunity to mumps from institutions such as schools and colleges that are affected by the outbreak. Once vaccinated, students and staff can be readmitted to school immediately, even if they have been exposed to a case of mumps. The period of exclusion for those who remain unvaccinated is 26 days after the onset of parotitis in the last person in the affected institution. Students who acquire mumps illness should be excluded from school until 9 days after the onset of parotitis. After an exposure to mumps, unvaccinated health-care workers without evidence of immunity should be vaccinated and excluded from duty from the 12th day after the first exposure through the 26th day after the last exposure. Health-care workers with mumps illness should be excluded from work until 9 days after the onset of parotitis.

In response to the current outbreak, the Iowa Department of Public Health (IDPH) issued vaccination recommendations in March targeting college campus and health-care worker populations at high risk. On April 14, CDC issued a Health Advisory Notice summarizing vaccine policy recommendations for mumps prevention and control. In conjunction with local health departments, IDPH launched a statewide vaccination campaign during April 24–26, targeting persons aged 18–22 years in the 35 Iowa counties with the state's largest colleges and universities. In the second phase of the campaign, conducted May 2–4, vaccination was expanded to the remaining 64 counties, targeting persons aged 18–25 years. A third phase of the vaccination campaign was begun May 10 and targets persons aged 18–46 years. Vaccination activities also are being conducted or planned in Kansas, South Dakota, and Wisconsin.

The data presented in this report are preliminary; the case count is likely to change as additional data become available. Certain reported cases might not have been caused by mumps; cases in persons without parotitis might have been misclassified on the basis of serologic tests. Because of the low number of reported mumps cases during the last decade, laboratorians have limited experience with mumps tests, particularly IgM antibody tests (10). Several different mumps IgM antibody tests are in use; however, neither the sensitivities nor specificities of these tests when used with serum specimens from either unvaccinated or vaccinated persons have been clearly defined. Consequently, interpretation of these antibody test results is difficult, especially in previously vaccinated persons. Studies to define the sensitivity and specificity of mumps IgM antibody tests and reverse transcription--polymerase chain reaction (RT-PCR) tests for mumps virus RNA are in progress.

CDC continues to work with state and local health departments to conduct mumps surveillance, assist with prevention and control activities, and evaluate vaccine effectiveness, duration of immunity, and risk factors for mumps illness.

References

(1) CDC. Mumps epidemic—Iowa, 2006. MMWR 2006;55:366–8.

(2) CDC. Summary of notifiable diseases—United States, 2003. MMWR 2005;52(54).

(3) CDC. Measles, mumps, and rubella—vaccine use and strategies for elimination of measles, rubella, and congenital rubella syndrome and control of mumps: recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR 1998;47(No. RR-8).

(4) Kolasa MS, Klemperee-Johnson S, Papania MJ. Progress toward implementation of a second-dose measles immunization requirement for all schoolchildren in the United States. J Infect Dis 2004;189(Suppl 1): S98–S103.

(5) Plotkin SA, Orenstein WA, eds. Vaccines. 4th ed. Philadelphia, PA: Elsevier Inc.; 2003:441–5.

(6) Harling R, White JM, Ramsay ME, Macsween KF, van den Bosch C. The effectiveness of the mumps component of the MMR vaccine: a case control study. Vaccine 2005;23:4070–4.

(7) Hersh BS, Fine PE, Kent WK, et al. Mumps outbreak in a highly vaccinated population. J Pediatr 1991;119:187–93.

(8) Kim-Farley R, Bart S, Stetler H, et al. Clinical mumps vaccine efficacy. Am J Epidemiol 1985;121:593–7.

(9) Cheek JE, Baron R, Atlas H, Wilson DL, Crider RD. Mumps outbreak in a highly vaccinated school population: evidence for large-scale vaccination failure. Arch Pediatr Adolesc Med 1995;149:774–8.

(10) Warrener L, Samuel D. Evaluation of a commercial assay for the detection of mumps specific IgM antibodies in oral fluid and serum specimens. J Clin Virol 2006;35:130–4.

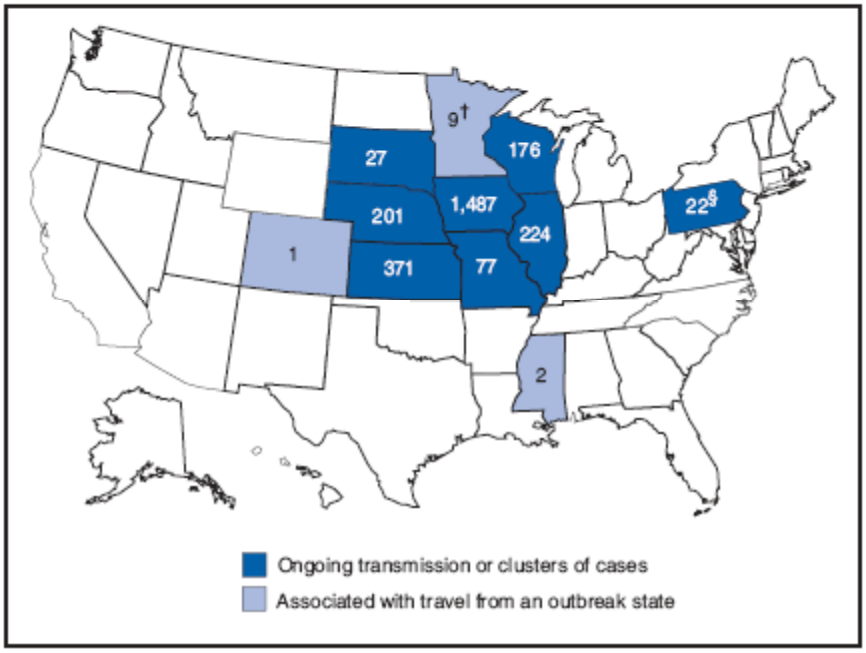
* Available at http://www.cste.org/ps/1999/1999-id-09.htm.

** Arizona, Arkansas, Colorado, Connecticut, Delaware, Georgia, Hawaii, Illinois, Indiana, Kansas, Louisiana, Massachusetts, Mississippi, Montana, Nevada, New York, North Carolina, North Dakota, Oklahoma, Oregon, Rhode Island, Tennessee, Texas, Vermont, and Virginia.

*** Combined MMR vaccine generally should be used whenever any of its component vaccines are indicated. For children aged 1–12 years, MMRV vaccine can be considered if varicella vaccine is indicated.

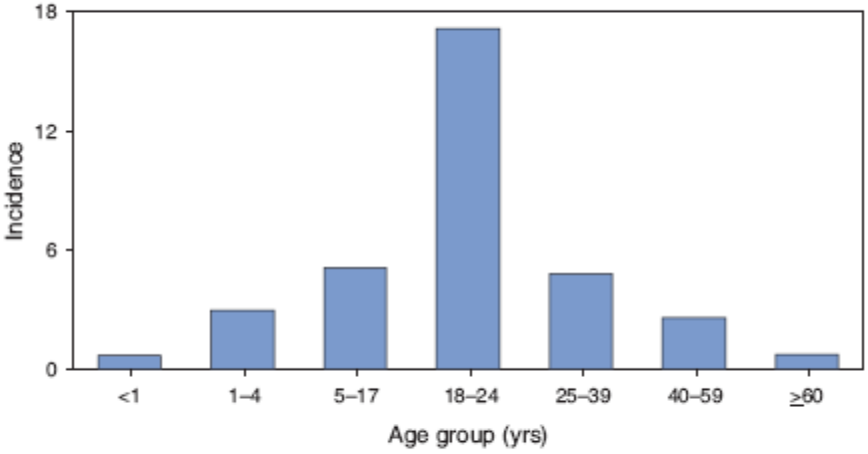
[**See** the **figures** on the pages that follow for a visual presentation of the key information discussed in this source reference.]

FIGURE 1. Number* of reported mumps cases linked to multistate outbreak, by state — United States, January 1– May 2, 2006



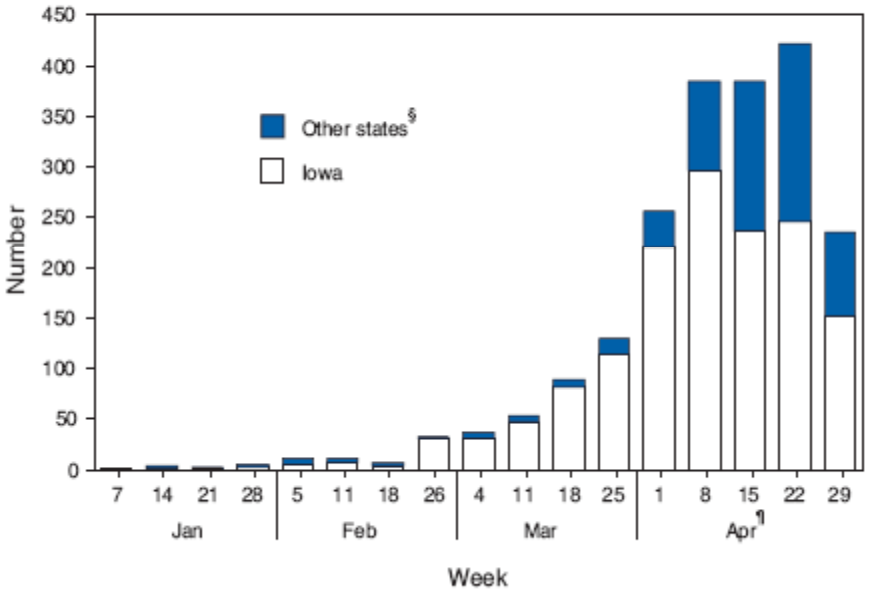
* N = 2,597.
† Three cases related to the outbreak.
§ Twelve cases related to the outbreak.

FIGURE 2. Incidence* of mumps reported in eight outbreak states,† by age group — United States, January 1– May 2, 2006



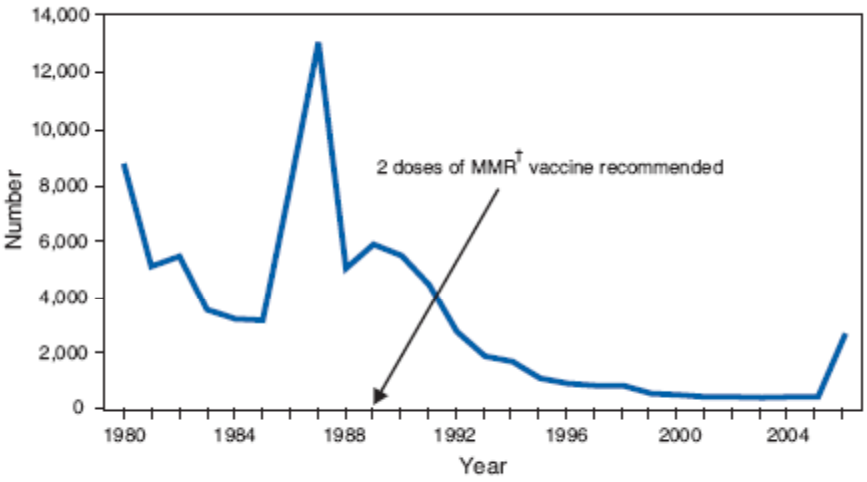
* Per 100,000 population (n = 2,061).
† Iowa, Illinois, Kansas, Missouri, Nebraska, Pennsylvania, South Dakota, Wisconsin.

FIGURE 3. Number* of reported mumps cases linked to multistate outbreak, by week of onset† — United States, January 1– May 2, 2006



* n = 2,073.
† Week of symptom onset for 1,880 (91%) cases, week of laboratory diagnosis for 131 (6%), week of report for 50 (2%), week of diagnosis for 11 (<1%), and category unknown for one (<1%).
§ Colorado, Illinois, Kansas, Minnesota, Mississippi, Missouri, Nebraska, Pennsylvania, South Dakota, and Wisconsin.
¶ Data for April are preliminary.

FIGURE 4. Number of reported mumps cases, by year — United States, 1980–2006*



* Data for 2005 and 2006 are provisional.
† Measles, mumps, and rubella.

"And a recent outbreak of whooping cough, or pertussis, in Jefferson County, W.Va., further illustrates the importance of immunizations, says Dr. Sarah Moerschel, a pediatrician with Harpers Ferry (W.Va.) Family Medicine. The only documented cases of the illness have been in children who had not received the pertussis vaccine, she says."

> Based on the observed resurgence of pertussis – predominately in those in their late teens and early twenties, the FDA licensed two "booster" vaccines and the CDC recommended adding these "Dtap" booster vaccines to the childhood vaccination program for 11- to 18-year olds.
>
> Given this addition, strong vaccine protection from pertussis should be extended until the adults so treated are in their late 30s to their early 50s.
>
> However, whether or not this is a cost-effective addition to the United States (U.S.) national childhood vaccination program has *not* been openly discussed.
>
> The absence of any "cost-benefit" discussion probably indicates that adding vaccine doses is *not* truly health cost effective – though this reviewer is certain that that it adds to the financial health of the "healthcare establishment."

"Doctors are most concerned about children younger than 1-year old getting whooping cough because it can lead to respiratory distress and death, she says."

See: http://www.cdc.gov/nip/diseases/pertussis/faqs.htm

"5. **How much has the reporting of pertussis among infants increased in the U.S.?**
The case-reports of pertussis among infants younger than 5 months have been increasing since the 1980s. **This age group is too young to be well protected by DTaP (diphtheria and tetanus toxoids and acellular pertussis) vaccine.** For example, the number of case-reports among infants younger than 5 months was about 600 per year in the early 1980s, and about 1,700 per year at the end of the 1990s. The average reported rate among infants in this age group increased more than 50% in the 1990s compared with the 1980s (the average reported rate was 89 in the 1990s per 100,000 infants). **By contrast, among infants aged 5 to 11 months, there was no increase in the reported rate from the 1980s to the present**."

> Since the immunization rate has *not* changed significantly, these data indicate that DPT dose given at 2 months are less effective (perhaps ineffective) than the writer's implicit claim and, *with the pressures of declining hygiene from increasing poverty and declining breastfeeding durations and, in some population segments, rates*, effective disease transmission rates are increasing, resulting in the disease increases observed.
>
> Therefore, *as the CDC's **answers** "**5**" and "**7**" indicate*, increasing the level of immunization in the very young would *not* significantly reduce the incidence of pertussis in those under 1 year of age.

"6. **Has there been a change in the severity of pertussis in infants?**
No. The severity of the pertussis illness among reported infant cases was comparable between the 1980s and the 1990s, judging from reported symptoms and the proportion of patients hospitalized. Although the number of cases reported among infants younger than 5 months increased, **the illnesses were just as serious as they were in the past**."

7. **What can we do to prevent infants from getting pertussis?**
In the U.S., we have the vaccine called DTaP (diphtheria and tetanus toxoids and acellular pertussis vaccine). DTaP is safe and effective, and prevents severe pertussis and death among infants and young children. The best way to protect infants from pertussis is to give DTaP vaccine starting on time at 2 months of age. Parents should vaccinate their infant on-time (at 2, 4, and 6 months of age) and complete all the recommended doses of DTaP vaccine to best protect their infant.

At least three DTaP doses are needed to have the maximum benefit from the vaccination. However, even **one or two doses of DTaP** will **provide some protection against pertussis**. Parents are urged to make sure their infant receives these doses on time.

Parents can also help protect their very young infants by minimizing exposure (close contact) with persons who have cold symptoms or cough illness. Coughing people of any age, including parents, siblings and grandparents can have pertussis. When a person has cold symptoms or cough illness, they need to stay away from young infants as much as possible."

Based on the CDC's views, the most important thing U.S. parents can do for babies is **to protect young babies from exposure to sick people with coughs** but the writer here has failed to:

a. Provide this advice **or**

b. Admit the limited protection provided by one dose (at 2 months) or two doses (one at 2 months and one at 4 months) of the DTaP vaccine.

In addition, the writer has implicitly presented the vaccine as fully protective when the CDC's own data and statements clearly says that it is *not*.

"Those who travel a lot definitely should opt for immunizations, says Dr. Laura Henderson with Smithsburg Family Medical Center.

Just because a disease might not exist or is rare in the U.S. doesn't mean a person won't be exposed to it elsewhere.

'It's not the same in every other country,' Henderson says."

This reviewer *cannot* disagree with the generalizations stated here.

However, this reviewer must note that there are endemic diseases in both the U.S. and foreign countries for which there is no vaccine (*e.g.*, in the U.S., the hanta viruses and Rocky-Mountain Spotted fever; and Malaria, Ebola, and Marburg, outside the U.S.).

In addition, the writer again fails to mention the importance of personal hygiene and safe eating and drinking habits in minimizing the risk of contracting a disease.

Further, the writer fails to mention that the increasing cumulative damage to the immune systems from the ever-growing vaccination programs may *decrease* the immune system's ability to fight off exposure to additional "disease" insults.

While *not* anti-vaccine *per se*, this reviewer has long understood that, proverbially, "there is no such thing as a free lunch."

For example, as a result of adventitious-virus-contaminated polio vaccines, millions of Americans have been infected with a host of animal-derived viruses (*e.g.*, SV-40, and RSV), which, *to say the least*, have *not* positively contributed to the health of those so infected.

Moreover, the steady rise in the rates of diabetes, obesity, MS, asthma, IDCM, certain childhood cancers in the 1980s and 1990s seems to be linked to the increased dosing with Thimerosal (from Thimerosal-preserved vaccines and other drugs) along with other vaccine ingredients that can "activate" the immune systems of those who are exposed to these ingredients. [**Note:** Coincidentally, along with the drop in neurodevelopmental disorders reported in epidemiological studies[2] in the U.S. to have occurred in 2002 (after Thimerosal-preserved childhood vaccines were phased out and before the Thimerosal-preserved influenza vaccines were added to the our national recommended childhood immunization schedule), the rates in diabetes and childhood obesity also seem to have dropped.[3]]

Thus, *if the total adverse costs were counted for all vaccines* (and, *to date*, they have *not* been honestly assessed, or, *for long-term effects*, even properly studied), several of these vaccines should have, *in this reviewer's evidence-based opinion*:

- **a.** not been U.S.-licensed (*e.g.*, either of the rotavirus vaccines, the current one [Merck's RotaTeq®] or the now withdrawn previous one [Wyeth-Ayerst's RotaShield®]),
- **b.** been conditionally licensed for use only during disease outbreaks of the covered organisms (*e.g.*, the current U.S.-licensed vaccines for *Neisseria meningitidis* serogroups A, C, Y and W-135 [Sanofi-Aventis' Menomune® and Menactra® vaccines] when there is an outbreak of *N. meningtidis* A, C, Y or W-135) or only in subpopulations with proven genetic risk factors for the disease (cervical cancer) that two of the four covered pathogen (HPV 16 and HPV 18) induces in only some of those exposed to it (*e.g.*, the recently licensed Gardasil® vaccine for certain HPVs), or
- **c.** *if licensed*, had their U.S.-licenses revoked based on population experience and/or clinical study irregularities (*e.g.*, the now-withdrawn ["for lack of demand"] LymeRix® vaccine for the Lyme disease and the U.S.-licensed Prevnar® vaccine for only seven (7) strains of S. pneumococcus).

This "cost assessment" problem exists because, *even though it has clear conflicts of interest*, the "healthcare establishment" is allowed to do the cost accounting.

Why is it, *whenever there is a clear "current vaccination program failure,"* that the only "solutions" proposed by the "healthcare establishment" are to:

- Implement an immediate vaccination campaign to "suppress" the outbreaks seen, and
- Add (or develop and add) a booster vaccine to the vaccination program without regard to its cost or benefit?

Who, *besides the "healthcare establishment,"* benefits from adding more and more "booster" vaccine doses to the national immunization programs?

"Also, if there is an epidemic in a part of the U.S. to which a family is traveling, immunizations against that disease are paramount, she says."

Here, the writer or the person to whom this remark is attributed begins with a false premise "epidemic in a part of the U.S."

This is the case because, *in the U.S. today*, there are no disease epidemics for which there are effective vaccines.

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2 **a.** Geier DA, Geier MR. An assessment of downward trends in neurodevelopmental disorders in the United States following removal of thimerosal from childhood vaccines. ***Med Sci Monit***. 2006 May 29; **12**(6): CR231-239.
b. Geier DA, Geier MR. A meta-analysis epidemiological assessment of neurodevelopmental disorders following vaccines administered from 1994 through 2000 in the United States. ***Neuro Endocrinol Lett***. 2006 Jun 29;**27**(3) [Epub ahead of print].

3 Personal communications.

This is also the case because, *for truly effective vaccine anti-disease components*, the U.S. national immunization program and vaccination rates exceeding "90%" have combined to reduce the incidence of these diseases to levels well-below "epidemic" levels.

Moreover, *whenever a given U.S.-licensed vaccine in the national immunization program repeatedly fails to effectively suppress a disease to very low levels*, then, the continued use of that vaccine should seriously questioned instead of simply increasing the number of doses administered.

"'Vaccinations protect children, family members and the community at large,' Moerschel says."

While this message is continually echoed by every vaccine apologist, the reality is, *at best*, some current "vaccinations protect" most children, most family members, and most of the community at large.

"'Nothing works better than immunization,' Lyon-Loftus says, adding that it is the most cost-effective way to protect one's health. 'If we can get rid of certain of these nasty killers ... then we can relax.'"

Again, these quotes are generalized "mantras" taken from the vaccine apologists' handbook.

Based on history, *for the current childhood viral diseases* (*e.g.*, measles, mumps, rubella, chicken pox, West Nile virus, *etc.*), having the disease and recovering "works better" than immunization in terms of providing lifetime immunity and minimizing long-term health risks from contracting the disease in later years provided, *for those diseases where exogenous boosting of the immune system is required to maintain "effective immunity" (e.g., chickenpox)*, periodic re-exposures to the active disease organism are maintained.

Factually, with the possible exception of smallpox, the reality is that vaccination has *not* gotten rid of any human-contagious disease, including the diseases that are quoted as being "these nasty killers."

"**Lessons in resistance**

The immune system knows the difference between 'you and not you,' Lyon-Loftus says. Anything it knows is not part of your body's typical workings will be attacked, he says."

Factually, the writer's quoted and attributed statements are, *at best*, inaccurate.

At birth, a baby's immune system is a virtual blank slate that, during birth, is supposed to receive a final infusion of protective antibodies during the transfer of the blood in the placenta to the baby prior to natural umbilical-cord collapse.

In addition, *immediately after birth*, the baby is supposed to naturally receive additional boluses of maternal antibody protection from the colostrum that his or her mother's breasts initial produce followed by a continuing stream of antibodies from the breast milk the child suckles for, in nature, two to three years.[4]

As a baby grows, his or her own immune systems begins to develop as the levels of maternal protective antibodies decline and the infant is exposed to an environment filled with a variety of substances that stimulate various aspects of the immune system.

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[4] Speaking from personal experience, my daughter, born in 1975, who was breast fed until she was about 3, only introduced to other foods after she cut her first baby teeth at age 15 months, and reasonably protected from exposure to infected people from the day she came home from the hospital, had no infections until after she was weaned (her first was one ear infection at just after 3 and followed shortly thereafter by a very mild case of the chickenpox [which her pediatrician initially claimed was not chickenpox but some mild rash that, *because the pediatrician told us it was okay to send her to school*, shut the private school she attended down for a week]). She did get her DTaP, polio and MMR vaccinations and does have mild pollen allergies (milder than her mother's).

Thus, the baby's immune system learns "the difference between 'you and not you,'" it does *not* innately know the difference as this article states.

Moreover, injection of 0.25 to 0.5 milliliter (mL) of a vaccine formulation is *not* the normal manner by which humans are exposed to disease components.

In addition, the vaccine formulations contain substances other than the disease components (*e.g.*, Thimerosal [49.55% mercury by weight; used as a preservative], aluminum salts [used as "adjuvants"; where "adjuvants" are non-specific immune-system-stimulating compounds], neomycin [an antibiotic used to suppress microbial growth], gelatin [a protein from animals' hooves] and adventitious disease organisms [biological contaminants from the environment used to manufacture the disease components for which immunity is desired]) to which, historically, baby humans were *not* routinely exposed to by this means *at any significant level*.

Based on the preceding realities, it should be obvious that:

- Such vaccine increase the risk of causing immune system dysfunction (leading to increased risks of having a dysfunctional immune system that increases the baby's risk of developing immune and autoimmune diseases at some point in his or her lifetime),
- Vaccines contaminated with adventitious microbial organisms, animal viruses and prions run the risk of introducing new diseases (*e.g.*, *for microbial organisms*, Serratia infections;

  for viruses, SV-40 and RSV; and, *for prions*, TSEs) into the population, and
- The immunity developed from injected vaccines is "incomplete" because its mode of immunity induction is *not* the same as:
  - The immunity developed by the inhalation of the disease organisms (*e.g.*, polio, measles, mumps, rubella),
  - Eating food and/or drinking water contaminated with the disease organisms (*e.g.*, hepatitis A and cholera), or
  - Surface transfer by a superficial puncture (*e.g.*, tetanus) or buy rubbing ones eyes with contaminated hands (*e.g.*, pink eye).

"'The immune system makes a Pac-Man antibody for every single antigen,' Lyon-Loftus says. Antigens are substances such as proteins and toxins against which the body reacts."

Accepting the quoted statement at face value, the article admits that, *in addition to the proteins and toxins that the vaccine is intended to cause the body to make antigens*, the body makes antigens to anything it does *not* recognize as "itself."

Furthermore, there are two key immune system issues that this article glosses over:

- Over-stimulation of the immune system by adjuvants,
- Proven immune-system dysregulation (disruption and/or poisoning) by mercury-containing compounds (*e.g.*, Thimerosal at levels below 0.03 parts per million [ppm], below 0.03 micrograms per gram or mL of biological system component) injected in 12.5- to 25- microgram amounts of mercury in each Thimerosal-preserved vaccine into babies typically weighing less than 4 kilograms (kg) when the EPA's suggested limit is 0.1 microgram of mercury per kg of body mass in any one day (> 31.2 to 62.5 times the EPA threshold).

Thus, immunization with the current injectable vaccines does more than help the body learn to recognize the disease organisms or toxins and develop antibodies to these entities.

In addition to the intended actions, the harmful "side effects" of the current injected vaccines include:

- Abnormally stimulation of the immune system by the adjuvants used, and

- Mercury poisoning (by the bioaccumulative highly poisonous mercury-based compound, Thimerosal [49.55% mercury by weight], in Thimerosal-containing vaccines) that, *among other things*, increases the risk that the recipients' immune systems will attack the body's own cells as well as, *through the "ethylmercury" released*, poisons other fundamental biochemical processes[5], and, because it is a teratogen,[6,7] can induce mutations that, in some, lead to birth defects and/or increased risks for certain cancers.

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[5]
- **a.** Geier DA, Geier MR. A clinical and laboratory evaluation of methionine cycle-transsulfuration and androgen pathway markers in children with autistic disorders. ***Horm Res***. 2006 May 9; **66**(1): 33-39 [Epub ahead of print]
- **b.** Im GS, Seo JS, Hwang IS, Kim DH, Kim SW, Yang BC, Yang BS, Lai L, Prather RS. Development and apoptosis of pre-implantation porcine nuclear transfer embryos activated with different combination of chemicals. ***Mol Reprod Dev***. 2006 May 30; [Epub ahead of print]
- **c.** Ariano P, Erriquez J, Gilardino A, Ferraro M, Lovisolo D, Distasi C. Calcium signals and the in vitro migration of chick ciliary ganglion cells. ***Cell Calcium***. 2006 Jul; **40**(1): 63-71.
- **d.** Woo KJ, Lee TJ, Bae JH, Jang BC, Song DK, Cho JW, Suh SI, Park JW, Kwon TK. Thimerosal induces apoptosis and G(2)/M phase arrest in human leukemia cells. ***Mol Carcinog***. 2006 Apr 30; [Epub ahead of print].
- **e.** Herdman ML, Marcelo A, Huang Y, Niles RM, Dhar S, Kiningham KK. Thimerosal induces apoptosis in a neuroblastoma model via the cJun N-terminal kinase pathway. ***Toxicol Sci***. 2006 Jul; **92**(1): 246-253. [Epub 2006 Apr 19.]
- **f.** Havarinasab S, Hultman P. Alteration of the spontaneous systemic autoimmune disease in (NZB x NZW)F1 mice by treatment with thimerosal (ethyl mercury). ***Toxicol Appl Pharmacol***. 2006 Jan 26; [Epub ahead of print].
- **g.** Yel L, Brown LE, Su K, Gollapudi S, Gupta S. Thimerosal induces neuronal cell apoptosis by causing cytochrome c and apoptosis-inducing factor release from mitochondria. ***Int J Mol Med***. 2005 Dec; **16**(6): 971-7.
- **h.** Perez R, Matabosch X, Llebaria A, Balboa MA, Balsinde J. Blockade of arachidonic acid incorporation into phospholipids induces apoptosis in U937 promonocytic cells. ***J Lipid Res***. 2006 Mar; 47(3): 484-91. [Epub 2005 Dec 2.]
- **i.** Mutkus L, Aschner JL, Syversen T, Shanker G, Sonnewald U, Aschner M. In vitro uptake of glutamate in GLAST- and GLT-1-transfected mutant CHO-K1 cells is inhibited by the ethylmercury-containing preservative thimerosal. ***Biol Trace Elem Res***. 2005 Summer; **105**(1-3): 71-86.
- **j.** Humphrey ML, Cole MP, Pendergrass JC, Kiningham KK. Mitochondrial mediated thimerosal-induced apoptosis in a human neuroblastoma cell line (SK-N-SH). ***Neurotoxicology***. 2005 Jun; **26**(3): 407-16.
- **k.** Parran DK, Barker A, Ehrich M. Effects of thimerosal on NGF signal transduction and cell death in neuroblastoma cells. ***Toxicol Sci***. 2005 Jul; **86**(1): 132-40. [Epub 2005 Apr 20].
- **l.** Havarinasab S, Haggqvist B, Bjorn E, Pollard KM, Hultman P. Immunosuppressive and autoimmune effects of thimerosal in mice. ***Toxicol Appl Pharmacol***. 2005 Apr 15; **204**(2): 109-21.
- **m.** Rampersad GC, Suck G, Sakac D, Fahim S, Foo A, Denomme GA, Langler RF, Branch DR. Chemical compounds that target thiol-disulfide groups on mononuclear phagocytes inhibit immune mediated phagocytosis of red blood cells. ***Transfusion***. 2005 Mar; ***45***(3): 384-93.
- **n.** James SJ, Slikker W 3rd, Melnyk S, New E, Pogribna M, Jernigan S. Thimerosal neurotoxicity is associated with glutathione depletion: protection with glutathione precursors. ***Neurotoxicology***. 2005 Jan; **26**(1): 1-8.
- **o.** Harry GJ, Harris MW, Burka LT. Mercury concentrations in brain and kidney following ethylmercury, methylmercury and Thimerosal administration to neonatal mice. ***Toxicol Lett***. 2004 Dec 30; **154**(3): 183-9.
- **p.** Waly M, Olteanu H, Banerjee R, Choi SW, Mason JB, Parker BS, Sukumar S, Shim S, Sharma A, Benzecry JM, Power-Charnitsky VA, Deth RC. Activation of methionine synthase by insulin-like growth factor-1 and dopamine: a target for neurodevelopmental toxins and thimerosal. ***Mol Psychiatry***. 2004 Apr; **9**(4): 358-70.
- **q.** Havarinasab S, Lambertsson L, Qvarnstrom J, Hultman P. Dose-response study of thimerosal-induced murine systemic autoimmunity. ***Toxicol Appl Pharmacol***. 2004 Jan 15; **194**(2): 169-79.
- **r.** Ueha-Ishibashi T, Oyama Y, Nakao H, Umebayashi C, Nishizaki Y, Tatsuishi T, Iwase K, Murao K, Seo H. Effect of thimerosal, a preservative in vaccines, on intracellular Ca2+ concentration of rat cerebellar neurons. ***Toxicology***. 2004 Jan 15; **195**(1): 77-84.
- **s.** Qvarnstrom J, Lambertsson L, Havarinasab S, Hultman P, Frech W. Determination of methylmercury, ethylmercury, and inorganic mercury in mouse tissues, following administration of thimerosal, by species-specific isotope dilution GC-inductively coupled plasma-MS. ***Anal Chem***. 2003 Aug 15; **75**(16): 4120-4.
- **t.** Baskin DS, Ngo H, Didenko VV. Thimerosal induces DNA breaks, caspase-3 activation, membrane damage, and cell death in cultured human neurons and fibroblasts. ***Toxicol Sci***. 2003 Aug; **74**(2):361-8. [Epub 2003 May 28.]

[6] Goncharuk GA. Experimental investigation of the effect of organomercury pesticides on generative functions and on progeny. ***Hyg. Sanit – USSR***. 1971; **36**(1): 40-43 (English translation).

[7] Digar A. Sensharma GC, Samal SN. Lethality and teratogenecity of organic mercury (Thimerosal) on the chick embryo. ***J Anat Soc India***. 1987; **36**(3): 153-159.

"When an immunization is administered, he says it gives the body 'a wanted poster for the most common, devastating diseases to mankind.'"

Based in the realities concerning the variety of immune-provoking components found in the current vaccine formulations, this statement is, *at best*, simplistic and, *at worst*, intentionally misleading.

"'The immune system is educable,' Lyon-Loftus says."

While this statement is true, this reviewer notes that:

- This statement is at odds with the previous statement that the "immune system knows the difference between 'you and not you,'" instead of continually learning and updating the body's understanding of this critical difference,
- The immune system is not only "**poisonable**," *an even larger "gorilla in this discussion*, but the current vaccine formulations also contain many components that have been shown to

  have adverse immune-system effects in some humans, and
- *When **poisoned***, the immune system can lose the ability to know "the difference between 'you and not you,'" to the point that it attacks "you" resulting in autoimmune diseases.

"So are the people who make the decisions about whether they - and their children - will be immunized."

While this reviewer agrees with the author that people are educable, he notes that most of the
vaccine information being published by the "healthcare establishment" is, in general:

a. *Neither* accurate (because the information typically provided to parents:
- Inflates the harm caused by the disease,
- Understates the risks associated with each vaccine,
- Generates artificial vaccine-friendly cost-benefit analyses [that knowingly: **a)** omit the costs of the harm caused by the vaccine's short-term adverse effects, **and b)** do *not* even consider the costs of the probable long-term side effects of mass immunization with each vaccine [that are *not* even properly studied in many cases],
- *When long-term problems do occur* [*e.g.*, the chickenpox vaccine], actively suppresses those adverse findings, and
- Often *not* continually updated to reflect actual post-licensing population experience)

b. *Nor* complete (for the same reasons that were cited in point "**a**").

In addition, *because healthcare providers knowingly fail to report all adverse vaccine reactions as they are currently required by statute to do*, the official government database for tracking adverse vaccine reactions, the Vaccine Adverse Events Reporting System (VAERS) database, is estimated by the government agencies in charge of VAERS (the CDC and the FDA) to contain only about 10% of the adverse vaccine events, including death, which actually occur.

"Reports that link immunizations with asthma, autism, learning disabilities and other serious problems have made some parents resistant to building their children's resistance."

Coupled with the knowing misrepresentation of the facts concerning vaccination (discussed in the previous response), the peer-reviewed scientifically sound published experimental reports "that link immunizations with asthma, autism, learning disabilities and other serious problems" have, *as they should*, helped to provide parents with information vital to their judging whether or not the claimed benefits of vaccination outweigh the harm, including death, that a given vaccine may inflict on their children.

Oddly, this writer has apparently forgotten that the parents who love their children are rightly responsible for protecting them from all harm or the real risks of harm associated with a given disease if their children, vaccinated or not, were to contract it.

Moreover, the writer's clever "resistant to building their children's resistance" ignores the reality that there is some documented evidence that vaccination before their child's immune system has matured to the point it is fully activated (which usually occurs about age 2) actually weakens the children's immune systems.

In addition, there is evidence that early vaccination also increases the incidence of SIDS as compared to immunization programs that, *for most vaccines*, support the parents who decide to wait until after the child is 2 years of age (**see** Japan's experience in this area) before most vaccinations are started and, unlike the U.S., tends to support "monovalent" vaccines for live viruses and provide the parents with the opportunity to allow spacing periods between each live-virus vaccination.

Moreover, this reviewer finds it odd that the U.S., *supposedly a democratic republic*, seeks to compel parents to vaccinate as a condition for their children's admission to the public schools their school and other taxes pay for but neither the country we fought with to become a "free" nation, England, nor the country we imposed our views of democracy on after World War II, Japan, seeks to compel parents to vaccinate their children – yet, for vaccines where there is no intra-country controversies or inter-country disagreements (*e.g.*, DTaP and IPV), the vaccination levels in all three countries are comparable.

Moreover, Japan, *which not only has risks for most all of the same childhood diseases as we do but also has endemic tuberculosis, Japanese Encephalitis risks and a higher level of hepatitis B risk*, has
a significantly lower infant mortality rate[8] of 3.24 childhood deaths per 1,000 births.

Since Japan's rate is almost half of the current rate in the United States (6.43 deaths per 1,000 birth), it suggests that:

- American parents' concerns about the recommended childhood vaccination schedule and some vaccines are valid, and
- The United States would be well served if its healthcare officials were to learn from and adopt the Japanese approach to childhood healthcare when it comes to childhood vaccines and the recommended childhood vaccination program.

"'They hear all the things on TV, the Internet,' Henderson says."

This reviewer is at a loss to understand the relevance of this remark.

"The most recent debate has raged over the safety of the mumps, measles and rubella (MMR) vaccine. "

This reviewer agrees with the writer that there has been and is a debate over whether or not the MMR vaccine is as safe as the "healthcare establishment" claims it to be.

However, *as previously stated*, the real debate is over whether vaccination with the trivalent MMR vaccine is as safe as vaccination with separate, time-separated, monovalent vaccines for measles, mumps and rubella.

Absent full tracking and disclosure of the real incidence of the severe adverse reactions, including death, severe brain damage, and abnormal and prolonged viral replication for the measles component in the MMR vaccine as well as the same data for the separate time-

[8] http://www.cia.gov/cia/publications/factbook/rankorder/2091rank.html [Note: This page was last updated on 29 March, 2006 when this reviewer last visited it on 18 Apr 2006

separated monovalent vaccines, there can be no definitive science-based assessment of the increased risk of harm, *if any*, associated with the combined vaccine.

However, *based on the lower Japanese infant-mortality rates and their experience with recommended separate vaccines for measles and rubella as well as a parent-optional mumps vaccine*, it would seem that vaccinating with separate measles and rubella vaccines (without a recommended mumps component) is safer overall.

In addition, *though better than the U.S. rate*, the United Kingdom (U.K.) infant-mortality rate is 5.08 childhood deaths per 1,000 births – still more than 55% higher than Japan's infant mortality (3.24 childhood deaths per 1,000 live births).

Perhaps the MMR, more Thimerosal-preserved vaccines, and, *effectively*, inoculation at earlier times have been significant contributors to the excess deaths in the U.S. and U.K.

Until the U.S. healthcare establishment honestly addresses the parent's rightful concerns and the issues raised with sound science rather than the current "trust us, its safe" rhetoric, this reviewer knows that the true safety of the MMR vaccine will remain an open issue – as it should.

"Some researchers believe Thimerosal, a compound containing mercury that is used as a preservative in the vaccine, can cause autism. "

Historically, in the 20th century, the "healthcare establishment" hid the form of mercury poisoning of babies caused by Calomel (mercury [I] chloride) [added to baby teething powders with "claims" of safety, but ***with no proof of safety***]. [**Note:** At its peak, about 1 in 500 babies who survived the mercury poisoning were left with significant long term neurological disabilities.]

These "healthcare providers" did this by labeling (diagnosing) the resulting Calomel-related mercury poisoning cases as some "causeless" disease (typically, Pink Disease or Acrodynia) instead of identifying it as the inorganic-mercury (Calomel) poisoning that it so obviously was.

When the public became aroused about this poisoning in the 1930s, the healthcare establishment responded by *quietly* and *slowly* withdrawing these Calomel-laced teething powders and other drugs that contained Calomel, or other inorganic mercury salts, from the "healthcare" market.

To replace the Calomel-based mercury poisoning of teething babies, the pharmaceutical manufacturing arm of the healthcare establishment turned to organic mercury compounds, mainly Thimerosal and phenylmercury[II] salts and, *without scientifically sound and appropriate proof of safety and effectiveness*, marketed these as antiseptics (typically, containing a 0.1% level of the organic mercury compound) for topical use and preservatives (typically, containing a 0.003% to 0.01% level of Thimerosal or a 0.01% level of some phenylmercuric salt) for serums and vaccines.

As with Calomel in teething powders and other drugs, these Thimerosal-containing drugs were represented and advertised as being both safe and effective without any scientifically sound and appropriate toxicological evidence to support either claim.

> Scientifically sound experimental studies from the 1930s and 1940s onwards have repeatedly established that Thimerosal was *neither* safe *nor* effective for use in topical products[9,10,11,12]
> or as a preservative in sera and vaccines.[13,14,15,16]
>
> In addition, there are numerous experimental studies that collectively have clearly established that Thimerosal is toxic to (mercury poisons) biological processes at levels below 0.05 ppm (< 0.05 micrograms of Thimerosal [49.55% mercury by weight] per gram of tissue or milliliter of biological fluid).[6,7,11,17]
>
> Moreover, the symptoms exhibited by developing animals and humans that have been sub-acutely mercury poisoned with Thimerosal include, *for those significantly affected clinically*, the set of symptoms used to diagnose "causeless" neurodevelopmental and behavioral disorders, including the neurodevelopmental disorder labeled "autism."
>
> In addition, case studies (in which the patients were evaluated using a scientifically sound differential diagnosis), which included genetic screening as well as screening for evidence of
>
> toxic levels of mercury and other heavy metals in children diagnosed with autistic spectrum disorders, have shown that more than 85% of the cases have a diagnosis of mercury and/or more-generalized heavy-metal poisoning.[18]

"According to the Centers for Disease Control and Prevention, Thimerosal has been removed from children's vaccines, except for trace amounts,"

> Since, in December of 2003, the Centers for Disease Control, and Prevention (CDC) added: a) the Thimerosal-preserved influenza vaccine to the childhood vaccination schedule and b) recommended immunizing pregnant women, this reviewer finds the writer's statement here, *at best*, problematic and clearly at odds with factual reality.

"and current scientific evidence does not support the hypothesis that the MMR vaccine, or any combination of vaccines, causes autism."

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9 Morton HE, North LL, Engley FD. The bacteriostatic and bactericidal actions of some mercurial compounds on hemolytic Streptococci – In vivo and in vitro studies ***JAMA*** 1948; **136**(1): 37-41.

10 Engley FB. Evaluation of mercurial compounds as antiseptics. ***Annals of the New York Acad Sci***. 1950; **53**: 197–206.

11 Engley FB. Mercurials as disinfectants – Evaluation of antimicrobic action and comparative toxicity for skin tissue cells. ***Soap and Chemical Specialties***. Dec. 1956:199,201,203,205,223-225.

12 Fagan DG, Pritchard JS, Clarkson TW, M. R. Greenwood MR, Organ mercury levels in infants with omphaloceles treated with organic mercurial antiseptic. ***Archives of Disease in Childhood***. 1977; **52**: 962-964.

13 Salle AJ, Lazarus AS. Pacific Coast Section. 7809 C. A comparison of the resistance of bacterial and embryonic tissues to germicidal substances. I. Merthiolate. ***Proc Soc Exp Biol and Med***. 1935; **32**(5): 665-667.

14 Stetler HC, Garbe PL, Dwyer DM, Facklam RR, Orenstein WA, West GR, Dudley KJ, Bloch AB. Outbreaks of group A Streptococcal abscesses following Diphtheria-Tetanus toxoid-Pertussis vaccination. ***Pediatrics***. February 1985; **75**: 299-303.

15 http://www.fda.gov/ola/2005/influenza0210.html, last visited 25 June 2006. "As you know, on October 5, 2004, the British Medicines and Healthcare products Regulatory Agency (MHRA) suspended Chiron's license to manufacture influenza vaccine due to sterility failures in filled vials of the vaccine."

16 http://www.fda.gov/foi/warning_letters/g5899d.html June 30, 2006, WARNING LETTER, Sanofi Pasteur, Inc., found, among other problems, INVESTIGATION OF FAILURES for "Eleven Fluzone® (preservative formula and no preservative formula) monovalent concentrate lots manufactured between February 2006 and April 2006 failed sterility. There were significant deficiencies in the investigation of these sterility failures."

17 Goth SR, Chu RA, Gregg JP, Cherednichenko G, Pessah IN. Uncoupling of ATP-mediated calcium signaling and dysregulated IL-6 secretion in dendritic cells by nanomolar Thimerosal. ***Environ Health Perspect***. **114** (48 pages) online 21 March 2006 at http://www.ehponline.org.

18 Private communications from both the researchers and some of the parents whose children have been treated.

This reviewer finds that there is a growing body of experimental science that does support the hypothesis that Thimerosal-preserved vaccines are a major factor in more than 85% of the children diagnosed with an autistic-spectrum disorder.

Moreover, epidemiological studies reviewing the data in multiple U.S. data bases[2] have clearly established that, *with the appropriate offset to allow time for the diagnosed neurodevelopmental disorders, including autism, to "develop,"* the rise, and subsequent fall, in the incidence of neurodevelopmental disorders tracked the rise and fall in the maximum exposure level for Thimerosal through 2003.

"Area doctors ease parents' concerns by educating them."

'I think it's important to provide parents with the available and accurate information about the vaccinations,' Moerschel says."

This reviewer agrees that "'it's important to provide parents with the available and accurate information about'" vaccinations and vaccines.

However, as this reviewer has noted, the general healthcare establishment sites cited by this writer seem to lack the accurate and complete information needed by parents and guardians to give, or withhold, their informed consent for their children to be vaccinated, or not to be vaccinated, with a given vaccine.

"She refers parents to reputable Web sites so they can read about immunizations and diseases. Among those she recommends are www.vaccine.chop.edu (the Vaccine Education Center of The Children's Hospital of Philadelphia); www.immunize.org (Immunization Action Coalition); and www.cdc.gov (Centers for Disease Control and Prevention)."

This reviewer finds that the general information provided on all three of the cited "reputable" sites is strongly biased toward vaccination.

However, the information obtainable by searching the CDC website, especially in the Morbidity and Mortality Weekly Reporter (MMWR) section, is often useful in finding out less biased information on the risks and benefits associated with a given vaccine.

For example, *while searching for publications that established that the human influenza vaccines are ineffective*, this reviewer found a scientifically sound and relative unbiased article in the MMWR.[19]

Similarly, the most recent CDC survey estimate for autism prevalence in the U.S. in 2003–2004 was published in the MMWR.[20]

However, this reviewer would recommend that the independent National Vaccine Information Center's website, http://www.909shot.com, because it is a much better source for unbiased information on vaccines and vaccination, and it has excellent links to other sources of valuable information.

For vaccine package inserts, this reviewer visits the webpage: http://poisonevercure.150m.com/vaccines/package_inserts/package_inserts.htm as well as uses Google's advanced-search capability.

"Lyon-Loftus says some of the parents of his patients say they don't want to put 'bad stuff' in their children's bodies."

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19 Centers for Disease Control and Prevention. Assessment of the effectiveness of the 2003-04 influenza vaccine among children and adults-Colorado, 2003. ***MMWR*** 2004; **53**:707-710 (2004).

20 Schieve LA, Rice C, Boyle C, Visser SN, Blumberg SJ. Mental Health in the United States: Parental Report of Diagnosed Autism in Children Aged 4–17 Years — United States, 2003–2004 ***MMWR***, May 5, 2006; **55**(17);481-486

This reviewer, a scientist who is also a father and grandfather, supports the validity of the views of those parents who say "they don't want to put 'bad stuff" in their children's bodies."

"He tries to dispel myths: 'You can't get measles from the measles shot. You can't get mumps from the mumps shot,' Lyon-Loftus says, because they contain killed, not live, viruses."

Since the MMR vaccine and the individual monovalent measles and mumps vaccines contain live viruses,[21] the fact is that most all children do get a case of the measles and the mumps when inoculated with these vaccines and, *worse*, in a percentage of those so inoculated, they do infect others with whom they have contact after vaccination.

Worse, for the MMR vaccine, more than one research team have confirmed Dr. Wakefield's findings of abnormal measles virus propagation in some of the children who have severe bowel damage and also have a diagnosis in the autistic spectrum.

Based on the preceding, either the doctor quoted here or the writer of the article need to update their understanding of reality, and, *in the case of the writer*, correct this article to report the facts accurately.

"Sometimes parents still opt not to have their children immunized, which can put doctors in a tough spot."

Since the decision to vaccinate or not to vaccinate is supposed to be the parent's decision, this reviewer does *not* understand what the "tough spot" really is.

However, since pediatricians reportedly derive more than 50% of their income from the well-baby visits tied to vaccination and bonuses paid for meeting high levels of compliance for the children in their practice, this reviewer does understand that each refusal costs the physician revenue – perhaps that is the "tough spot" to which the writer is referring.

"So they don't expose other patients to potential disease, Henderson says some physicians refuse to provide medical care to patients who opt out of immunizations. They also fear putting their patients at risk of severe illness and death if they do not inoculate, she says."

First, vaccinated patients can pose the same, or a higher risk, if, when sick, they are allowed to come in close contact with other patients because, *even when vaccinated*, not all develop immunity and some can not only contract diseases but, *even before they have visible symptoms*, can also expose others to various contagious diseases.

Using Henderson's logic, physicians should refuse to provide medical care to any patients in their offices because all of their patients, *vaccinated or not*, can, *if actively shedding infectious disease organisms*, "expose other patients to potential disease."

Factually, since:

a. the "risk of severe illness and death" in the unvaccinated segments of the U.S. population seems to be the same as, or lower than, the "risk of severe illness and death" from the adverse effects of vaccination in the vaccinated segments of the U.S. population, and

b. asthma appears to be "very rare" on the unvaccinated segments of the U.S. population,

this reviewer finds that the stated "fear" is, *if real*, less than rational.

"Others, like Moerschel, agree to disagree.

'Someone has to take care of them. You can't force people to do things,' she says.

'It is a personal decision for parents to make,' Moerschel says, adding that most parents who have been resistant to having their children inoculated usually agree to it after being given up-to-date information."

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[21] http://poisonevercure.150m.com/vaccines/package_inserts/MERCK-mmr.pdf

This reviewer finds the views espoused by Moerschel to be more rational.

However, this reviewer finds that, *when accurately and completely informed of the potential risks and the short-term benefits as well as the long-term problems that vaccination may exacerbate*, many such parents:

- Practice sound hygiene and teach sound hygiene practices to their children,
- Teach abstinence and, *when appropriate*, safe sexual practices to their children,
- Closely monitor their children's activities and contacts,
- Opt to restrict vaccination to the proven childhood vaccines, DPaT, IPV, and the MMR (or the separate monovalent measles and rubella vaccines without the mumps vaccine) to which their children are likely to be exposed
- Breastfeed their children for extended periods,
- Delay the start of vaccination until their child's immune system matures (at about 2 years of age), and
- Appropriately expose their children to the other common childhood diseases (like, chickenpox and mumps) because
  - the risk of a severe disease incident is, in their minds, miniscule and
  - the longer-term immunity conferred by periodic exposure to these diseases are perceived to outweigh the disease risks.

Because of these families' lifestyles, *even when transiently exposed*, their children have little risk of contracting chronic cases of hepatitis A, hepatitis B, hepatitis C, and other lifestyle-related diseases (including syphilis, gonorrhea, chlamydia, and HPVs).

Moreover, their children also seem to have little, or no, risk of contracting meningococcal, and other air- and dirt- borne bacterial, infections that home remedies and OTC drugs, like colloidal silver and 1% phenol solutions cannot effectively treat in most cases.

Moreover, *based on the case evidence from practices that do not push immunization*, asthma and other autoimmune diseases are rare condition in the unvaccinated and minimally vaccinated population segments.

Perhaps it is time to conduct comparative "conception to age 18" studies comparing the health of healthy neonates who are naturally delivered, breastfed, raised, and unvaccinated to matched healthy neonates who, though naturally delivered, are raised in a fully vaccinated environment provided vaccinations are limited to those vaccines that have unequivocally proven effectiveness periods of at least 10 years.

This reviewer knows that such studies, *if properly conducted by unbiased researchers*, would be highly informative.

However, this reviewer also notes that the U.S. healthcare establishment has vigorously opposed these studies.

"**Not a one-shot deal**

While there is no limit to the number of shots children can receive in one visit, Henderson says that to be humane, she will not administer more than four at a time."

This reviewer finds that the article's views here ignore the reality that the ideal is to give each vaccine to a healthy child separately with a suitable period between vaccines to ensure that, should any short-term adverse effect be observed, it would be easy to identify the vaccine that caused the adverse reaction.

In addition, the level, and risk, of vaccine interference, a known reality, increases as the number of vaccines delivered at one time increases.

From what this reviewer can see, the rush is to give more vaccines and to combine vaccine components so that even more vaccines can be licensed and used in order to maximize the healthcare provider's and the vaccine makers' profit with apparently little regard for the best interests of the children (or their parents).

"Moerschel says children who have fallen behind on their immunizations might require more shots at one time, sometimes as many as six."

Some can be combined, which reduces the number of injections, but the sting of the immune boosters is inevitable."

This reviewer finds that these remarks indicate an even-less-caring attitude toward parents and children than the previous remarks.

"Lyon-Loftus says parents can give their children Tylenol before and after a shot to ease discomfort, plus offer reassurance that the pain from the injection will not last long.

'It's usually harder on the parents than it is on the kids,' Henderson says."

This reviewer first notes that these remarks seem to reduce children to little more than cattle.

In addition, this reviewer finds it difficult to accept Henderson's glib remark "'It's usually harder on the parents than it is on the kids,'" when it is the "kids" who are permanently harmed and, in some cases, die, whenever there is immediate (*e.g.*, high fever, seizures and anaphylactic shock) or delayed (*e.g.*, SIDS) serious harm.

In closing, this reviewer reminds the writer that vaccines do maim and kill hundreds of babies each year.

In a society that claims to honor the rights and the freedoms of the individual, this reviewer again finds it incongruous that parents are coerced into vaccinating their children for the "common good" when there are other societies, *which have even more endemic transmissible diseases and do not similarly coerce parents*, that have significantly lower infant mortality rates than the U.S. infant mortality rate.

Based on an infant mortality rate almost twice the Japanese rate, it is obvious to this reviewer:

- The U.S. vaccination programs are significant direct and indirect contributors to the excess deaths 3+ childhood deaths per 1,000 births seen in the U.S.,
- The U.S. vaccination programs need to be scrapped and restarted with all vaccines being completely free of Thimerosal or any other mercury-based compound,
- In general, all childhood vaccination should be delayed until the child's immune system is fully functional or, at a minimum, until a single vaccine dose can be shown to provide effective immunity for longer than 5 years,
- If a live-virus vaccine is recommended for the national immunization program for a disease, all live-virus vaccines should be given separately,
- Vaccines that do *not* provide coverage for all endemic strains of a disease organism should: **a)** be clearly identified as such, **b)** only offered as an option to parents **and c)** *not* included in the universal childhood vaccination program
- To be included in the recommended national program, the vaccine should provide proof of the long-term effectiveness comparable to the disease for any childhood-disease vaccine that is given to children,
- All coercive vaccination laws should be scrapped, and
- The pertinent parts of the Japanese national vaccination schedule should be adopted as the basis for the U.S.-recommended national childhood vaccination program.

"Sources: Centers for Disease Control and Prevention; Dr. Laura Henderson with Smithsburg Family Medical Center; Dr. Sarah Moerschel, a pediatrician with Harpers Ferry (W.Va.) Family Medicine"

In general, the sources used by this reviewer include the references cited.

In addition, this reviewer relies on years of research into the U.S. healthcare establishment and conversations with similarly concerned healthcare providers, research scientists, health advocates, and concerned parents in the U.S. and elsewhere.