

Monday, 28 January 2008

To The Reader:

The text following this page is a review of an online article, “**Vaccinations are still needed for kids,**” by “DR. MEG FISHER” that this reviewer found and downloaded on December 30, 2007 from:

<http://www.courierpostonline.com/apps/pbcs.dll/article?AID=/20071230/OPINION/712300316/1047>

The formal review, which is titled “**A Review of: ‘Vaccinations are still needed for kids,’**” begins on the next page.

Introductory Remarks

First, *to simplify this review*, the statements in the article by the writer, Margaret (Meg) C. Fisher, MD, FAAP, will be quoted in a “Times New Roman” font.

Second, remarks by this reviewer, Paul G. King, PhD, will be presented in indented text following each of the writer’s quoted remarks.

In addition, this reviewer’s remarks will be in a **dark blue** “News Gothic MT” font except when he quotes: a) from or refers to any federal statute or regulation, the text will be in a “Lydian” font and b) from other sources, the quotations will be in an “Arial” font.

When this reviewer quotes from statements made in the writer’s column, this reviewer will use an *italicized “Times New Roman”* font.

Finally, should anyone find any significant factual error for which they have published substantiating documents, please submit that information to this reviewer so that this reviewer can improve his understanding of factual reality and appropriately revise his views and this review.

With these things in mind, this review of “**Vaccinations are still needed for kids,**” begins on the next page.

Respectfully,

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A Review of: “Vaccinations are still needed for kids”

“Vaccinations are still needed for kids

“Immunizations have been the greatest public health success story of the past century.”

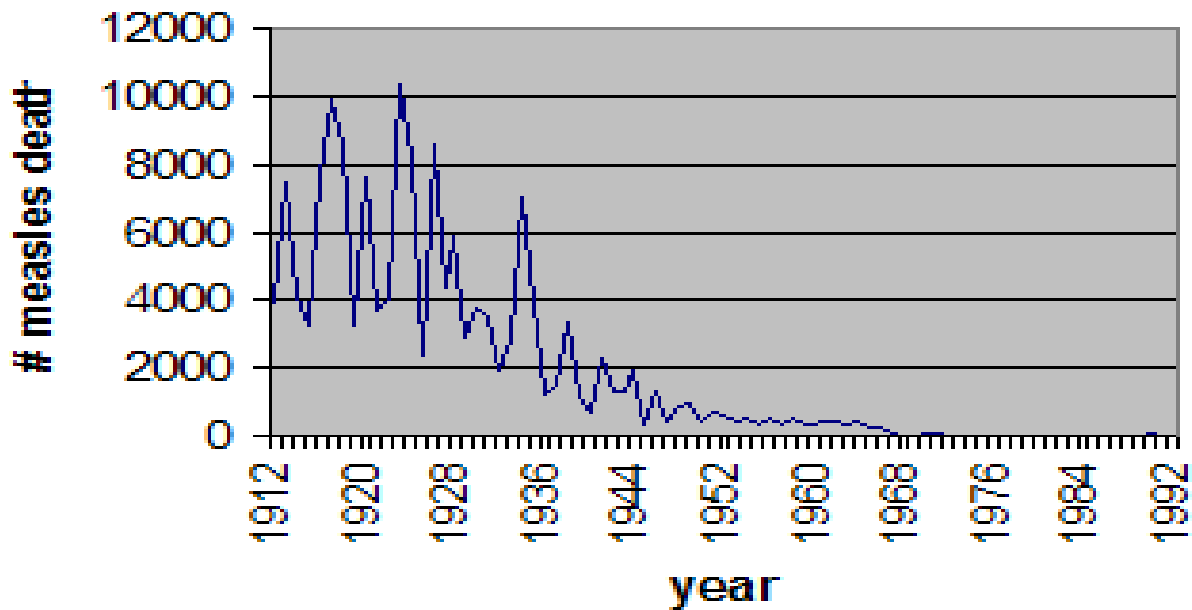
Why is it that vaccine apologists begin their articles with unsubstantiated statements, like this, that ignore the greater public health success stories involving the provision of clean potable water, sanitary sewers, wastewater treatment, and sanitary garbage collection and disposal, as well as improvements in the provision of adequate shelter and nutrition to most of the American public?

Accurately, more than 90 % of the declines in the annual numbers of deaths for contagious diseases endemic in the United States, other than smallpox, (e.g., cholera, measles, rubella, polio) occurred before there were vaccines for them.

For example, the estimated annual average pre-vaccine cases and deaths from measles are generally based on the years 1953-1962,¹ the decade prior to the introduction of an effective measles vaccine in 1963.

By then (see **Fig. 1**), the annual number of deaths in the 1953-1962 period (<800 per year) had already dropped by more than 93% from the peak annual deaths in the 1915-1924 period (> 10,000 in 1924).¹

Figure 1. Measles deaths by year, 1912 to 1993



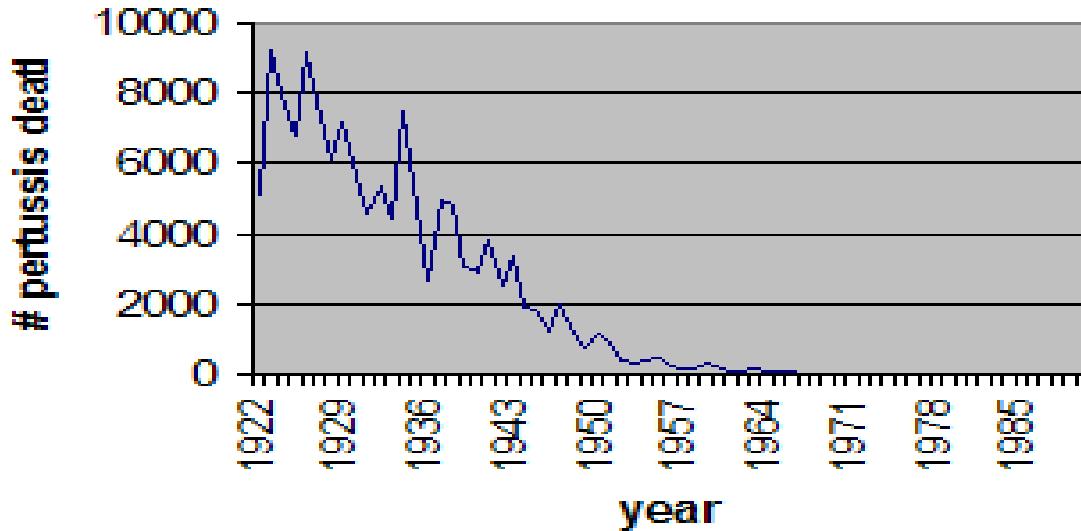
Ignoring the earlier years *inaccurately* represents the magnitude of the decline in measles that is attributable to vaccination as the most significant factor when the real major factors in the decline in measles deaths were pre-vaccine factors, such as significant increases in the availability of safe food and drinking water, and major improvement in sanitation, housing and nutrition.

¹ Centers for Disease Control (CDC). Reported Measles Cases, Deaths, Deaths-to-Cases Ratio and Estimated Population in the United States, 1912-1984. Provisional Data; Doc #0051m

Lest the reader think that this is an isolated instance, the data for pertussis deaths from 1922-1999² (see **Figure 2**) shows a similar pattern.

Again, more than 90 % of the drop in annual deaths occurred before the United States had an effective standardized vaccine (in the early 1950s).

Figure 2. Pertussis deaths by year, 1922 to 1999



Ignoring the earlier years, as vaccine apologists are prone to do, again inaccurately attributes most of the decline in deaths to vaccination.

Further, the data for clinical polio cases in the United States³ (see **Figure 3** on the following page) clearly indicates that there was a significant decline in clinical polio cases before the first Salk vaccine was introduced in 1955.

Moreover, the reality for paralytic polio is much more complex than the information provided in this article portrays it and, as is the case currently with *Thimerosal* and *neurodevelopmental and other developmental disorders in children*, human-made (iatrogenic) environmental factors, chlorinated chemicals (labeled as “DDT-like chemicals,” and “DDT” in the figure), appear to have been significant causal cofactors in the rise (1912 – 1953) and fall (1953 – 1970) of clinical cases of “Poliomyelitis” in the U.S.

Based on the preceding examples (for measles, pertussis and polio), it is clear that the vaccines mentioned by this writer have been a significant, albeit minor, factor in the decline in the level of human harm caused by these diseases in the United States.

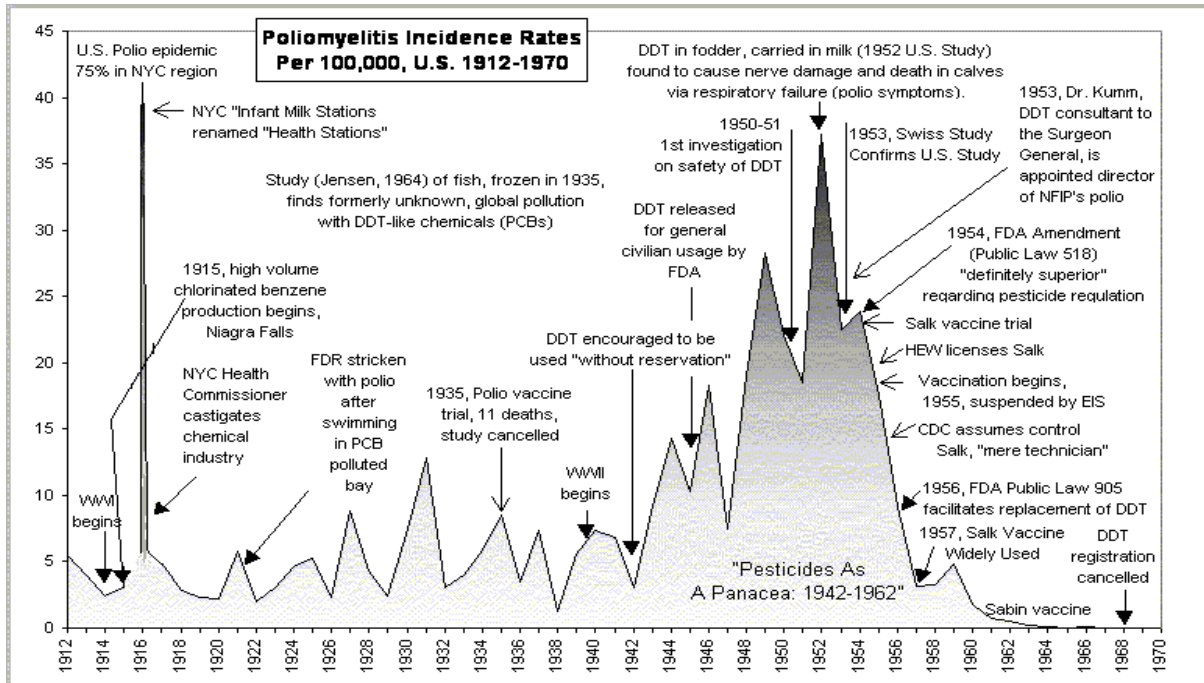
In addition, in the case of polio, it appears that chlorinated pesticides (“DDT”) were a major factor in the increase in clinical cases of polio in the period from 1943 to 1952.

“Small pox has been eliminated from the world, polio from the western hemisphere, and both

² “Pertussis (Whooping Cough) – Reported cases and deaths per 100,000 population, by year, United States, 1922-1981.” [Graph]. In Centers for Disease Control. Annual Summary 1981: reported morbidity and mortality in the United States. *Morbidity and mortality weekly report (MMWR)*. 1982 Oct; **30**(54): 65.

³ http://www.geocities.com/harpub/pol_all.htm last accessed 24 November 2007.

Figure 3: Poliomyelitis: "Graphic Timeline: U.S. 1912-1970"



measles and rubella from the United States.”

Smallpox and Polio

While this reviewer does not dispute the claim for smallpox, the 2005 cluster of non-paralytic cases of vaccine-strain-related polio⁴ clearly indicates that the polio virus has not been eliminated “*from the western hemisphere.*”

Moreover, the latest published “**Summary of Notifiable Diseases**” report⁵, published in the March 30, 2007 issue of the *Morbidity and Mortality Weekly Report (MMWR)* [MMWR 2007 March 30; 54(53): 2-92], reported being notified of one vaccine-strain-related case of paralytic polio.

Measles

Similarly, apparently 9 of the 66 clinical cases of measles reported in 2005⁶ were not traceable to sources outside the United States, indicating that the measles virus has apparently not yet been completely eliminated from the United States.

Moreover, since, in at least two cases in the Indiana outbreak, the persons having a clinical case of the measles were fully vaccinated, it is clear that full vaccination is not completely protective.

Considering all of the preceding, it seems that measles has not been eliminated “*from the United States*” as the writer states here.

⁴ <http://www.medpagetoday.com/PublicHealthPolicy/PublicHealth/tb1/1935> last visited 14 November 2007

⁵ <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5453a1.htm> last visited 31 December 2007

⁶ http://www.cbsnews.com/stories/2006/12/21/health/main2290957.shtml?source=search_story last visited 31 December 2007

Rubella

Based on absence of reported congenital rubella cases in newborns, “in 2005, CDC announced the elimination of rubella virus in the United States.”⁷

However the published “*Summary of Notifiable Diseases – United States, 2005*” report⁵ lists “11” “reported” cases of rubella, including “1” case of congenital rubella syndrome.

Reviewer’s Conclusion from the Data Reported

First, *though these disease conditions are “reportable,”* not all clinical cases may have been reported to the Centers for Disease Control and Prevention

Moreover, *because there is no active screening for non-clinical cases of these diseases,* the reported clinical cases represent a lower-bound least estimate of the actual incidence of infection by these diseases.

Based on all of the above, it is clear that the writer’s “vaccination success” claims for polio, measles and rubella are somewhat inflated.

In addition, because there is no routine monitoring program for these diseases in unaffected individuals (those who show no clinical disease symptoms), the published data only track the level of clinical disease and not the level of “infection by” the various disease organisms mentioned.

“Further, the incidence of tetanus, diphtheria, pertussis (whooping cough), bacterial meningitis and hepatitis has fallen dramatically.”

This reviewer accepts that “*the incidence of tetanus, diphtheria, pertussis (whooping cough), bacterial meningitis and hepatitis have*” declined significantly in the United States.

However, this reviewer does not know what percentage of the decline observed is attributable to vaccination nor does the writer of this article address this point.

Fundamentally, this reviewer again knows that better education, improved hygiene, safe food and drinking water, and improved sanitation as well as better housing and nutrition were significant contributors to the declines observed.

Moreover, in the case of hepatitis B, this reviewer notes that:

- Because:
 - The early vaccination program used does not provide long-term immunity, to those vaccinated, and
 - The general risk of contracting the disease is limited to IV-drug users and those engaged in risky sexual practices with multiple partners,the CDC’s recommended early “universal” vaccination program for hepatitis B does not appear to be designed to provide effective protection for hepatitis B to children during the at-risk period of childhood development (starting at about age 10) and,
- Based on the French experience, increases the risk that the children vaccinated will later develop multiple sclerosis (MS).

⁷ <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5515a6.htm> last visited 31 December 2007

Unfortunately, this reviewer is not aware of any long-term safety studies evaluating the hepatitis-B-vaccine-associated risk for MS and any other autoimmune diseases in vaccinated U.S. children as compared to matched “normal children” who have not been vaccinated with the hepatitis B vaccine.

“Since the use of Haemophilus influenzae type b vaccine in the mid-1980s, this infection has almost disappeared; it was a major cause of brain, airway, joint and skin infection in young children.”

Based on this reviewer’s previous published reviews that include a review of the “*Haemophilus influenzae type b vaccine*” (the “Hib” vaccine), the writer has inflated: a) the cases of Hib infections before the vaccine and b) the vaccine’s effect on the outcomes observed in children.

Consulting the CDC’s “**Summary of Notifiable Diseases – United States, 2002**” report,⁸ this reviewer finds the following for reported “*Haemophilus influenzae*” cases:

“Haemophilus influenzae, Invasive Disease

In 2002, 331 cases of invasive Haemophilus influenzae disease in children aged <5 years were reported; 34 (10%) were reported as H. influenzae type b (Hib), 144 (44%) were reported as other serotypes or non-typeable isolates, and 153 (46%) were reported with serotype information unknown or missing. The continued remarkably low number of invasive Hib infections in children (down from an estimated 20,000 cases annually in the prevaccine era) is a result of the successful delivery of highly effective conjugate Hib vaccines to children, beginning at age 2 months (1,2).

Because discrepancies in serotyping results have occurred between laboratories, CDC requests that state health departments obtain and send all invasive H. influenzae isolates from children aged <5 years to CDC for serotype confirmation (3,4).

1. CDC. Progress toward elimination of Haemophilus influenzae type b disease among infants and children---United States, 1998--2000. *MMWR* 2002; **51**: 234-237.
2. Zhou, F, Bisgard KM, Yusuf H, et al. Impact of universal Haemophilus influenzae type b vaccination starting at 2 months of age in the United States: an economic analysis. *Pediatrics* 2002; **110**: 653-661.
3. LaClaire LL, Tondella ML, Beall DS, et al. Identification of Haemophilus influenzae serotypes by standard slide agglutination serotyping and PCR-based capsule typing. *J Clin Microbiol* 2003; **41**: 393-396.
4. CDC. Serotyping discrepancies in Haemophilus influenzae type b disease---United States, 1998--1999. *MMWR* 2002; **51**: 706-707.”

Moreover, this report’s “**Table 1**” lists 1,743 cases of invasive *Haemophilus influenzae* and the total reported cases for children under 5 is 331.

In addition, the 2002 report’s “down from an estimated 20,000 cases annually in the prevaccine era” statement reveals that the government had no solid data for cases of *Haemophilus influenzae*, or disease prevalence data for the Hib strain in children under 5 before the current Hib vaccines were introduced on the 1980s.

Next, consulting the CDC’s “**Summary of Notifiable Diseases – United States, 2005**” report,⁵ this reviewer finds the following for reported “*Haemophilus influenzae*” cases:

⁸ <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5153a1.htm> last visited 31 December 2007. *MMWR* 2004 April 30; **51**(53): 1-84.

- Oddly, there is no paragraph discussing *Haemophilus influenzae* in the report.
- However, this “2005” report’s “**Table 1**” lists:
 1. 2,304 cases of invasive *Haemophilus influenzae*; a 32% increase from 2002.
 2. For children under five:
 - a. 9 serotype B cases (a 70+ % decrease from 2002),
 - b. 135 nonserotype B cases (a 6+ % decrease from 2002),
 - c. 217 unknown serotype cases (a 42 % increase from 2002), and
 - d. 361 total cases (a 9% increase from 2002).

Given the increase in unknown serotype cases,

- The CDC’s 2002 request “that state health departments obtain and send all invasive *H. influenzae* isolates from children aged <5 years to CDC for serotype confirmation” was ignored, and/or
- The CDC did not confirm the serotyping or serotype the majority of the isolates submitted as “unknown serotype cases,” and/or
- New strains of this disease were emerging that, *lacking suitable anti-sera*, the states and/or the CDC could not serotype.

Subsequently, consulting the CDC’s “**Notice to Readers: Final 2006 Reports of Nationally Notifiable Infectious Diseases**,”⁹ this reviewer finds in its “**Table 2**” the following data are reported for “*Haemophilus influenzae*” cases:

1. 2,436 cases of invasive *Haemophilus influenzae*; a 6% increase from 2005 cases.
2. For children under five:
 - a. 29 serotype B cases (a 320+ % increase from 2005)
 - b. 175 nonserotype B cases (a 30 % increase from 2005),
 - c. 179 unknown serotype cases (an 17+ % decrease from 2005), and
 - d. 383 total cases (a 6 % increase from 2005).

Based on all the published CDC data available to this reviewer, it appears that the Hib vaccines are shifting the distribution of serogroups toward other serogroups.

Furthermore, recent reports indicate that other organisms that are more difficult to treat than Hib are beginning to fill the bacterial “niche” left by the Hib vaccine.

In addition, studies have reported that there is a “causal relationship between the haemophilus vaccine and the development of insulin dependent diabetes ... 3 – 4 years after four doses of Hib.”¹⁰

Since the cost impacts of the short-term adverse effects were not considered in the initial licensing of the Hib vaccines and the long-term adverse effects to health (e.g., insulin-dependent diabetes) and the rise in infections by other microorganisms filling the niche left by the Hib vaccine, rather than continuing this line of reasoning, which looks to modify the strains in the vaccine, the public needs to reconsider whether or

not a vaccine for Hib is *medically* cost-justifiable because the published data seem to indicate that this is not the case.

⁹ <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5633a4.htm> last visited 31 December 2007. *MMWR*, 2007 August 24; **56**(33): 851,853-863.

¹⁰ <http://www.vaccines.net/newpage112.htm> last visited 31 December 2007.

“Because we have done so well at protecting our children, most parents and many physicians have never seen the diseases we are preventing.”

While this reviewer does not dispute the writer’s assertion here, IF “*we have done so well protection our children,*” THEN:

1. Why is it that US infant mortality is twice the rate in Japan?
2. Why is it that we have epidemic increases in the levels of neurodevelopmental disorders, childhood obesity, both types of childhood diabetes, childhood gastrointestinal disorders, childhood cardiovascular disease, childhood asthma and COPD, other childhood autoimmune diseases including childhood MS, certain childhood cancers, and severe food allergies and food intolerances in American children?
3. Why is it that this doctor does not even mention, *much less address*, any of these realities?

In most cases, *for most such diseases (including those for which there is no current vaccine) except for chickenpox and wound-acquired bacterial organisms like tetanus*, immunologically and dietarily healthy children exposed to most childhood diseases will, *after some exposures*, be infected, have a sub-clinical or mild case of the disease, rapidly recover, and have near lifetime immunity.

This reviewer finds that trading any of these childhood diseases for an epidemic increase in the incidence of the chronic diseases addressed in the prior questions does not appear *societally* cost effective, and is definitely not *medically* cost effective.

For diseases like measles, polio, tetanus, rubella and diphtheria, this reviewer sees merit in the current federally backed vaccination programs for these diseases, albeit with much greater flexibility.

However, *for many of the other CDC-recommended vaccines*, this reviewer finds either:

- No justification for a national vaccination program, or,
- *When the current vaccines have been proven ineffective in protecting those vaccinated from getting a disease (as is the case for the current influenza vaccines, for example) and there is a proven prophylactic treatment (appropriate daily doses of vitamin D-3,¹¹ that protect against infection by all strains of influenza, for example), no justification for the continued licensing of the such vaccines.*

“This success has made people question whether we need to vaccinate if the diseases are gone.”

First, as this reviewer has shown, *except for smallpox*, these diseases are definitely not “gone.”

Second, with the “*success*” in trading single acute disease cases for epidemic levels of chronic lifetime “disease” conditions (like those outlined by this reviewer in his question “**2**” on the previous page), this reviewer wonders why any rational person

would advocate continuing the current U.S. national vaccination programs or, *worse*, recommend expanding them to include other vaccines for which there is even less evidence of medical cost effectiveness (e.g., the rotavirus vaccine) or, *in some cases*,

¹¹ Cannell JJ, R. Vieth R, Umhau JC, Holick MF, Grant WB, Madronich S, Garland CF, Giovannucci E. Epidemic influenza and vitamin D. *Epidemiol. Infect.* 2006 Dec; **134**(6): 1129-1140.

no proof of long-term effectiveness for preventing the end-stage disease against which the vaccine is represented to protect (e.g., the HPV vaccines represented to protect against cervical cancer that may develop decades later but has not even been proven to provide long-term [> 40 -year] protection against getting an HPV infection from even the few stains of human papilloma viruses covered – much less to protect against the development of cervical cancer).

“The answer is a big ‘yes.’”

Since the writer is a vaccine apologist and derives her prestige and income from vaccination, no reader should be surprised that this writer would answer an implicit question that she herself has stated with “*a big ‘yes.’*”

“Whenever countries have stopped or slowed their immunization efforts, the illnesses have returned.”

Since the disease organisms have never left and, *in the case of the live-virus vaccines*, have merely had their strain-diversity altered, all that changed when “*countries have stopped or slowed their immunization efforts*” is the number of clinical cases of disease in those countries where other effective disease countermeasures:

- Increased specific vitamin supplementation during the infection (e.g., natural vitamin A to suppress the virulence of the measles infection or vitamin D-3 to suppress influenza),
- Increased supplementation with appropriate levels of vitamins and minerals that the individual’s diet and lifestyle may not provide (e.g., with vitamin A, the B vitamins, vitamin C, vitamin E, vitamin D-3, folate or folinate, omega-3 fatty acids, zinc and magnesium) to bolster the body’s immune systems, and
- Improved hygiene, sanitation, housing, and nutrition

have not been taken.

“There were major outbreaks of measles in the United Kingdom and Ireland, whooping cough returned in several areas when immunization rates dropped.”

This reviewer does not dispute that there were “*outbreaks of measles in the United Kingdom and Ireland ... when immunization rates dropped*” or that “*whooping cough returned in several areas*” except that it even “*returned*” in areas of the U.S. where the vaccination rates had not dropped and a number of fully vaccinated persons have been diagnosed with whooping cough – indicating that even multiple initial doses of the vaccine do not provide true long-term immunity to contracting whooping cough.

However, *in most cases*, the two doses of measles virus and rubella virus “infections” given to those vaccinated with the current live-virus vaccines do seem to provide near lifetime immunity.

“Until an illness is eliminated from the world, we must protect our children since the infections are just a plane ride away.”

Since there are tens of illnesses in the world that “*are just a plane ride away*” for which there is no vaccine and several diseases endemic to parts of the U.S. for which there is a vaccine (e.g., cholera and rabies) but no justification for a national vaccination, this reviewer finds little of value in this writer’s statement here.

Moreover, if we really wanted to “*protect our children*” from exposure to diseases by persons arriving by plane from outside the U.S., then we should require all such persons to be tested for all diseases endemic to the countries they had visited and to be quarantined until the results for all tested indicate that none had any such disease – a requirement that would, *for example*, most certainly have caught the recent TB cases and all that may have been exposed to them, and also significantly raised the airline ticket’s cost for that plane trip and significantly extended the arriving overseas traveler’s “travel time.”

However, this reviewer observes no action by the CDC, or the Advisory Committee on Immunization Practices (ACIP), *of which this writer is apparently a member*, to even suggest, much less demand, a decrease in the risks of in-flight disease exposure and in-flight disease transmission by, *in the first instance*, requiring the airlines to: a) double the hourly exchanges of air in the plane and b) require that sterilized and tested 0.1-micron HEPA filters be installed on all air discharges into the airplane’s pressurized and heated areas prior to each flight into or within the U.S. and/or, *in the second instance*, requiring that the airplanes returning from overseas must be both fumigated and disinfected after landing in the U.S.

“New Jersey and most states have laws which require immunization for school or child-care entry.”

This reviewer notes that this writer is not only mistaken here but is also making a knowingly misleading statement.

Factually, “*New Jersey and most states have laws*” requiring each child to have proof of:

- a. Certain vaccinations (or, *for those who have had a given childhood disease*, established immunity to those diseases) or
- b. Appropriate exemptions from those vaccinations

as a condition for that child to attend a public school or, *in some*, child-care facility.

For those who are vaccinated in an acceptable manner, no proof of immunization is required.

Thus, because:

- There are exemptions from vaccination and
- Vaccination does not ensure immunization,

“*New Jersey and most states*” do not have laws “*which require immunization for school or child-care entry*”!

“These laws have been a major factor in increasing immunization rates in our country.”

While this reviewer agrees that the coercive aspects of the state vaccination laws “*have been a major factor in increasing*” vaccination “*rates in our country*,” this reviewer observes that Japan and other western democratic nations that do not have such coercive laws also have vaccination uptake rates for the vaccines they recommend that are similar to the U.S. vaccination rates.

“They have been the reason that racial disparities in vaccine access have drastically changed.”

While these laws may have been a factor in the decline in the “*racial disparities in vaccine access*,” this reviewer finds that low-cost access by governmental purchase and distribution of recommended vaccines has also been a significant factor.

“It is essential that we continue to support this legislation and that we make access to care for all children a priority.”

Here, unless the “we” in this doctor’s statement are the healthcare providers and vaccine makers, this reviewer finds that it is absurd to blindly support laws and practices that have:

- Dropped us to last place in developed countries for infant mortality, with an infant mortality rate (6.4+ per 1,000 live births) almost twice that of Japan, the leading industrialized country (3.2+ per 1,000 live births), and
- Replaced, *in many instances*, some risk of acute childhood illnesses from which most children completely recover within days with:
 - A significant risk of short-term harm and death from vaccination (e.g., Guillain Barré syndrome, anaphylactic shock, seizures, and SIDS), and
 - Epidemic increases in long-term chronic-conditions’ harms from the current vaccination programs (epidemic increases in chronic childhood conditions that this reviewer has addressed in question “2” that he previously asked in this review).

As this reviewer has suggested, we, the people of New Jersey, need to remake the law in New Jersey into the form that has given Japan the lowest infant mortality while attaining and maintaining high vaccination rates and low disease outbreak rates for the diseases for which the vaccines recommended have been proven to be *medically cost-effective*.

We need to do this because the current laws and programs have given us high infant mortality and failed to give us healthy children with the low levels of chronic disease that children born in the early 1940s had and, *except for diseases caused by or aggravated by the contaminants in the polio vaccines (e.g., SV-40-associated/caused brain tumors)*, continued to have into adulthood and beyond.

Thus, we need to:

- Abandon the state-mandated approach,
- Only recommend giving those vaccines whose vaccination programs are *medically cost-effective* to our children, and
- Adopt a voucher program where, *up to 96 months of age*:
 - The parent can have their children vaccinated with no cost to them for the vaccines, and,
 - *If they use a public clinic*, no cost for their administration and recordskeeping, so that we use “carrots” rather than “sticks” to encourage vaccination.

“Children are our future and we want them to be healthy and protected from what were once the usual childhood infections.”

As a parent and now grandparent, this reviewer agrees that “(c)*children are our future and we want them to be healthy.*”

However, as an adult who had most of the childhood diseases growing up including clinical cases of measles, mumps, rubella, chickenpox, and whooping cough as well as probably sub-clinical cases of polio and hepatitis A, this reviewer is opposed to protecting children from “*what were once the usual childhood infections*” whenever:

- *As the case appears to be today, any of these vaccines, as they are recommended to be given today, significantly increase the risk for:*
 - Long-term chronic conditions, and/or
 - Chronically unhealthy children,
- *As the case seems to be, or is, for the chickenpox, rotavirus and HPV vaccines, the vaccination programs, even excluding their proven-short term harm and putative long-term harm, are not medically cost-effective, OR*
- *As the case is for the some vaccines, the vaccines have not truly been proven to be in-use effective in preventing those vaccinated from getting the disease (e.g., influenza and *increasingly* chickenpox).*

Therefore, this reviewer challenges the writer to provide published peer-reviewed scientifically sound articles and the data and detailed procedures used in them that refutes the findings alluded to here since, *to this reviewer's knowledge*, there are no such unbiased scientifically sound publications.

Thus, *except for individual-component measles, rubella, diphtheria, tetanus, and polio vaccines and appropriately tailored vaccination programs where some groups should get another vaccine (e.g., mumps vaccine for males who are 10 or older, have not had a clinical case of the mumps or had an incomplete case, and have no evidence of immunity to mumps)*, this reviewer is not willing to trade:

- a. Short-term avoidance of childhood illnesses that, *in most cases*, cause no long-term harm and/or
- b. Vaccination for diseases where most American children have little risk or no risk for contracting a clinical case of the disease (e.g., hepatitis B and HPV), for the epidemic increase in the long-term chronically unhealthy children that today's (from the late 1980s until the present) "universal" vaccination programs for the other diseases seem to have produced.

"Recent legislation adds several vaccines to the requirements: influenza and pneumococcal vaccine for children attending child care and for preschoolers, and Tdap (the tetanus, diphtheria and whooping cough booster) and meningococcal vaccine for sixth graders and transfer students."

Since the changes in the New Jersey laws are administrative in nature, it is, *at best*, misinformed, and, *at worst*, duplicitous, to state, *as this New Jersey doctor does here*: "(r)ecent legislation adds several vaccines to the requirements."

Since the New Jersey legislature passed no law to add these vaccines, they were not added by legislation.

Essentially, the New Jersey health officials, *ignoring the informed public's valid objections*, recommended adding these to the required vaccination schedule and New Jersey Gov. Corzine did not oppose the health officials' recommendations

"These vaccines have been recommended for some time; the legislation will help increase the number of our children who are protected."

Again, there was no "legislation," and the overall outcomes from adding these four vaccinations to the New Jersey requirements remain to be seen.

In the short run, *given the high-handed manner in which New Jersey health officials have*

proceeded and the nature of the vaccines added, this reviewer would suggest that this may be the proverbial slap on the other cheek that causes many knowledgeable New Jersey parents to:

- Realize that these state health officials do not have the best interests of the children of New Jersey at heart,
- Have a religious epiphany, and,
- *To protect their children from the machinations of bureaucratic state health officials*, immediately apply for a religious exemption.

In this reviewer's theological view, a person should:

- Trust the God who commands us to worship no manmade idols, places cleanliness next to godliness, and forbade His chosen people to eat blood and unclean animals, and
- Reject all vaccines that are not proven medically cost-effective by independent scientists as the manmade idols to greed, *the root of all evil*, that vaccines that are not medically cost effective so obviously are.

“Yearly shot

Influenza vaccines have been available for more than 30 years.”

While the preceding is true, no large-scale studies have ever proven that these vaccines are truly effective in preventing those vaccinated from getting influenza.

Furthermore, this statement is misleading because the CDC's recommendation for “universal” vaccination of any age-group of children, *without any proof of effectiveness or safety*, only started in 2002, about 6 years ago.

Since the requirements for all drugs, including vaccines, mandate that they be proven to be both safe and effective, how can the CDC or any other any governmental agency legally continue to recommend use of any drug that lacks in-use proof of effectiveness?

Specifically, recent studies^{12,13} (and the applicable references contained therein) have shown that these vaccines were not effective in preventing those who were vaccinated from *subsequently* getting influenza.

In fact, the retrospective study of U.S. influenza vaccination, influenza-related deaths, influenza cases, and influenza-related hospitalizations for the period from 1979 to 2000¹³ found no correlation between influenza vaccinations and: a) influenza cases, b) influenza-related (mostly pneumonia) deaths, and c) influenza-related hospitalizations in any of the years where there was published comprehensive data.

Moreover, this review study found that the annual number of influenza-related deaths ranged from 604 to 3001 – and not the “estimated” 36,000 influenza-related deaths per year that the CDC and, *until recently*, the media have reported to occur each year.

¹² Jefferson T. Influenza vaccination: Policy versus evidence. *BMJ (British Medical Journal)* 2006 October 28; **333**: 912-915.

¹³ Geier DA, King PG, Geier MR. Influenza Vaccine: Review of effectiveness of the U.S. immunization program, and policy considerations. *JAPS (Journal of American Physicians and Surgeons)* 2006 Fall; **11**(3): 69-74.

In addition, other studies have *conclusively* shown that the influenza vaccines are not effective in protecting young children from getting influenza.^{14,15}

Worse, since 1977, if not before, the CDC and all the medical community have known, or they have been responsible for knowing, that injecting pregnant women with a Thimerosal-preserved influenza vaccine significantly increases the risk that their children will be born with serious birth defects¹⁶, how is it that, after 1977, they have recommended and/ or injected and are continuing to recommend and/ or inject pregnant women with Thimerosal-containing influenza vaccines?

Obviously, their commitment to inoculating pregnant women with a less-than-effective influenza vaccine apparently outweighs their concern, *if any*, for the increases in the birth defects that injecting pregnant women with Thimerosal-preserved influenza vaccines has been shown to cause.

So much for the claim that there is no evidence that Thimerosal-preserved vaccines have caused harm to children.

SINCE: The current influenza vaccines are not generally effective in preventing those vaccinated from getting influenza and, *even in small trials*, and are not effective in preventing young children from getting influenza; and most of the vaccine doses contain a toxic level of Thimerosal (49.55 weight-% mercury),

THEN: Why would New Jersey health officials recommend adding this ineffective vaccine to the vaccination schedule for children who are in day-care or are entering school without, *at least*, mandating the influenza vaccine used must: a) not give the child inoculated a case of influenza, *as the MedImmune's live-virus FluMist® does*, and b) be manufactured without using Thimerosal, *since there is a licensed no-Thimerosal inactivated-virus influenza vaccine formulation that is approved for children 6-month old and older?*

Hopefully, when those who are engaged in this conspiracy to force vaccines that are not proven effective and/or not proven safe upon New Jersey children are brought to justice, those New Jersey officials who participated in any aspect of this conspiracy to defraud the public, *including*

- *The vaccine manufacturers: Sanofi Aventis, MedImmune (AstraZenaca) and, probably, Novartis, as well as*
- This writer and
- Any other vaccine apologists or officials,

who are on record as supporting the vaccination of children with ineffective drugs, will all be prosecuted to the full extent of the law under the federal criminal RICO statutes for activity that appears *clearly* criminal in this reviewer's understanding of the laws regulating the sale and promotion of drugs that, *in addition to requiring proof*

of safety, require in-use proof of effectiveness – proof that is clearly lacking for the influenza vaccines given to young children.

¹⁴ Jefferson T, Smith S, Demicheli V, Harnden A, Rivetti A, Di Pietrantonj C. Assessment of the efficacy and effectiveness of influenza vaccines in healthy children: systematic review. *Lancet* 2005; **365**: 773-780.

¹⁵ Maeda T, Shintani Y, Nakano K, Terashima K, Yamada Y. Failure of inactivated influenza A vaccine to protect healthy children aged 6-24 months. *Pediatr Int* 2004; **46**: 122-125

¹⁶ Heinonen, O. P., Slone, D., and Shapiro, S. 1977. Birth Defects And Drugs In Pregnancy. Littleton: Publishing Sciences Group, Inc.

Since only Sanofi Aventis' inactivated-influenza Fluzone vaccines are approved for children 6 months to 2 years of age and only their and MedImmune's live-virus influenza vaccine FluMist (that infects each child inoculated with it with 3 cold-adapted bioengineered strains of influenza) are approved for children 2 years to 4 years of age, these firms are the principal short-term financial beneficiaries of the New Jersey annual flu-vaccine directive.

In addition, Novartis' inactivated-influenza vaccine is also approved for children 4 years of age and older and it will financially benefit when, *as now projected for next year*, the federal government recommends an annual flu shot for "almost all" children 6 months to 18 years of age instead of the current age-group recommendations, which stop at 5 years, or, in some cases, 9 years of age but suggest continued immunization for children in certain risk groups.¹⁷

Hopefully, after reading this review, readers will contact the appropriate New Jersey and federal authorities and demand that all those involved in this conspiracy to force vaccines that have been shown to be ineffective and/or have not been proven safe to the biological-drug standard "sufficiently nontoxic" (see 21 CFR Sec. 610.15(a)) for all of the children of New Jersey are prosecuted to the full extent of all applicable laws and statutes – state and federal.

"Since the protection from the vaccine [f]or the disease is short-lived, it is recommended that vaccine be given yearly."

Since the current influenza vaccines are not effective in preventing those inoculated from getting influenza, this reviewer wonders why any knowledgeable person could, *in good faith*, recommend that any young child or, *for that matter*, any person be given an annual flu inoculation, unless their ethics has been corroded by their lust for power and/or monetary gain.

Since this reviewer understands the reality that all influenza vaccines are not effective in preventing influenza infection except *possibly* for infections in some by one of the three strains of influenza virus used to make the vaccine, while taking 1,000 to 5,000 IU of vitamin D-3 daily (depending on the person's body weight, skin pigmentation, and daily exposure to the sun) is effective in minimizing the risk of contracting a clinical case of any strain of influenza,¹¹ this reviewer is at a loss to see any medical justification for the continued use of any influenza vaccine.

"About 45 percent of children are infected each year, frequently at school or in child care."

Since, for the period 1979 through 2000, about 32 % to 51 % of the U.S. population apparently contracted influenza,¹³ this reviewer has no problem accepting that the "*About 45 percent of children are infected each year*" portion of this statement may be valid.

However, this reviewer respectfully requests this writer to provide the studies that establish that the "*frequently at school or in child care*" portion of the statement is valid since the articles, *which this reviewer has read that mention this subject*, report that most Americans contract influenza in the workplace.

"These children take the infections home to their parents and grandparents."

¹⁷ <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5701a8.htm>.

First, this writer is not clear as to which are the children that “*take the infections home to their parents and grandparents.*”

Second, since today most grandparents:

- Have been targeted for influenza vaccination for decades,
- Have been being vaccinated for influenza with the same strains as the strains in the vaccines given to children for years, and
- Do not live with their grandchildren,

this reviewer observes that the writer’s claim that “*children take the infections home to their ... grandparents*” seems to be counter to the norms in today’s America except for those cases where the grandparent(s) is(are) the parent(s) or live with the parents.

“We know the best way to protect the entire community is to vaccinate the children.”

Based on the scientific facts, the best way to protect the entire community from getting any influenza strain would be to recommend that everyone, *except for a nursing baby whose mother is taking supplementary D-3*, take about 1,000 to 5,000 IU of vitamin D-3 daily, depending on the person’s body weight, skin pigmentation, and daily exposure to the sun.

“Each year, more than 100 children die from complications of influenza and thousands of adults die because of this virus.”

This reviewer is skeptical of the writer’s claim that “*more than 100 children die from complications of influenza*” on the U.S. because, *for the period from 1979 to 2001*, 15 to 42 annual deaths for children 14 years of age and under, with a median and average of 28 annual deaths, were attributed to influenza¹³ and the trend is to fewer annual deaths as the age of the children increases (*on average, for 1979 – 2001*, about 10/year for children up to 1-year old; about 2/year for children 1 to 4+ years of age; and roughly 1/year for children 5 to 14+ years of age).

Unless this writer can provide published data indicating a significant increase in confirmed influenza-related deaths during the influenza seasons for the 5 U.S. flu seasons from 2003 (for the 2002-2003 flu season) to 2007 (for the 2006-2007 flu season), this reviewer must conclude that the average number of confirmed annual flu-related deaths is closer to not more than 40 children than it is to the writer’s unsupported claim of “*more than 100.*”

“Vaccinating our young children will protect them and their families.”

Based on the published information presented by this reviewer, “(v)accinating our young children” will not “*protect them and their families*” from getting influenza.

If the reader wants to protect young children and their families from getting human influenza, then he or she should join in advocating that daily supplementation with the appropriate amount of vitamin D-3 be used by all during the influenza season.

In any case, the reader should oppose the mandated use of influenza vaccines in any case because they are not effective.

“The pneumococcal vaccine has been very successful in decreasing infections due to the bacteria,

Streptococcus pneumoniae.”

Here, the writer begins by making a statement that is, *at best*, inexact.

Factually, the “*pneumococcal vaccine has been very successful in decreasing infections*” only when caused by those strains of *Streptococcus pneumoniae* that are presently in the licensed vaccine.

“These bacteria are a major cause of serious bacterial infection (brain, lungs, joints, skin and overwhelming total body infection) in young infants and a major cause of pneumonia at all ages.”

While this statement is generally factual, it does not even note the long-term-usage problems with any vaccine that only protects against certain strains of a multi-strain mutating disease organism.

Those problems are that such vaccines: a) promote strain drift and b) favor the potential occupation of the biological niche for current vaccine-covered strains of *Streptococcus pneumoniae* by other adventitious organisms that, *in either case*, may be more virulent and/or drug resistant than the *S. pneumoniae* strains in the current vaccine, Wyeth Pharmaceuticals Inc’s Prevnar® for children, the vaccine being added to the New Jersey vaccination schedule.

“The vaccine was licensed and recommended for universal use in 2000.”

While the writer’s statement is true, this reviewer is at a loss to see the justification for licensing this vaccine since it is not very effective and has other serious problems.¹⁸

Moreover, a subsequent end of 2007 report¹⁹ has not only confirmed the potential problems associated with Prevnar but also confirmed that the use of Prevnar has facilitated the proliferation of a more-dangerous antibiotic-resistant strain of *S. pneumoniae* in the niche formerly fully occupied by other strains of *S. pneumoniae* including the seven “major” strains displaced by vaccination with Prevnar.

Since the vaccine:

- Has:
 - Limited efficacy,
 - Significant risks for serious side effects and
 - A confirmed risk of strain drift to a more dangerous strain, and
- Is relatively expensive (> US\$ 45 per dose of vaccine),

it is clear to this reviewer that this vaccine cannot be medically cost-effective.

Based on all of the preceding, rather than adding this vaccine to the New Jersey schedule, responsible public health officials should have:

- Condemned this vaccine,
- Pressed the CDC to withdraw recommendations for its general use, and

¹⁸ <http://www.whale.to/v/prevnar2.html> last visited 31 December 2007.

¹⁹ <http://www.whale.to/v/prevnar.htm> last visited 31 December 2007

- Urged the FDA to severely restrict its use in children to only those children with a proven susceptibility to *S. pneumoniae* who are allergic to most of the antibiotics approved to treat a *S. pneumoniae* infection.

“Since then, the rates of infection in both children and the elderly have decreased.”

Examining the CDC’s MMWR-reported data for 2002, 2005, and 2006, this reviewer found the data reported in **Table 1** (on the next page).

Based on this recent data for the reporting states, it is clear that the invasive cases of *S. pneumoniae* in those under 5 years of age are increasing significantly from year to year after just 2 years of “universal” vaccination.

Additionally, the annual rate of increase for invasive cases in those under 5 years of age is significantly larger than the corresponding rate of “increase” for drug-resistant invasive cases.

This data also appears to indicate this vaccine is:

- Not truly effective in preventing invasive cases of this disease in young children,
- A probably significant factor in the rise of antibiotic-resistant strains, and
- Possibly losing its effectiveness in preventing cases of the strains in the vaccine.

Table 1: Streptococcus pneumoniae data

Disease Item	1999 ²⁰	2000 ²¹	2001 ²²	2002 ²³	2003 ²⁴	2004 ²⁵	2005 ²⁶	2006 ²⁷
<i>Streptococcus pneumoniae</i> , invasive, drug resistant [% change from 2001]	4,618	4,533	2,896	2,546 [- 12.1%]	2,356 [- 18.6%]	2,590 [- 10.6%]	2,996 [+ 3.5%]	3,308 [+ 14.2%]
<i>Streptococcus pneumoniae</i> , invasive, < 5 years old [% change from 2001]	N/R	N/R	498	513 [+2.9%]	845 [+ 69.7%]	1,162 [+ 133%]	1,495 [200%]	1,861 [+ 274%]

Moreover, based on this reviewer’s personal experience with the vaccines for adults, Merck’s Pneumovax® 23, cases of *S. pneumoniae* disease in those who are fully

²⁰ <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm4853a1.htm> last visited 1 January 2008. **MMWR** 2001 April 06; **48**(53): 1-104. 1999 summary report.

²¹ <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm4953a1.htm> last visited 1 January 2008. **MMWR** 2002 June 14; **49**(53): 1-102. 2000 summary report.

²² <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5053a1.htm> last visited 1 January 2008. **MMWR** 2003 May 2; **50**(53): 1-108. 2001 summary report.

²³ <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5153a1.htm> last visited 1 January 2008. **MMWR** 2004 April 30; **51**(53): 1-84. 2002 summary report.

²⁴ <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5254a1.htm> last visited 1 January 2008. **MMWR** 2005 April 22; **52**(54): 1-85. 2003 summary report.

²⁵ <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5353a1.htm> last visited 1 January 2008. **MMWR** 2006 June 16; **53**(53): 1-79. 2004 summary report.

²⁶ <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5453a1.htm> last visited 1 January 2008. **MMWR** 2007 March 30; **54**(53): 2-92. 2005 summary report.

²⁷ <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5633a4.htm> last visited 1 January 2008. **MMWR** 2007 August 24; **56**(33): 851,853-863. Notice to Readers: Final 2006 Reports of Nationally Notifiable Infectious Diseases.

vaccinated tend to be diagnosed as conditions other than that which they actually have (e.g., severe bronchitis when this reviewer's condition was, *based on the chest X-ray taken and the bloody yellow/green mucous coughed up*, obviously, pneumonia in one lung).

This diagnostic bias seems to occur because the treating healthcare providers' innate belief that the vaccine is effective appears to be blinding them to diagnosing the obvious.

“Not all strains are covered by the vaccine, so we haven't eliminated disease but we have done well at decreasing it.”

This reviewer finds that the writer's “*we have done well at decreasing it*” ignores the reality that the vaccine is not effective in preventing those inoculated from getting the other strains of the disease which are increasing in their prevalence and fact that vaccination with Prevnar is helping to increase the incidence of antibiotic resistant strains of this disease making treatment of those children infected increasingly difficult and harmful to them.

Thus, apparently for the profit of the healthcare establishment, healthcare providers, and the vaccine's maker and the furtherance of the vaccination creed, the writer's “*we have*”:

- Simply overlooks:
 - The long-term harm that this vaccine has caused, is causing, and will cause, and
 - Prevnar's failure to be *medically* cost-effective,
- Is currently looking forward to the introduction of a reformulated vaccine in a few years that will:
 - Probably decrease the number of reported cases,
 - *Based on the history of such vaccines*, make it even harder to treat those who are still infected and
 - Be even less *medically* cost-effective than the current vaccine, and
- Considers the casualties that have occurred, are occurring and will occur as necessary sacrifices (“collateral damage”) to the “vaccine” god that they appear to *blindly* serve, if not worship.

“Tdap is a booster shot for adolescents and adults.”

This reviewer agrees with the writer in that the “Tdap” vaccines, *currently Sanofi Pasteur, Ltd's Adacel®, and GlaxoSmithKline Biologicals' Boostrix®*, are vaccines marketed as booster shots for “*adolescents and adults.*”

Specifically, these vaccines are vaccines for tetanus, diphtheria, and pertussis where, *because of its neurotoxicity*, the pertussis components have been significantly reduced from the levels in the childhood DTaP vaccines.

“It is what is needed to continue to protect you from lock jaw (tetanus), diphtheria (a throat and skin infection) and whooping cough (pertussis). Over time, your protection from either the vaccine or the natural infection drops; so you need a boost. This vaccine will boost your antibody levels to the

range needed for protection. By protecting teens and adults from whooping cough, we hope to prevent them from infecting young babies who aren't yet protected by immunization (it takes three doses of the vaccine to protect an infant).”

Since almost all Americans born from 1940 onwards have been vaccinated with one of the DTP vaccines, there is little data to support the writer’s assertion that, *for pertussis specifically*, the immunity from natural infection drops significantly.

In addition, there is an ever increasing body of data that the immunity from early childhood immunization does indeed drop to the point that some action may be needed – either a rethinking of vaccinating to protect against pertussis or, *as those who favor adding more “new” vaccines (for which they can charge significantly higher prices) to the vaccination schedule for children and adults have done*, developing booster vaccines, the “Dtap” vaccines, and adding them to the recommended vaccination schedule for those entering the “6th” grade (typically, those aged 11 to 13 years).

Rather than leave these Dtap vaccines as vaccines that parents may elect to have administered or not, New Jersey health officials have elected to add these vaccines to the New Jersey vaccination schedule.

Yet, in their typical myopic fashion, these health officials did not include an explicit exemption for all neurologically damaged children with an automatic substitution of an appropriate diphtheria/tetanus booster vaccine for these children, as cautious health officials would have done.

This is the case because even the acellular pertussis antigens contain some level of highly neurotoxic components²⁸ that are even more neurotoxic on a molecular basis than Thimerosal.

Thus, the actions of the New Jersey health officials to add the Dtap vaccines to the New Jersey vaccination schedule in the manner they have done is another reason that informed parents may seek a religious exemption from vaccination for their children and themselves.

“Finally, the new meningococcal vaccine was licensed and recommended for use in 2005.”

First, this writer’s statement is somewhat misleading because the addition to the New Jersey schedule does not necessitate the use of the new Sanofi Pasteur, Inc’s Menactra® A, C, Y and W-135 (“MPSV4”) to which she is apparently alluding.

Factually, Sanofi Pasteur Inc’s previous vaccine, Menomune® A, C, AC and A/C/Y/W-135 (“MCV4”) is still available and actually recommended by the CDC²⁹ for the first dose.

Because the multi-dose formulation of Menomune is Thimerosal preserved (0.01% Thimerosal; 25 micrograms of mercury per 0.5-mL dose), if the New Jersey health officials were truly concerned about the health of our children, their addition of this

²⁸ <http://www.vaclib.org/chapter/inserts.htm> last visited on 1 January 2008 contains links to some manufacturers’ package inserts and to sites that link to these package inserts. Readers having children and grandchildren who may be adversely affected by a Dtap booster vaccine are strongly encouraged to read and study the package inserts, especially, the contraindications, warnings, and other risk information provided – understanding that the data presented provides the least information that the FDA will approve concerning these risks.

²⁹ <http://www.state.nj.us/health/cd/documents/child-schedule.pdf> last visited 1 January 2008

vaccine would have, *at a minimum*, included an absolute prohibition against the use of any Thimerosal-preserved vaccine to satisfy this vaccination mandate – but, *as far as this reviewer can ascertain*, no such prohibition was included in the regulations they approved.

Moreover, as this reviewer has testified to the FDA prior to the FDA's approval of Menactra,

- There is no direct outbreak-quelling proof this vaccine is effective against the disease strains covered (surrogate serological endpoints against animal antisera were used to assess antibody titer),
- The short-term (3 year) efficacy studies show significant loss of antibody titers for all components with not more than 80 % “efficacy” assured for 3 years,
- The vaccine continues to provide a false sense of vaccination security because (based on the prior military experience with Menomune):
 - Menactra provides no protection against the “B” strain of the disease, the strain found in more than 25% of the cases typed, and
 - Vaccination with Menactra will, *as giving Menomune has already done*, actually increase the prevalence of the “B” strain of the disease in the vaccinated community, and
- Based on the data that this reviewer was allowed to review, Menactra is a vaccine that:
 - Identifies those who, *when injected with it*, will generate antibodies to the antigens for the 4 strains injected but not necessarily protect them from contracting the disease even if they are exposed to one of the covered strains, and
 - Lacks any long-term (10-year) safety studies to assess its long-term adverse effects.

Based on all of the preceding information and the vaccine's per dose costs, it is clear that adding these vaccines for *Neisseria meningitidis* to the New Jersey schedule is not medically cost effective and a better use of New Jersey healthcare dollars would be to teach children and families to observe better hygiene practices, including hand and face washing, because *N. meningitidis* is a dirt-borne organism

“It will protect high school students from most cases of meningococemia, a life threatening illness. It is safe and effective. It provides protection against four of the five most common strains of these bacteria.”

Here, this reviewer finds that this writer is being too simplistic since about 15 % of those vaccinated with MPSVA, the new vaccine about which she is speaking, will not, *based on the manufacturer's submission data*, have an effective level of protection against the four strains covered and none will have any immunity against the “B” strain found in more than 25% of the typed cases or other less-common strains of the disease organism *Neisseria meningitidis*.

Statistically, the general level of protection provided by this vaccine is less than less than 63% and, *when the child is exposed to the “B” strain of N. meningitidis*, the level of protection provided against “B” strain infection is zero.

Based on the preceding realities, it is definitely not medically cost-effective to add this vaccination to the New Jersey schedule and, *given the short duration of the protection*

and the incomplete protection provided, it is probably not societally cost-effective to add it either.

Thus, the addition of this vaccine to the New Jersey schedule is but another case where a vaccine is being added to this schedule for the financial benefit of the healthcare establishment, healthcare providers, and the vaccines' manufacturer at the expense of the financial health of the New Jersey public.

“Every medicine and every immunization has side effects. All vaccines have been tested extensively and found to be safe.”

This reviewer can only agree with the writer's first statement: *“Every medicine and every immunization has side effects.”*

This is the case because, based on the data available to this reviewer:

- The safety of most vaccines is not studied for more than 6 months beyond the date of last dose in the vaccination series (they should be studied for at least as long as the time the vaccine's efficacy is monitored and probably should be studied for twice this period).
- Vaccine safety is not always, *as it should be*, studied against a sterile isotonic saline placebo (e.g., in the Merck Gardasil® vaccine case, the “placebo” was “allowed” to be the vaccine formulation without the HPV-related components in most cases so that the relative incidence rates for the adverse effects in the vaccine arm would be masked by high rates of similar short-term side effects in the “control”/“placebo” arm of the trial).
- The safety is not studied with all combinations of vaccines that may be given at the same time,
- No, or *inadequate*, safety studies are done for the vaccines' carcinogenicity, mutagenicity, genotoxicity, and adverse effects on human immune system health,
- No, or *inadequate*, safety studies are done to ensure that the vaccine has no short-term or long-term adverse effect on human reproduction,
- The “phase 3” clinical trials fail to have sufficient individuals in the test and control arms of the trial to reliably find adverse effects that occur at nominal levels of 1 in 10,000.
- The population in the “phase 3” clinical trials does not always reside in an environment (hygiene, sanitation, drinking water, food, and shelter) and/or always have a genetic make-up that mimics the situation in the U.S., and
- In general, the “phase 3” clinical trials for the recently approved new vaccines (e.g., HVP and the new rotavirus) have obviously been intentionally biased to conceal the harm and the lack of effectiveness for the protection claimed.

“There is no link of any vaccine to autism.”

Here, this writer is simply either uninformed or intentionally stating the opposite of the truth as if it were true – a classical doublespeak technique.

Since this reviewer has no personal knowledge of this writer, he leaves it to the readers who know this writer to assess which of the two possibilities is the case in this instance.

Tellingly, in a vaccine court injury case, which was originally scheduled to be heard as a

“Thimerosal causes autism” case in the Autism Omnibus, *Hannah Poling v. Sec. HHS* (02-1466V) [**Poling**], the government conceded this vaccine-injury-compensation “Thimerosal causes autism” case in November of 2007, before it was heard – even before the plaintiffs’ experts had filed their official reports with the clerk of the administrative vaccine court.

Apparently, after reviewing Hannah Poling’s medical records and the information in them provided by the plaintiffs and the Plaintiff Hannah Poling’s healthcare providers, the federal government in **Poling** has:

- Conceded that the vaccines given Hannah Poling are causal factors in her injuries and,
- *Obviously, by conceding this case*, admitted that there was a link between vaccines and autism in this vaccine injury case.

Furthermore, as this reviewer understands and all who read the ever-growing body of evidence should know, the proven reality is that injecting mercury³⁰ (from Thimerosal added to vaccine formulations as an in-process sterilant or a preservative) into children, *without the required proof of safety*,³¹ mercury poisons some of those developing children to the point that they exhibit the set sub-acute clinical mercury-poisoning symptoms that are used to diagnose autism and also harms other children to a lesser extent.

“Furthermore, there is no evidence that thimerosal, a preservative used in multidose vials of vaccines and used in some steps in making some vaccines, has caused any problems to those who received these vaccines.”

In addition to the putative “Thimerosal (in vaccines) causes autism” Autism Omnibus test case conceded in November of 2007 by the federal government (*Hannah Poling v Sec. HHS* [case: 02-1466V]), this reviewer would suggest that this writer get the list of applicable documents cited in the recent citizen petition filed with the U.S. Food and Drug Administration (FDA) on 24 August 2007 by the Coalition for Mercury-free Drugs (CoMeD) and assigned FDA Public Docket #: 2007P-0331, a copy of which is filed in the “Documents” web page on the CoMeD website, <http://www.mercury-freedrugs.org> with the title, “2007P-0331 Ban Use of Mercury In Medicine, UNLESS Proven Toxicologically Safe to the CGMP Standard Sufficiently Nontoxic (24 August 2007; 447 pages).”

Furthermore, in *Appendices “4” and “5” of the BIRTH DEFECTS AND DRUGS* (1977), Heinonen et al. reported that Thimerosal-preserved influenza-vaccine shots given to pregnant women significantly increased the relative risk for certain birth defects.¹⁶

For those readers who seek:

- More recent information and additional insights into the reality that those given Thimerosal-containing vaccines and/or other mercury-containing drugs are mercury poisoned to varying degrees or
- More information on the problems with some of the newer vaccines,

³⁰ Indirect mercury poisoning from injecting the developing children’s mother with a Thimerosal-containing vaccine while the children are in the womb and direct mercury poisoning when the post-natal children are injected with vaccines containing any level of added Thimerosal or other mercury compound.

³¹ 21 CFR Sec. 610.15(a).

this reviewer suggests that the reader review some of the newer documents posted in the CoMeD web site's "Documents" section:

- "A Review of the Doublespeak in: 'Vaccines and Autism: Myths and Misconceptions' By Steven Novella (18 December 2007; 63 pages),"
- "A Review of 'Parental Dilemma: To Get Kids Immunized or Not'" By Allen Mask, M.D. (28 November 2007; 15 pages),"
- "A Rebuttal to the Doublespeak in: 'Parents, officials struggle over right to refuse vaccines' By Logan Molyneux (25 November 2007; 39 pages),"
- "Thimerosal Causes Mercury Poisoning XVI - No Proof Of Safety for Thimerosal in Vaccines - A Rebuttal to the Doublespeak in: 'Suffer the Little Children' No More By Michael Fumento (29 October 2007; 20 pages)," and
- "Thimerosal Causes Mercury Poisoning XV - Mercury Poisoning by Thimerosal in Vaccines - A Rebuttal to the Doublespeak in: 'On Vaccines, Immune to Reason' By Paul Howard (18 October 2007; 19 pages)"

In addition, this reviewer suggests that the reader revisit the CoMeD web site in the middle of each month's as the web site is updated just after the first of each month.

Furthermore, for those interested in establishing whether they, their children and/or grand children (or other family members and friends) are clinically mercury poisoned or not, this reviewer suggests that these readers read and study all of the information posted in the CoMeD web site's "Urine Porphyrin Profile Analysis (UPPA)" web page.

Finally, for those interested in keeping abreast of the Geiers' published Thimerosal-related articles, this reviewer recommends that they read the articles posted in the CoMeD web site's "Geiers' Other Thimerosal-related Articles" web page.

Hopefully, *after reading any of the preceding articles*, the reader will understand that the writer's statement here is an apparently intentional misstatement that ignores the facts.

"Vaccinations are a life-preserving public health tool."

First, this writer's generalization here is, *at best*, an unsupported oversimplification.

Factually, the administration of some vaccines to exposed individuals, *like the rabies vaccine for those who have been bitten by a rabid animal*, is a life-saving public health tool.

In addition, the "universal" administration of some other highly effective childhood vaccines that have been proven to be medically cost-effective, *like the live-virus measles vaccine, the live-virus rubella vaccine, the inactivated polio and the Thimerosal-free DTaP vaccines*, seems to be a life-preserving public-health tool whose general use seems to be justified.

However, for childhood vaccines recommended for universal use that:

- Are not effective (e.g., the influenza vaccines, and the now-withdrawn LymeRix® vaccine),
- Cause more harm than the disease (e.g., the now-withdrawn RotaShield® bioengineered human-monkey hybridized multi-valent rotavirus vaccine),
- Infect populations with little or no disease exposure risk and seem, *based on the VAERS reports*, to be causing a level of harm that appears to exceed the pre-

vaccine level by a factor of 10 (e.g., the current Merck bioengineered human-bovine multi-valent hybridized rotavirus vaccine, RotaTeq®),

- Trade the risk of an acute short-term infection for the same or, *in most cases*, a significantly higher risk for several long-term chronic diseases (e.g., shingles, diabetes, or MS), or cause more harm or as much harm as the disease (e.g., Merck's Varivax® chickenpox vaccine, which has *significantly* increased the risk of childhood shingles and, *with full-population vaccination and even two doses of Merck's Varivax*, is less than 73% effective in protecting those vaccinated from getting a case of the native chickenpox virus),
- Provide: a) immunity when none is needed, b) almost no immunity when it is needed (e.g., the hepatitis B vaccines that, *based on the experience in France*, significantly increases the "long-term" risk for vaccine-related autoimmune diseases – a 4-year delayed increase in childhood MS cases until the "universal" vaccination program was discontinued, and, *probably*, the new HPV vaccines, which also seem to have significant severe side-effect risks, including Guillain Barré syndrome and death),
- Provide: a) limited immunity and b), based on published studies, increase the risk for insulin-dependent diabetes 7 years after the last childhood dose is administered (e.g., the Hib vaccines),
- Provide incomplete immunity for a given disease organism – vaccines that give a false sense of vaccine protection and cause strain drift and/or organism displacement (e.g., the Wyeth Prevnar, the Merck Pneumovax 23, the Sanofi Aventis Menomune and Menactra vaccines), and/or
- That are not *medically* cost-effective (like most of the vaccines licensed since 1986) or even *societally* cost-effective (e.g., the Merck Varivax, where 2 doses are now recommended, as well as Merck's RotaTeq and Gardasil vaccines),

are not a valid public-health tool, much less, "*a life-preserving public health tool.*"

"There are vaccines for babies, infants, children, teens and adults."

This reviewer agrees that this statement is true.

Moreover, there are also vaccines recommended for pregnant women of all ages without the requisite proofs of safety³¹ as well as vaccines for the elderly that also have not been proven to be safe ("*sufficiently nontoxic*") in the manner required by law.³¹

"These are very important medications that protect us; please call your doctor and see if you or your children could benefit from an immunization."

Obviously, this writer, who is a doctor with a clearly vested interest in promoting vaccination, is recommending that you "*call your doctor*" and implicitly trust her or him to tell you "*if you or your children could benefit from an immunization.*"

In contrast, this reviewer, who is not a medical doctor and has no vested interest in promoting, or not promoting, vaccination, is recommending that you:

- Study the all of the available published information, *pro and con*, on each vaccine,
- Take any information provided by any party with a vested interest in promoting vaccination or a particular vaccine with a *proverbially* large grain of salt,

- Make your own judgment as to which vaccines to give and when they should be given to, and
- Resist, *by any and all legal means*, any attempt by any “health official” to override or change your decisions while being open to all new information and/or conditions that may cause you to reconsider your decision.

Reviewer’s Concluding Remarks

Hopefully, the remarks and information provided by this reviewer have addressed all of the comments made by this writer in a straightforward and factual manner.

Perhaps, in the face of the *Poling* decision, the influenza-vaccine-related birth-defect relative risks that were reported in 1977 in **BIRTH DEFECTS AND DRUGS**¹⁶, which reviewed the data from government-funded studies involving 50,000+ pregnancies between 1958 and 1965, and the growing body of case-control evidence that most children diagnosed with autism are mercury poisoned, this writer will:

- Cease denying the reality that injecting Thimerosal into developing children mercury poisons all who are so inoculated to varying degrees
- Join the effort to remove Thimerosal from all vaccines and other drugs, and to recall and destroy all existing doses of all such drugs, and
- Demand that the licenses and approvals for all drugs containing any level of added mercury be revoked.

However, this reviewer will, *in any case*, continue to answer those who, like this writer, are vaccine apologists bent on touting the benefits of vaccines and vaccination and denying harm even in cases where there appear to be no net benefits to the public.

Furthermore, this reviewer challenges this writer to provide *scientifically sound* toxicity and case-control studies, *not other epidemiological studies of patient records*, that have established that mercury in the form of Thimerosal, any of its mercury-containing solvolysis products (ethylmercury chloride and ethylmercury hydroxide), and/or its final metabolism end products in the human body (tissue-retained “inorganic” mercury species) are not toxic to humans at biological systems’ levels below 1 ppm.

Finally, this reviewer

- Is not anti-vaccine,
- Understands that some vaccines are medically cost-effective, and,
- *If bitten by an animal suspected to be rabid*, would immediately seek to be given the rabies vaccine doses need to protect him from contracting rabies.

Background on the writer of “Vaccinations are still needed for kids”

Since Dr. Margaret C. (Meg) Fisher did not include any information about herself in this article, this reviewer offers the following mid-2006 “**Press Release**.”³²

“CONTACT: **Kristine A. Brown**

Director of Public Relations
(732) 557-7167

³² http://www.sbhcs.com/hospitals/monmouth_medical/PRESS/2006/treasurer.html last visited 1 January 2008.

The Children Hospital at Monmouth's Medical Director Elected Treasurer of American Academy of Pediatrics' New Jersey Chapter

LONG BRANCH, NJ, JUNE 27, 2006 - Margaret C. Fisher, M.D., FAAP, medical director of The Children's Hospital at Monmouth Medical Center, has been elected treasurer of the American Academy of Pediatrics' New Jersey Chapter.

Dr. Fisher assumes her one-year post on the chapter's five-member Executive Committee after serving as its secretary/editor in 2004 and 2005. Active in the national American Academy of Pediatrics (AAP), Dr. Fisher last year edited a book titled *Immunizations & Infectious Disease: An Informed Parent's Guide*, published by AAP. She has been a member of its Section of Infectious Disease Executive Committee since 2003 and this year, she was elected chairperson of that section.

Under her leadership at Monmouth Medical Center, where she has served as chair of the Department of Pediatrics since 2000, the 527-bed teaching hospital recently was licensed by the state of New Jersey as an official children's hospital for Monmouth and Ocean counties. For the past 35 years, Monmouth, an affiliate of the Saint Barnabas Health Care System, has built an immeasurable record of achievement as the region's leading provider of pediatric care that spans nearly 30 specialties.

Dr. "Meg" Fisher, a resident of Sea Bright, is widely recognized in the field of pediatrics — as a clinician, educator, author and leading expert in children's health. Before joining Monmouth as Pediatrics chair, she was the associate chair of education at St. Christopher's Hospital for Children, Philadelphia. She headed the pediatric clerkship of Drexel University College of Medicine — Monmouth Medical Center's Philadelphia-based teaching affiliate — and continues to serve there as a professor of pediatrics.

In her academic role at Monmouth, Dr. Fisher has consistently captured Drexel's most prestigious annual teachings awards bestowed by its medical students, including the Dean's Special Award for Excellence in Clinical Teaching in 1997, 1999, 2002 and 2004, and the Golden Apple Award in 1999, 2003 and 2005. In 2003 and 2005, Monmouth Medical Center's pediatric residents presented her with their Best Teacher Award.

Board certified in pediatrics and pediatric infectious disease, Dr. Fisher earned her medical degree from the UCLA School of Medicine, Los Angeles, before completing her residency in pediatrics and a fellowship in pediatric infectious disease at St. Christopher's Hospital for Children.

A fellow of the AAP since 1982, she served on its Committee on Infectious Diseases from 1996 to 2002 and again starting in 2006. She is a member of its Committee on Continuing Medical Education and is on the editorial board of the Pediatrics Review and Education Program (PREP) Audio.

Her recently published *Immunizations & Infectious Disease: An Informed Parent's Guide* is a 425-page evidence-based reference book on keeping children healthy through immunizations, preventing and controlling infections, and understanding the use of antibiotics. It is based on the AAP's *Red Book: Report of the Committee on Infectious Disease*, the leading authoritative physicians' guide on diagnosing and treating infectious disease.

Since joining Monmouth Medical Center, Dr. Fisher has been an active member of AAP's New Jersey chapter, a Trenton-based organization that represents pediatricians across the state dedicated to improving children's health through advocacy, legislative efforts, public awareness and education."

Background on the reviewer of "Vaccinations are still needed for kids"

For information on Paul G. King's credentials, background, activities and interests, you can visit his web site: <http://www.dr-king.com>.