Sunday, 28 February 2010

To All:

The text following this page is a draft review of: "**The damage done**", dated February 17, 2010, by Michael Fumento (fumento@pobox.com) as downloaded by this reviewer on 18 February 2010 from the Internet from: http://www.nationalpost.com/todays-paper/story.html?id=2573624&p=1 and: http://www.nationalpost.com/todays-paper/story.html?id=2573624&p=2.

This draft response, titled "**Draft Review of Michael Fumento's: 'The damage done**'," begins on the next page.

REVIEWER'S INTRODUCTORY REMARKS

First, *to "simplify" this response*, when portions of the article being reviewed are addressed in the review, the statements in this article will be quoted in a "Times New Roman" font.

Second, except for his introductory remarks, the remarks by this reviewer, Paul G. King, PhD, are presented in indented text following the section of the article that is being reviewed.

In addition, this reviewer's remarks and suggested changes are in a "News Gothic MT" font except, when he quotes: **a)** from or refers to any US statute or regulation, the text will be in a "Franklin Gothic Medium Cond" font or **b)** from other sources, the quotations will be in an "Arial Narrow" font. When this reviewer quotes from statements made in the article, 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 he can improve his understanding of factual reality and appropriately revise his views and the final review.

Respectfully,

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Draft Review of Michael Fumento's: "The damage done"

REVIEWER'S INTRODUCTION

As a researcher and supporter of safe, effective and cost-effective vaccination programs, where such exist, this reviewer is taken aback by another in a long line of articles that distort the facts, and misrepresent reality, in an attempt to vilify those who seek safe, effective and cost-effective vaccines and vaccination programs that have been proven not to increase the rates of chronic diseases in our children.

Finding evidence that some vaccines and/or vaccinations programs have not been proven to be sufficiently safe, truly effective and/or cost effective, these individuals simply seek to have: **a)** the vaccine makers[1] and the federal government[2] comply with the provisions of the National Vaccine

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1 "Sec. 300aa-22. Standards of responsibility

(a) General rule

Except as provided in subsections (b), (c), and (e) of this section[,] State law shall apply to a civil action brought for damages for a vaccine-related injury or death.

(b) Unavoidable adverse side effects; warnings

(1) No vaccine manufacturer shall be liable in a civil action for damages arising from a vaccine-related injury or death associated with the administration of a vaccine after October 1, 1988, if the injury or death resulted from side effects that were unavoidable even though the vaccine was properly prepared and was accompanied by proper directions and warnings.

(2) For purposes of paragraph (1), a vaccine shall be presumed to be accompanied by proper directions and warnings if the vaccine manufacturer shows that it complied in all material respects with all requirements under the Federal Food, Drug, and Cosmetic Act [21 U.S.C. 301 et seq.] and section 262 of this title (including regulations issued under such provisions) applicable to the vaccine and related to vaccine-related injury or death for which the civil action was brought unless the plaintiff shows -

(A) that the manufacturer engaged in the conduct set forth in subparagraph (A) or (B) of section 300aa-23(d)(2) of this title, or

(B) by clear and convincing evidence that the manufacturer failed to exercise due care notwithstanding its compliance with such Act and section (and regulations issued under such provisions).

(c) …

(d) …

(e) Preemption

No State may establish or enforce a law which prohibits an individual from bringing a civil action against a vaccine manufacturer for damages for a vaccine-related injury or death if such civil action is not barred by this part". [Emphasis added.]

2 "Sec. 300aa-27. Mandate for safer childhood vaccines

(a) General rule

In the administration of this part and other pertinent laws under the jurisdiction of the Secretary, the Secretary shall -

(1) promote the development of childhood vaccines that result in fewer and less serious adverse reactions than those vaccines on the market on December 22, 1987, and promote the refinement of such vaccines, and

(2) make or assure improvements in, and otherwise use the authorities of the Secretary with respect to, the licensing, manufacturing, processing, testing, labeling, warning, use instructions, distribution, storage, administration, field surveillance, adverse reaction reporting, and recall of reactogenic lots or batches, of vaccines, and research on vaccines, in order to reduce the risks of adverse reactions to vaccines.

(b) Task Force … .

(c) Report … ."

Injury Compensation Act (Title 21 of the United States Code, Sections 300aa-1 through 300aa-34 [21 U.S.C. §§ 300aa-1 – 300aa-34]) with respect to proving vaccine safety and safening vaccines and **b)** all federal-government-recommended vaccination programs be independently proven to be truly cost effective when all of the costs of the adverse reactions to the vaccines, secondary vaccine-related-strain infection, and the increased rates of chronic disease associated with any aspect of any program are considered.

The purpose of this review is to provide, where and as appropriate, an in-depth, fact-based assessment of the statements made by Michael Fumento, the writer, or the statements attributed to other persons or officials by said writer.

However, this reviewer would be remiss if he did not point out that "***The damage done***" is replete with this writer's "interesting", and carefully framed, statements, which often appear to be more doublespeak[3] (Orwellian Newspeak) than honest discourse.

Finally, at times this document makes strong assertions.

Nonetheless, this reviewer has made objective assessments based on the facts, as he clearly understands and, where critical, documents them.

"Anti-vaccinationists initially claimed California autism cases dropped after the removal of thimerosal. That isn't true. The 'data do not show any recent decrease in autism in California' despite the discontinuation of thimerosal use, the state's Department of Developmental Services found in 2008."

Any claim that includes assertions like "*after the removal*" or "*despite the discontinuation*" with regards to Thimerosal (used as a preservative and in-process sterilant or denaturant in the manufacture of biological drug

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[3] Doublespeak is "a deliberate, calculated misuse of language in which a statement is intended to do one or more of the following:

- mislead
- distort reality
- pretend to communicate
- make the bad seem good
- avoid, or shift, responsibility
- make the negative appear positive
- create a false view of factual reality
- limit, corrupt, and/or prevent thinking
- make the unpleasant seem attractive or tolerable, and
- create a disconnect between what is reality and what is being said, or not said".

Thus, doublespeak can be viewed as a fusion of "doublethink" and "Newspeak", constructs created by George Orwell in his book, **1984**. In Orwell's fictional world, using "doublethink", the people could hold two opposing ideas in their minds at the same time without questioning the validity of either, and "Newspeak" was the official language used to express the ideas of doublethink.

products, including vaccines, as well as in other drug products) is at odds with the following realities:

1. Thimerosal continues to be used as a preservative and/or processing aid in the manufacture of a number of licensed vaccines[4,5] as well as in some other drug products.
2. The maximum cumulative level of Thimerosal to which a child born in late 2009 to a mother who received Thimerosal-preserved seasonal and 2009-A-H1N1 flu shots during her pregnancy may be exposed from conception to adulthood (18 years of age in the USA) under the 2009 – 2010 vaccination schedules recommended by the US Centers for Disease Control and Prevention (CDC) actually exceeds the maximum amount that a child conceived in 1999 and vaccinated under the 1999 – 2000 vaccination schedules recommended by the CDC until age 18 would have received by a factor of "2" presuming that child received two Thimerosal-preserved 0.25-mL doses of both the "seasonal" and the 2009-A-H1N1 flu shots as the CDC recommendations permit[6].
3. Since:
   - Thimerosal has not been removed from all the vaccines that may be given to pregnant women and children;

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4 http://www.fda.gov/BiologicsBloodVaccines/SafetyAvailability/VaccineSafety/UCM096228, last updated 2/19/2010; last visited 22 February 2010 for all except the 2009-A-H1N1 influenza vaccines that are not even mentioned.

5 http://www.fda.gov/BiologicsBloodVaccines/GuidanceComplianceRegulatoryInformation/Post-MarketActivities/LotReleases/ucm181956.htm, last updated 2/19/2010; last visited 22 February 2009. Though the information is buried in the links, the multi-dose formulations of the Influenza A (H1N1) 2009 Monovalent Vaccine (CSL Limited), Influenza A (H1N1) 2009 Monovalent Vaccine (ID Biomedical Corporation of Quebec), Influenza A (H1N1) 2009 Monovalent Vaccine (Novartis Vaccines and Diagnostics Limited), and Influenza A (H1N1) 2009 Monovalent Vaccine (Sanofi Pasteur, Inc.) are all Thimerosal-preserved inactivated influenza formulas. In addition, packaged in single-dose formats, Sanofi Pasteur also produced some doses, mainly for children and since mostly recalled, of a "no Thimerosal" formula; CSL Limited also produces a few doses of a "no Thimerosal" formulation; and Novartis Vaccines and Diagnostics Limited produced some doses of a "reduced Thimerosal" formulation.

6 http://mercury-freedrugs.org/docs/090813_fnldrft_TheNoThimerosalPreservedVaccineLie_r6b.pdf, dated "12 August 2009" and last visited on 22 February 2010. The paper's totals are correct except that because only one dose was recommended for pregnant women but two doses were recommended for children under 10 years of age, the maximum additional exposure ranged from 25 micrograms of mercury for the child developing in utero plus, for the child born in mid-September 2009 to such a mother and getting exposure to an additional 25 micrograms (µg) of mercury (Hg) from two, 2009-A-H1N1 flu shots (at 6 and 7 months) would be: a) 50 µg of Hg for such children; b) 25 µg of Hg additional for children born in 2009 before the 2009-A-H1N1 flu shot was available for pregnant women, or under the age of 3 years, or 10-years of age or older; and c) an additional 50 µg of Hg exposure for a child over the age of 3 but less than 10 years of age in the 2009-2010 flu season. This, the maximum dose is 25 to 50 µg of Hg higher than the 462.5 µg to 665.8 µg of Hg without the 2009-A-H1N1 exposures for a maximum of from 487.5 µg of Hg to 715.8 µg of Hg (>1.6 to 2.4 times the 1999-vaccination-program's maximum level).

- The children whose data were reported in the 2007 – 2009 CDC-backed survey studies were born before the level of Thimerosal in the DTaP, Hib and Hep B vaccines began to be reduced and had received most (>162 µg of Hg) of their 1999-projected maximum 18-year exposure (≤ 300 µg of Hg); and
- Rather than declining, the maximum cumulative exposures for developing children have repeatedly been knowingly increased until, in 2009, with the CDC's current recommendations for annual flu shots until age 18 years and doses of the 2009-A-H1N1 influenza vaccine in the 2009 – 2010 flu season,

the maximum dose is in the range of 487.5 µg of Hg to 715.8 µg of Hg (>1.6 to 2.4 times the 1999-vaccination-program's maximum level).

Thus, whatever their source, the writer's preceding statements are plainly designed to mislead the reader by creating a false view of factual reality.

"Published evaluations of children in Sweden, Denmark and Canada have also shown that autism diagnoses continued to increase after the discontinuation of vaccinations with thimerosal. U.S. cases keep rising as well."

First, the studies in question did not directly evaluate children[7] and contain no "*[p]ublished evaluations of children*"; instead, the researchers evaluated the medical records of some groups of children in each instance.

In addition, independent researchers have been denied access to the actual data used in the "*[p]ublished evaluations of children in Sweden, Denmark and Canada*" to which this writer is referring.

In the case of the "Montreal, Quebec, Canada" study published by Fombonne et al[8], Dr. Fombonne has refused to provide the raw cases data to independent researchers who have requested it and attempts under the Canadian "freedom of information" statutes to obtain the data from the schools has been met with claims that the schools "lost" the data. Furthermore, several discrepancies between the statements in the article and reality as to vaccine uptake rates, vaccines given, and the number of diagnosed cases have been reported and confirmed.

Further, statements in the paper published by Fombonne et al as well as an unrebutted commentary of it[9] by this reviewer have clearly established that

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7 http://www.fourteenstudies.org/studies.html, last visited 28 February 2010.

8 Fombonne E, Zakarian R, Bennett A, Meng L, McLean-Heywood D. Pervasive Developmental Disorders in Montreal, Quebec, Canada: Prevalence and Links With Immunizations. ***PEDIATRICS*** July 2006, **118**(1): e139-e150.

9 http://mercury-freedrugs.org/docs/060827_PGKsCmmnts_CanadianEpidemioStudy_Pediatrics-Full-b.pdf, published in August of 2006

the data points for grades "11" and "K" should have been excluded from consideration.

When those biased data points were excluded, the data points for grades "10" through "1" actually revealed a decline in the apparent average rate of cases following the replacement of the Thimerosal-preserved DTP vaccine with a "no preservative" pentavalent DTP-Hib-IPV vaccine[10] (the trend line for the data for grade "3" through grade "1").

In the case of the published studies in Sweden and Denmark, other independent reviewers have pointed out that design errors, misclassification and/or inconsistent case inclusions combined with the lack of access to the appropriate raw data sets by independent reviewers, which collectively invalidate the findings in those studies [see footnote **7**].

Collectively, the refusal or the inability ("because the raw data has been 'lost'") of the researchers to provide qualified independent reviewers with all of the initial raw data records in an easily reviewed format have consigned these so-called peer-reviewed studies to the dustbin reserved for studies that cannot even have their results independently verified.

"Some groups claim only to oppose mandatory vaccines; but this ignores the need for what's called 'herd immunity.' That means a certain level of the population must be vaccinated (generally around 85% to 90%) so that those unvaccinated are still protected."

Here, the writer begins with a near truth, "*Some groups claim only to oppose mandatory vaccines*".

Factually, some groups oppose mandatory vaccination programs.

This writer then proceeds to state "*but this ignores the need for what's called 'herd immunity'*" – a statement that ignores the reality that vaccination with the current vaccines does not produce disease "immunity" but rather confers only some limited-duration protection from some disease strains to some who are vaccinated.

Moreover, in some instances, like the 2009-A-H1N1 influenza vaccines, the claimed fraction of the population vaccinated who may expect this limited protection is not even 50%.

In addition, this "*herd immunity*" posturing ignores several significant realities:

1. Your best protection from contacting a disease is to prevent, or minimize, your exposure to the organism(s) that cause the disease.
2. Even if "fully vaccinated", there is no guarantee that, if exposed, your vaccine-provided protection will keep you from contracting the disease or, if infected, ensure that you will have a mild case.

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10 Ibid, page "3", "**Reviewer's Crude Bar Graph**".

3. Unlike those highly communicable "childhood" non-herpes viral diseases (e.g., measles, mumps, rubella, rotavirus, and polio), where most contract the disease once and do usually have lifetime immunity from that disease, vaccination not only provides less-than-complete, limited-duration protection but also requires several exposures (doses) for some to even obtain the limited protection vaccines may provide.
4. Because vaccination generally produces less than natural and incomplete immunity, vaccinated women are much less able to subsequently pass effective disease protection to their young babies through their breast milk.
5. Because of the artificial nature of vaccination, the incomplete immune-system response that it provokes, and the deleterious effects on the immune system that some of the vaccine's components may have or are known to have on some who are vaccinated, vaccination:
   - ♦ May actually weaken your immune system's ability to properly handle disease infection and
   - ♦ Does most definitely increase your risk of adverse autoimmune injury when the vaccine's components over stimulate some component of your immune system or confuse your immune system's ability to differentiate between "you" and the pathogens or other deleterious substances that it is supposed to "handle" when exposed to them.
6. No matter what percentage of the "herd" is fully vaccinated, IF:
   - ♦ You are too young to be vaccinated or
   - ♦ Your body does <u>not</u> develop effective disease protection from being vaccinated or
   - ♦ You have a compromised immune system and
   - ♦ You are exposed to a significant number of a given disease organisms,

   THEN, you will probably contract the disease. [**Note:** The hundreds of mumps cases each year in those who are "vaccinated" are clear evidence of this reality.]

Moreover, when there is a disease outbreak, the best way to stop the disease from spreading is to quarantine those who have the disease from those who do <u>not</u> and to treat them – <u>not</u> to vaccinate them or those in close proximity to them, which:

1. In the near-term, reduces the vaccinated person's immune system's capacity and

2. Takes time (weeks or months) to build whatever level of protection that a vaccine dose or multiple doses may provide.

If "*herd immunity*" worked as advertised then there should be almost no cases of measles, mumps or rubella in children each year because their vaccination rates exceed 95%, and the actual number of cases of each disease should be about the same or, failing that, the number of cases in the fully vaccinated group should be about the same for each disease.

Factually, we have hundreds to thousands of mumps cases annually, less than 150 measles cases a year – with some cases being "isolated cases" with no identifiable infection source – and, after 2000, only a handful of rubella cases a year, typically less than 24 cases.[11,12,13,14,15,16,17,18,19].

In addition, the unofficial notified cases of mumps, measles and rubella for 2008 and 2009[20] reported by the CDC were:

Year	Mumps cases	Measles cases	Rubella Cases
2008	454	**140**	3
2009	**1,338**	63	16

[11] http://www.cdc.gov/mmwr/preview/mmwrhtml/mm4853a1.htm, "**Summary of Notifiable Diseases --- United States, 1999**", last visited 23 February 2010 – Mumps 387, Measles 100, and Rubella 267 cases.

[12] http://www.cdc.gov/mmwr/preview/mmwrhtml/mm4953a1.htm, "**Summary of Notifiable Diseases --- United States, 2000**", last visited 23 February 2010 – Mumps 338, Measles 86, and Rubella 176 cases.

[13] http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5053a1.htm, "**Summary of Notifiable Diseases --- United States, 2001**", last visited 23 February 2010 – Mumps 266, Measles 116, and Rubella 23 cases.

[14] http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5153a1.htm, "**Summary of Notifiable Diseases --- United States, 2002**", last visited 23 February 2010 – Mumps 270, Measles 44, and Rubella 18 cases.

[15] http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5254a1.htm, "**Summary of Notifiable Diseases --- United States, 2003**", last visited 23 February 2010 – Mumps 231, Measles 56, and Rubella 7 cases.

[16] http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5353a1.htm, "**Summary of Notifiable Diseases --- United States, 2004**", last visited 23 February 2010 – Mumps 258, Measles 37, and Rubella 10 cases.

[17] http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5453a1.htm, "**Summary of Notifiable Diseases --- United States, 2005**", last visited 23 February 2010 – Mumps 314, Measles 66, and Rubella 11 cases.

[18] http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5553a1.htm, "**Summary of Notifiable Diseases --- United States, 2006**", last visited 23 February 2010 a – **Mumps 6,584**, Measles 55, and Rubella 11 cases.

[19] http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5653a1.htm, "**Summary of Notifiable Diseases --- United States, 2007**", last visited 23 February 2010 – Mumps 800, Measles 43, and Rubella 12 cases.

[20] http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5906md.htm, last visited 23 February 2010.

Thus, the overall cases for the period from 1999 through 2008 (shown on the following page) indicate that, in spite of an MMR vaccination level above 95% for our children, the instances of cases of each disease is not "zero" and, for mumps, the vaccine is not adequately protective when, as in 2006 and, to a lesser extent in 2009, the public is, for whatever reasons, exposed to the mumps virus in the USA.

Year	Mumps cases	Measles cases	Rubella Cases
1999	387	100	**267**
2000	338	86	**176**
2001	266	116	23
2002	270	44	18
2003	231	56	7
2004	258	*37*	10
2005	314	66	11
2006	**6,584**	55	11
2007	*800*	43	12
2008	454	*140*	3
2009	**1,338**	63	16

Based on the outcomes observed, it is obvious that vaccinating more than 95% of our children with the MMR vaccine did not stop there being cases of measles, mumps, or rubella.

Further, when there was a large outbreak of mumps in 2006, in addition to the millions of vaccine-related infections from the live measles, mumps and rubella viruses in the Merck MMR II vaccine that are injected into children each year, there were 6,584 notified mumps cases – many of which occurred in persons who had been vaccinated and almost all occurred in areas where most of the children were fully vaccinated with two (2) doses of Merck's MMR® II vaccine, since the use of the second dose[21] was

[21] http://en.wikipedia.org/wiki/MMR_vaccine, last visited 23 February 2010:

"The **MMR vaccine** is an immunization shot against measles, mumps and rubella (also called German measles).

The vaccine is a mixture of three live attenuated viruses, administered via injection. The shot is generally administered to children around the age of one year, with a second dose before starting school (i.e. age 4/5). The second dose is not a booster; it is a dose to produce immunity in the small number of persons (2–5%) who fail to develop measles immunity after the first dose.[1] In the United States, the vaccine was licensed in 1971 and the second dose was introduced in 1989.[2] It is widely used around the world; since introduction of its earliest versions in the 1970s, over 500 million doses have been used in over 60 countries. As with all vaccinations, long-term effects and efficacy are subject to continuing study. The vaccine is sold by Merck as M-M-R II, GlaxoSmithKline Biologicals as Priorix, Serum Institute of India as Tresivac, and Sanofi Pasteur as Trimovax.

It is usually considered a childhood vaccination. However, it is also recommended for use in some cases of adults with HIV.[3][4]

[1] *a b* "MMR vaccine questions and answers". Centers for Disease Control and Prevention. 2004. http://cdc.gov/vaccines/vpd-vac/combo-vaccines/mmr/faqs-mmr-hcp.htm. Retrieved 2008-05-28.

[2] Banatvala JE, Brown DW (2004). "Rubella". *Lancet* **363** (9415): 1127–37. doi:10.1016/S0140-6736(04)15897-2. PMID 15064032.

implemented in 1989 for children 4 to 6 years of age (those born in or after 1983).

"Lack of herd immunity is what killed Gabriella 'Brie' Romaguera. The New Orleans baby died of pertussis, or 'whooping cough.' At one time, this disease afflicted more than 250,000 American children yearly, killing 9,000. Vaccinations reduced that to just 1,000 new cases annually by 1976; but by 2008, cases had soared back up to more than 10,000 annually."

Here, the writer begins by making two unsubstantiated statements:

"*Lack of herd immunity is what killed Gabriella 'Brie' Romaguera.*"

and

"*The New Orleans baby died of pertussis, or 'whooping cough.'*".

Turning to the CDC's own data[22], this reviewer finds that, with a 3-dose coverage in excess of "95 %" and a 4-dose coverage of "84+ %", "*[l]ack of herd immunity*" did not kill this child.

This is the case because, based on the writer's definition of "*herd immunity*": "*That means a certain level of the population must be vaccinated (generally around 85% to 90%) so that those unvaccinated are still protected*", the "*herd*" into which she was born supposedly had "*herd immunity*".

TABLE 1. Estimated vaccination coverage among children aged 19--35 months (N = 18,430), by selected vaccines and dosages --- National Immunization Survey (NIS), United States, 2004--2008

	2004*		2005†		2006§		2007¶		2008**	
Vaccine	**%**	**(95% CI††)**	**%**	**(95% CI)**	**%**	**(95% CI)**	**%**	**(95% CI)**	**%**	**(95% CI)**
DTP/DT/DTaP§§										
≥3 doses	95.9	(±0.5)	96.1	(±0.5)	95.8	(±0.5)	95.5	(±0.5)	96.2	(±0.5)
≥4 doses	85.5	(±0.8)	85.7	(±0.9)	85.2	(±0.9)	84.5	(±0.9)	84.6	(±1.0)

* Born during January 2001--July 2003.
† Born during February 2002--July 2004. § Born during January 2003--June 2005 (2006 estimates based on NIS dataset, which was rereleased on February 25, 2008, after correcting for Hispanic overcount in nine states). ¶ Born during January 2004--July 2006. ** Born during January 2005--June 2007. †† Confidence interval. §§ Diphtheria, tetanus toxoids and pertussis vaccines, diphtheria and tetanus toxoids, and diphtheria, tetanus toxoids, and any acellular pertussis vaccine.

Further, while this reviewer concedes that this child had pertussis and pertussis was a contributing factor, absent a complete review of the treatment and other medicals record and a full and impartial autopsy record for this child, this reviewer is unable to know what this "*New Orleans baby died of*".

[3] "Case 4: Discussion - Appropriate Vaccinations - Initial Evaluation - HIV Web Study". http://depts.washington.edu/hivaids/initial/case4/discussion.html.
[4] "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)". http://www.cdc.gov/mmwr/preview/mmwrhtml/00053391.htm." [Emphasis added.]

22 http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5833a3.htm, last visited 23 February 2010.

If "*herd immunity*", as defined by the writer, were the protective reality he claims it to be, then this child should neither have contracted nor "*died of pertussis, or 'whooping cough.'*"

Moreover, one of the hidden realities about pertussis vaccination is that, unlike having this bacterial infection naturally, some percentage of those vaccinated against pertussis will develop a chronic subacute pertussis infection and become long-term spreaders of the disease.

Thus, fully vaccinating the population to the current 85- to 95- plus percentage levels has the undisclosed effect of creating an unknown number of long-term active pertussis carriers who, though symptom free, can infect those with whom they have close contact.

Therefore, for all we know, this child contracted pertussis from one of the pertussis carriers created by the vaccination program.

Turning to the rest of the writer's remarks here:

> "*At one time, this disease afflicted more than 250,000 American children yearly, killing 9,000. Vaccinations reduced that to just 1,000 new cases annually by 1976; but by 2008, cases had soared back up to more than 10,000 annually*",

this reviewer first notes that the writer's "*[a]t one time*" speaks to a time in the USA before:

1. Widespread sanitary-sewer, clean-water, and garbage-pickup systems were available in most of the USA and
2. Antibiotics that can kill the pertussis bacteria were available.

In addition, the vaccination reductions from the first effective DTP vaccines that reduced the cases to "*1,000 new cases annually by 1976*" occurred during the "honeymoon period" when natural immunity reduces the number of people who can contract the disease.

In this period, the existing natural immunity to pertussis provided by a population who mostly had had pertussis and, through maternal immunity passed to the children, could convey short-term protection from pertussis to very young children.

However, these natural protections have been replaced by the "vaccine protection" afforded by the vaccines most of the population has received and the incidences of pertussis infection in those too young to be vaccinated, those who are vaccinated, and those who are unvaccinated have all increased.

In addition, the pertussis carrier[23] population is also increasing to the point that the CDC has recommended additional vaccinations, using the "Tdap"

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[23] Srugo I, Benilevi D, Madeb R, Shapiro S, Shohat T, Somekh E, Rimmar Y, Gershtein V, Gershtein R, Marva E, Lahat N. Pertussis Infection in Fully Vaccinated Children in Day-Care Centers, Israel. ***Emerging Infectious Diseases*** September–October 2000; **6**(5): 526-529.

vaccines (Adacel® by Sanofi Pasteur, Ltd and Boostrix® by GlaxoSmith-Kline Biologicals) introduced in the mid-2000s for use in older children (age 11 and older) and adults – possibly in an attempt to add additional vaccine doses to counter the impact of the pertussis-vaccination-induced carriers who are silently spreading vaccination-resistant pertussis?

Turning to the cases data for the pertussis, tetanus and diphtheria, the data tabulated on the next page clearly indicate that, for whatever reasons, the pertussis components of the vaccines containing pertussis antigens are not effective in preventing cases of pertussis, while the tetanus and diphtheria toxoid components in these vaccines appear to be effective in minimizing cases of tetanus and diphtheria.

The lack of diphtheria cases in the period 2004 – 2007 and the 1 or 2 cases a year in the 1999 – 2003 period also indicate that the vaccines containing the diphtheria toxoid are effective in preventing diphtheria. [**Note:** The apparent protection from diphtheria may be further enhanced by the conjugation of polysaccharide antigens from other diseases with the diphtheria toxoid in other vaccines (e.g., in the Sanofi Pasteur, Inc. Menactra® vaccine) clearly serves to further augment the level of antibodies in the vaccinated population leading to absence of reported cases of diphtheria.]

Additionally, the tabulated data clearly indicate that vaccination against pertussis is not an effective strategy and adding more doses of pertussis-component-containing vaccines (the Tdap vaccines) has not only not provided effective protection but also:

1. Added validity to the reality that a non-vaccine control strategy is needed for pertussis, a bacterial disease that is curable by early intervention with the proper antibiotics and
2. Increased the possibility that the current DTaP/DT/Tdap vaccination program is not cost effective as well as clearly not truly effective in preventing pertussis infection in, and transmission by, fully vaccinated individuals.

Furthermore, these pertussis-component-containing vaccines are usually absorbed onto polymeric hydroxyaluminum components used as adjuvants even though the toxicological and/or immunological safety of these polymeric components has also not been rigorously established as required by law (21 CFR § 610.15(a)).

"**Conclusions** The effects of whole-cell pertussis vaccine wane after 5 to 10 years, and infection in a vaccinated person causes nonspecific symptoms (3-7). Vaccinated adolescents and adults may serve as reservoirs for silent infection and become potential transmitters to unprotected infants (3-11). The whole-cell vaccine for pertussis is protective only against clinical disease, not against infection (15-17). Therefore, even young, recently vaccinated children may serve as reservoirs and potential transmitters of infection. ..." [Emphasis added.]

Year	Pertussis cases	Tetanus cases	Diphtheria Cases
1999	7,288	40	1
2000	7,867	35	1
2001	7,580	37	2
2002	9,771	25	1
2003	11,647	20	1
2004	25,827	34	0
2005	25,616	27	0
2006	15,632	41	0
2007	10,454	28	0

Thus, it is not clear that the current adjuvanted Td, DT, and TT vaccines that lack a pertussis component, even when manufactured without Thimerosal, are adequately safe.

Based on:

1. The outcomes observed – the serious adverse reactions that the pertussis component causes in some of those inoculated with a vaccine containing it – and
2. The availability of antibiotics that are highly effective against *Bordetella pertussis*,

the pertussis component should be removed from all formulations containing it and a cost-effective "early detection, antibiotic-susceptibility determination, and specific antibiotic treatment" disease management strategy should be adopted in the USA.

Unfortunately, most of the current FDA-approved available DT and Td vaccine formulations that could be used as a substitute for the DTaP and Tdap vaccines are problematic because, without proof of safety, Thimerosal is still unnecessarily used in the production of these vaccines.

However, the makers of the current no-Thimerosal DTaP and Tdap vaccine formulations could easily provide interim no-Thimerosal TD and Td vaccine formulations by simply not adding the pertussis ("aP" or "ap") component to their current no-Thimerosal DTaP/Tdap vaccines formulations.

Since there are "no" cases of diphtheria in the USA currently and most of the few cases of tetanus occur in the elderly, concerned parents would do well to consider skipping vaccines containing a diphtheria, tetanus or pertussis component or, at a minimum, delay vaccination with them until after the child's immune system is more fully developed to reduce the risk

for the child's developing chronic childhood asthma[24]. [**Note:** In lieu of vaccination, breastfeeding until the child is 2 years of age or older, making sure all of the child's key vitamins (e.g., A, Bs, D-3, C, and K-2), nutrients (e.g., alpha-lipoic acid, lysine, glycine, methylated and non-methylated glycines, methionine, cysteine, and carnitine), biomarkers, and minerals (e.g., iron, magnesium, calcium, potassium, boron, iodine, silicon, molybdenum, vanadium, copper, and zinc) are at optimal (typically, near or above the midpoint in the "normal" range) levels, and minimizing his or her exposure to others, while practicing sound care giving and hygiene, can be used to both minimize a baby's risk of contracting one of these bacterial illnesses and, if contracted, help ensure a mild disease process with a rapid and full recovery.]

After all, before there were vaccines for diphtheria, pertussis and tetanus and antibiotics but after the introduction of sanitary sewers, uncontaminated water for drinking, proper garbage disposal, adequate food and housing, most healthy children, including this reviewer, either did not have these diseases or had mild cases from which they fully recovered.

"Brie contracted the disease when she was a month old, too young for her first pertussis vaccine. 'I'm not laying blame,' her mother, Danielle, told me. 'But people need to know they can infect other people's babies. It kills. People think these diseases don't exist anymore but that's only because children are being vaccinated.'"

While this reviewer does not dispute the that "*Brie contracted the disease when she was a month old*", this reviewer again notes that those who really "*need to know they can infect other people's babies*" are not the unvaccinated or, for children, their unvaccinated parents, who, unless they are infected, cannot infect others and, because they do not vaccinate, are more likely to keep their children away from others' children at the first sign of any infection but rather those who have been vaccinated and their vaccinated parents, who, though they have no disease symptoms, may be the silent pertussis carriers who can spread and currently may be a major vector in the spread of the pertussis infection to others – especially to those too young to be vaccinated.

Finally, contrary to the view, "*[p]eople think these diseases don't exist anymore but that's only because children are being vaccinated*" attributed to "*Danielle*", the reality is that people have been, and are continually being, brainwashed into believing:

- The fiction that a vaccine component provides "immunity" to a given disease for those who are vaccinated and

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24 McDonald KL, Huq SI, Lix LM, Becker AB, Kozyrskyj AL. Delay in diphtheria, pertussis, tetanus vaccination is associated with a reduced risk of childhood asthma. ***J Allergy Clin Immunol***. 2008 Mar; **121**(3): 626-631. Epub 2008 Jan 18.

- The unproven assertion that, provided more than 85% to 95% are vaccinated with it, the vaccine protects the unvaccinated and those whose immune systems do not recognize the vaccine's antigens,

when the realities are:

1. Vaccines provide a limited-duration protection to only some of those vaccinated "n" times where, unlike the disease, "n" is currently in the range from 2+ to 5+ times and increasing,
2. For those who are protected, vaccines provide protection only for a certain number of the currently identified strains (serogroups) of the disease, some possible lesser protection in some cases for related strains, and no protection, in many cases, for other strains,
3. Vaccination programs that "protect" against certain disease strains "promote" the invasion of other strains and other diseases for which there is no vaccine into the biological niche occupied by the "vaccine strains" – "nature" truly does abhor "empty" biological niches,
4. Overall, vaccination programs that unnaturally expose, typically by injection, the person to disease organism fragments or inactivated or live disease organisms,
   - May weaken and confuse the human immune system and
   - Do increase the risk of that the vaccinated individuals may develop an autoimmune disease,
5. Vaccination programs that use live viruses infect the person vaccinated with some strain or strains of the actual disease.
   - If the route of infection for the live virus is abnormal (e.g., injection for measles, mumps, rubella, and herpes varicella zoster [chicken pox initially, shingles later]), then: **a)** the person inoculated may still develop some form of the disease and, though less of a risk than if the exposure route where the natural one, infect others; **b)** the "protection" provided by the challenged immune system will, of necessity, be incomplete and **c)** for females who may later bear children, provide less protection to their offspring than being naturally infected with the disease and recovering from it.
   - When the exposure route is the same as, or similar to, the exposure route for the disease (e.g., currently, the rotavirus and influenza vaccines in the USA), then: **a)** those inoculated will not only contract the disease but also have a significant risk of spreading it to others for some time and may, in some instances, become chronic shedders for an extended period of time (years); **b)** for the MMR II and MMRV vaccines, the immune system of the person

inoculated is forced to simultaneously deal with multiple infections at the same time – increasing the risk of severe adverse outcomes and decreasing the probable duration of the protection provided for one or more of the components; **c)** for the rotavirus vaccines, inoculation with the five-component Merck RotaTeq® bioengineered human-cow rotavirus strains: **i)** appears to guarantee that the person inoculated may have a more severe case of rotavirus than naturally contracting the native/wild human rotavirus, **ii)** spreads rotavirus to the non-inoculated at a rate as great or greater than the previous live poliovirus vaccine did, and may be spreading rotavirus re-infection to adults who are immune to the human rotavirus; while **d)** inoculation with the GlaxoSmithKline Rotarix® or the RotaTeq vaccines may increase the risk of serious adverse effects as compared to a natural rotavirus infection (for Rotarix, intussusception and pneumonia; for RotaTeq, intussusception and Kawasiki's disease).

6. Vaccination with a live-virus vaccine for herpes varicella zoster (HVZ) for chickenpox (Merck's Varivax®) is an obviously futile practice that not only has failed to meet the criteria used to approve it (societally cost effective if one dose provided lifetime protection without serious adverse effects in the vaccinated population) but also has increased the annual disease treatment costs to the American people by more than US $ 700 million. Because the vaccine is injected (an abnormal route of exposure that does reduce live-virus shedding) and some wild strains are "stronger" than the attenuated strain, the current non-cost-effective two-dose vaccination program has:

- Reduced the ability of the females who are vaccinated to pass protection to their offspring,
- Guaranteed that those vaccinated are infected with a herpes virus that, like all herpes viruses, is a lifetime infector with alternating periods of activity and dormancy,
- Increased the risk that those inoculated will have two cases of chickenpox (vaccination-related and "break through" natural cases),
- Increased the risk that adults will have shingles (a recurrence of the HVZ), and
- When the costs associated with the adverse reactions the vaccine causes are included, probably increased the overall annual healthcare costs in the USA by more than (>) US $ 1,000 million (> US $ 1 billion annually).

The facts are that most of the claims about the benefits of today's vaccination programs in the USA:

1. Lack substance and
2. Are essentially propaganda designed to sell unsubstantiated and false claims of:
   - Societal benefit ("herd immunity") rather than benefit to the individual vaccinated and
   - "de minimus" risk to the person vaccinated.

Furthermore, the true beneficiaries are the Establishment – particularly the health care, health insurance, healthcare provider, and pharmaceutical segments who directly benefit from not only the current recommended vaccination programs but also from all of the chronic disease cases that these vaccination programs have apparently created, and are increasingly creating, to the point that about 25 % of US children have a chronic medical condition today and, in the USA, the program and adverse event costs and risks fall on the public.

"Romaguera is especially upset by 'celebrity science,' as exemplified by Jenny Mc-Carthy.

The actress and former Playboy Playmate claims vaccines made her son autistic, but that she 'cured' him. There is no cure. Mc-Carthy's antics include yelling at three physicians on Larry King Live, and exclaiming: 'My son died in front of me from a vaccine injury!' Her son is alive, as she later acknowledged.

Yet she'd be little more than an opinionated pinup girl but for being invited to share her 'expertise' on Larry King, ABC's 20/20, Good Morning America and other popular shows. All this has helped propel McCarthy's two books on autism to bestsellerdom. 'Celebrities are entitled to support a cause,' said San Diego's Sawyer. 'But when they give professional advice, I think that's dangerous.'

'It makes it hard for doctors,' said Romaguera. 'Our pediatrician says parents tell him all the time they don't care what the science says. And because of it, babies and kids are dying.'"

As with most vaccine apologists who are unable to attack the actual science and historical records that clearly support the problematic, propaganda-based nature of most of our current vaccination programs, this writer turns to attacking prominent individuals who dare to question any aspect of any vaccine or vaccination program.

While this reviewer sees little to be gained by: **a)** rebutting the writer's disjoint sound-bite-based diatribe or **b)** pointing out that we all should respect the right of every person, including celebrities, to express their view of reality in a manner that has meaning to them, this reviewer must point out that our current vaccination programs that start before birth and continue from birth are certainly significant factors in our ranking in the 40s among the ranks of developed nations for infant mortality, with a first-year infant mortality rate that is more than twice that of Japan.

Based on the preceding infant-mortality ranking and the continuing reports of vaccination-related deaths in children of all ages, this reviewer understands that "*because of it*" [the current US vaccination program] "*, babies and kids are dying*" – not because of the statements made by celebrities, whose words, to date, have been drowned out by wave after wave of media propaganda such as this article and, to date, have not resulted in any significant change in childhood vaccination rates.

Finally, given the statements continually being made by those who represent pediatricians, most of whom derive half of their income from "well baby visits" caused by our current vaccination programs, this reviewer finds that it is the pediatricians, and not the parents, who, contrary to the pediatrician's quoted remarks, often "*don't care what the science says*".

"The doctor who launched the modern anti-vaccine movement acted 'dishonestly and irresponsibly,' Britain's General Medical Council has ruled. But fear not. Dr. Andrew Wakefield is still a hero to his many acolytes. And others, with curious credentials, fight on to terrify parents into denying their children vaccines.

In 1998 Wakefield wrote and then vociferously hawked an article in the British medical journal Lancet linking autism to the MMR vaccine (measles, mumps and rubella). After the council's decision, Lancet retracted the article on Jan. 28. Among the facts that have come out of the inquiry into Wakefield's research is that two years before his paper appeared, lawyers seeking to sue vaccine-makers paid Wakefield the equivalent of $700,000."

Here, this writer begins by fabricating "*the modern anti-vaccine movement*" and then false declaring that Dr. Wakefield launched it ("*[t]he doctor who launched the modern anti-vaccine movement*").

Factually, with respect to vaccination, all that Dr. Wakefield did in 1998 after the publication of his paper was recommend that the vaccinations for measles, mumps, and rubella vaccinations should be given with separate vaccines instead of as a combined 3-in-1 vaccine based on his research findings and the prior history, mainly attributed to a 3-in-1 measles-mumps-rubella vaccine containing the Urabe strain of mumps, which had caused so many adverse reactions that it had been abandoned by the Canadians even before the UK decided to approve its use, and which had led to a drop in vaccination uptake some years before Dr. Wakefield's 1998 publication in the ***Lancet***.

Based on Wakefield's actions, advocating for separate vaccine administration instead of a combined 3-in-1 vaccination program, he clearly established himself as a proponent of a safer vaccination practice – a most certainly pro-vaccine position.

"After Wakefield's article ran, vaccination levels plummeted in Britain and declined in the United States, and the diseases they prevented surged. Measles cases increased sevenfold in the U.S. 'One

person's research set us back a decade and we're just now recovering from that,' Mark Sawyer, a pediatrician and infectious disease specialist at Radey Children's Hospital in San Diego, told me in an interview.

> Though this reviewer is not intimately familiar with the annual vaccination levels and disease cases data for the UK, this reviewer could find no significant decrease in vaccination uptake rates for the MMR vaccine or surge in the diseases it "prevents" in the US for the period from 1998 through 2009.

Report Year	Measles cases†	The Ratio of the number of measles cases to the number of measles cases in 1997	Measles cases per 100,000 individuals in USA, estimated from the data in Wikipedia†[25]
1997[26]	*138*	1.0000	***0.0508***
1998[27]	100	0.7246	0.0368
1999	100	0.7246	0.0359
2000	86	0.6232	0.0306
2001	116	0.8406	0.0408
2002	44	0.3188	0.0153
2003	56	0.4058	0.0193
2004	*37*	0.2681	*0.0126*
2005	66	0.4783	0.0223
2006	55	0.3986	0.0185
2007	43	0.3116	*0.0143*
2008	***140***	1.0145	*0.0461*
2009	63	0.4565	0.0206
Mean (SD)	80.3 (± 35.7)	.....	0.0280 (± 0.0129)

† The numbers in italics are outside of "mean ± 1-SD" ranges computed; the numbers in ***bolded italics*** are the highest values in the 1997 -2009 period.

> Further, the available data, tabulated previously for mumps, measles and rubella for the period 1997 – 2009 found no instance where "*[m]easles cases increased sevenfold in the U.S.*"
>
> In fact, as shown in the preceding tabulation, except for the number of cases reported in 2008, the number of measles cases declined in the USA from the number reported in 1997, the year before Dr. Wakefield and his fellow researchers published their recently withdrawn paper in the ***Lancet***.
>
> Thus, this writer's claim that "*[m]easles cases increased sevenfold in the U.S.*" is clearly false and undermines the little credibility that this reviewer could

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25 http://en.wikipedia.org/wiki/Demographics_of_the_United_States, last visited 23 Feb 2010

26 http://www.cdc.gov/mmwr/preview/mmwrhtml/00056071.htm, last visited 23 Feb 2010.

27 http://www.cdc.gov/mmwr/preview/mmwrhtml/mm4753a1.htm, last visited 23 Feb 2010.

give to anyone who, if this writer's statements are to be trusted, claims: "*One person's research set us back a decade and we're just now recovering from that,*" as this writer states, "*Mark Sawyer, a pediatrician and infectious disease specialist at Radey Children's Hospital in San Diego, told me in an interview.*"

Moreover, on average, given a growing population, as the previous tabulation also shows, the number of cases of measles per 100,000 population has declined and even the "resurgence" in 2008 resulted in about 9% fewer reported measles cases per 1000,000 Americans in 2008 (0.0461 per 100,000) than in 1997 (0.0508 per 100,000), the year before Wakefield's paper was published[28].

Thus, it seems that the writer and "*Mark Sawyer, a pediatrician and infectious disease specialist*", are speaking of some alternate reality with respect to the USA.

"But are we recovering? New anti-vaccination groups have popped up like toadstools after rain (there are more than 180 on the Web), while older ones such as the National Vaccine Information Center are reinvigorated. For the most part, these groups have had only a marginal effect on North American vaccination rates, but they have encouraged localized boycotts of immunization. (In one county in Washington state, a stunning 27% of children had vaccination exemptions in 2006-2007.) The result has been a resurgence of diseases gone so long that some doctors don't even recognize them. And children die because of it."

Here, the writer reverts to his "*anti-vaccination groups*" mantra and attempts to portray pro-vaccine groups with safety, effectiveness, and cost-effectiveness concerns, like the National Vaccine Information Center, as if they were anti-vaccination.

Grudgingly, this writer admits "*these groups have had only a marginal effect on North American vaccination rates*" but, without citing any substantiating documents, inferentially claims that his unnamed "*they*" have "*encouraged localized boycotts of immunization*" when none of the groups of which this reviewer is aware have ever encouraged "*boycotts of immunization*", defined as a refusal to deal with immunization[29].

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28 To put these incidence rates into perspective, today the corresponding " 1 in 100" rate for "autism", a chronic lifetime condition, is about "100" per 100,000 Americans or more than 19,000 time higher than for measles, an acute short-term illness in America from which most fully recover in a period of days. Talk about proverbially straining at the gnat (a continual uproar about few measles cases annually) and swallowing the camel (the Establishment complacency and muted response to the tens of thousands annual "autism" cases).

29 For all of the childhood diseases for which we have a "reasonably effective" vaccine, the only way that an individual can be immunized (provided near-lifetime protection from re-infection upon re-exposure) is to be naturally exposed to that disease and have it trigger a complete response by his or her immune system. Therefore, in actuality, those who tout the corresponding vaccination programs are the ones who, in essence, are boycotting immunization.

Factually, many groups do encourage each and every person and parent or guardian to exercise their legal rights to elect to vaccinate or, if they have legitimate concerns, elect to avail themselves of the legal exemptions from vaccination that are available to them – a "novel" idea, encouraging people to exercise their constitutionally guaranteed bodily integrity rights to chose, or refuse, medical treatment for themselves and their children and wards.

Moreover, this reviewer finds this writer's parenthetical comment, "*In one county in Washington state, a stunning 27% of children had vaccination exemptions in 2006-2007*" (emphasis added) to be ironic.

This is this reviewer's reality because, in some areas in Pennsylvania, where the population is predominately non-vaccinating Old Amish, the percentage of children exempted from vaccination exceeds 90 % apparently without any higher rate of communicable disease mortality than like areas in New Jersey where more than 85 % of the children are fully vaccinated.

Moreover, in these Amish areas, there are near-zero (< 1 in 5,000) rates of neurodevelopmental disorders, like "autism".

In stark contrast, the rate for "autism" exceeds 1 in 100 children in the adjacent highly vaccinated State of New Jersey.

Yet the mainstream media and the healthcare establishment seem not to notice or care about this stark difference in realities between the fully vaccinated children and young adults and their never-vaccinated counterparts.

Moreover, the recently published study reporting that about "25 %" of today's American children have a chronic disease is barely reported in the mainstream media even though this is a hyper-epidemic increase from the < 1 % levels seen only 30 years earlier.

However, this writer's closing remarks:

> "*The result has been a resurgence of diseases gone so long that some doctors don't even recognize them. And children die because of it.*"

make clearly misleading assertions because, though reduced to lower levels or altered strains in the case of measles, mumps, rubella, H influenza B, *S. pneumoniae*, *N. meningitides*, and pertussis or altered in its expression and timing, in the case of herpes varicella zoster, none of these diseases are gone, much less "*gone so long*" nor have the specific diseases for which there is effective vaccine protection resurged.

Again, this writer is: **a)** clearly speaking of some alternative USA, **b)** unaware of the facts, or **c)** intentionally distorting reality.

"Before the MMR vaccine became available in 1971, measles, mumps and rubella annually afflicted 530,000, 162,000 and 48,000 U.S. children, respectively, killing a total of more than 600. By the

middle of the last decade, there were fewer than 7,000 new cases annually and zero deaths. But the anti-vaccine groups generally claim the injections were irrelevant and that factors such as better nutrition caused the declines."

> In this paragraph, this writer clearly reverts to a tried and true disinformative discourse that begins by stating some unsupported, appropriately vague and difficult to verify historical "facts" about measles, mumps, and rubella infections and the total deaths from all three diseases that: **a)** have little or nothing to do with today's realities and **b)** fail to put the hundreds of deaths into their proper rate and demographic perspectives.
>
> Then, the writer jumps the narrative to some unspecified date in "*the middle of the past decade*" (2005/6?) and speaks in generalities about disease cases and deaths but fails to mention, much less address, the number of vaccine-related deaths and severe injuries caused by the MMR, HVZ and other vaccination programs.
>
> Finally, this writer jumps to "*injections*" and his straw men, "*the anti-vaccine groups*", and vaguely asserts claims that he has apparently fabricated out of whole cloth.
>
> Factually, the pro-vaccine-safety groups, who make up the majority of those questioning the current vaccination programs and those who, on sound scientific, ethical and/or religious grounds, oppose vaccination <u>all</u> claim that the issues of lack of proof of: **a)** safety, **b)** effectiveness and/or **c)** cost effectiveness, which surround today's vaccination programs, are highly relevant and in need of the scientifically sound and appropriate independent safety, effectiveness, and cost-effectiveness studies that, to date, have <u>not</u> been conducted.
>
> Moreover, the unbiased historical data, as briefly discussed in some of this reviewers previous reviews (e.g., "**A Review of: 'Vaccinations are still needed for kids By Meg Fisher, MD**' (27 January 2008; 27 pages)"[30]), clearly support the reality that factors other than vaccination have accounted for most all of the decline in infections and deaths for those diseases, like measles and pertussis, that were killing thousands each year in the USA in the early 1900s.

"Meanwhile their 'science' comes down to little more than the observation that autism symptoms are often first recognized at the same age that children are getting their first vaccinations. So they lump the MMR in with a list of other childhood vaccines that formerly contained the mercury-based preservative thimerosal, although the MMR never contained thimerosal itself."

> As a scientist, a PhD Analytical Chemist, MS Inorganic Chemist, and Computer Systems Programmer/Analyst with decades of experience in

[30] http://mercury-freedrugs.org/docs/080127MegFisher1b.pdf, last visited 23 Feb 2007.

designing experiments and analyzing data, including a decade plus of time in researching vaccine issues and assisting in experiments designed to shed light on or address Thimerosal-related issues including its ongoing presence, and the toxicity of Thimerosal and its initial and bioaccumulated mercury-containing metabolites, this reviewer is always amazed when anyone writes about any aspect of the US vaccination program when the writer has no demonstrated understanding of the factual data much less the fundamental scientific and other issues that surround:

1. The admittedly illegal use of Thimerosal as a preservative in vaccines from the late 1960s onwards and
2. From the late 1970s onwards, the illegal approval of Thimerosal-preserved vaccine formulations by the US Secretary of Health and Human Services, the US Commissioner of the Food and Drug Administration, and their agents.

Understanding the writer's desire to simply dismiss scientific realities that, for whatever reasons, he does not wish to mention or address, this reviewer is bemused by this writer's apparently intentional dismissive distortion of reality: "*their 'science' comes down to little more than the observation that autism symptoms are often first recognized at the same age that children are getting their first vaccinations*".

Factually, even in the most recent publication[31], where some symptoms of neurodevelopmental deficits began to be significantly noticeable after the children were 6 months of age, "*autism symptoms*" begin to be noticed long after the "*age that children are getting their first vaccinations*".

This is the case, because children receive their first "inoculations" from:

- The flu shots that, since 2002, pregnant women who follow the vaccination recommendations of the CDC that permit Thimerosal-preserved flu shots to be administered (and who got 2 flu shots in 2009, "seasonal" and "2009-A-H1N1" where both may be Thimerosal preserved vaccine formulations) and,
- Before 2002, the Rho(D) serum shots, which could have been Thimerosal-preserved because RhoGAM was the most frequently used serum and it was Thimerosal-preserved until the early 2000s, recommended for all Rh-negative pregnant women at 28 weeks and with any spotting episode,

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[31] Ozonoff S, Iosif A-M, Baguio F, Cook IC, Hill MM, Hutman T, Rogers SJ, Rozga A, Sangha S, Sigman M, Steinfeld MB, Young GS. A Prospective Study of the Emergence of Early Behavioral Signs of Autism. ***J. Am. Acad. of Child and Adolescent Psychiatry*** 2010 March; **49**(3): 256-266. Published online: 08 Feb. 2010. http://www.jaacap.com/article/S0890-8567%2809%2900031-8/fulltext, last visited on 25 February 2010.

when these children are developing in utero at times more than 6 months before any developmental symptoms, other than fetal death, miscarriage, stillbirth, slowed growth, and/or low birth "APGAR" score, can be observed.

In addition, as of 2010[32], a child is recommended to receive:

- At birth (hepatitis B, which until the early 2000s was Thimerosal-preserved and, up until after 2007, could still be a reduced-Thimerosal vaccine) [1 more dose],
- At 1-2 months and 6 months, 2 more Hep B vaccine doses that may have been Thimerosal-preserved until the early 2000s and may have contained reduced amounts until the late 2000s [a cumulative total of 3 more]
- At 2, 4, and 6 months (three DTaP vaccines that until the early 2000s were Thimerosal preserved and until the late 2000s may have be reduced-Thimerosal vaccines), three Hib vaccine doses, which may have been Thimerosal-preserved prior to the early 2000s, three pneumococcal vaccine doses, three inactivated polio vaccine doses, and 2 or 3 live-virus rotavirus shots) [a cumulative total 17 or 18 more] and
- At 6 and 7 months (the initial post-natal flu shots, which may still be Thimerosal preserved and this year may have been four shots for a maximum nominal exposure to 100 micrograms of Thimerosal [50 micrograms of mercury]) [a total of 19 to 22 more]

for a subtotal exposure of somewhere in the range of 20 to 24 major immune-system challenges before the child is more than 7 months old.

Further, between 12 months and 18 months, a child following the 2010 schedule may receive 1 more Hib, 1 more pneumococcal, 1 – 2 more flu shots (which may be Thimerosal-preserved), 1 live-virus MMR shot for measles, mumps, and rubella, 1 live-virus herpes varicella zoster shot and 1 to 2 Hep A shots for an additional 6 to 8 more major immune-system challenges or a grand total of 26 to 32 major immune-system challenges before the child is two years of age, the age at which diagnoses of neurodevelopmental disorders begin to be made.

Clearly, the writer's assertion "*that autism symptoms are often first recognized at the same age that children are getting their first vaccinations*" misrepresents the facts.

To use the writer's imprecise phrasing, it is true that "*autism symptoms*" are generally recognized clinically after the CDC-schedule-compliant child had

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32 http://www.cdc.gov/vaccines/recs/schedules/downloads/child/2010/10_0-6yrs-schedule-bw.pdf, last visited 23 February 2010.

more than half of his childhood vaccinations – indicating a temporal "cause and effect" relationship.

However, contrary to this writer's views, these "*autism symptoms*" are generally recognized more than 6 months after the "*age that children are getting their first vaccinations*".

At the earliest, "*autism symptoms*" begin to be recognized some time after the child receives a 6- or 7-month's flu shot or, more typically, sometime after the child receives an MMR shot or, worse, an MMR-V shot, which apparently doubles the child's risk of vaccine-induced seizures vis-à-vis the MMR vaccine, at 12 to 15 months of age.

Finally, based on the only US-FDA-recognized chronic toxicity study for injected Thimerosal, the safe-exposure level (the projected no observed adverse-effect level [NOAEL]) for developing humans from injected Thimerosal-related mercury is less than (<) 0.0042 micrograms of mercury (Hg) per kilogram of body weight day[33] or more than twenty times lower than the EPA's accepted reference dose (RfD) for ingested mercury (mercury in food).

This projected NOAEL means that even a reduced-Thimerosal vaccine's dose of not more than 1 microgram of Hg exceeds the NOAEL injected mercury as Thimerosal, developing human safety level by more than a factor of 20 when the child weighs less than 10 kilograms (22.05 pounds).

"And don't dismiss the power of a good old-fashioned conspiracy. 'It's astounding to me that people can imagine that America's pediatricians and family physicians and public health officials are scheming to harm children,' says Sawyer."

Here, the writer begins by belittling reality and then has someone, pediatrician "*Sawyer*" who, based on his previous less than accurate an/or misleading, statements, is, if there is a "*conspiracy*", apparently one of the schemers, be astounded that "*people can imagine that America's pediatricians and family physicians and public health officials are scheming to harm children*" when the most recent study points out that our "healthcare systems" have created a generation of children in which "25 %" have a chronic illnesses[34] – which typically translate into a lifetime of office visits and treatments.

Obviously, if the percentage of children with chronic illnesses were < 1 %, as it was in the 1970s, the health insurance industry, the health care establishment, the healthcare providers, the drug industry and their

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33 http://mercury-freedrugs.org/docs/090812_fnldrft_TheTruthAboutTheToxicityOfThimerosalr5b.pdf, visited on 23 Feb 2010.

34 Van Cleave J, Gortmaker SL, Perrin JM. Dynamics of Obesity and Chronic Health Conditions Among Children and Youth. ***JAMA*** 2010 Feb 17; **303**(7): 623-630.

supporting industries would have a much, much smaller customer base and massively reduced revenues.

Moreover, most of our public health officials would be much less subsidized than they currently are by the industries that are profiting from the epidemic increases in chronic illnesses that seem to be related to the current unchecked growth in our vaccination programs.

Further, there is little or no proof: **a)** that these programs are not a major causal factor in the epidemic of chronic childhood diseases and serious developmental deficits that today's children are experiencing or **b)** that the vaccines individually and as a group are "safe" or "effective" or "safe and effective".

Finally, the discarding of all pretence that our recommended vaccination programs must be cost-effective when all costs are fully considered has clearly established that all of the direct and indirect players in the US vaccination programs are, at a minimum, "knowingly" or "unknowingly" colluding to bankrupt American families by increasing:

- The risk of harm to our children and
- The costs to mitigate that harm

in order to line their pockets.

Clearly, the continuation of the non-cost-effective "chickenpox" (herpes varicella zoster [HVZ]) vaccination program is a poster child for the fleecing of the public.

Since the original HVZ vaccination program was deemed to be marginally cost effective and implemented as a marginally socially cost-effective national program based on one dose of the vaccine's providing "lifetime" protection without including the probable costs to those families the vaccine harms or the increased costs for the treatment of shingles (the recurrence of the HVZ).

Yet, after it was determined that 2 doses of vaccine were needed to provide even short-term protection in our "fully" vaccinated population, instead of stopping the program, because it was no longer even marginally cost effective, the CDC ignored the 2-dose program's lack of cost effectiveness and recommended that children be given a second dose of vaccine thereby destroying any semblance of the program's being cost effective so that the putative benefits might outweigh the costs.

Moreover, considering the added annual costs for the additional shingles cases that are being caused by the CDC's recommended non-cost-effective HVZ vaccination program which have been conservatively estimated at US $ 700 million without fully counting the costs of a third higher-HVZ-concentration dose of Merck's Zostavax and the harm it is causing to some who are vaccinated with it, the current program is even less cost-effective

because the CDC is now effectively recommending a 3-dose regimen (2 childhood shots and one more expensive, older-adult shot).

Additionally, the annual numbers of HVZ-related adverse events reported to the Vaccine Adverse Event System: **a)** are higher for the HVZ vaccines than for any other similar vaccines and **b)** collectively point to significant vaccine-associated risks for serious vaccine-related injury.

Worse, since the current, effectively 3-HVZ-dose vaccination program is a seriously non-cost-effective program with significant risks for serious adverse outcomes, it is obvious that, though Merck, the healthcare providers, public health officials, health insurance companies and the healthcare providers clearly benefit financially and their customer-contacts base has broadened, the benefits to the public are very negative, and no honest risk-benefit analysis could find that the benefits, being negative, outweigh the risks for the current CDC-recommended HVZ vaccination program,

Collectively, the preceding realities unequivocally establish that all of the involved sectors of the Establishment, including our elected and appointed government officials, are knowingly colluding to support a vaccination program that fiscally as well as, in many instances, emotionally and/or physically harms:

- Each of us individually,
- Our families and friends, and
- Our children

for their direct or indirect profit!

"Never mind that by 2008 more than 20 articles published in peer-reviewed medical journals found no connection between MMR vaccine and autism, while two suggested a connection -- one by Wakefield."

Factually, not including Wakefield's study, which did not suggest "*a connection*" but rather suggested that additional studies were needed to assess the possibility of an association between the measles component in the MMR and the unique type of gastrointestinal damage seen in some children who had a diagnosis in the autism spectrum, there are more than two articles that have reported some evidence of a possible causal link between the MMR vaccine and some of the symptoms that many of those with an autism spectrum diagnosis exhibit.

In addition, independent reviews of the data in some of this writer's "*20 articles published in peer-reviewed medical journals*" that reported, in this writer's simplistic terms, "*no connection between MMR vaccine and autism*", uncovered errors or distortions that, when corrected, clearly established that the MMR vaccine or, if given singly, the measles vaccine is causally connected to

post-vaccination adverse events that include the neurodevelopmental symptoms that characterize "*autism*".

Furthermore, the US "Vaccine Court" has repeatedly recognized that measles vaccination can cause irreversible brain damage in some individuals who are vaccinated with either a Merck MMR vaccine or a single-component measles vaccine and has awarded compensation to several petitioners for this recognized damage that causes the "same" symptomology that those with a diagnosis of "autism" or "pervasive developmental disorder – not otherwise specified" have been shown to exhibit.

However, in most all of the preceding instances, the damaged children had previously received and/or concomitantly received Thimerosal-preserved vaccines where the level of the Thimerosal clearly exceeded that necessary to disrupt the immune system's normal functioning.

Thus, most probably, the prior and/or concomitant Thimerosal exposures weakened and/or disrupted the immune system of the person who had been inoculated with them to the point that the person's immune system was no longer to stop the measles virus from infecting the brain and the gut and wreaking havoc in both systems.

The result is typically a brain-damaged child who, following his or her MMR or measles shot, begins to "rapidly" regress and, in short order, starts to exhibit the symptoms of autism and related neurodevelopmental disorders as well as symptoms of serious gastrointestinal damage.

"Incidentally, there's also a mountain of reassuring evidence regarding thimerosal-preserved vaccines. While the studies strongly reaffirm the safety of thimerosal, they exist only because the U.S. and other countries gave in to activist demands and had the preservative removed from childhood vaccines. That gave researchers a wonderful opportunity to do 'before and after' studies."

With respect to the writer's claim of "*a mountain of reassuring evidence regarding thimerosal-preserved vaccines*", most all of the writer's "*reassuring evidence*":

- Was produced by researchers operating under the oversight of some branch of the Department of Human Services, who is also responsible for permitting Thimerosal-preserved vaccines to be marketed without the required proofs of safety and for failing to act decisively, as the Secretary is mandated to do, to safen vaccines by requiring that no Thimerosal can be used in the manufacture of any vaccine, and
- Cannot be independently reevaluated because the raw data has been lost by the governmental agency who is responsible for maintaining it or the researchers have refused to release it to independent reviewers, or

- Belongs to studies that been "independently" reviewed by IOM Committees and other qualified researchers and found to be fatally flawed in one or more key aspects or to contain apparently knowing misrepresentations and/or non-scientifically sound manipulations of the underlying raw data.

On the other hand, there are hundreds of in vitro and in vivo toxicity studies published in peer-reviewed journals, including the one chronic toxicity study for injected Thimerosal that even the FDA recognizes, that have repeatedly established that the level of Thimerosal in even a 0.25-mL dose of a Thimerosal-preserved vaccine is not safe for any young child to the legal minimum "**sufficiently nontoxic so that the amount present in the recommended dose of the product will not be toxic to the recipient**, …" set forth in 21 CFR § 610.15(a).

Furthermore, the amount of mercury in a 0.5-mL Thimerosal-preserved flu shot injected into a pregnant woman carrying even a 1-kg fetus exceeds the putative NOAEL $_{\text{injected Thimerosal, developing human}}$ for the fetus by more than a factor of 1,000 even if the fetus is exposed to only 20 % of the injected dose (and, based on animal studies, typically about 75 % injected is retained by the developing fetus).

With respect to the writer's closing remarks:

> "*While the studies strongly reaffirm the safety of thimerosal, they exist only because the U.S. and other countries gave in to activist demands and had the preservative removed from childhood vaccines. That gave researchers a wonderful opportunity to do 'before and after' studies.*"

the following realities apply:

1. Since:
   a. The safety of Thimerosal can only be proven/established by the appropriate scientifically sound toxicity studies, which both the vaccine makers and the FDA have repeatedly admitted have not been done, and
   b. The studies to which this writer repeatedly refers without citing them are epidemiological studies that cannot prove safety,

   the studies in question clearly cannot prove safety much less "*reaffirm the safety*" of Thimerosal that the scientifically sound and appropriate toxicity studies have failed to establish.
2. The epidemiological studies to which this writer refers only exist because US governmental agencies and self-interested vaccine makers colluded to conduct them in a manner that was preordained to not find evidence of a statistically significant link between Thimerosal exposure and the risk of the "causeless" neurodevelopmental disorder labeled "autism".

3. For the epidemiological studies referred to by this writer, the conflicts of interest within the US governmental agencies overseeing both the vaccination programs and vaccine safety as well as those of the vaccine makers and the "independent" panels hired by the US CDC to review the literature collectively have virtually precluded:
    a. Any scientifically sound study, or the publication of any study or account, that could or would find a statistically sound causal link between Thimerosal exposure and "autism",
    b. Similar scientifically sound studies of the linkage between Thimerosal exposure and other newly epidemic (becoming epidemic in the last 30 years) childhood disorder (like, asthma, type 2 diabetes, MS, IDCM, leukemia, obesity, life-threatening allergies, epilepsy and other seizure disorders, severe gastrointestinal dysfunction and disease, mitochondrial dysfunction, ADHD, and scleroderma, to name a few), and
    c. Comparative clinical studies of all aspects of the health of not less than 25,000 totally unvaccinated children 8,400 males and 16,600 females whose parents were also never vaccinated and a similar ten-times-larger group of age-, ethnicity-, sex-, location-and socioeconomically matched fully vaccinated children, addressing, but not limited to, the relative rates for autism and every other chronic childhood disease that is currently at epidemic (> 1 case in 3,000 children) levels in our children as well as the monitoring of the fluctuation of all measurable biological parameters and gene expression/regulation.

In addition, since the reported levels of autism and asthma in the never vaccinated breast fed children are reportedly on the order of 1 in 5,000 and 1 in 20,000, respectively, in the children treated in a clinic in Chicago, a study that group of children against a fully matched ten-times-larger set of Chicago children who were "fully" vaccinated according to the CDC's recommended vaccination programs for children born between 1985 and 2005 could help establish what the differences are for the prevalence rates are for all of the childhood diseases, disorder, conditions and syndromes that are currently at epidemic levels (> 1 in 3,000).

However, the federal government has steadfastly refused to fund any such study even though such studies, given the timeframes and the changes in the vaccination programs and the formulations of the vaccines available for the program, could definitively address the Thimerosal, MMR, adjuvant, other specific vaccine, and other vaccine component relative risk issues vis-à-vis the outcome differences observed between the matched vaccinated group and the never-vaccinated children.

Unless every facet of the Establishment quits stonewalling on providing the missing proofs of safety for each vaccine and:

- Outlaws those vaccination programs that are not cost effective,
- Bans the use of have vaccine components and formulations that cannot be proven to be safe to the standard "sufficiently nontoxic …" against a pH-adjusted, sterile, isotonic saline placebo, and
- Revokes the licenses of all vaccine formulations that have not been proven to be adequately safe or not in-use effective, where the threshold for in-use effectiveness is disease-challenge protection in not less than 90% of those volunteers who, after being appropriately inoculated and having their level of protection deemed to be adequate in not less than 80 % of those vaccinated, are appropriately challenged with the disease,

then the American public's confidence In the current vaccination programs, the government administrators, federal and state officials, the healthcare establishment, and the pharmaceutical industry will continue to erode at an ever-increasing pace.

In the 1930s, before there was an FDA, faced with a similar uproar over Calomel (mercury (I) chloride) in teething powders and other medicines, that, without proof of safety, were similarly claimed to be safe, the Establishment simply removed these drugs from the market.

Hopefully, today's Establishment understands that it needs to take similar action soon or else, as some have suggested, there may soon be no nationally recommended vaccination programs even for those vaccines that may be: **a)** reasonably safe, **b)** fairly in-use effective and **c)** truly cost effective.

Finally, this reviewer finds that most of the researchers who were given a "*wonderful opportunity to do 'before and after' studies*", have, with a few exceptions, squandered that opportunity by conducting scientifically unsound and biased studies predetermined to find no statistically significant evidence of harm as the governmental and industry groups who funded them had encouraged them to do.

About The Reviewer

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