Facility Automation Management Engineering Systems (*FAME* Systems)
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Wednesday, 5 February 2014

On 25 December 2013, Paul G. King, PhD, downloaded an October 28, 2013 on-line article by "Tara Haelle", that was titled "**Setting the record straight: Debunking ALL the flu vaccine myths**" from http://www.redwineandapplesauce.com/2013/10/28/setting-the-record-straight-dubunking-all-the-flu-vaccine-myths/#givesflu.

Dr. King's responses to only the "myths" that Ms. Haelle enumerates follows these introductory remarks and three (3) "table of contents" pages.

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This analytical response is titled, **"Reality-based Responses to 'Setting the record straight: Debunking ALL the flu vaccine myths'"**.

Introductory Remarks

First, each portion of article's text is quoted in a grayed "Trebuchet MS" font.

Second, Dr. King's comments follow in a "Verdana" font and are indented.

Third, when quoting from the item's text, the quoted portions of the text are in an *italicized* "*Times New Roman*" font.

Fourth, when quoting/referencing other sources, the text is in an "Arial Narrow" font.

Finally, should anyone find any significant factual error in this response for which they have independent[a], scientifically sound, peer-reviewed-published-substantiating documents, please submit that information to Dr. King so that he can improve his understanding of factual reality and, where appropriate, revise his views and this formal response document.

Respectfully,

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[To whom all responses should be directed]

[a] To qualify as an independent document, the study should be published by researchers who have no direct or indirect conflicts of interest from their ties to either those commercial entities who profit from the sale of any product or practice addressed in this response or those entities, academic, commercial or governmental, who directly or indirectly, actively promote any product or practice, the development of any product or practice, and/or programs using any product or practice covered in this response.

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"Reality-based Responses to

'Setting the record straight: Debunking ALL the flu vaccine myths'"

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Reality-based Responses to "Setting the record straight: Debunking ALL the flu vaccine myths"

"Setting the record straight: Debunking ALL the flu vaccine myths

It's that time again — that time when dozens of spurious articles pop up all over the web touting all the dangers of the flu vaccine. Articles on unreliable, alarmist, misinformative sites like Natural News, Mercola, chiropractic blogs and other such sites rail against the "toxins" in the vaccine, or claim the flu vaccine doesn't work, or that it causes this or that horrible disease, or that the flu itself just really isn't all that bad. (I'm not going to link to any of them. They get too much attention as it is.)"

In keeping with the approach espoused by Ms. Tara Haelle, the writer of what seems to be a vaccine-apologist's views about influenza, influenza vaccines and vaccination, and the "flu" in the United States of America (USA), this respondent, Paul G. King, PhD, will not address the extensive narrative composed by Ms. Haelle and her "assistants", "*Kathy McGrath, Nathan Boonstra, Jessica Atwell, Rene Najera, Amber Bickford Cox and Emily Willingham*".

Instead, after some introductory remarks, Dr. King, a PhD analytical chemist with a masters degree in inorganic chemistry, will simply respond to the list of 25 remarks about the "flu", and influenza vaccines and vaccination with the science that establishes the facts that this article twists, misstates and/or misrepresents in what are implicitly Ms. Haelle's and/or her assistants' views concerning the current non-science-based influenza vaccination programs in the USA.

Dr. King's Introductory Remarks

There are independent, peer-reviewed published papers as well as some of Dr. King's independent, peer-reviewed articles on Thimerosal and vaccines, which deflate the implicit claims of "vaccine safety" for vaccines using Thimerosal as a preservative.

In addition those papers and articles establish that, when used as "disease preventive" (prophylactic) biological drug products, influenza vaccines do not even meet the preclinical toxicological safety prerequisites for inoculating any person with any of the current influenza vaccines in a clinical trial.

Moreover, lacking the required preclinical proofs of safety, the current influenza vaccines are adulterated and misbranded drugs that

fail to meet the requirements set forth in 42 U.S.C. 262(a)(2)(C)(i)(I)[1] for "safe" vaccines.

For Thimerosal and its initial mercury-containing breakdown products in the human body, ethylmercury chloride and ethylmercury hydroxide, the facts are:

1. Thimerosal and ethylmercury compounds have been shown to be able to cross the blood-brain "barrier" (see, for example, Zimmermann (2013)[2]).
2. The clearance of ethylmercury compounds from the blood does not mean that these ethylmercury compounds, including Thimerosal, are cleared from the body.

   Factually, based on ^{203}Hg radiolabeled dosing studies in rats and monkeys, more than 85% of a vaccine-level dose of ethylmercury compounds did not rapidly clear the body but rather accumulated in the body's organs and tissues to varying degrees[3]).
3. In the body, ethylmercury compounds are metabolized in the cells into the corresponding methylmercury compounds and into inorganic mercury[4], which has a long half-life in the tissues[5].
4. The only published chronic-toxicity-study-based estimate of the NOAEL[6] for injected Thimerosal shows that an influenza

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1 42 U.S.C. 262(a)(2)(C)(i)(I) (emphasis added),
Sec. 262. Regulation of biological products
(a) Biologics license
(1) No person shall introduce or deliver for introduction into interstate commerce any biological product unless - ….
(2) (A) The Secretary shall establish, by regulation, requirements for the approval, suspension, and revocation of biologics licenses.
(B) Pediatric studies. - ….
(C) The Secretary shall approve a biologics license application -
(i) on the basis of a demonstration that -
(I) the biological product that is the subject of the application is safe, pure, and potent; and …

2 Zimmermann LT, Santos DB, Naime AA, Leal RB, Dórea JG, Barbosa F Jr., Aschner M, Rocha JBT, Farina M. Comparative study on methyl- and ethylmercury-induced toxicity in C6 glioma cells and the potential role of LAT-1 in mediating mercurial-thiol complexes uptake. *NeuroToxicol*. 2013 Sept; 38: 1-8.

3 Takahashi T, Kimura T, Sato Y, Shiraki H, Ukita T. Time-dependent Distribution of [203]Hg-Mercury Compounds in Rat and Monkey as Studied by Whole Body Autoradiography. *J Hygenic Chem* (Japan) 1971; 17(2): 93-107.

4 Rodriques JL, Serpeloni JM, Batista BL, Souza S, Barbarosa Jr F. Identification and distribution of mercury species in rat tissues following administration of Thimerosal or methyl mercury {chloride}. *Arch Toxicol* 2010; 84: 891-896.

5 Sugita M. The biological half-time of heavy metals. The existence of a third, "slowest" component. *Int Arch Occup Environ Health* 1978; 41(1): 25-40.

6 NOAEL is the acronym for the "no observed adverse-effect level", the level in a chronic toxicity study below which there should be no long-term harm to a given human population based on the known inter-species-toxicity-crossing factors between the test subjects (typically rats and monkeys) and the corresponding population. For neurotoxicity, the known basis factors between the rat and the human population are a factor of 10 for the interspecies difference between the neurotoxicity of a substance in the rat brain and that substance in the human brain, a factor of 10 for the human population variability, and a factor of 10 for developing humans over developing rats. Taken together, to estimate the NOAEL toxicity level for Thimerosal from valid rat observations, divide the NOAEL

vaccine dose, nominally delivering 25 micrograms (µg) of Thimerosal (12.5 µg of organic mercury [o-Hg]) in a 0.25-milliliter (mL) volume, exceeds this estimated NOAEL value for Thimerosal in this Thimerosal-preserved dose of an injected inactivated-influenza vaccine given to a developing child ($NOAEL_{\text{injected Thimerosal, developing child}}$) by a factor greater than (>) 2976 divided by the recipients weight in kg or, *putting it succinctly*, the dose, from a 0.25-mL injection of a Thimerosal-preserved inactivated-influenza vaccine, exceeds the $NOAEL_{\text{injected Thimerosal, developing child}}$ unless the infant weighs more than 2976 kg (6,561 pounds)[7].

Since no developing human child weighs more than that weight, the Thimerosal dose in even a 0.25-mL dose of influenza vaccine is clearly toxicologically unsafe.

5. In the 2005 study by Burbacher et al.[8], both o-Hg and inorganic-mercury (i-Hg) species were found in the brain tissues of monkeys that had been injected with vaccine levels of Thimerosal months after the last dose was administered.
6. No "safe" level has been established for either ethylmercury or inorganic mercury species in brain tissue and, based on short-term *in-vitro* studies, neuronal cell toxicity has been observed in developing neurons at Thimerosal levels that were below 0.000001% (< 0.01 parts-per-million [ppm]).

Moreover, studies published in 2011 and 2012 have shown that getting an influenza vaccination increases the vaccinees' risk of con-

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$_{\text{Thimerosal, rat}}$ by a factor of 100 for the $NOAEL_{\text{Thimerosal, adult human}}$ and by 1,000 for the $NOAEL_{\text{Thimerosal, developing child}}$. When no lower limit is observed below which no toxicity is observed and the level of toxic effects decreases in a linear fashion with decreasing dosing level, the NOAEL should be estimated by placing a less than sign (<) in front of the LOAEL (the "lowest observed adverse-effect level") as Dr. King did in his article, http://dr-king.com/docs/090812_fnldrft_TheTruthAboutTheToxicityOfThimerosalr5b.pdf.

[7] See, http://dr-king.com/docs/090812_fnldrft_TheTruthAboutTheToxicityOfThimerosalr5b.pdf, which has been freely available on-line since August 2009 and which, in its "CONCLUDING REMARKS" section, stated,

"Should any reader find significant factual errors in this short article, then please send the author (at paulgkingphd@gmail.com) your proposed changes to the article along with e-mail attachments that contain copies of the published documents that provide the proof needed to substantiate your claims.

Then, as has been the case in the past, after verifying the validity of your concerns, the confirmed significant factual errors will be appropriately corrected and a corrected document posted."

As of the end of 2013, no person has challenged the validity of Dr. King's assertions nor provided published toxicological studies that refute Dr. King's estimate for the NOAEL for injected Thimerosal in adults or in developing children. Moreover, given the CDC's current recommendation that all persons be repeatedly directly or indirectly inoculated with one or more doses of influenza vaccine(s) annually from before birth until they die, the CDC's current recommendations, which extend beyond the rat's chronic dosing (from post birth to the equivalent of middle age) in the rat study that Dr. King used as his basis for estimating the NOAEL and allow Thimerosal-preserved inactivated-influenza vaccines to be given every time, should, if anything make Dr. King's estimate a conservative one.

[8] Burbacher TM, Shen DD, Liberato N, Grant KS, Cernichiari E, Clarkson T. Comparison of blood and brain mercury levels in infant monkeys exposed to methylmercury or vaccines containing Thimerosal. *Environ Health Persp* 2005; 113(8): 1015-1021.

tracting a non-influenza viral respiratory infection[9,10] (by a factor of 3.4-plus to 4.0 according to the results in the 2012 study).

Additionally, in a 2013 study by Doshi[11], the author found, using the federal government's own data, that, on average, less than 20% of all ILI (influenza-like illnesses) cases were confirmed influenza cases — meaning that all of the claims about influenza vaccination's decreasing the risk of "flu" are, *at best*, suspect.

Moreover, the annual deaths reported are mostly flu-related pneumonia deaths with only somewhere between 200 and 3,000 being probably not attributable to a subsequent bacterial infection in a given year.

Based on all of the preceding, Dr. King suggests that, in addition to the cited studies, Ms. Haelle and her "assistants" should read more of Dr. King's articles on Thimerosal as well as the pertinent peer-reviewed published papers where David A. Geier, Janet K. Kern, Gary S. Goldman, and/or Neil Z. Miller are one of the authors and the article addresses Thimerosal, influenza or developmental damage.

Ms Haelle's "*Myth*" and Dr. King's Response

With respect to each "*myth*", Dr. King's fact-based response follows each of Ms. Haelle's assertions:

"Myth #1: The flu vaccine gives you the flu or makes you sick. (No, it doesn't.)"

1. The vaccines being discussed are influenza vaccines, not "*flu*" vaccines. At best, these vaccines apparently provide no protection from 80% of the ILI that are called "*flu*".
2. The live-virus influenza vaccine (e.g., MedImmune's FluMist®):
   a. Infects about 80%[12] of those inoculated with it with at least one (1) of the now four (4) live strains of the influenza virus in it;

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9 Kelly H, Jacoby P, Dixon GA, Carcione D, et al. Vaccine Effectiveness against laboratory-confirmed influenza in healthy young children: a case-control study. *Pediatr Infect Dis J* 2011; 30: 107–111.

10 Cowling BJ, Fang VJ, Nishiura H, et al. Increased Risk of Noninfluenza Respiratory Virus Infections Associated with Receipt of Inactivated Influenza Vaccine. *Clin Infect Dis.* 2012 June 15; 54(12): 1778-1783.

11 Doshi P, Influenza: marketing vaccine by marketing disease. *British Med J. [BMJ]* 2013; 346 doi: http://dx.doi.org/10.1136/bmj.f3037 (Published 16 May 2013).

12 From 2009 Package Insert for MedImmune's FluMist (emphasis added),
"14.5 Transmission Study
FluMist contains live attenuated influenza viruses that must infect and replicate in cells lining the nasopharynx of the recipient to induce immunity. Vaccine viruses capable of infection and replication can be cultured from nasal secretions obtained from vaccine recipients. The relationship of viral replication in a vaccine recipient and transmission of vaccine viruses to other individuals has not been established.

b. Sickens most all of those who are inoculated with it; and

c. For at least 3 weeks, some unknown percentage of those who have been inoculated may shed live virus and infect others.

In addition, between late 2007, the start of the 2007-2008 "flu" season and early 2013 (the end of the 2012-2013 "flu" season, there have been 15 post-vaccination deaths associated with administering some lot of the FluMist or, for the 2009-2010 "flu season", a 2009 A-H1N1 'mist' vaccine (see **Appendix A**, where the VAERS [Vaccine Adverse-Events Reporting System jointly maintained by the U.S. Centers for Disease Control and Prevention (CDC) and the U.S. Food and Drug Administration (FDA)] records are posted, with Dr. King's annotations).

Based on this rough audit, FluMist/Pandemic 'mist' vaccine definitely was a major causal factor in four (4) of these reports.

In two (2) reports, the FluMist/Pandemic 'Mist' vaccine did not appear to be a causal factor.

In the remaining nine (9) reports to VAERS, the FluMist or the pandemic 'mist' vaccine appeared to be a possible or probable causal factor.

Excluding the 2009-2010 "flu" season, there was about 1 death report per year from FluMist [for the 2007-2008 flu season – "1"; for the 2008-2009 flu season – "1" but probably not FluMist related; for the 2010-2011 flu season "2"; for the 2011-2012 flu season "1"; and for the 2012-2013 flu season "1".

This indicates that the probable level of FluMist-related death reports to VAERS is on the order 1 per flu season or, presuming a 1% reporting level, roughly 100 deaths per year.

Using the frozen formulation, a prospective, randomized, double-blind, placebo-controlled trial was performed in a daycare setting in children <3 years of age to assess the transmission of vaccine viruses from a vaccinated individual to a non-vaccinated individual. A total of 197 children 8-36 months of age were randomized to receive one dose of FluMist (n=98) or placebo (n=99). Virus shedding was evaluated for 21 days by culture of nasal swab specimens. Wild-type A (H3N2) influenza virus was documented to have circulated in the community and in the study population during the trial, whereas Type A (H1N1) and Type B strains did not.

At least one vaccine strain was isolated from 80% of FluMist recipients; strains were recovered from 1-21 days post vaccination (mean duration of 7.6 days ± 3.4 days). The cold-adapted (ca) and temperature-sensitive (ts) phenotypes were preserved in 135 tested of 250 strains isolated at the local laboratory. Ten influenza isolates (9 influenza A, 1 influenza B) were cultured from a total of seven placebo subjects. One placebo subject had mild symptomatic Type B virus infection confirmed as a transmitted vaccine virus by a FluMist recipient in the same playgroup. This Type B isolate retained the ca, ts, and att phenotypes of the vaccine strain, and had the same genetic sequence when compared to a Type B virus cultured from a vaccine recipient within the same playgroup. Four of the influenza Type A isolates were confirmed as wild-type A/Panama (H3N2). The remaining isolates could not be further characterized.

Assuming a single transmission event (isolation of the Type B vaccine strain), the probability of a young child acquiring vaccine virus following close contact with a single FluMist vaccinee in this daycare setting was 0.58% (95% CI: 0, 1.7) based on the Reed-Frost model. With documented transmission of one Type B in one placebo subject and possible transmission of Type A viruses in four placebo subjects, the probability of acquiring a transmitted vaccine virus was estimated to be 2.4% (95% CI: 0.13, 4.6), using the Reed-Frost model.

The duration of FluMist vaccine virus replication and shedding have not been established."

In the 2009-2010 flu season, increased emphasis on reporting and the fact that 2 flu vaccines were given, a monovalent A(H1N1) vaccine and a trivalent seasonal influenza vaccine, generated nine (9) live-virus death reports to VAERS.

However, based on the facts given, one (1), *which was a seasonal FluMist vaccination*, was definitely related to another vaccine given at the same time.

Since, for the eight (8) remaining reports, the fact that two (2) vaccines were given resulted in deaths that were reported as monovalent A(H1N1) 'mist' death reports.

This elevated reporting level should probably be attributed to the increased reporting and double dosing such that the probable increase in death reports attributable to a live-virus influenza vaccine was probably no more than 20 per year.

Thus, on balance, since the start of the 2007-2008 flu season, the live-virus influenza vaccines probably are a causal factor in the death outcomes observed in *no more than* about 100 to *no more than* 200 cases per year.

3. In a randomized, double-blind, true-placebo-controlled, case-control study (*a "gold" study*) with 9 months of intensive follow-up in children 6-15 years of age, the authors (see footnote "**10**") found little protection from contracting influenza in the vaccinated group as compared to those getting the saline placebo injection and a 3.4-plus to 4-fold increased risk of a non-influenza viral respiratory infection, *which made them sick*, in the vaccinated children relative to those getting the true-placebo injection.

Given these findings, influenza vaccination did significantly contribute to the ILI ("***flu***") cases that these vaccinated children subsequently contracted and did not significantly protect those who were vaccinated from subsequently contracting an influenza infection.

Based on the preceding realities, the live-virus influenza vaccines do give most inoculees influenza ("*give you the flu*") and the inactivated-influenza vaccines have been proven to increase your risk for contracting a noninfluenza ILI (a "flu"), which, when contracted, "*makes you sick*".

"Myth #2: Flu vaccines contains dangerous ingredients, such as mercury, formaldehyde and antifreeze. (Not exactly, and the ingredients aren't dangerous.)"

Dr. King agrees with Ms. Haelle's "*Not exactly*" assertion because only "*formaldehyde*" is an ingredient/component in vaccines.

Factually, "*mercury*" is an element in a chemical called Thimerosal that is used as a preservative (in Thimerosal-preserved inactivated-influenza vaccines) or an in-process sterilization aid (in the reduced-Thimerosal Novartis Fluviron® inactivated-influenza vaccine).

Furthermore, the term "*antifreeze*", like the term "preservative", refers to one of the uses of an ingredient in a given influenza vaccine formulation and not to any specific chemical compound or to diethylene glycol, which is often called "antifreeze" because of its decades-long use as an antifreeze agent in automobile cooling systems.

However, Dr. King must disagree with Ms. Haelle's "*and the ingredients aren't dangerous*" assertion because influenza vaccines do contain ingredients, like Thimerosal, which are inherently dangerous to all humans, as well as components, like ovalbumin (an egg protein), which are only dangerous to those who are truly allergic to them.

In general, the package inserts for the influenza vaccines contain a section that is labeled, "4 CONTRAINDICATIONS", which generally states something like,

> "A severe allergic reaction (e.g., anaphylaxis) to any component of the vaccine [see *Description* (11)], including egg protein, or to a previous dose of any influenza vaccine is a contraindication to administration of" <the influenza vaccine's trade name>.

Clearly some of the ingredients in the influenza vaccines are dangerous to some to the point that those who truly have had such life-threatening adverse reactions should not be administered another dose of such influenza vaccines because that immune-system rechallenge can cause an anaphylactic reaction, which can be fatal for any person who is truly allergic.

Turning to the specific ingredient that is currently used as a preservative in all multi-dose vials of inactivated-influenza vaccines, which represent roughly half of all the doses of the inactivated-influenza vaccines, namely sodium ethylmercurithiosalicylate, known by the trade name Thimerosal, Dr. King's articles and the toxicological literature have clearly established that Thimerosal is highly toxic, a known human carcinogen, mutagen, carcinogen, immune-system toxin with strong autoimmune-inducing effects, and a reproductive toxin at tissue exposure levels below 1 part per million (< 1 microgram [µg] of Thimerosal per gram of wet tissue) in *in-vivo* animal studies and *in-vitro* developing human neuronal studies.

To make a valid claim that the amount of any highly toxic ingredient, like Thimerosal, in a vaccine is not dangerous to, for example,

the developing child, the writer, who is a formally trained journalist, would, at a minimum, have to cite scientifically sound and appropriate, peer-reviewed, published toxicological studies that have unequivocally proven that the amount of Thimerosal injected in a Thimerosal-preserved inactivated-influenza vaccine dose is at least 10-fold lower than the NOAEL (no observed adverse-effect level) for the lowest weight subjects (developing children) receiving that dose.

Finally, based on Dr. King's 2009 unrebutted published article (see footnote "**7**"), the amount of Thimerosal in even a 0.25-mL dose of a Thimerosal-preserved inactivated-influenza vaccine is clearly dangerous because, for the developing child, the amount of Thimerosal injected is, for a 10-kg child, more than 291 times the developing child's NOAEL for injected Thimerosal [where Dr. King has estimated that the $NOAEL_{\text{injected Thimerosal, developing child}}$ is < 0.0086 µg/kg of weight/day].

"Myth #3: Pregnant women should not get the flu shot. (They should.) / The flu shot can cause miscarriages. (It doesn't.) / Pregnant should only get the preservative-free flu shot. (Nope.)"

First, absent proof that inoculating any pregnant woman with a 0.5-mL dose of a Thimerosal-preserved inactivated-influenza vaccine, which delivers a nominal 50-µg dose of Thimerosal to that pregnant woman, can cause no inflammatory process in the developing child's developing brain and is not neurotoxic to the developing child's brain as well as not toxic to any other developing tissue or organ, pregnant women should not be administered any Thimerosal-preserved inactivated-influenza vaccine.

Second, absent proof that inoculating any pregnant women with a 0.5-mL dose of a no-Thimerosal inactivated-influenza vaccine cannot cause any inflammatory process in the developing child's central and peripheral nervous system, pregnant women should not be administered any influenza vaccine.

Since the preceding proofs of safety have not been provided, no pregnant woman should get any influenza vaccine whatsoever.

This is a reality because inoculating a pregnant woman risks long-term neurodevelopmental harm to the developing child or children that she is carrying.

Turning to the issue of evidence of harm,

1. As per Goldman GS (2013), getting two (2) doses of influenza vaccine in the 2009-2010 "flu season" caused a significant

elevation in the risk of fetal loss (miscarriage and stillbirth) attributable to the Thimerosal in the Thimerosal-preserved influenza vaccine doses that about half of the vaccinated pregnant women received[13].

2. Two other studies[14,15] showed significant risk when pregnant women were given Thimerosal-preserved Rho(D) [an immunoglobulin used to prevent Rhesus-factor antigenic incompatibility between the mother and the fetus] products. [**Note:** A contrary study[16], which is titled, "Lack of association between Rh status, Rh immune globulin in pregnancy and autism", is suspect for a number of reasons. Dr. King suggests that those who want to know more about the contrary study's problems should consult the independent review of it published by SafeMinds[17].
3. As Dr. Russell Blaylock, a now-retired neurosurgeon, who studies vaccination-related neurodevelopmental and inflammation issues, has observed[18], pregnant women should get no vaccine whatsoever during pregnancy because all such vaccines can cause persistent brain inflammation in the developing child.

"Myth #4: Flu vaccines can cause Alzheimer's disease. (They can't.)"

When the influenza vaccines are Thimerosal preserved, they can and do cause varying levels of mercury intoxication (poisoning) in the brain from Thimerosal's bioaccumulative final metabolite, brain-cell-retained inorganic mercury (i-Hg), that, *in the elderly*, has been demonstrated to be a causal factor in Alzheimer's[19].

"Myth #5: Flu vaccines provide billions of dollars in profits for pharmaceutical companies. (Maybe, maybe not, but so what?)"

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13 Goldman GS. Comparison of VAERS fetal-loss reports during three consecutive influenza seasons. Was there a synergistic fetal toxicity associated with the two-vaccine 2009/2010 season? *Hum Exp Toxicol* 2013 May; 32(5): 464-475. doi:10.1177/0960327112455067.

14 Geier DA, Geier MR. A prospective study of thimerosal-containing Rho(D)-immune globulin administration as a risk factor for autistic disorders. *J Maternal-Fetal and Neonat Med* 2007 May; 20(5): 385–390.

15 Geier DA, Mumper E, Gladfelter B, Coleman L, Geier MR. Neurodevelopmental Disorders, Maternal Rh-Negativity, and Rho(D) Immune Globulins: A Multi-Center Assessment. *Neuroendocrinol Lett* 2008; 29(2): 272-280.

16 Miles JH, Takahashi NT. Lack of association between Rh status, Rh immune globulin in pregnancy and autism. *American Journal of Medical Genetics Part A*. 2007; 9999(9999): 1-11.

17 Bernard S, Blaxill M, Redwood L. A REVIEW OF MILES & TAKAHASHI STUDY AND RELATED LITERATURE ON AUTISM RISK FROM ANTENATAL RHO-D IMMUNE GLOBULIN. http://www.safeminds.org/news/pressroom/press_releases/Review_Miles_Takahashi_6-20-07.pdf, published 20 June 2007.

18 See, "The Danger of Excessive Vaccination During Brain Development The Case for a Link to Autism Spectrum Disorders By Russell L. Blaylock, M.D.", published on April 1, 2008 at http://curezone.com/forums/fm.asp?i=1145597.

19 Mutter J, Annika Curth A, Naumann J, Deth R, Walach H. Does Inorganic Mercury Play a Role in Alzheimer's Disease? A Systematic Review and an Integrated Molecular Mechanism. *J Alzheimer's Disease* 2010; 22: 357–374. [**Note:** This article can be downloaded from http://iris.lib.neu.edu/cgi/viewcontent.cgi?article=1007&context=bouve_fac_pubs.]

Since the influenza vaccines are not really *effective* in preventing influenza infection in a significant percentage of those who are inoculated with these vaccines, the current influenza vaccination programs are a waste of healthcare dollars that could be better spent.

Based on the results of several studies[20,21,22], we would be better off giving everyone, on average, sufficient vitamin D-3 (with vitamin K-2 and/or probiotics to ensure absorption as well as adequate levels of vitamin C, zinc and magnesium) to raise everyone's blood 25-hydroxy-vitamin-D level to at least 55 nanograms per milliliter (ng/mL) [138 nanomoles per liter (nm/L)][23], which would effectively provide protection from most all ILI (flu cases) during the flu season as well as also provide protection from other viral, mycobacterial, mold, fungal, and bacterial infections and many cancers.

Thus, the answer to Ms. Haelle's "***but so what?***" question: For much less cost, the American people could be much healthier.

Therefore, the "*billions of dollars in profits for pharmaceutical companies*" clearly come at a significant cost of the health of the American public, who overpays for a prophylactic treatment, influenza vaccination, that is not effective rather than invests in a proven disease preventive

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20 **a.** Aloia J, Li-Ng M. Re: epidemic influenza and vitamin D. *Epidemiol Infect* 2007; 135: 1095–1096.
b. Cannell JJ, Zasloff M, Garland CF, Scragg R, Giovannucci E. On the epidemiology of influenza. *Virol J* 2008; 5: 29.
c. Li-Ng M, Aloia JF, Pollack S, et al. A randomized controlled trial of vitamin D3 supplementation for the prevention of symptomatic upper respiratory tract infections. *Epidemiol Infect* 2009; 137: 1396–1404.
d. Ginde AA, Mansbach JM, Camargo CA Jr. Association between serum 25-hydroxyvitamin D level and upper respiratory tract infection in the Third National Health and Nutrition Examination Survey. *Arch Intern Med* 2009; 169: 384–390.
e. Yamshchikov AV, Desai NS, Blumberg HM, Ziegler TR, Tangpricha V. Vitamin D for treatment and prevention of infectious diseases: a systematic review of randomized controlled trials. *Endocr Pract* 2009; 15: 438–449.

21 Urashima M, Segawa T, Okazaki M, Kurihara M, Wada Y, Ida H. Randomized trial of vitamin D supplementation to prevent seasonal influenza A in schoolchildren *Am J Clin Nutr* 2010; 91:1255–1260.

22 Bergman P, Lindh ÅU, Björkhem-Bergman L, Lindh JD. Vitamin D and Respiratory Tract Infections: A Systematic Review and Meta-Analysis of Randomized Controlled Trials. *PLoS ONE* 2012 Jun 19; 8(6): e65835.. DOI: 10.1371/journal.pone.0065835. Article available at: http://www.plosone.org/article/info%3Adoi%2F10.1371%2Fjournal.pone.0065835.

23 At levels of 55 ng/mL and above, 25-hydroxy-vitamin D has been shown to cause the otherwise nutrient-sufficient person to be able to make its own disease-tailored antibiotics (cathelicidins, defensins and protegrins) at clinical-disease-preventive levels. In general, a healthy person needs to make daily and/or take 70-80 IUs (1.75 – 2.0 µg) of vitamin D-3 per kilogram of his or her body weight to attain a 55 ng/mL level of 25-hydroxy-vitamin D. Thus, a 100 kg (220.5 pound) person needs to take 7,000 to 8,000 IUs of vitamin D-3 daily. In contrast, a 10 kg child (22 pound) need only take 700 to 800 IUs daily and a 150 kg (331 pound) person needs 10,500 to 12,000 IUs per day. Since the normal blood-level range for 25-hydroxy-vitamin D is roughly 30 to 100 ng/mL and no adverse effects have been observed for long-term levels up to 200 ng/mL, the suggested dosing schedule has a significant safety margin. Furthermore, because the suggested dosing is daily, the dose does not have a significant risk of causing too high a 25-hydroxy vitamin D-3 level or a risk of the daily dose's not being effectively absorbed. Moreover, like vitamin C, when a person is ill, the body apparently uses up its circulating 25-hydroxy vitamin D stores more rapidly so that absorbable 2,200-IU-per-kg doses can be administered with the appropriate level of probiotics and/or vitamin K-2 to ensure absorption for short periods of time (7 to 14 days) or the disease symptoms subside, whichever is sooner, with no observed adverse risks. [**Note:** For a guide to the use of sodium ascorbate in the treatment of illness, see Cathcart RF, III. The Method of Determining Proper Doses of Vitamin C for the Treatment of Disease by Titrating to Bowel Tolerance. *Orthomolecular Psychiatry* 1981; 10(2): 125-132.]

treatment, supplementation with adequate amounts of vitamin D-3 during the winter, if not all year round, which is not only an effective influenza-preventive measure but is also a general disease-preventive measure for most infectious diseases, including most all ILI cases, at a much lower overall cost to the public.

"Myth #6: Flu vaccines don't work. (Um, they do work.)"

First, since there are no "*[f]lu vaccines*" but only influenza vaccines, these non-existent "*[f]lu vaccines*" cannot work to prevent "flu" because influenza vaccines only provide limited protection for some strains of influenza A and influenza B to some percentage of those inoculated with then where collectively influenza cases only make up less than 20% of the annual cases of "flu" (see footnote "**11**"), where the disease "flu" is defined by the person's symptoms (see **Appendix B**).

Second, at best, the current INFLUENZA vaccines are not very effective and, in absolute terms only, at best, reduce the level of "flu" cases by 1 to 2 % (in terms of influenza, the reduction in cases is roughly 5 to 10% at best) over the level of disease in the non-vaccinated portion of the population who gets the "flu".

Moreover, because inactivated-influenza vaccination has clearly been shown to increase the risk of the inoculees' subsequently contracting one or more noninfluenza viral respiratory infections by more than a factor of 3.4-plus-fold over those who were given a saline placebo injection (see footnote "**10**") and the live-virus influenza vaccines infect those who are inoculated with them with live influenza virus(es), which most inoculees contract and can spread to others, overall it would appear that influenza vaccination actually promotes or causes increased levels of ILI in the population.

IF the goal is to make those who get influenza vaccines less healthy, THEN the influenza vaccines work to that end.

However, IF, *as claimed*, the goal is to effectively protect almost all of those who are vaccinated with an influenza vaccine from getting the "flu" (any ILI), THEN the influenza vaccines simply do not work.

Given the preceding realities, the current influenza vaccination programs should be stopped because they clearly appear to cause more harm than they provide "flu" protection!

"Myth #7: Flu vaccines don't work for children. (Again, they work.)"

Factually (see, Cochrane Library review, 2012[24]), one need only read the "Main results"[25] and the "Authors' conclusions"[26] in the "ABSTRACT" and the "**PLAIN LANGUAGE SUMMARY**"[27] section of the cited review, "Vaccines for preventing influenza in healthy children (Review)", by Jefferson T, Rivetti A, Di Pietrantonj C, Demicheli V, and Ferroni E, where a reprint of this Cochrane review, published in ***The Cochrane Library*** ( ) and originally published in *The Cochrane Library* 2012, Issue 8, can be downloaded from http://www.update-software.com/pdf/CD004879.pdf.

For children under two (2) years of age, *where only inactivated-influenza vaccines are recommended*, "Inactivated vaccines in children aged two years or younger are not significantly more efficacious than placebo".

Thus, more than not being effective in preventing influenza virus

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[24] Jefferson T, Rivetti A, Di Pietrantonj C, Demicheli V, Ferroni E. Vaccines for preventing influenza in healthy children (Review). The Cochrane Library 2012, Issue 8. This is a reprint of a Cochrane review, prepared and maintained by The Cochrane Collaboration and published in http://www.thecochranelibrary.com. Abstract at http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD004879.pub4/abstract; full article available at http://www.update-software.com/pdf/CD004879.pdf.

[25] See "Main results" (emphasis added),

"We included 75 studies with about 300,000 observations. We included 17 RCTs, 19 cohort studies and 11 case-control studies in the analysis of vaccine efficacy and effectiveness. Evidence from RCTs shows that six children under the age of six need to be vaccinated with live attenuated vaccine to prevent one case of influenza (infection and symptoms). We could find no usable data for those aged two years or younger.

Inactivated vaccines in children aged two years or younger are not significantly more efficacious than placebo. Twenty-eight children over the age of six need to be vaccinated to prevent one case of influenza (infection and symptoms). Eight need to be vaccinated to prevent one case of influenza-like-illness (ILI). We could find no evidence of effect on secondary cases, lower respiratory tract disease, drug prescriptions, otitis media and its consequences and socioeconomic impact. We found weak single-study evidence of effect on school absenteeism by children and caring parents from work. Variability in study design and presentation of data was such that a meta-analysis of safety outcome data was not feasible. Extensive evidence of reporting bias of safety outcomes from trials of live attenuated influenza vaccines (LAIVs) impeded meaningful analysis. One specific brand of monovalent pandemic vaccine is associated with cataplexy and narcolepsy in children and there is sparse evidence of serious harms (such as febrile convulsions) in specific situations."

[26] See "Authors' conclusions" (emphasis added),

"Influenza vaccines are efficacious in preventing cases of influenza in children older than two years of age, but little evidence is available for children younger than two years of age. There was a difference between vaccine efficacy and effectiveness, partly due to differing datasets, settings and viral circulation patterns. No safety comparisons could be carried out, emphasising the need for standardization of methods and presentation of vaccine safety data in future studies. In specific cases, influenza vaccines were associated with serious harms such as narcolepsy and febrile convulsions. It was surprising to find only one study of inactivated vaccine in children under two years, given current recommendations to vaccinate healthy children from six months of age in the USA, Canada, parts of Europe and Australia. If immunisation in children is to be recommended as a public health policy, large-scale studies assessing important outcomes, and directly comparing vaccine types are urgently required. The degree of scrutiny needed to identify all global cases of potential harms is beyond the resources of this review.

This review includes trials funded by industry. An earlier systematic review of 274 influenza vaccine studies published up to 2007 found industry-funded studies were published in more prestigious journals and cited more than other studies independently from methodological quality and size. Studies funded from public sources were significantly less likely to report conclusions favourable to the vaccines. The review showed that reliable evidence on influenza vaccines is thin but there is evidence of widespread manipulation of conclusions and spurious notoriety of the studies. The content and conclusions of this review should be interpreted in the light of this finding."

[27] See, "PLAIN LANGUAGE SUMMARY" (emphasis added),

"Vaccines for preventing influenza in healthy children

Children (< 16 years old) and the elderly (above 65 years old) are the two age groups that appear to have the most complications following an influenza infection. Influenza has a viral origin and often results in an acute respiratory illness affecting the lower or upper parts of the respiratory tract, or both. Viruses are mainly of two subtypes (A or B) and spread periodically during the autumn-winter months. However, many other viruses can also cause respiratory tract illnesses.

Diffusion and severity of the disease could be very different during different epidemics. Efforts to contain epidemic diffusion rely mainly on widespread vaccination. Recent policy from several internationally-recognised institutions, recommend immunisation of healthy children between 6 and 23 months of age (together with their contacts) as a public health measure.

The review authors found that in children aged from two years, nasal spray vaccines made from weakened influenza viruses were better at preventing illness caused by the influenza virus than injected vaccines made from the killed virus. Neither type was particularly good at preventing 'flu-like illness' caused by other types of viruses. In children under the age of two, the efficacy of inactivated vaccine was similar to placebo. It was not possible to analyse the safety of vaccines from the studies due to the lack of standardisation in the information given, but very little information was found on the safety of inactivated vaccines, the most commonly used vaccine in young children."

infection, giving inactivated-influenza vaccines to children two years of age or younger does not even produce any significant level of antibodies to the inactivated-influenza antigens (because these antibodies define vaccine "efficacy").

Therefore, there is no justification for giving any supposedly "disease preventive" (prophylactic) influenza vaccination to children that are two (2) years of age or younger.

For children two to six years of age, "six children under the age of six need to be vaccinated with live attenuated vaccine to prevent one case of influenza (infection and symptoms)" and, for the inactivated-influenza vaccines, "[t]wenty-eight children over the age of six need to be vaccinated to prevent one case of influenza (infection and symptoms)".

Thus, if these findings are valid, then the live-virus influenza vaccine, which now infects all those vaccinated with up to four (4) live influenza viruses, is no more than 17% effective in preventing those who are inoculated with it from subsequently contracting influenza.

Similarly, if the review findings are valid, the inactivated-influenza vaccines are about 3.6 % effective in preventing influenza in those children inoculated with them.

However, remembering the abstract's admonition,

> "The review showed that reliable evidence on influenza vaccines is thin but there is evidence of widespread manipulation of conclusions and spurious notoriety of the studies",

the reported findings are overestimates of the effectiveness of influenza vaccination in children.

Moreover, as the review reports, "Children (< 16 years old) ... appear to have the most complications following an influenza infection".

Thus, though "efficacious" (produces a sufficient antibody-titer) in a significant percentage of those inoculated with them, influenza vaccine inoculation is not highly effective in preventing influenza infection in children and, *based on the recent studies cited initially*, influenza vaccine inoculation significantly increases the vaccinated children's risk of subsequently contracting noninfluenza viral respiratory infections.

In addition, as the cited review reports, children have a significant level of "complications" (adverse reactions), including hospitalization, temporary and permanent disability, and death.

Given all of the preceding review observations, *though they "work" for the vaccine makers who make billions in profit selling them*, clearly, influenza "*vaccines don't work for children*", when it comes to protecting:

- Most all of the vaccinated children from subsequently contracting an influenza infection or

- All of them from having serious vaccination-related harm, as the "safest of medicines" should.

In addition, based on the previously cited clinical studies published in 2011 (see footnote "**9**") and 2012 (see footnote "**10**"), influenza vaccination *significantly* increases the risk that inoculees will subsequently contract an ILI that is not either a covered virus strain of influenza A or influenza B as compared to that risk in children who were not given an influenza vaccine inoculation.

"Myth #8: Flu vaccines make it easier for people to catch pneumonia or other infectious diseases. (No, they make it harder.)"

First, to the extent that they consume immune-system resources and suppress the innate immune system, influenza vaccines, like almost all vaccines, increase the recipient's susceptibility to other diseases and, based on some recent studies in Canada[28] and the Netherlands[29], apparently make it harder for the immune system to respond to other influenza strains.

Second, in Cowling, et al. (2012), the study's "DISCUSSION" section states (emphasis added),

> "In the prepandemic period of our study, we did not observe a statistically significant reduction in confirmed seasonal influenza virus infections in the TIV [trivalent inactivated-influenza vaccine] recipients (Table 3), although serological evidence (Supplementary Appendix) and point estimates of vaccine efficacy based on confirmed infections were consistent with protection of TIV recipients against the seasonal influenza viruses that circulated from January through March 2009 [16]. We identified a statistically significant increased risk of noninfluenza respiratory virus infection among TIV recipients (Table 3), including significant increases in the risk of rhinovirus and coxsackie/echovirus infection, which were most frequently detected in March 2009, immediately after the peak in seasonal influenza activity in February 2009 (Figure 1)" (see footnote "**10**").

In addition, Kelly, et al. (2011) found that those who were vaccinated but did not get a laboratory-confirmed case of influenza had significantly higher levels of non-influenza respiratory infections than those non-vaccinated participants who did not get a laboratory confirmed case of influenza.

Moreover, the researchers stated (emphasis added),

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[28] **a.** Skowronski DM, De Serres G, Crowcroft NS, Janjua NZ, Boulianne N, et al. Association between the 2008–09 Seasonal Influenza Vaccine and Pandemic H1N1 Illness during Spring–Summer 2009: Four Observational Studies from Canada. *PLoS Med.* 2010 7(4): e1000258.

b. Viboud C, Simonsen L. Does Seasonal Influenza Vaccination Increase the Risk of Illness with the 2009 A/H1N1 Pandemic Virus? *J. PLoS Medicine* 2010 April; 7(4): e1000259

[29] Bodewes R, Fraaij PLA, Geelhoed-Mieras MM, van Baalen CA, et al. Annual Vaccination against Influenza Virus Hampers Development of Virus-Specific CD8+ T Cell Immunity in Children. J. Virol. 2011 Nov; 85(22): 11995-12000.

> "We concluded that the use of ILI controls without influenza virus being identified is the appropriate choice of comparison group for the influenza cases in this study design. However, within the control group, we found that there was significantly higher vaccination coverage among those who tested positive for other respiratory viruses than among those who tested negative for all viruses. This could be interpreted to mean that influenza vaccination increases the risk of being infected by viruses other than influenza, but we believe that this explanation is biologically implausible" (see footnote "**9**").

Based on these findings, clearly influenza vaccination "*make it easier for people to catch … other infectious diseases*".

"Myth #9: Flu vaccines cause vascular or cardiovascular disorders. (No, they don't.)"

One of the serious adverse reactions to influenza vaccines is vasculitis (inflammation of the blood vessels).

A search of VAERS for "vasculitis" reports following an influenza vaccine inoculation produced 54 vasculitis reports for the 2003-2004 through 2012-2013 flu seasons with 19 (35%) of the 54 reports occurring in the 2009-2010 flu season when 2 to 4 doses of influenza vaccines (one trivalent seasonal vaccine and one monovalent 2009-A(H1N1) pandemic vaccine) were recommended.

Excluding the 2009-2010 flu season, an average of 3.5 vasculitis reports related to influenza vaccination were filed in VAERS.

Subtracting "4" from the "19" vasculitis reports in the 2009-2010 flu season, there were an excess of 15 vasculitis reports following the influenza vaccine inoculation.

Based on other studies, including Goldman (2013) [see footnote "**13**"], the observed 19 vasculitis reports exceeded the expected "7–9" vasculitis reports in VAERS based on double dosing and some increased reporting, which is, again, an indication that the mercury from the Thimerosal in the Thimerosal-preserved inactivated-influenza vaccines is, at a minimum, an aggravating factor for vasculitis.

Based on the historical reporting of adverse events in the 10% to 1% range[30], the VAERS reports' data indicate that, on average, 35 to 350 post-seasonal-influenza-vaccination-related vasculitis cases probably occur during each "flu season".

Thus, though the level is low, based on the signals observed in VAERS, influenza vaccines definitely can cause vasculitis, which definitely is one of the known "*vascular or cardiovascular disorders*".

Finally, there are published studies that have found a link between

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[30] Kessler, DA, the Working Group, Natanblut S, Kennedy D, Lazar E, Rheinstein P, et al. Introducing MEDWatch: a new approach to reporting medication and device adverse effects and product problems. *JAMA* 1993; 269(21): 2765.

influenza vaccination and vasculitis[31].

"Myth #10: Flu vaccines can break the "blood brain barrier" of young children and hurt their development. (No, they can't.)"

First, there is no need for any vaccine to "*break the 'blood brain barrier'*".

All that is needed is for any substance in a vaccine that is potentially deleterious to the brain to be transported across the blood-brain barrier into the brain or to be transported across those parts of the brain that are not protected from exposure by the gaps in the blood-brain barrier.

Moreover, because: **a)** the blood-brain barrier is incompletely formed in young children[32] and **b)**, *even when it is completely formed*, the blood-brain barrier does not completely enclose the entire brain[33], children's developing brains are more susceptible to injury by substances in the influenza vaccines that are directly or indirectly toxic or deleterious to brain development and/or healthy function.

Such substances include, *but are not limited to*, undisclosed adventitious viruses that may be contaminating the influenza vaccine formulation, the surfactant in the vaccine formulation, formaldehyde or another virus inactivating substance in the inactivated-influenza vaccines, bioactive recombinant DNA fragments in the live-virus influenza vaccine, polymeric hydrated aluminum salts (adjuvants), and Thimerosal in the several multi-dose preserved inactivated-influenza vaccine formulations and the one reduced-Thimerosal, single-dose inactivated-influenza vaccine formulation (Novartis' single-dose Fluvirin®).

Despite claims to the contrary, studies have unequivocally shown that ethylmercury species are transported across the blood-brain bar-

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31 **a.** Yanai-Berar N, Ben-Itzhak O, Gree J, Nakhoul F. Influenza vaccination induced leukocytoclastic vasculitis and pauci-immune crescentic glomerulonephritis. *Clin Nephrol* 2002; 58: 220-223.

b. Mader R, Narendran A, Lewtas J, et al. Systemic vasculitis following influenza vaccination—report of 3 cases and literature review. *J Rheumato* 1993; 20: 1429-1431.

c. Blumberg S, Bienfang D, Kantrowitz FG. A possible association between influenza vaccination and small-vessel vasculitis. *Arch Intern Med* 1980; 140: 847-848.

32 Rubin LL, Staddon JM, THE CELL BIOLOGY OF THE BLOOD-BRAIN BARRIER *Annual Rev Neurosci* 1999 Mar; 22: 11-28. DOI: 10.1146/annurev.neuro.22.1.11. **Abstract** (emphasis added),

"The blood-brain barrier (BBB) is formed by brain capillary endothelial cells (ECs). In the late embryonic and early postnatal period, these cells respond to inducing factors found in the brain environment by adopting a set of defined characteristics, including high-electrical-resistance tight junctions".

33 Partridge WM. Blood-brain barrier biology and methodology. *J NeuroViriol* 1999; 5: 556-569, page 557 (emphasis added),

"**Blood-brain barrier methodology**

Until the late 1960's, blood-brain barrier function in vivo was studied with vital dyes such as trypan blue. These large molecular weight, highly anionic dyes that are tightly bound by albumin, do not cross the BBB in vivo with two exceptions. First, there are a half dozen tiny areas of the brain, called circumventricular organs (CVOs), such as the choroid plexus, that are perfused by porous fenestrated capillaries. Second, in pathophysiologic conditions, there may be BBB disruption, leading to focal uptake of vital dyes. …."

rier (see footnote "**2**"), where these ethylmercury species poison the brain tissues and are metabolized within the cells into tissue-retained inorganic mercury (i-Hg) species by degradation pathways that also generate methylmercury species (see footnote "**4**" and Burbacher et al. (2005) [footnote "**8**"], a study in macaque monkeys that found o-Hg species and i-Hg species in the brains of the Thimerosal-injected monkeys with no discernable decrease in the i-Hg level in their brain tissues over time).

Thus, as has been shown, some toxic and/or deleterious influenza vaccine components/ingredients can and do cross the blood-brain barrier "*of young children and",* and, *in some instances*, do "*hurt their development*".

"Myth #11: Flu vaccines cause narcolepsy. (Not the seasonal flu vaccine, and not most others.)"

First, based on the experience with GlaxoSmithKline's Pandermix® pandemic influenza vaccine, there is a narcolepsy (and catalepsy) risk for developing children and young adults, which is associated with any inactivated influenza vaccine that contains added Thimerosal and uses a squalene-and-vitamin-E-based oil-in-water adjuvant as Ms. Haelle's remarks indicate.

However, something in CSL's Afluria® seasonal inactivated-influenza formulations also produces an elevated risk of potentially harmful febrile seizures in young children so much so that the FDA has raised the lower-limit on the age minimum for eligible recipients of the Afluria vaccine from 6 months to, in the 2013-2014 flu season, 5 years and the CDC does not recommend giving this vaccine to children under 9 years of age.

Finally, Ms. Haelle's "*not most others*" indicates that some other vaccines can cause "*narcolepsy*".

"Myth #12: The flu vaccine weakens your body's immune response. (It actually strengthens it.)"

Because the injected inactivated-influenza vaccines only strongly interact with the circulating immune system (commonly referred to as the "Th2"-based immune system) and do not interact strongly, if at all, with the innate immune system (commonly referred to as the "Th1"-based immune system), these vaccines can only imbalance the immune system, an action that does not strengthen "*your body's immune response*" but rather unbalances the body's immune system.

Similarly, because the live-virus influenza vaccines expose your innate immune system with an abnormally high level of virus entities to ensure that the innate immune system is overwhelmed so that the virus is assured of interaction with your circulating immune system, which then must make specific antibodies for up to four (4) separate influenza viruses, the live-virus vaccine also unbalances the immune system.

Overall, all influenza vaccines imbalance the immune system and the inactivated-influenza ones suppress the innate immune system.

Table 1 Guillain Barré Syndrome [GBS] reports, influenza vaccine data and derived data

Flu Season [July 1990 – June 2013]	Guillain Barré Syndrome [GBS] Reports In VAERS			Difference [ALL – Influenza-Vaccine-Related]	Million Doses of 'Flu' Vaccine Distributed [1,2,3,4]	≈ GBS Reports/ $10^{\wedge 6}$ doses distributed	At presumed 1% reporting rate, Estimated GBS Incidence/$10^{\wedge 6}$ doses distributed	At a presumed 10% to 1% reporting rate, Estimated GBS Incidence/$10^{\wedge 6}$ people inoculated[5]
	ALL	'Flu' Vaccine	'Flu' % of All					
1990-1991	49	**33**	**67.3**	16	≈ 32.8	**1.00**	**100**	11 – 111
1991-1992	37	**29**	**78.4**	15	≈ 40.3	**0.72**	**72**	8 – 80
1992-1993	57	**39**	**68.4**	18	≈ 43.0	**0.91**	**91**	10 – 101
1993-1994	99	**78**	**78.8**	21	≈ 60.1	**1.30**	**130**	14 – 144
1994-1995	76	**46**	**60.5**	30	≈ 36.5	**1.26**	**126**	14 – 140
1995-1996	71	**52**	**73.2**	19	≈ 38.9	**1.34**	**134**	15 – 149
1996-1997	96	**75**	**78.1**	21	≈ 41.0	**1.83**	**183**	20 – **203**
1997-1998	42	**29**	**69.0**	13	≈ 48.1	**0.60**	**60**	7 – 67
1998-1999	61	**44**	**72.1**	17	≈ 60.5	**0.73**	**73**	8 – 81
1999-2000	56	**39**	**69.6**	17	≈ 65.6	**0.59**	**59**	6 – 65
2000-2001	47	**30**	**63.8**	17	≈ 62.0	**0.48**	**48**	5 – 53
2001-2002	46	**33**	**71.7**	13	≈ 87.7	**0.38**	**38**	**4** – 42
2002-2003	47	**30**	**63.8**	17	≈ 83.0	**0.36**	**36**	**4** – 40
2003-2004	51	**29**	**56.9**	22	≈ 87.0	**0.33**	**33**	**4** – 37
2004-2005	36	22	61.1	14	≈ 60-66 (recall)	**0.3_7–0.3_3**	≈ **35**	≈**4** – ≈39
2005-2006	69	**37**	**53.6**	32	≈ 86.0	**0.43**	**43**	**4** – 48
2006-2007	97	**51**	**52.6**	46	> 100.0	**0.51**	≤ **51**	6 – ≤ 57
2007-2008	113	**61**	**54.0**	52	≈ 113.0	**0.54**	**54**	6 – 60
2008-2009	107	**70**	**65.4**	37	≈ 113.0	**0.62**	**62**	6 – 58
2009-2010	*341*	***270***	***79.2***	*71*	≈ 114.0 (seasonal) ≈ 125 (pamdemic)	**1.13**	**113**	13 – 126
2010-2011	156	**127**	**81.4**	30	≈ 163.0	**0.78**	**78**	9 – 87
2011-2012	128	**91**	**71.1**	37	≈ 134.9	**0.67**	**67**	7 – 74
2012-2013	136	**89**	**65.4**	47	≈ 141.5	**0.63**	**63**	7 – 70
					Average [SD]	**0.76_{04} [0.38_{71}]**	**$76._{04}$** [$38._{71}$]	

[1] Data for 1990-1991 through 2000-2001 flu seasons were from a CDC report http://wonder.cdc.gov/wonder/help/vaers/ss5201.pdf

[2] Data for 2001-2002 through 2009-2010 flu seasons were from the CDC "Vaccine Supply" sections in the ACIP"s recommendations for the next influenza season as found in the CDC's ***Morbidity and Mortatlity Weekly Report*** (***MMWR***).

[3] Data for 2010-2011 through 2012-2013 flu seasons were from CDC reports of doses distributed. [See, http://www.cdc.gov/flu/professionals/vaccination/vaccinesupply.htm]

[4] Data for 2009-2010 pandemic influenza vaccine was from wwwnc.**cdc**.gov/eid/article/19/3/12-0394.htm.

[5] Presumes that, on average, only 90% of distributed doses were used and the other 10% were discarded or returned.

Thus, influenza vaccines inherently weaken the person's overall immune system and, when repeatedly administered[34], risk inducing autoimmune responses in some of those who are vaccinated with influenza vaccines.

"Myth #13: The flu vaccine causes nerve disorders such as Guillain Barre syndrome. (Extremely rarely – and more commonly with flu infections.)"

Here, the writer, Ms. Haelle, is simply mistaken.

A search of the VAERS database, using the MedAlert interface, from 1990 through the middle of 2013 found that, on average, 70% of all of the reports of Guillain Barré Syndrome [GBS] in VAERS were associated with a report where the GBS onset occurred after an influenza vaccination.

Against a "natural" rate of GBS from "flu" of 1 to 2 cases in a million flu cases, the apparent rate for GBS reports to VAERS after influenza vaccination was on the order of 4 to 200-plus cases per million doses of influenza vaccine administered (see **Table 1** on the previous page), depending on the reporting rate to VAERS (which is most probably in the range of 10 % to 1%, with the probable reporting rate closer to 1% than 10% [see footnote "**30**"]).

A significant spike (about 4 times the historical baseline) in GBS reports, when less than a 2.6-fold spike was "expected" in the 2009-2010 flu season, again points to the reality that Thimerosal probably was (see footnote "**13**") a factor in GBS risk following influenza vaccination since 50-plus-% currently to 100% before late 2002 of the available doses of influenza vaccines were Thimerosal-preserved influenza vaccine doses.

In addition, several older studies reported finding links between influenza vaccination and GBS[35].

"Myth #14: The flu vaccine can cause neurological disorders. (No, it can't.)"

Since GBS is a "neurological disorder", clearly Ms. Haelle's "*No, it can't*" is misrepresenting the facts here.

Moreover, there are studies implicating influenza vaccination as a causal factor for Bell's palsy[36], another neurological disorder.

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34 Tsumiyama K, Miyazaki Y, Shiozawa S. Self-Organized Criticality Theory of Autoimmunity. *PLoS ONE* 2012 Dec 31; 4(12): e8382 (9 pages).

35
a. Haber P, DeStefano F, Angulo FJ, et al. Guillain-Barre syndrome following influenza vaccination. *JAMA* 2004; 292: 2478-2481.
b. Geier MR, Geier DA, Zahalsky AC. Influenza vaccination and Guillain Barre syndrome. *Clin Immunol* 2003; 107: 116-121.
c. Lasky T, Terracciano GJ, Magder L, et al. The Guillain-Barre syndrome and the 1992-1993 and 1993-1994 influenza vaccines. *New Engl J Med* 1998; 339: 1797-1802.
d. Schonberger LB, Bregman DJ, Sullivan-Bolyai JZ, et al. Guillain-Barre syndrome following vaccination in the National Influenza Immunization Program, United States, 1976-1977. *Am J Epidemiol* 1979; 110: 105-123.

In addition, there are numerous independent peer-reviewed published studies[37], including a CDC presentation abstract, and a published CDC study for which the original data sets are claimed to have been "lost"[38], which clearly show that exposures to Thimerosal-preserved serums and vaccines, including the Thimerosal-preserved influenza vaccines, causes neurodevelopmental harm in children.

"Myth #15: Influenza isn't that bad. Or, people recover quickly from it. (Uh, it's pretty bad.)"

What has Ms. Haelle's response," *Uh, it's pretty bad*", have to do with the assertion that "*people recover quickly from it*"?

Since "*isn't that bad*" and "*it's pretty bad*" are both subjective generalizations, Dr. King only observes that, *as stated*, both generalizations cannot be "true", and, therefore, the actual situation probably is that neither observation accurately represents reality.

Turning to the second half of Ms. Haelle's "***Myth # 15***", "*people recover quickly from it*", Dr. King finds that this statement is probably true when otherwise healthy persons, who still contract influenza, get the proper nutrition and supportive dietary supplementation for those vitamins and minerals that the infected body consumes at an accelerated rate during an illness.

For influenza and other ILIs, rapid recovery requires an appropriate supportive treatment program that supplements the infected

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36 **a.** Mutsch M, Zhou W, Rhodes P, et al. Use of the inactivated intranasal influenza vaccine and the risk of Bell's palsy in Switzerland. *New Engl J Med* 2004; 350: 896-903.

b. Zhou W, Pool V, DeStefano F, et al., and VAERS Working Group. A potential signal of Bell's palsy after parenteral inactivated influenza vaccines: reports to the Vaccine Adverse Event Reporting System (VAERS) United States, 1991-2001. *Pharmacoepidemiol Drug Saf* 2004; 13: 505-510.

37 **a.** Kern JK, Geier DA, Audhya T, King PG, Sykes LK, Geier MR. Evidence of parallels between mercury intoxication and the brain pathology in autism. *Acta Neurobiol Exp* 2012; 72: 113-153.

b. Young HA, Geier DA, Geier MR. Thimerosal exposure in infants and neurodevelopmental disorders: an assessment of computerized medical records in the Vaccine Safety Datalink. *J Neurol Sci* 2008;271: 110-118. x

c. Geier DA, Geier MR. A two-phased population epidemiological study of the safety of thimerosal-containing vaccines: a follow-up analysis. *Med Sci Monit* 2005; 11(4): CR160-CR170.

d. Halsey NA. Limiting infant exposure to thimerosal in vaccines and other sources of mercury. *JAMA* 1999; 282: 1763-1766.

e. Ayoub DM, F. Yazbak FE. Influenza vaccination during pregnancy: a critical assessment of the recommendations of the Advisory Committee on Immunization Practices (ACIP). *J Am Phys Surg* 2006; 11: 41-47.

38 **a.** Verstraeten T, Davis RL, DeStefano F, Lieu TA, Rhodes PH, Black SB, et al. Safety of Thimerosal-containing vaccines: a two-phased study of computerized health maintenance organization databases. Pediatrics 2003; 112:1038–48. [found causal link to tics and delayed language/speech development], and

b. Thomas M. Verstraeten, R. Davies, D. Gu, F DeStefano. Increased risk of developmental neurologic impairment after high exposure to thimerosal-containing vaccine in first month of life. 2000 EIS Conference abstract submission form, uncovered in 2013 in a CDC response to a specific inquiry by a member of the U.S. House of Representatives. http://mercury-freedrugs.org/docs/00mmdd_EISAbstractSubmission_IncreasedRiskOfDevelopmentalNeurologicImpairmentAfterHighExposureToThimerosal-containingVaccine_.pdf [reported statistically significant links between Thimerosal exposure and the "relative risk (RR) of developing a neurologic development disorder", "autism", "non organic sleep disorders" and "speech disorders".]

person's diet, not with pharmaceutical drugs, but rather with appropriately increased doses of vitamin C, lysine, vitamin D-3 (with vitamin K-2 and/or appropriate probiotics to ensure vitamin D-3 absorption), zinc and magnesium, and nutritionally sound, non-GMO foods (including chicken soup) as well as a regimen that ensures that the infected person gets at least "8 hours" of sleep daily.

Thus, those who get the "flu" tend to recover rapidly and have milder cases when they appropriately increase their dietary supplement consumption than those who get the "flu" and do not take these precautions or, worse, take the immune-system-weakening antivirals, fever-reducing drugs, and/or the bacteria-specific antibiotics that allopathic healthcare providers are known to prescribe.

"Myth #16: People don't die from the flu unless they have another underlying condition already. (Actually, healthy people DO die from the flu.)"

Factually, most of the flu-related deaths are deaths from a pneumonia infection and most flu-related deaths occur in those over 60 years of age.

Only a small percentage of the flu-related deaths are deaths where the influenza virus was the direct "cause" of death and many of those deaths may have been "caused" by the inappropriate use of antiviral drugs (*that are known to cause lung edema and interfere with breathing*) and pharmaceutical antibiotics, which tend to disrupt the body's gastrointestinal system and have side effects that can exacerbate the patient's symptoms and interfere with his or her recovery from the "flu".

Furthermore, most of those who die from "influenza" do not get appropriate dietary supplementation and additional rest, and/or they have other serious medical conditions that prevent their immune system from resolving the infections that they have in a manner that returns them to health.

In general, Dr. Doshi's article (see footnote "**11**") puts the true level of "influenza deaths" into its proper perspective and a nationwide epidemiological study of the USA[39] covering a significant period of time, when, *for the most part*, mostly the elderly were recommended to get an annual Thimerosal-preserved inactivated-influenza vaccine inoculation, found that the influenza vaccination program was

[39] Geier DA, King PG, Geier MR. Influenza Vaccine: Review of Effectiveness of the U.S. Immunization Program, and Policy Considerations. *J Am Physicians Surgeons [JPandS*] 2006 Fall; 11(3): 69-74. http://www.jpands.org/vol11no3/geier.pdf.

not effective in preventing influenza-related illness, influenza-related hospitalizations, or influenza-related deaths.

"Myth #17: People with egg allergies cannot get the flu shot. It will kill them! (No, it won't, and there's an egg-free vaccine.)"

First, some people, those who are truly allergic to egg albumin, are at risk of anaphylaxis and death if given most of the influenza vaccines.

Factually, there are two egg-free inactivated-influenza vaccines, a cell-line vaccine produced from caterpillar-virus-based that is genetically engineered (Protein Sciences Corporation's Flublok®, which contains purified HA proteins produced in a continuous insect cell line "(expreSF+®) that is derived from Sf9 cells of the fall armyworm, *Spodoptera frugiperda*", and contains residual amounts of the baculovirus and host cell proteins "(≤ 28.5 mcg)", and baculovirus and cellular DNA "(≤ 10 ng)"); and a vaccine produced from an immortal Madin Darby Canine Kidney (MDCK) cell line (Novartis' Fucelvax®, which contains residual MDCK cell protein "(≤ 8.4 µg)", protein other than HA "(≤ 120 µg)", MDCK cell DNA "(≤ 10 ng)", polysorbate 80 "(≤ 1125 µg)", cetyltrimethylammonium bromide "(≤ 13.5 µg)", and β-propiolactone "(≤ 0.5 µg)").

However, there is no history of what new problems these vaccines may cause or with what new adventitious viruses or genetically active viral fragments of said viruses these vaccines may be contaminated.

"Myth #18: If I get the flu, antibiotics will take care of me. (No, they can't.)"

As stated, "***Myth #18***" is ambiguous.

Dr. King's response presumes that term "*antibiotics*" refers to those pharmaceutical drug products sold as "*antibiotics*".

Factually, antiviral and antifungal medications also belong to the general class of "*antibiotics*" meaning "against life" because viruses and fungi are living organisms.

If by "*antibiotics*", the writer means drugs that are prescribed to kill bacteria, Dr. King agrees that, in general, these have little-to-no effect on influenza viruses.

However, if the patient also has a secondary bacterial lung infection, then, the appropriate bacterial-organism-specific inhaled antibiotic drug may be helpful in treating such patients.

On the other hand, if by "*antibiotics*" one means those biologically active compounds produced by humans to combat invasive infections, then Ms. Haelle's statement is inaccurate because the human body can

produce a variety of polypeptide "antibiotics" (e.g., cathelicidins and defensins[40]) that are lethal to viruses.

"Myth #19: The flu shot doesn't work for me, personally, because last time I got it, I got the flu anyway. (It still reduces your risk.)"

Absent proof that the person making this assertion actually develops antibodies after vaccination, there is no proof that an influenza vaccine may "*reduce*" that person's risk of contracting influenza in the future.

In addition, for those with a history of GBS or other serious adverse reactions (e.g., anaphylaxis) to influenza vaccination, subsequent influenza vaccination is contraindicated since another vaccination may be lethal.

Furthermore, even if the unidentified person making this assertion does develop antibodies to the influenza vaccine's viruses, as the recent studies cited by Dr. King earlier (see footnotes "**9**" and "**10**") found, influenza vaccination significantly increases the risk that those who are vaccinated will contract noninfluenza "flu" (any ILI that is not influenza).

Factually, influenza vaccination: **a)** is, at best, only moderately effective in protecting those inoculated from subsequently contracting influenza and **b)** significantly increases the risk of the inoculees' subsequently contracting a noninfluenza ILI ("*flu*").

Thus, being vaccinated with an influenza vaccine does not reduce the risk of contracting "flu".

Therefore, getting an inoculation with the current influenza vaccines does not reduce the inoculees' risk of contracting "*flu*" even though it may protect some small percentage of them from contracting influenza.

"Myth #20: I never get the flu, so I don't need the shot. (You can see the future?)"

Here, Ms Haelle's response, "*You can see the future?*" does not address the validity of "*Myth #20*".

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[40]
a. Tripathi S, Tecle T, Verma A, Crouch E, White M, Hartshorn KL. The human cathelicidin LL-37 inhibits influenza A viruses through a mechanism distinct from that of surfactant protein D or defensins. *J Gen Virol.* 2013 Jan; 94 Pt 1: 40-49. The in-press copy may be accessed here.

b. Tripathi S, White MR, Hartshorn KL. The amazing innate immune response to influenza A virus infection. *Innate Immunity* 2013 Nov 11; 2013: 1753425913508992. The on-line article may be accessed here.

c. Cannell JJ, Zasloff M, Garland CF, Scragg R, Giovannucci E. On the epidemiology of influenza. *Virol J.*2008, 5: 29 doi:10.1186/1743-422X-5-29 [Review]. OPEN ACCESS.

d. Barik S. New treatments for influenza. *BMC Medicine* 2012, 10: 104 [Review] Highly accessed Open Access doi:10.1186/1741-7015-10-104.

Absent proof that the unidentified person was exposed to influenza A and/or influenza B viruses and has antibodies to these viruses, the writer cannot know whether that unidentified person has any susceptibility to influenza infection or may, in fact, be totally immune to contracting influenza and/or the other human infective organisms that can cause those who are infected by them to exhibit "*flu*"-like symptoms (an "ILI").

Can Ms. Haelle see the antibody levels in this unidentified individual's body or the status of that person's innate immune system?

Moreover, since getting an influenza-vaccine injection significantly increases the risk of the inoculees' risk of contracting a noninfluenza viral respiratory infection but does not significantly reduce the inoculees' risk of contracting the influenza vaccine strains in the vaccine (see footnote "**10**"), getting an influenza vaccination would seem to be contraindicated if one's goal is to protect oneself from getting the "*flu*" (any ILI).

"Myth #21: I can protect myself from the flu by eating right and washing my hands regularly. (No, you can't.)"

Provided that right eating includes avoiding GMO-containing foods and consuming sufficient amounts of vitamins and minerals that suppress influenza infection, frequent hand washing is more effective than influenza vaccination in preventing a person from contracting "*flu*". [**Note:** An abstract[41] of a study in which a group of children in Canada were examined for the relationship between their level of 25-hydroxyvitamin D in the blood and their risk for a viral respiratory-tract infection, reported (emphasis added),

> "Results. Seven hundred forty-three children aged 3–15 years were followed between 22 December 2008 and 23 June 2009. The median serum 25(OH)D level was 62.0 nmol/L (interquartile range, 51.0–74.0). A total of 229 participants (31%) developed at least 1 laboratory-confirmed viral RTI. Younger age and lower serum 25(OH)D levels were associated with increased risk of viral RTI. Serum 25(OH)D levels <75 nmol/L increased the risk of viral RTI by 50% (hazard ratio [HR], 1.51; 95% confidence interval [CI], 1.10–2.07, P = .011) and levels <50 nmol/L increased the risk by 70% (HR, 1.67; 95% CI, 1.16–2.40, P = .006).
>
> *Conclusions*. Lower serum 25(OH)D levels were associated with increased risk of laboratory-confirmed viral RTI in children from Canadian Hutterite communities. Interventional studies evaluating the role of vitamin D supplementation to reduce the burden of viral RTIs are warranted".]

Thus, lower 25-hydroxyvitamin D levels, were shown to significantly increase the risk for viral respiratory-tract infection.

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41 Science M, Maguire JL, Russell ML, Smieja M, SD, Loeb M. Low Serum 25-Hydroxyvitamin D Level and Risk of Upper Respiratory Tract Infection in Children and Adolescents. *Clin Infect Dis.* 2013; 57 (3): 392-397. doi: 10.1093/cid/cit289. First published online: May 15, 2013. [Abstract]

Since none of these children had a 25-hydroxyvitamin D level that was in the range for optimum immune-system boosting and specific antiviral polypeptide production range (138 nmol/L – 250 nmol/L {55ng/mL -100 ng/mL}), it is not surprising that "229 participants (31%) developed at least 1 laboratory-confirmed viral RTI".

This finding supports the reality that, had they had immune-system-optimal blood levels of 25-hydroxy-vitamin D, the level of viral RTI infection would have been significantly reduced.

"Myth #22: It's okay if I get the flu because it will make my immune system stronger. (Selfish, much? And no, it doesn't.)"

All unbiased studies have shown that naturally contracting a viral disease and recovering from it produces more complete disease protection that lasts much longer than, if any, the incomplete and limited-duration protection provided by vaccination.

Moreover, having influenza and recovering from it provides protection to a wider range of influenza strains than the vaccine, which, given that its protections are represented to last no more than about 9 months, provides some level of very limited-duration protection to, at best, the strains in the influenza vaccine and some closely related ones to some percentage of those inoculated with them (which, *in absolute terms*, can range from near "0" percent, when the strains in the vaccine do not match the strains to which the public is actually exposed, to no more than a few percent, when the circulating strains match those in the vaccine [best case]) [see the pertinent Cochrane Library reports].

Finally, based on the recent studies cited by Dr. King, influenza vaccination significantly increases the inoculees' risk of subsequently contracting a noninfluenza viral respiratory infection (see footnote "**10**") as well as exposes inoculees to the risk of serious adverse events, including death, that can be triggered by vaccination, which, for those whose incidence can be estimated, seem to exceed their risk from having them as a result of naturally contracting influenza.

"Myth #23: Making a new vaccine each year only makes influenza strains stronger. (No, it doesn't.)"

The problem is not with the influenza vaccine but rather with its adverse effects on the recipient's immune system when a person is inoculated with that influenza vaccine.

The immune-system-associated issues with repeated injection of similar antigens have been known for some time (see footnote "**34**").

Moreover, recent single-antigen, repeated-challenge studies in an autoimmune-resistant rat strain have clearly established that such repeated challenges are not only detrimental in the short term to the subjects repeatedly inoculated with a single antigen but also, *after some small number of such periodic exposures*, induce a persistent autoimmune state in the test subjects, which is detrimental to their health and long-term survival (see Tsumiyama K, Miyazaki Y, Shiozawa S. Self-Organized Criticality Theory of Autoimmunity [footnote "**34**"]).

"**Myth #24: The side effects of the flu shot are worse than the flu. (No, they aren't.)**"

For those who do have serious adverse reactions to their influenza vaccination or die from it, the side effects of the influenza vaccination are clearly worse than the influenza that such vaccinated persons may never have contracted.

To see some small measure of the harm caused to some by the influenza vaccines, see the latest statistics report for the National Vaccine Injury Compensation Program (NVICP), where the majority (about 83%) of the about 790 influenza-vaccination-related cases that have been filed since 2005 (when the influenza vaccine was added to the vaccines covered by the NVICP) were compensated[42].

"Myth #25: The flu vaccine causes Bell's palsy. (No, it doesn't.)"

Again, Bell's palsy is one of the peripheral neuropathies caused by the adverse interaction of the person's immune system with the influenza and other vaccines.

In some instances, an influenza vaccination probably was "cause of" or "trigger for" the recipients "Bell's palsy".

"Unfortunately", there is no specific coded search term for "Bell's palsy" in VAERS so that Dr. King could not easily see what its reporting instances are (unlike Guillain-Barré Syndrome, which has an assigned search term in VAERS symptoms' dictionary).

Thus, a search was conducted using related terms that are in the VAERS encoding list displayed by the MedALERT search interface (e.g., "facial paralysis").

However, as shown in "**Table 2**" on the next page, there appears to be some association between both types of influenza vaccines, inac-

[42] http://www.hrsa.gov/vaccinecompensation/statisticsreports.html#Stats, as of December 2, 2013.

tivated and live-virus, and a small risk of developing the symptoms of "Bell's palsy" after an influenza vaccine inoculation.

Table 2 Bell's palsy reports in VAERS, influenza vaccine data, and derived data

Flu Season [July 1990 – June 2013]	"Bell's palsy [Bp]" Reports In VAERS			Million Doses of 'Flu' Vaccine Distributed [1,2,3,4]	≈ Bp Reports/ $10^{\wedge 6}$ doses distributed	At presumed 1% reporting rate, Estimated 'Bp' Incidence/ $10^{\wedge 6}$ doses distributed	At presumed 10 to 1% reporting rate, Estimated 'Bp' Incidence/ $10^{\wedge 6}$ people inoculated[5]
	ALL Influ-enza	'Inactivated Influenza' Vaccines	'Live virus' Vaccines				
1991-1992	**8**	**8**	**---**	≈ 40.3	**0.198**	**20**	2 – 22
1992-1993	**8**	**8**	**---**	≈ 43.0	**0.186**	**19**	2 – 21
1993-1994	**11**	**11**	**---**	≈ 60.1	**0.183**	**18**	2 – 20
1994-1995	**9**	**9**	**---**	≈ 36.5	**0.246**	**25**	3 – 27
1995-1996	**7**	**7**	**---**	≈ 38.9	**0.180**	**18**	2 – 20
1996-1997	**17**	**17**	**---**	≈ 41.0	**0.415**	**42**	**5 – 46**
1997-1998	**10**	**10**	**---**	≈ 48.1	**0.208**	**21**	2 – 23
1998-1999	**13**	**13**	**---**	≈ 60.5	**0.215**	**22**	2 – 24
1999-2000	**6**	**6**	**---**	≈ 65.6	**0.091**	**9**	1 – 10
2000-2001	**12**	**12**	**---**	≈ 62.0	**0.193**	**19**	2 – 21
2001-2002	**8**	**8**	**---**	≈ 87.7	**0.091**	**9**	1 – 10
2002-2003	**9**	**8**	**1**	≈ 83.0	**0.108**	**11**	1 – 12
2003-2004	**15**	**14**	**1**	≈ 87.0	**0.172**	**17**	2 – 19
2004-2005	11	10	1	≈ 60-66 (recall)	**0.18_3–16_7**	≈ **17**	≈2 – ≈19
2005-2006	**21**	**17**	**4**	≈ 86.0	**0.244**	**24**	3 – 27
2006-2007	**26**	**22**	**4**	> 100.0	**0.260**	≤ **26**	3 – ≤ 29
2007-2008	**28**	**25**	**3**	≈ 113.0	**0.248**	**25**	3 – 27
2008-2009	**33**	**22**	**11**	≈ 113.0	**0.292**	**29**	3 – 32
2009-2010 (seasonal & *pandemic vaccines*)	**45**	**40**	**5**	≈ 114 (seasonal)	**0.395**	**39**	4 – **44**
	97	***74***	***23***	≈ 125 (pandemic)	**0.776**	**78**	*9 – **86***
2010-2011[6]	4	1	3	≈ 163.0	0.024	2	'0' – 3
2011-2012[6]	4	1	3	≈ 134.9	0.030	3	'0' – 3
2012-2013[6]	3	1	2	≈ 141.5	0.021	2	'0' – 2

1 Data for 1990-1991 through 2000-2001 flu seasons were from a CDC report http://wonder.cdc.gov/wonder/help/vaers/ss5201.pdf

2 Data for 2001-2002 through 2009-2010 flu seasons were from the CDC "Vaccine Supply" sections in the ACIP"s recommendations for the next influenza season as found in the CDC's ***Morbidity and Mortatlity Weekly Report*** (***MMWR***).

3 Data for 2010-2011 through 2012-2013 flu seasons were from CDC reports of doses distributed http://www.cdc.gov/flu/professionals/vaccination/vaccinesupply.htm

4 Data for 2009-2010 pandemic influenza vaccine was from wwwnc.**cdc**.gov/eid/article/19/3/12-0394.htm.

5 Presumes that, on average, only 90% of distributed doses were used and that the other 10% were discarded or returned.

6. The drop in Bell's palsy reports may have been caused by a tendency toward increased GBS reporting observed after the 2009-2010 flu season (see **Table 1**).

Finally, there are studies in the literature that have looked into the issue of a possible causal linkage between influenza vaccination and Bell's palsy and, in at least two instances, found evidence that there was one[43].

[43] **a.** Mutsch M, Zhou W, Rhodes P, et al. Use of the inactivated intranasal influenza vaccine and the risk of Bell's palsy in Switzerland. *N Engl J Med [NEJM]* 2004; 350: 896-903. The abstract for this article states (emphasis added), "BACKGROUND After the introduction of an inactivated intranasal influenza vaccine that was used only in Switzerland, 46 cases of Bell's palsy were reported. METHODS

However, examining the "**Table 1**" and the "**Table 2**" reports after the 2009-2010 "flu season", it appears that the observed drop in reports of Bell's palsy seems to be offset by an apparently significant increase in reports of Guillain-Barré syndrome ("GBS") in the 2010-2011 through 2012-2013 flu seasons.

As with the spectrum of neurodevelopmental disorders in young children that, according to many, should, at a minimum, include ADD and ADHD, with the new three-levels of Autism Spectrum Disorders, perhaps a more accurate assessment could be made if GBS and Bell's palsy reports were lumped together and a similar multi-level group term devised (e.g., vaccination-related non-brain neurological dysfunction ["VNND"], which would describe this reality.

Influenza Vaccination Realities that Ms. Haelle Ignored

1. Two-year-old and Younger Children Should Not Be Given Any of the Current Influenza Vaccines

There is no scientifically or logically sound justification for inoculating any child two years of age or less with any influenza vaccine, as such inoculations do not provide any protection to these children from contracting influenza.

Because all vaccine inoculations have some risk of serious injury

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We conducted a matched case–control study and a case-series analysis. All primary care physicians, ear, nose, and throat specialists, and neurologists in German-speaking regions of Switzerland were requested to identify cases of Bell's palsy diagnosed in adults between October 1, 2000, and April 30, 2001. Each physician was invited to select three control patients for each patient with Bell's palsy, with matching according to age, date of the clinic visit, and physician. Vaccination information was provided by the physicians.

RESULTS

A total of 773 patients with Bell's palsy were identified. Of the 412 (53.3 percent) who could be evaluated, 250 (60.7 percent) were enrolled and matched with 722 control patients; the other 162 patients had no controls. In the case–control study, we found that 68 patients with Bell's palsy (27.2 percent) and 8 controls (1.1 percent) had received the intranasal vaccine (P<0.001). In contrast to parenteral vaccines, the intranasal vaccine significantly increased the risk of Bell's palsy (adjusted odds ratio, 84.0; 95 percent confidence interval, 20.1 to 351.9). Even according to conservative assumptions, the relative risk of Bell's palsy was estimated to be 19 times the risk in the controls, corresponding to 13 excess cases per 10,000 vaccinees within 1 to 91 days after vaccination. In the case-series analysis, the period of highest risk was 31 to 60 days after vaccination.

CONCLUSIONS

This study suggests a strong association between the inactivated intranasal influenza vaccine used in Switzerland and Bell's palsy. This vaccine is no longer in clinical use".

b. Zhou W, Pool V, DeStefano F, et al., and VAERS Working Group. A potential signal of Bell's palsy after parenteral inactivated influenza vaccines: reports to the Vaccine Adverse Event Reporting System (VAERS)United States, 1991-2001. *Pharmacoepidemiol Drug Saf* 2004; 13: 505-510. The abstract for that article states (emphasis added),

"PURPOSE: Post-licensure experience with a new intranasal inactivated influenza vaccine in Switzerland recently identified an increased risk for Bell's palsy. We reviewed reports in the Vaccine Adverse Event Reporting System (VAERS) to assess if parenteral inactivated influenza vaccines (influenza vaccines) may also increase the risk for Bell's palsy.

METHODS: Reports of Bell's palsy after influenza vaccines in VAERS from 1/1/1991 to 12/31/2001 were identified by searching the Coding Symbols for Thesaurus of Adverse Reaction Terms (COSTART) for 'paralysis facial' and by text string search in the automated database. The text descriptions on each report were reviewed to verify the diagnosis. The proportional reporting ratio (PRR) was calculated to aid signal detection.

RESULTS: We found a total of 197 reports of Bell's palsy after receipt of influenza vaccines. The diagnosis was verified for 154 (78.2%), of which 145 (94.2%) had received influenza vaccines alone. The verified reports were submitted from 35 states; 58% of the reports involved persons living in states where the risk of Lyme disease, which can also cause facial paralysis, was low, minimal or none. The PRRs in all age groups exceeded the criteria for a signal of possible association. The highest PRR was 3.91 in the > or = 65 years age group.

CONCLUSIONS: Our findings revealed a signal of possible association between influenza vaccines and an increased risk of Bell's palsy. A population-based controlled study is needed to determine whether this association could be causal and to quantify the risk."

to some who are vaccinated with them, it is illogical to inoculate any such child with a vaccine that provides no protection, but may injure that child.

Moreover, for children two years of age and under, there can be no way that the zero benefits to these inoculees can outweigh the risks associated with these vaccines because the benefit to these children is known to be "zero" [see the applicable Cochrane Library reports].

2. No Pregnant Woman or Developing Child should be given Any Influenza Vaccine that Contains Any Level of Added Thimerosal

Given the significant increase in fetal losses observed when two influenza vaccines (seasonal and pandemic), for which most of the doses deemed suitable to be given to pregnant women were preserved with Thimerosal (49.55% mercury by weight), were given to pregnant women (see footnote "**13**"), Thimerosal-preserved inactivated-influenza vaccines can definitely cause harm to the developing fetus.

In addition, no "safe" level has been established for fetal mercury exposure[44].

However, based on the only published estimate for the NOAEL for injected Thimerosal in developing children (see footnote "**7**", < 0.0086 microgram (µg) of Thimerosal per kilogram (kg) of child weight per day [< 0.0086 µg/kg/day] and presuming that a bolus dose may not exceed this NOAEL limit by more than a factor of three (3), the maximum exposure dose for the developing child is 0.026 µg times the child's weight in kg.

Because the minimum dose for a Thimerosal-preserved inactivated-influenza vaccine is nominally 25 µg of Thimerosal for a 0.25-mL dose of vaccine, the developing child must weigh *more than* [25 µg of Thimerosal divided by 0.026 µg of Thimerosal per kg] or *more than* 961.5 kg (> 2119.8 pounds) for that dose to possibly be "safe".

As it is *impossible* for a fetus or developing child to weigh *more than* 961.5 kg (> 2119.8 pounds), no Thimerosal-preserved influenza vaccine is safe to give to any pregnant woman or developing child[45].

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[44] Brown IA, Austin DW. Maternal transfer of mercury to the developing embryo/fetus: is there a safe level?, *Toxicological Environ Chem* 2012; DOI:10.1080/02772248.2012.724574. http://www.tandfonline.com/doi/abs/10.1080/02772248.2012.724574#.UuGRm9Io69I .

[45] For pregnant women, presuming that the fetus is exposed to no more than half of the Thimerosal in a 0.5-mL dose of the reduced-Thimerosal inactivated-influenza vaccine (0.5-microgram), it is not safe to give a reduced-Thimerosal vaccine to any pregnant woman. This is the case since the developing fetus weighs between a few micrograms at conception to generally no more than 6 kg (13.2 pounds) at birth, when the fetus' minimum weight at any time during gestation for a "safe" exposure would have to be more than 19.23 kg (> 42.4 pounds).

Thus, none of the current FDA-approved inactivated-influenza vaccines, which contain a preservative level of Thimerosal, or, for that matter, a reduced level of Thimerosal, should be given to any pregnant woman or developing child.

3. Factually, No Person Should be Given Any Influenza Vaccine

First, the current influenza vaccination program does not even provide protection from contracting influenza to all who are vaccinated with a given influenza vaccine.

Moreover, the Cochrane reviews for influenza vaccines in any population (e.g., children, adults, healthcare workers, and the elderly) have failed to find them effective in:

- Preventing those who are vaccinated with influenza vaccines from subsequently contracting "flu";
- Preventing the spread of the "flu"; or
- Protecting populations other than those inoculated from contracting the "flu".

In addition, the current influenza vaccines provide no protection for ILI diseases other than those caused by a few influenza strains and actually increase the risk that those who are vaccinated will subsequently contract a noninfluenza viral respiratory infection (see footnotes "**9**" and "**10**").

Furthermore, noninfluenza infections make up, on average, *more than* 80% of all "flu" cases (see footnote "**11**") even when they provide significant levels of influenza antibodies for the influenza virus strains used to make the influenza vaccines.

Moreover, the current CDC-recommended influenza vaccination program, supposedly a "disease preventive" (prophylactic) vaccination program: **a)** has repeatedly been shown to fail to be influenza disease preventive; **b)** does not provide protection from noninfluenza ILI disease; and **c)** actually significantly increases the risk of contracting

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Unfortunately, the preceding situations continue to exist because: **a)** the FDA still allows the use of Thimerosal (an ethylmercury compound) as a component in those inactivated-influenza vaccines that may be given to pregnant women; **b)** the CDC still does not specifically disallow giving Thimerosal-containing inactivated-influenza vaccines to pregnant women; and **c)** protected from liability, most of the manufacturers of inactivated-influenza vaccines still use Thimerosal in some of the vaccines they market in the USA (and elsewhere).

Finally, since the reported values are only upper-bound estimates for the NOAEL values for injected Thimerosal in developing humans and adult humans (see footnote "7"), until accurate values, not upper-bound estimates, are published for the requisite NOAELs, no valid determination can be made as to what lower levels of Thimerosal in a vaccine are truly "safe": a) to directly inject into a child or adult, or b) for the fetus developing in utero, when pregnant women are injected with a Thimerosal-containing vaccine.]

noninfluenza viral respiratory diseases for those who are vaccinated (see footnotes "**9**" and "**10**").

Clearly, this vaccination program seems to be causing more ILI ("flu") cases overall than the cases of influenza that it prevents.

Thus, other than profiting the vaccine makers and the vaccine providers, the current CDC-recommended influenza vaccination program is not an effective vaccination program, a cost-effective vaccination program, or a disease-preventive health measure.

Even vaccine apologists and acolytes admit that the influenza vaccination program is not highly effective[46] and essentially argue that "we" should keep it because it is the "best" disease-preventive program that allopathic healthcare providers have to offer[47].

Moreover, even the CDC admits, "In addition, good health habits, such as covering your cough and frequently washing your hands with soap, can help prevent the spread of the flu and other respiratory illnesses" (see footnote "**46**").

However, as Dr. King has shown, there are dietary/nutritional alternatives that studies have shown to be more effective than influenza vaccination in preventing "flu", not just influenza infection, during the "flu season" as well as, for those who contract the "flu", reducing the severity and duration of their "flu" infection.

Given all of the preceding realities, obviously, the failed allopathic vaccination-centric approach to preventing and treating influenza infection should be abandoned and, at a minimum, the dietary and nutritional modalities recommended by those who practice orthomolecular medicine should be adopted by allopathic medicine as the basis for addressing "flu" infection along with those homeopathic remedies that have been proven to combat the "flu".

Dr. King's Concluding Remarks

In his responses, Dr. King has established that the alleged "*25*" "myths" listed by Ms. Halle are partly, mostly or completely factual realities for the current influenza vaccines approved by the FDA and the influenza vaccination program recommended by the CDC.

Hopefully, the evidence-supported responses provided will allow those seeking peer-reviewed and alternative sources of information about influenza vaccines and influenza vaccination to make a more

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46 See http://www.cdc.gov/flu/about/qa/vaccineeffect.htm, "Vaccine Effectiveness - How Well Does the Flu Vaccine Work?", page last updated "November 7, 2013", which was last visited on 13 January 2014.

47 See http://www.cdc.gov/flu/professionals/vaccination/effectivenessqa.htm, "Flu Vaccine Effectiveness: Questions and Answers for Health Professionals", page last updated "November 27, 2013", which was last visited on 13 January 2013.

informed decision about the "safety" and "effectiveness" of an annual influenza inoculation.

Acknowledgments

For contributing valuable insights and providing their personal experience-based knowledge in various areas, Dr. King thanks Mayer Eisenstein, MD, JD, MPH; Gary S. Goldman, PhD; Boyd E. Haley, PhD; Melissa and Doug Troutman; Eileen Dannemann; Brian Hooker, PhD; Janet K. Kern, PhD; Catherine J. Frompovich; Neil Z. Miller; Mark R. Geier, MD, PhD; and David A. Geier.

Additionally, Dr. King specifically thanks Catherine J. Frompovich, Gary S. Goldman, and Melissa Troutman for their support, suggestions, corrections and alternate wordings that helped him to finalize this response.

About the Writer, Tara Haelle

Contact: thaelle@gmail.com as listed in http://www.tarahaelle.net/bio/
Source of "About" information was http://www.linkedin.com/in/thaelle, last visited on 13 January 2014

"Tara Haelle's Overview

Current
Freelance Writer and Photojournalist at Tara Haelle Media
Health and Science Blogger at Red Wine and Apple Sauce
Tutor at Test Prep Tutor - Independent Contractor

Past
Tutor at More Than A Teacher
Newborn, Child and Family Photographer at Tara Haelle Photography
Photojournalism/Journalism Graduate Student at University of Texas at Austin
Journalism Teacher at K12, Texas Virtual Academy
Photo Editor at Reporting Texas
Teaching Assistant, Self and Soul Philosophy Undergraduate Seminar at University
Test prep instructor at Sherwood Test Prep
Teaching Assistant, Italian Cinema Signature Course at University of Texas at Austin
Teaching Assistant at J336, University of Texas at Austin
Fellow/Intern/Reporter/Photographer at News21
News Reporter at Daily Texan newspaper
member at Photo Imaging Educators Association
High School Teacher, Journalism & English at Arlington ISD
City Desk Correspondent at Fort Worth Star-Telegram
Food runner at Reata Restaurant
Substitute Teacher at Kennedale ISD
Freelance journalist at Fort Worth Star-Telegram
Development Office Manager at Downlands College
Associate Editor/Intern at American Woman, Men's
Organizations Editor at Cactus
Bureau Assistant and Reporter at Fort Worth Star-Telegram

Education
The University of Texas at Austin
The University of Texas at Austin

	Santa Fe Photographic Workshops
	Tarrant County College
	Martin High School
	Sam Houston high school
Recommendations	5 people have recommended Tara
Connections	500+ connections
Websites	Writer, Educator, Photographer
	Red Wine & Apple Sauce Blog
	Tutoring by Tara

Tara Haelle's Summary

Journalist and photographer with credits in more than a dozen local, state and national publications. Tara specializes in health and medical writing (especially pediatrics, vaccines, prenatal health, nutrition, obesity and sleep), science writing (especially marine biology) and education/curriculum development (primarily for secondary and middle school). Seeking writing and/or multimedia news or long-form journalism assignments and contract projects in publishing or development of educational materials for ages 8-22. Working independently on one parenting book and both children's and young adult publishing projects.

Specialties: Health, medical and science writing; education (seven years of secondary school teaching experience; four years of college teaching experience); test prep (SAT, ACT, GRE, COMPASS, general standardized test taking); multimedia; social media; Adobe Creative Suite, including advanced skills in Photoshop and InDesign; audio and video recording and editing; digital/film SLR photography; medium and large-format photography; darkroom skills; experience in HTML and CSS; extensive world travel (40+ countries on 6 continents); basic Spanish proficiency.

Tara Haelle's Experience

Freelance Writer and Photojournalist
Tara Haelle Media

May 1996 – Present (17 years 9 months) Austin, Texas Area

Specialize in health, medical and science reporting, especially vaccines, infectious diseases, pediatrics, prenatal health, women's health, sleep medicine, nutrition, obesity, and mental and behavioral health. Extensive experience and skills in interpreting medical studies, including basic principles of epidemiology and biostatistics. Major publications/clients include Slate.com, Scientific American, Nature, IMNG Medical Media, Science and the Sea (of The University of Texas Marine Science Institute), Muse Magazine, Alcalde Magazine, The Chicago Bureau, Chicago Sun-Times, NPPA News Photographer Magazine and dailyRx News. I have completed several personal multimedia projects, such as www.uncelebratedpeople.com.

Health and Science Blogger
Red Wine and Apple Sauce

October 2011 – Present (2 years 4 months)

Blog about health and science news for moms.

Tutor
Test Prep Tutor - Independent Contractor

2003 – Present (11 years)

Specialize in SAT, ACT and GRE prep. Also have experience with various other standardized tests, including COMPASS, GMAT, naval flight test, TAKS, STAAR and other specialized or local tests.

Tutor
More Than A Teacher

August 2011 – August 2012 (1 year 1 month) Austin, Texas Area

Tutored in ACT, SAT and GRE prep, both individualized and teaching prep courses. Also tutored in biology, writing, English, math and COMPASS test.

Newborn, Child and Family Photographer
Tara Haelle Photography

August 2009 – May 2012 (2 years 10 months) Austin, Texas Area

Specialize in photographing newborns and infants, but I also photograph children of all ages, families, couples and maternity.

Photojournalism/Journalism Graduate Student
University of Texas at Austin
Educational Institution; 10,001+ employees; Higher Education industry
August 2008 – May 2012 (3 years 10 months) Austin, Texas Area
Concentration in health reporting and photography. Also used skills in multimedia storytelling while working on the "Wildfire Project," covering the central Texas fires of fall, 2011.

Journalism Teacher
K12, Texas Virtual Academy
Public Company; 1001-5000 employees; LRN; E-Learning industry
August 2011 – March 2012 (8 months) Texas
Taught approximately 160 Texas high school students journalism online at the public charter virtual school Texas Virtual Academy, powered through the online education delivery of K12. Also the yearbook sponsor.

Photo Editor
Reporting Texas
May 2010 – June 2011 (1 year 2 months) Austin, Texas Area
Assigned art to photographers, edited images for publications, made editorial decisions regarding art placement and design

Teaching Assistant, Self and Soul Philosophy Undergraduate Seminar
University of Texas at Austin
Educational Institution; 10,001+ employees; Higher Education industry
January 2011 – May 2011 (5 months) Austin, Texas Area
Assisted Paul Woodruff with undergraduate seminar; led two weekly discussion sections; met with students regularly to teach and guide writing at the college level.

Test prep instructor
Sherwood Test Prep
April 2010 – May 2011 (1 year 2 months) Austin, Texas Area
Taught prep classes in GRE and SAT preparation.

Teaching Assistant, Italian Cinema Signature Course
University of Texas at Austin
Educational Institution; 10,001+ employees; Higher Education industry
August 2010 – December 2010 (5 months)
Taught undergraduate students writing skills and lead three hour-long discussion sections each week.

Teaching Assistant
J336, University of Texas at Austin
August 2008 – May 2010 (1 year 10 months)
Taught InDesign, Photoshop and design layout skills
Conducted two weekly labs and three weekly open labs
Graded individual assignments and final design portfolios

Fellow/Intern/Reporter/Photographer
News21
Nonprofit; 51-200 employees; Broadcast Media industry
March 2009 – August 2009 (6 months)
Our news team of 12 journalists produced the website http://northwestern.news21.com as part of the News 21 program. As part of the Medill School of Journalism, our news product was aimed at second-generation young Americans living in urban areas. We produced stories, videos, photo stories, podcasts and other content of interest to the post-college-grad generation in the midst of making difficult decisions about the future.

News Reporter
Daily Texan newspaper
August 2008 – January 2009 (6 months)
Pitched and wrote news and feature stories

member
Photo Imaging Educators Association
2006 – 2009 (3 years)
Applied skills and professional development to teaching photography.

High School Teacher, Journalism & English
Arlington ISD
Educational Institution; 51-200 employees; Education Management industry
August 2003 – June 2008 (4 years 11 months)
Taught freshman English for two years; taught journalism, photojournalism, newspaper production and yearbook production for three years; Most Outstanding First-Year Teacher Award in 2003; Two-time Grant Winner from Arlington Education Foundation.

City Desk Correspondent
Fort Worth Star-Telegram
Public Company; 501-1000 employees; MNI; Newspapers industry
August 2002 – December 2003 (1 year 5 months)
Covered city beat for five small cities in the Fort Worth area

Food runner
Reata Restaurant
2002 – 2003 (1 year)
Food runner

Substitute Teacher
Kennedale ISD
2002 – 2003 (1 year)
Substitute teaching for secondary school

Freelance journalist
Fort Worth Star-Telegram
Public Company; 501-1000 employees; MNI; Newspapers industry
May 1996 – July 2003 (7 years 3 months)
I have written articles and occasionally shot photographs for the Star-Telegram on a periodic basis over these years. I also had photos published in August, 2007. During 2002-2004, I covered the city hall beats for Westworth Village, White Settlement, Edgecliff Village, River Oaks and Benbrook.

Development Office Manager
Downlands College
August 2001 – February 2002 (7 months)
Coordinated recruitment and alumni outreach efforts, including publication of quarterly alumni magazine.

Associate Editor/Intern
American Woman, Men's
May 1999 – August 1999 (4 months)
Editorial intern, including basic intern duties and some filler writing.

Organizations Editor
Cactus
August 1998 – May 1999 (10 months)
Planned, designed and oversaw creation of organizations section of the school yearbook.

Bureau Assistant and Reporter
Fort Worth Star-Telegram
Public Company; 501-1000 employees; MNI; Newspapers industry
September 1996 – May 1999 (2 years 9 months)
Covered Austin bureau feature news and assisted bureau reporters in legislative session coverage.

Tara Haelle's Languages

Spanish

Tara Haelle's Skills & Expertise

Multimedia, Journalism, Writing, Photography, Video, Editorial, Copy Editing, Editing, Final Cut Pro, Social Media, Blogging, InDesign, Photoshop, Research, Teaching, Newspaper, Public Speaking, Video Editing, Copywriting, Social Networking, …

Tara Haelle's Education

The University of Texas at Austin
Masters of Journalism, Multimedia/Photojournalism and Reporting/Writing
2008 – 2012

The University of Texas at Austin
BA, English-Plan II-Journalism
1996 – 2000
Activities and Societies: Orange Jackets, Phi Beta Kappa, Gamma Beta Phi, Texas Exes, Plan II, Texas Scholars, Torchlight Society

Santa Fe Photographic Workshops
2008 – 2008

Tarrant County College
2002 – 2008

Martin High School
Diploma
1993 – 1996

Sam Houston high school

Tara Haelle's Additional Information

Websites:
- Writer, Educator, Photographer
- Red Wine & Apple Sauce Blog
- Tutoring by Tara

Interests:

reporting, photography, feature writing, science, health, children's publishing, educational publishing, marine biology, sharks, multimedia, high school teaching, tutoring, test prep, international travel, nonprofit work in international education and health services, video production, audio recording, curriculum development

Groups and Associations:

Association of Health Care Journalists, National Association of Science Writers, American Society of Journalists and Authors, Society of Environmental Journalists, National Press Photographers Association, Society of Professional Journalists, Phi Beta Kappa, Medicine in the Media alumna

ASMP: American Society of Media Photographers - National

Association of Health Care Journalists

Canon EOS Digital Photography

Coca-Cola Scholar Alumni Group

Daily Texan Alumni

Documentary Photography

Freelance Photo Assignments

International Online Tutors Association

Martin High School (Arlington, TX)

NATIONAL PRESS PHOTOGRAPHERS ASSOCIATION

NIH Medicine in the Media Participants, Alumni, Faculty, and Speakers

NPPA - National Press Photographers Association

News21

Nonprofit Social Media & Multimedia Marketing -- Mojalink

Online Teaching

Online reporters and editors

Plan II Alumni

SAT Prep Teachers

Society of Professional Journalists

Test Prep & Tutoring Professionals

Texas Exes - The University of Texas Ex-Students' Association

Texas Photographers

USA Triathlon

UT Austin Alumni Group

UT Communication Alumni & Student Network

University of Texas at Austin

University of Texas at Austin School of Journalism Alumni

Women in Photography

World Press Gallery

Honors and Awards:

Carnegie-Knight News21 Fellow
Most Outstanding First-Year Teacher Award, 2003
Rhodes Scholar Nominee for UT-Austin, 2000
Coca Cola National Scholar, 1996-2000
Texas Scholar, 1996-2000
Headliners Scholarship, 1998, 1999"

About the Responder, Paul G. King, PhD

In addition to the information available on his web site, http://www.dr-king.com/, Dr. Paul G. King, an analytical chemist with an MS in inorganic chemistry, is the Science Advisor to the Coalition for Mercury-Free Drugs (CoMeD, Inc., http://www.mercury-freedrugs.org/, which is a 501(3)(c) not-for-profit corporation as well as the Science Advisor to the National Coalition of Organized Women (NCOW).

Additionally, he has been an author of papers bearing on issues related to the toxicity of Thimerosal and other compounds and, if any, their connection to a range of chronic neurodevelopmental, other developmental and behavioral abnormalities, which appear to be well-above (> 1 in 10 children; asthma and obesity), above (> 1 in 100 children; the autism spectrum disorders), at (> 1 in 1000 children; non-genetic childhood diabetes), or nearing (peanut allergy), epidemic childhood levels in the USA.

More recently, Dr. King was the co-author of a review paper in the journal ***Vaccine*** with Gary S. Goldman, PhD, which evaluated the CDC-recommended universal varicella vaccination program[48].

That paper established that the current CDC-recommended two-dose vaccination program was not effective in preventing all those who have been fully vaccinated from subsequently contracting chickenpox.

Since that program has greatly increased the public's risk of having clinical cases of shingles, it is also not societally cost-effective for universal use.

In addition, Dr. King was a co-author of a follow-up paper[49] published by the journal *Human & Experimental Toxicology* with Gary S. Goldman, PhD, that provided more evidence that the U.S. "universal varicella vaccination program is neither effective nor cost-effective".

Moreover, Dr. King was also one of the authors of a paper in the journal *Int. J. Environ. Res. Public Health*, where the lead author was Janet K. Kern, PhD. This paper reviewed Thimerosal exposure and the roles of sulfation chemistry and thiol availability in autism[50].

Furthermore, Dr. King was one of the authors in a review chapter, "Mercury Induced Autism"[51] (pages 1411-1432), in Comprehensive Guide to Autism Editors: Vinood B. Patel, Victor R. Preedy, Colin R. Martin. Springer New York (2014), where the lead author was Mark R. Geier, MD, PhD. This chapter presented updated evidence that mercury, including the bolus doses delivered when certain preserved vaccines and preserved serum products are given to pregnant women and young children, is a significant causal factor in "autism" and other developmental disorders, dysfunctions, and syndromes.

Finally, Dr. King was one of the authors of a paper, "A two-phase study evaluating the relationship between Thimerosal-containing vaccine administration and the risk for an autism spectrum disorder diagnosis in the United States", in the journal, *Translational Neurodegeneration*, where the lead author was David A. Geier. This open-access paper contributed more evidence to the actuality that there is a causal relationship between Thimerosal-preserved vaccine administration and the subsequent risk of a child's being diagnosed with "autism" in the USA[52].

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48 Goldman GS, King PG. Review of the United States universal varicella vaccination program: Herpes zoster incidence rates, cost effectiveness, and vaccine efficacy based primarily on the Antelope Valley Varicella Active Surveillance Project data. *Vaccine* 2013 March 25; 31(13): 1680-1684 (open access). [See, http://www.sciencedirect.com/science/journal/0264410X/31/13, article "6".]

49 Goldman GS, King PG. Vaccination to prevent varicella: Goldman and King's response to Myers' interpretation of Varicella Active Surveillance Project data . *Hum Exp Toxicol*. 2013 Dec. 10. [http://het.sagepub.com/content/early/2013/12/10/0960327113512340.full.pdf+html.] .

50 Kern JK, Haley BE, Geier DA, Sykes LK, King PG, Geier MR. Thimerosal Exposure and the Role of Sulfation Chemistry and Thiol Availability in Autism [Review]. *Int. J. Environ. Res. Public Health* 2013 Aug, 10, 3771-3800. OPEN ACCESS

51 See, http://www.researchgate.net/publication/258009647_Mercury_Induced_Autism/file/60b7d526955a643330.pdf for the complete chapter.

52 Geier DA, Hooker BS, Kern JK, King PG, Sykes LK, Geier MR. A two-phase study evaluating the relationship between Thimerosal-containing vaccine administration and the risk for an autism spectrum disorder diagnosis in the United States. *Translational Neurodegeneration* 2013 Dec. 16; 2:25 (12 pages). In the first month after publication, it was accessed more than 10,500 times.

APPENDIX A

Audited Records from VAERS for Reports of Patient Death Following Inoculation with a Live-virus Influenza Vaccine for the Period from mid-2007 to mid 2013

[**Note:** 15 Records were identified and audited]

1. 25-yr-old male died in sleep 15 days after vaccination – FluMist vaccine implicated as a causal factor

VAERS ID: 296231 (history) Vaccinated: 2007-10-17
Age: 25.0 Onset: 2007-11-01, Days after vaccination: 15
Gender: Male Submitted: 2007-11-06, Days after onset: 5
Location: California Entered: 2007-11-09, Days after submission: 3

Vaccination	Manufacturer	Lot	Dose	Route	Site
FLUN3: INFLUENZA (SEASONAL) (FLUMIST)	MEDIMMUNE VACCINES, INC.	500486P		IN	
TDAP: TDAP (ADACEL)	SANOFI PASTEUR	C2758AA		UN	LA

Administered by: Private Purchased by: Other

Symptoms: Cardiac septal defect, Cardiomegaly, Death, Left ventricular hypertrophy, Lung hyperinflation, Lymphadenopathy, Mitral valve prolapse,Parachute mitral valve, Pneumomediastinum
SMQs:, Cardiac failure (broad), Asthma/bronchospasm (broad), Congenital, familial and genetic disorders (narrow), Cardiomyopathy (broad), Eosinophilic pneumonia (broad)

Write-up: A 25-year-old patient, with no reported concurrent illnesses, pre-existing medical conditions, or use of other medications, had received a left deltoid (route not provided) dose of Adacel (lot number C2758AA), and a dose (route not provided) of FluMist (manufacturer MedImmune) (lot number 500486P) on 17 October 2007. Fifteen days post-vaccinations, on 01 November 2007, the patient expired in his sleep. At the time of the report, the autopsy was not complete. No cause of death has been determined at this time. 12/14/07 Received vax record from provider which confirms lot #s as reported. 1/18/08 Reviewed autopsy report which states COD as idiopathic mitral prolapse. Findings at autopsy included: enlarged dilated heart w/LVH & clean coronaries; parachute deformity w/hooding of anterior mitral cusp & lengthening of the chordae tendineae w/mild white thickening of the septal endocardim behind mitral valve; hyperinflated lungs; pneumomediastinum; enlarged liver/spleen/hepatic portal lymph nodes.

Life Threatening? No
Died? Yes
Date died: 2007-11-01
Days after onset: 0
Permanent Disability? No
Recovered? No
ER or Doctor Visit? No
Hospitalized? No
Previous Vaccinations:
Other Medications:
Current Illness:
Preexisting Conditions: None
Diagnostic Lab Data:
CDC 'Split Type': 200703735

2. 19-yr-old female – died 12 days after vaccination – FluMist a possible contributory factor but, from pre-death symptoms, more probably Gardasil® and Menactra® related.

VAERS ID: 334611 (history) Vaccinated: 2008-11-26
Age: 19.0 Onset: 2008-12-08, Days after vaccination: 12
Gender: Female Submitted: 2008-12-10, Days after onset: 2
Location: Illinois Entered: 2008-12-10

Vaccination	Manufacturer	Lot	Dose	Route	Site
FLUN3: INFLUENZA (SEASONAL) (FLUMIST)	MEDIMMUNE VACCINES, INC.	500569P			
HPV4: HPV (GARDASIL)	MERCK & CO. INC.	0070X	2		LA
MNQ: MENINGOCOCCAL CONJUGATE (MENACTRA)	SANOFI PASTEUR	U2730AA			RA

Administered by: Unknown Purchased by: Unknown

Symptoms: Autopsy, Cold sweat, Death, Dizziness, Headache, Malaise, Nausea,Toxicologic test normal, Urinary incontinence
SMQs:, Acute pancreatitis (broad), Anticholinergic syndrome (broad), Gastrointestinal nonspecific symptoms and therapeutic procedures (narrow), Vestibular disorders (broad)

Write-up: Patient, a previously healthy 19 year-old female college freshman died suddenly yesterday, approximately 10 days after receiving Gardasil & menningococcal vaccines. Vaccines were administered by a medical provider in her hometown while she was home for the Thanksgiving holiday, sometime around

Life Threatening? No
Died? Yes
Date died: 2008-12-08
Days after onset: 0
Permanent Disability? No
Recovered? No
ER or Doctor Visit? No
Hospitalized? No
Previous Vaccinations:
Other Medications: None known. ?? oral contraceptive or an antibiotic for acne.
Current Illness: None.
Preexisting Conditions: Acne. PMH: PCN allergy. Acne. On OCs (Yaz). 12/10/2008 Recived records from health center via CDC. Seen 11/3/08 with c/o sore throat, cough, muscle aches and nasal d/c. PE (+) for pharyngeal erythema, purulent

11-28-08. She had a medical appointment pending for 12-8-08 (the day of her death) with the Student Health Service; medical clerk had entered "possible seizure" as the reason for making the appointment. Patient had no history of epilepsy. She complained of a headache and not feeling well in the 24 hours prior to her death. She went to bed at 10:30 PM on 12-7-08, in her dorm room with a roomate. She appeared to still be sleeping the next morning when her roomate left for class. Her body was discovered still in bed around 5 PM that day (12-8-08) with rigor mortis. No history of substance abuse, alcohol intake, or depression or other mental health issues. She was a happy, achieving student. This report is filed by a friend of patient"s parents, who is a physician (board certified internal medicine & geriatrics). Report also filed online today with the FDA. Patient"s mother can be reached at home for additional details. Memorial service & funeral 12-12-08 and 12-13-08. Only known past medical history requiring physician attention was facial acne. 12/10/2008 Recived records from health center via CDC. Seen 11/3/08 with c/o sore throat, cough, muscle aches and nasal d/c. PE (+) for pharyngeal erythema, purulent nasal drainage, nasal turbinate changes, and lymphadenopathy. Assessment: Probable viral URI with ? sinusitis. Tx: Biaxin. Received from CDC via email: The patient had no previous health problems. She was a freshman and was seen at the college health clinic only once on 11/3/08 for sinusitis. She was on Yaz birth control pills and a topical acne medication. After the death, police questioned her roommate who said that the pt did go out on the evening of 12/6/08 and had a few alcoholic drinks, but not an excessive a

nasal drainage, nasal turbinate changes, and lymphadenopathy. Assessment: Probable viral URI with ? sinusitis. Tx: Biaxin.

Diagnostic Lab Data: Autopsy performed 12-9-08 was unrevealing per family verbal report to me; no signs of intracranial bleed, meningitis, cardiomyopathy, trauma. Toxicology report still pending at this time. Post-mortem tox screen (-).

CDC 'Split Type':

3. 9-yr-old female – died 6 days after vaccination – evidence of infection by pandemic A(H1N1) influenza –'Mist' vaccine was definitely a causal factor.

VAERS ID: 361353 (history) Vaccinated: 2009-10-08
Age: 9.0 Onset: 2009-10-14, Days after vaccination: 6
Gender: Female Submitted: 2009-10-16, Days after onset: 2
Location: California Entered: 2009-10-16

Vaccination	Manufacturer	Lot	Dose	Route	Site
FLU3: INFLUENZA (SEASONAL) (FLUZONE)	SANOFI PASTEUR	U3203AA	2	IM	LA
FLUN(H1N1): INFLUENZA (H1N1) (H1N1 (MONOVALENT) (MEDIMMUNE)	MEDIMMUNE VACCINES, INC.	500751P	0	IN	

Administered by: Private Purchased by: Unknown

Symptoms: Apnoea, Blood albumin decreased, Blood alkaline phosphatase normal,Blood calcium decreased, Blood glucose normal, Bronchopneumonia, Cardiac arrest, Chills, Death, Diffuse alveolar damage, Drug screen positive,Electrocardiogram abnormal, Eosinophil count decreased, Full blood count abnormal, Haematocrit decreased, Haemoglobin decreased, Immunohistochemistry,Influenza, Leukopenia, Lividity, Lung consolidation, Monocyte count decreased,Neisseria test positive, Neutrophil count decreased, Pallor, Pneumonia pneumococcal, Pulse absent, Pupil fixed, Red blood cell count decreased, Red blood cell sedimentation rate increased, Red cell distribution width increased,Resuscitation, Streptococcus identification test positive, Trisomy 21, White blood cell count decreased
SMQs:, Torsade de pointes/QT prolongation (broad), Rhabdomyolysis/myopathy (broad), Anaphylactic reaction (broad), Haematopoietic erythropenia (narrow), Haematopoietic leukopenia (narrow), Haemorrhage laboratory terms (broad), Interstitial lung disease (narrow), Systemic lupus erythematosus (broad), Arrhythmia related investigations, signs and symptoms (broad), Shock-associated circulatory or cardiac conditions (excl torsade de pointes) (narrow), Congenital, familial and genetic disorders (narrow), Drug abuse and dependence (broad), Acute central respiratory depression (narrow), Cardiomyopathy (broad), Eosinophilic pneumonia (broad), Hypotonic-hyporesponsive episode (broad), Chronic kidney disease (broad), Tumour lysis syndrome (broad)

Write-up: None Stated. On 10/19/09, the PCP stated that coroner called him and told him that he found consolidation of the lungs on autopsy. Autopsy report is not complete yet. 10/20/09 ER records received service date 10/14/09. Assessment: Cardiac arrest. CPR initiated. Pupils fixed and dilated. Apnea, pale. Rigor, lividity. 1022/09 PCP /Nursing medical records received, service dates 11/11/03 to 10/14/09. Assessment: Death. Office staff unable to contact patient"s family, eventually visited patient"s home. learnd that patient was found dead at home and taken to ER. 11/3/09 Additional ER records received for service date 10/14/09. Found supine on floor at home apneic and pulseless. Cardiac arrest. CPR initiated. 12/8/09 Autopsy received. Pronounced dead on 10/13/2009 Final cause of death: Pneumococcal Pneumonia. Pandemic Influenza A. Additional Information Abstracted: Other contributing conditions - Leukopenia, history of leukemia, Down syndrome. Drug Screen Heart Blood: Dextromethorphan <0.10 ug/ml, Promethazine 0.11 ug/ml. /ksk 12/28/09 Pathology report received. Receipt date 10/23/2009. Sign out date 12/21/2009. Diagnosis: Lung - Diffuse alveolar damage and bronchopneumonia. Immunohistochemical and molecular evidence of novel influenza A H1N1. Immunohistochemical and molecular evidence of Streptococcus pneumoniae. Immunohistochemical evidence of Neisseria meningitidis without molecular confirmation. No immunohistochemical evidence of Group A Streptococcus or Haemophilus influenzae. All follow-up attempts have been completed per company SOPs. No further information available.

Life Threatening? No
Died? Yes
Date died: 2009-10-14
Days after onset: 0
Permanent Disability? No
Recovered? No
ER or Doctor Visit? No
Hospitalized? No
Previous Vaccinations:
Other Medications: None
Current Illness: Limping
Preexisting Conditions: H/O Leukemia 2002; Down"s Syndrome. 1022/09 PCP /Nursing medical records received, service dates 11/11/03 to 10/14/09. Down Syndrome. Cough, fever. Frequent colds. Discharge from eyes. Vomiting and diarrhea. Lymphadenopathy. Foot pain. CBC abnormal.

Diagnostic Lab Data: CBC: 2.5, 7.5, 21.3, 207; Sed rate 125. 10/20/09 ER records received service date 10/14/09. LABS and Diagnostics: EEG - Asystole. CHEM - Glucose 107 mg/dL (H) Calcium 3.5 mg/dL (L) Albumin 3.4 g/dL (L) Alk Phos 170 U/L (L). CBC - WBC 2.5 Thou/uL (L) RBC 2.57 Mill/uL (L) HGB 7.5 g/dL (L) HCT 27.3% (L) RDW 16.4% (H) Neut ABS 565 cells/uL (L) Mono ABS 33 cells/uL (L) Eosin 3 cells/uL (L)

CDC 'Split Type':

4. 35-yr-old female – died 3 days after vaccination –'Mist' inoculation probably a contributory factor

VAERS ID: 362855 (history) Vaccinated: 2009-10-22
Age: 35.0 Onset: 2009-10-25, Days after vaccination: 3
Gender: Female Submitted: 2009-10-26, Days after onset: 1
Location: Oregon Entered: 2009-10-26

Vaccination	Manufacturer	Lot	Dose	Route	Site
FLUN(H1N1): INFLUENZA (H1N1) (H1N1 (MONOVALENT) (MEDIMMUNE)	MEDIMMUNE VACCINES, INC.	500765P	0	IN	

Administered by: Unknown Purchased by: Unknown

Symptoms: Abdominal pain upper, Acidosis, Acute respiratory distress syndrome,Anisocytosis, Asplenia, Band neutrophil percentage increased, Base excess decreased, Blood bicarbonate decreased, Blood bilirubin increased, Blood creatinine increased, Blood culture positive, Blood glucose decreased, Blood potassium decreased, Brain injury, Cardiac arrest, Cerebrovascular arteriovenous malformation, Chest X-ray abnormal, Chills, Cyanosis, Death, Diarrhoea, Dyspnoea,Electrocardiogram ST-T change, Electrocardiogram abnormal, Electromechanical dissociation, Endotracheal intubation, Glomerular filtration rate decreased, Gram stain positive, Granulocyte count decreased, Haematocrit decreased, Haemolytic anaemia, Histology abnormal, Hyperhidrosis, Hypotension, Infection, Influenza like illness, Influenza serology negative, Intensive care, Livedo reticularis, Lung infiltration, Lymphocyte count increased, Lymphocyte morphology abnormal,Lymphocyte percentage increased, Mean cell haemoglobin, Mean cell haemoglobin concentration, Metamyelocyte percentage increased, Nausea, Neutrophil percentage decreased, Oxygen saturation decreased, PCO2 increased, Platelet count increased, Pneumococcal sepsis, Pneumonia pneumococcal, Pulse absent,Red blood cell abnormality, Red blood cell count decreased, Red cell distribution width increased, Renal disorder, Respiratory arrest, Resuscitation, Sepsis, Septic shock, Sinus tachycardia, Splenectomy, Streptococcus identification test positive,Tachycardia, Tachypnoea, Vaginal haemorrhage, Vomiting, White blood cell count increased, White blood cell morphology abnormal
SMQs:, Torsade de pointes/QT prolongation (broad), Rhabdomyolysis/myopathy (broad), Acute renal failure (broad), Liver related investigations, signs and symptoms (narrow), Haemolytic disorders (narrow), Anaphylactic reaction (narrow), Acute pancreatitis (narrow), Agranulocytosis (broad), Angioedema (broad), Asthma/bronchospasm (broad), Haematopoietic erythropenia (narrow), Haematopoietic leukopenia (narrow), Lactic acidosis (broad), Haemorrhage terms (excl laboratory terms) (narrow), Haemorrhage laboratory terms (broad), Hyperglycaemia/new onset diabetes mellitus (broad), Interstitial lung disease (narrow), Neuroleptic malignant syndrome (broad), Systemic lupus erythematosus (broad), Anticholinergic syndrome (broad), Arrhythmia related investigations, signs and symptoms (broad), Supraventricular tachyarrhythmias (broad), Retroperitoneal fibrosis (broad), Shock-associated circulatory or cardiac conditions (excl torsade de pointes) (narrow), Toxic-septic shock conditions (narrow), Congenital, familial and genetic disorders (narrow), Pseudomembranous colitis (broad), Malignancy related therapeutic and diagnostic procedures (narrow), Acute central respiratory depression (narrow), Biliary system related investigations, signs and symptoms (narrow), Pulmonary hypertension (broad), Guillain-Barre syndrome (broad), Gastrointestinal nonspecific symptoms and therapeutic procedures (narrow), Cardiomyopathy (broad), Eosinophilic pneumonia (broad), Cardiac arrhythmia terms, nonspecific (narrow), Cerebrovascular disorders, not specified as haemorrhagic or ischaemic (broad), Conditions associated with central nervous system haemorrhages and cerebrovascular accidents (broad), Hypotonic-hyporesponsive episode (broad), Chronic kidney disease (broad), Hypersensitivity (broad), Malignant lymphomas (broad), Myelodysplastic syndrome (broad), Noninfectious diarrhoea (narrow), Tumour lysis syndrome (narrow)

Write-up: Patient got sick with flu like symptoms on 10/24 around 1PM, went to hospital with trouble breathing around 9PM, was pronounced deceased at 1AM on 10/25. 10/27/09 ER and hospital records received service date 10/25/09. Assessment: Death due to septic shock secondary to infection of unknown source. Asplenia. Patient had nausea, vomiting, chills, stomach cramping, diarrhea, tachypnea, hypotension, diaphoresis for one day. Limited oral intake. Became cyanotic around lips, fingernails, and toenails. Presented to ER hypotensive, hypoxic, no longer breathing. Tachycardia. Cardiac arrest presenting as pulseless electrical activity (PEA). Hyperacidemia. Resusitation. Intubated and transported to ICU. Bilateral infiltrates consistent with acute respiratory distress syndrome. End-organ damage including kidneys and brain. Repeated PEA. No pulse. Mottling of head and extremities. Overwhelming sepsis and septic shock. Patient expired. 11/02/09: Primary Care Records received for date of service 10/9/09. Seasonal flu vaccine record received VAERS updated. Assessment: Presented with vaginal bleeding x 3 weeks, had hx. of D&C in 08 2/2 heavy vaginal bleeding. Also presented with a cold that started 5 days prior, afebrile at visit. Seasonal Flu vaccine given. 11/05/09 Diagnostic/lab results received. IDPB Test results: Lung section shows increased interstitial inflammatory infiltrates. Heart section shows focal interstitial edema and extravasation. No evidence of myocarditis. Liver section shows increased portal infiltrates and dilated sinusoids with Kupffer cell hyperplasia. Special stains: Scattered gram-positive cocci in lung, heart and liver. Immunohistochemical Assays: (+) Strep penumoniae in lung, heart and liver. (-) for influenza virus. PCR Assays: Negative for 2009 pandemic H1N1 influenza A virus. PCR for penumoniae

Life Threatening? No
Died? Yes
Date died: 2009-10-25
Days after onset: 0
Permanent Disability? No
Recovered? No
ER or Doctor Visit? Yes
Hospitalized? No
Previous Vaccinations:
Other Medications: none known
Current Illness: spherocytosis, hemolitic onemica
Preexisting Conditions: none. /27/09 ER and hospital records received service date 10/25/09. Splenectomy. Appendectomy. 11/02/09: Primary Care Records received for date of service 10/9/09. PMH: Heriditary spherocytosis with splenectomy, D&C, L ACL Repair, L arthroscopic knee surgery.
Diagnostic Lab Data: /27/09 ER and hospital records received service date 10/25/09. LABS and DIAGNOSTICS: ECG - Abnormal, sinus tachycardia, Nonspecific ST and T wave abnormality. Arterial Blood gases: pCO2 50 mmHg (H) O2 Sat 83% (L) Bicarb 8.0 mmol/L (L) Base Excess -26.0 mEq/L (L) pH 6.8 (L). CHEM - Potassium 3.0 mmol/L (L) Glucose 27 mg/dL (L) Creatinine 2.42 mg/dL (H) AST 121 IU/L (H) Bilirubin Total 1.6 mg/dL (H). GFR 28 mL/min/1.73 m2 (L). CBC - RDW 15.0% (H) PLT 91 10^9/L (L) Neutrophils 20.0% (L) Bands 20% (H) Metamyelocytes 3% (H) Lymph 55.0% (H) Lymphs Atyp 1% (H) Anisocytosis slight, Howell Jolly Body few, Vacuolated Polys moderate. Blood culture (+) for Streptococcus pneumoniae. Chest X-ray - Abnormal. 10/29/09 Hospital lab report. Blood Culture Fi
CDC 'Split Type':

pending. 12/14/09 Autopsy Records receivedI. DOD 10/25/09. Final Cause of Death: Streptococcus Pneumonia Sepsis. II. Hemolytic Anemia with Splenectomy. Additional information abstracted: Arteriovenous malformation of brain. Cholecystectomy remote. Blood cultures (+) for streptococcus pneumonias.

5. 18-yr-old male – died shortly after being given 'Mist' injection – 'Mist' vaccination possibly a contributory factor

VAERS ID: 367792 (history) Vaccinated: 2009-11-03
Age: 18.0 Onset: 2009-11-03, Days after vaccination: 0
Gender: Male Submitted: 2009-11-16, Days after onset: 13
Location: New Mexico Entered: 2009-11-16

Vaccination	Manufacturer	Lot	Dose	Route	Site
FLUN(H1N1): INFLUENZA (H1N1) (H1N1 (MONOVALENT) (MEDIMMUNE)	MEDIMMUNE VACCINES, INC.	500781P		IN	

Administered by: Unknown Purchased by: Unknown

Symptoms: Aspiration, Blood pressure, Cardiac arrest, Chest X-ray abnormal,Death, Endotracheal intubation, Hypertrophic cardiomyopathy, Myocardial fibrosis,Poor dental condition, Pulmonary congestion, Pulse absent, Resuscitation,Vomiting
SMQs:, Torsade de pointes/QT prolongation (broad), Cardiac failure (broad), Anaphylactic reaction (broad), Acute pancreatitis (broad), Angioedema (broad), Arrhythmia related investigations, signs and symptoms (broad), Shock-associated circulatory or cardiac conditions (excl torsade de pointes) (narrow), Congenital, familial and genetic disorders (narrow), Acute central respiratory depression (broad), Gastrointestinal nonspecific symptoms and therapeutic procedures (narrow), Cardiomyopathy (narrow)

Write-up: Patient had sudden cardiac arrest and had CPR from onset, was picked up by EMS and transported to hospital and pronounced dead at approx 11:30 PM. 12/16/09 Report of death received for 11/03/09. Decedent fell on the floor while in a social gathering. No pulse, CPR performed by school nurse for 10 mins until EMS came. Decedent had emesis while compressions were performed. EMS started ACLS, intubation, 3 IV lines, 4 Epi, 3 Atropine and 1 amp Bicarb. Sinus rhythm established 1 time, but lost. CPR unsuccessful. Decendent pronounced dead. 12/16/09 Autopsy results revealed no visible internal signs of trauma. All systems autopsy: normal. Teeth in poor condition. Cardiovascular system: myocardium: focal areas of fibrosis, atrial; bulges in atrial and ventricular muscular fee walls, interventricular septum 3cm thick. Pathologist opinion: Hypertrophic cardiomyopathy (790gr). Heart severely congested and lungs heavy with possible aspiration. 12/24/09 Toxicology report received. This report showed that no drugs were used. 01/04/09 Medical/dental record received for DOS 10/29/09. Debridement performed. Anesthesia used. Moderate to heavy generalized bleeding. Tx: Chlorhexidine gluconate oral rinse. DX: Gingivitis, periodontal disease.

Life Threatening? No
Died? Yes
Date died: 2009-11-03
Days after onset: 0
Permanent Disability? No
Recovered? No
ER or Doctor Visit? No
Hospitalized? No
Previous Vaccinations:
Other Medications:
Current Illness: gingivitis. dental care provided 10/29/2009
Preexisting Conditions: PMH: loose teeth, gum pain and bleeding, hit head when young.
Diagnostic Lab Data: OMI results not available at this time however chest xray showed enlarged heart, no pulmonary effusion
CDC 'Split Type':

6. 57-yr-old male – died 13 days after vaccination – 'Mist' vaccination possibly a contributory factor

VAERS ID: 373122 (history) Vaccinated: 2009-11-25
Age: 57.0 Onset: 0000-00-00
Gender: Male Submitted: 2009-12-14
Location: Texas Entered: 2009-12-14

Vaccination	Manufacturer	Lot	Dose	Route	Site
FLUN(H1N1): INFLUENZA (H1N1) (H1N1 (MONOVALENT) (MEDIMMUNE)	MEDIMMUNE VACCINES, INC.	500829P	0	IN	

Administered by: Other Purchased by: Other

Symptoms: Arteriosclerosis, Coronary artery disease, Death, Myocardial infarction
SMQs:, Myocardial infarction (narrow), Embolic and thrombotic events, arterial (narrow), Other ischaemic heart disease (narrow)

Write-up: Notified by patient''s co-worker that patient had passed away. 12/15/09 Death Certificate received. DOD 12/08/2009. Cause of Death: Myocardial Infaction. Atherosclerotic Coronary Vascular Disease.

Life Threatening? No
Died? Yes
Date died: 2009-12-08
Permanent Disability? No
Recovered? No
ER or Doctor Visit? No
Hospitalized? No
Previous Vaccinations:
Other Medications: Unknown
Current Illness: Smoking; Cardiac condition
Preexisting Conditions: Per patient''s co-worker, patient has hx of smoking and cardiac condition. 12/16/09 PCP medical records received. Service dates 3/8/08 to 11/18/08. Cough, shortness of breath, low back pain, dizziness, essential hypertension, atherosclerosis, anxiety. Alcohol dependence, alcoholic gastritis, chronic insomnia, depression, erectile dysfunction, hip pain, loss of

weight.

Diagnostic Lab Data: Unknown

CDC 'Split Type':

7. 37-yr-old male – died 1 day after vaccination – 'Mist' vaccination probably a contributory factor

VAERS ID: 373547 (history) Vaccinated: 2009-12-03
Age: 37.0 Onset: 2009-12-04, Days after vaccination: 1
Gender: Male Submitted: 2009-12-16, Days after onset: 12
Location: Florida Entered: 2009-12-16

Vaccination	Manufacturer	Lot	Dose	Route	Site
FLUN(H1N1): INFLUENZA (H1N1) (H1N1 (MONOVALENT) (MEDIMMUNE)	MEDIMMUNE VACCINES, INC.	500804P	0	IN	

Administered by: Unknown Purchased by: Unknown

Symptoms: Abdominal adhesions, Arteriosclerosis, Autopsy, Brain oedema, Cardiac hypertrophy, Cholecystectomy, Congenital central nervous system anomaly,Coronary artery disease, Death, Foot deformity, Laboratory test, Limb deformity,Malaise, Scar, Spina bifida, Urinary tract infection, Ventriculo-peritoneal shunt
SMQs:, Retroperitoneal fibrosis (broad), Congenital, familial and genetic disorders (narrow), Gallbladder related disorders (narrow), Hyponatraemia/SIADH (broad), Haemodynamic oedema, effusions and fluid overload (narrow), Cardiomyopathy (narrow), Other ischaemic heart disease (narrow)

Write-up: Per co-workers, patient reported "not feeling well" on 12/04/09. 12/29/09 Autopsy received. DOD 12/06/2009. Cause of Death: Long-term Sequelae of Spina Bifida. Additional information abstracted: Contributory - Associated Chronic and Acute Urinary Tract Infection. Summary of Autopsy Findings: I. Spina bifida - A. Large puckered lower lumbar scar. B. Chronic lower extremity atrophy with bilateral foot deformities. C. Indurated scars and large scarring - buttock and legs. D. Chronic and acute urinary tract infections. E. Posterior absence of corpus callosum. F. Ventriculoperitoneal shunt. G. Congested, dusky leptomeninges with associated cerebral edema. II. Other findings - A. Moderate atherosclerotic coronary artery disease. B. Minimal to moderate cardiac hypertophy. C. Acute visceral adhesions. D. Old abdominal adhesions. E. Status-post cholecystectomy.

Life Threatening? No

Died? Yes
Date died: 2009-12-06
Days after onset: 2

Permanent Disability? No

Recovered? No

ER or Doctor Visit? No

Hospitalized? No

Previous Vaccinations:

Other Medications: Unknown.

Current Illness: Screening questions were asked prior to vaccination by school nurse, screener, and vaccinator and no illness reported.

Preexisting Conditions: Birth Defect: Spina Bifida. 12/17/09 PCP past medical records received. Service dates 9/27/99 to 10/25/07 History of spina bifida, paraplegia, wheelchair use. Decubitis ulcer. UTI. Hyperlipidemia. Hearing deficit, tinnitus. Sinus infection. URI. Allergy to Bactrim. Epigastric pain. Headache.

Diagnostic Lab Data: Autopsy performed. Cause of death pending results of various labs sent out.

CDC 'Split Type':

8. 43-yr-old female – was ill before vaccination, prescribed TamiFlu and given A(H1N1) vaccine; then had flu-like symptoms, lethargy and died – 'Mist' vaccination a causal factor – also seemed to be medical malpractice because patient was ill before being given this live-virus influenza vaccine.

VAERS ID: 376388 (history) Vaccinated: 2009-10-21
Age: 43.0 Onset: 0000-00-00
Gender: Female Submitted: 2010-01-07
Location: New Mexico Entered: 2010-01-08, Days after submission: 1

Vaccination	Manufacturer	Lot	Dose	Route	Site
FLUN(H1N1): INFLUENZA (H1N1) (H1N1 (MONOVALENT) (MEDIMMUNE)	MEDIMMUNE VACCINES, INC.	500756P		IN	

Administered by: Public Purchased by: Unknown

Symptoms: Arrhythmia, Aspiration, Choking, Death, Fatigue, Hypoxia, Influenza,Influenza like illness, Resuscitation, Unresponsive to stimuli
SMQs:, Anaphylactic reaction (broad), Angioedema (broad), Asthma/bronchospasm (broad), Hyperglycaemia/new onset diabetes mellitus (broad), Neuroleptic malignant syndrome (broad), Acute central respiratory depression (broad), Guillain-Barre syndrome (broad), Noninfectious encephalitis (broad), Noninfectious encephalopathy/delirium (broad), Noninfectious meningitis (broad), Cardiomyopathy (broad), Eosinophilic pneumonia (broad), Cardiac arrhythmia terms, nonspecific (narrow), Hypotonic-hyporesponsive episode (broad), Hypersensitivity (broad)

Write-up: Seen in clinic 10/21/09 with cough, congestion, and "feels hot". Prescribed TAMIFLU on 10/21/09 and given intranasal H1N1 vaccine on 10/21. Subsequently apparently had flu-like symptoms and tiredness for unspecified period of time and apparently found unresponsive in home. Resuscitation unsuccessful.

Life Threatening? No

Died? Yes
Date died: 0000-00-00

Permanent Disability? No

Recovered? No

ER or Doctor Visit? No

Hospitalized? No

Previous Vaccinations:

Other Medications: Iron pills; Prenatal vitamins; Lisinopril

Current Illness: INFLUENZA

Preexisting Conditions: Iron deficiency anemia; Dysfunctional uterine bleeding; Hypertension.

Diagnostic Lab Data: No autopsy performed, apparently no recent influenza tests performed.

CDC 'Split Type':

9. 13-yr-old female – died 37 days after vaccination – from symptoms, Gardasil was probably the causal factor.

VAERS ID: 380740 (history) Vaccinated: 2009-08-25
Age: 13.0 Onset: 2009-10-01, Days after vaccination: 37
Gender: Female Submitted: 2010-02-18, Days after onset: 140
Location: Washington Entered: 2010-02-18

Vaccination	Manufacturer	Lot	Dose	Route	Site
FLUN3: INFLUENZA (SEASONAL) (FLUMIST)	MEDIMMUNE VACCINES, INC.	500673P		IN	
HPV4: HPV (GARDASIL)	MERCK & CO. INC.	0671Y	0	IJ	AR

Administered by: Private Purchased by: Other

Symptoms: Alanine aminotransferase increased, Convulsion, Death, Decreased activity, Fall, Headache, Hypertension, Hypoaesthesia, Injury, Loss of control of legs, Lymphocyte percentage increased, Menstruation irregular, Monocyte percentage increased, Oedema peripheral, Paraesthesia, Peripheral coldness,Pulmonary congestion, Pulmonary oedema, Sensory loss, Sudden unexplained death in epilepsy, Unresponsive to stimuli, Weight increased, White blood cell count decreased
SMQs:, Cardiac failure (narrow), Liver related investigations, signs and symptoms (narrow), Angioedema (broad), Haematopoietic leukopenia (narrow), Peripheral neuropathy (narrow), Hyperglycaemia/new onset diabetes mellitus (broad), Neuroleptic malignant syndrome (broad), Systemic lupus erythematosus (broad), Convulsions (narrow), Guillain-Barre syndrome (broad), Noninfectious encephalitis (broad), Noninfectious encephalopathy/delirium (broad), Noninfectious meningitis (broad), Accidents and injuries (narrow), Hostility/aggression (broad), Haemodynamic oedema, effusions and fluid overload (narrow), Hypertension (narrow), Fertility disorders (broad), Hypotonic-hyporesponsive episode (broad), Generalised convulsive seizures following immunisation (narrow)

Write-up: Patient received the HPV as well as the flu nasal spray on Aug 25th. I first declined getting her the vaccination but her doctor ensured me that it was safe. I had declined the same vaccination a year earlier at the downtown public health center. Patient was getting ready for school and was standing by her closet, and all of a sudden she fell, she lost total control of her legs. She went to school and could not engage in any of the activities because of the numbness in her legs and the swelling of her foot. She also, started to get a really bad headache. Days later she woke up out of her sleep complaining of a severe headache, which usually she gets if she has a seizure but she hadn"t had a seizure this night. She continued to say she had not feeling in her foot and tingling feeling in her leg. After I examined her foot I noticed it was swollen. The next morning I called her doctors office and made her doctors appointment for Oct 23rd. During the month of October she had irregular periods. My daughter never made it to Oct 23rd, which as also her birthday. She passed on Oct. 17th, I found her cold unresponsive in her room at 7am, which I went in to wake her up to take her morning pills.

Life Threatening? No
Died? Yes
Date died: 2009-10-17
Days after onset: 16
Permanent Disability? No
Recovered? No
ER or Doctor Visit? No
Hospitalized? No
Previous Vaccinations:
Other Medications: Trileptol and Keppra
Current Illness: My daughter had a seizure disorder that came on with her periods.
Preexisting Conditions: Patient had a pre-existing seizure disorder which she was on trileptol and Keppra to control the seizures.
Diagnostic Lab Data:
CDC 'Split Type':

10. 2-yr-old male –died 1 day after vaccination – probably vaccination related – but also medical malfeasance – vaccinated an obviously sick child with both types of influenza vaccine, a trivalent seasonal inactivated-influenza vaccine and a 'Mist' 2009 A-H1N1 live-virus vaccine

VAERS ID: 381178 (history) Vaccinated: 2010-02-10
Age: 2.0 Onset: 2010-02-11, Days after vaccination: 1
Gender: Male Submitted: 2010-02-18, Days after onset: 7
Location: New Mexico Entered: 2010-02-24, Days after submission: 6

Vaccination	Manufacturer	Lot	Dose	Route	Site
FLU3: INFLUENZA (SEASONAL) (FLUZONE)	SANOFI PASTEUR	U3260AA	1	IM	RL
FLUN(H1N1): INFLUENZA (H1N1) (H1N1 (MONOVALENT) (MEDIMMUNE)	MEDIMMUNE VACCINES, INC.	500824P	0	IN	
HEPA: HEP A (HAVRIX)	GLAXOSMITHKLINE BIOLOGICALS	AHAVB349AA	1	IM	LL

Administered by: Public Purchased by: Public

Symptoms: Cardio-respiratory arrest, Condition aggravated, Contusion, Cough,Croup infectious, Death, Head injury, Pulmonary congestion, Pulmonary oedema,Respiratory syncytial virus infection, Respiratory syncytial virus test positive,Tracheobronchitis, Viral test positive
SMQs:, Torsade de pointes/QT prolongation (broad), Cardiac failure (narrow), Anaphylactic reaction (narrow), Haemorrhage terms (excl laboratory terms) (narrow), Arrhythmia related investigations, signs and symptoms (broad), Shock-associated circulatory or cardiac conditions (excl torsade de pointes) (narrow),

Life Threatening? No
Died? Yes
Date died: 2010-02-11
Days after onset: 0
Permanent Disability? No
Recovered? No
ER or Doctor Visit? No
Hospitalized? No
Previous Vaccinations:
Other Medications: Dexamethasone one dose
Current Illness: Viral croup
Preexisting Conditions: 30 weeks gestation at birth --$g respiratory distress
Diagnostic Lab Data:
CDC 'Split Type':

Acute central respiratory depression (broad), Accidents and injuries (narrow), Haemodynamic oedema, effusions and fluid overload (narrow)

Write-up: 28 month old (ex - 30 week preemie) male was seen in pediatric clinic for outpatient evaluation of croup. Examining attending physician described barking cough but no stridor at rest. Given dexamethasone 9 mg and vaccines. Child put to bed "fine". Found dead next morning. Unsuccessful resuscitation.

11. 19-yr-old male – died ~ 32 days after vaccination – 'Mist' vaccination was probably a causal factor.

VAERS ID: 404478 (history) Vaccinated: 2009-10-19
Age: 19.0 Onset: 0000-00-00
Gender: Male Submitted: 2010-10-20
Location: Utah Entered: 2010-10-20

Vaccination	Manufacturer	Lot	Dose	Route	Site
FLUN(H1N1): INFLUENZA (H1N1) (H1N1 (MONOVALENT) (MEDIMMUNE)	MEDIMMUNE VACCINES, INC.	500779P	0	IN	

Administered by: Public Purchased by: Private

Symptoms: Death, Fatigue, Myocarditis
SMQs:, Cardiomyopathy (broad)

Write-up: A couple weeks after receiving the H1N1 Flumist, client complained of being tired and felt tired "all the time".

Life Threatening? No
Died? Yes
Date died: 2009-11-20 [32 days post vaccination]
Permanent Disability? No
Recovered? No
ER or Doctor Visit? No
Hospitalized? No
Previous Vaccinations:
Other Medications:
Current Illness: None
Preexisting Conditions: None
Diagnostic Lab Data: Medical examiner said client died of myocarditis. Attributed to a recent viral infection. Patient had not had any known infections prior.
CDC 'Split Type':

12. 5-yr-old female – died 45 days after FluMist vaccination – 'Mist' vaccination possibly a causal factor but autopsy data missing so cannot assess probability.

VAERS ID: 413215 (history) Vaccinated: 2010-11-01
Age: 5.0 Onset: 2010-12-06, Days after vaccination: 35
Gender: Female Submitted: 2010-12-20, Days after onset: 14
Location: Virginia Entered: 2010-12-20

Vaccination	Manufacturer	Lot	Dose	Route	Site
FLUN3: INFLUENZA (SEASONAL) (FLUMIST)	MEDIMMUNE VACCINES, INC.	501049P	1	IN	

Administered by: Public Purchased by: Public

Symptoms: Blindness, Death, Headache, Intensive care, Pyrexia, Vomiting
SMQs:, Acute pancreatitis (broad), Neuroleptic malignant syndrome (broad), Anticholinergic syndrome (broad), Gastrointestinal nonspecific symptoms and therapeutic procedures (narrow), Glaucoma (broad), Optic nerve disorders (broad), Retinal disorders (broad)

Write-up: On 12/6/10, developed fever & headache. Treated with Advil until 12/9/10; went to PMD; patient vomiting, 12/10/10, vision loss, adm. to E.R. 12/11/10, transferred to PICU. Expired 12/16/10.

Life Threatening? Yes
Died? Yes
Date died: 2010-12-16
Days after onset: 10
Permanent Disability? No
Recovered? No
ER or Doctor Visit? Yes
Hospitalized? No
Previous Vaccinations:
Other Medications:
Current Illness:
Preexisting Conditions:
Diagnostic Lab Data:
CDC 'Split Type': VA10020

13. 7-yr-old female – died 51 days after vaccination – probably caused by influenza-vaccine-induced (viral) inflammation – FluMist vaccination was a causal factor

VAERS ID: 414511 (history) Vaccinated: 2010-11-08
Age: 7.0 Onset: 2010-12-19, Days after vaccination: 41
Gender: Female Submitted: 2011-01-11, Days after onset: 23
Location: Pennsylvania Entered: 2011-01-11

Vaccination	Manufacturer	Lot	Dose	Route	Site
FLUN3: INFLUENZA (SEASONAL) (FLUMIST)	MEDIMMUNE VACCINES, INC.	501013P		IN	

Life Threatening? No
Died? Yes
Date died: 2011-01-02
Days after onset: 14
Permanent Disability? No
Recovered? No
ER or Doctor Visit? Yes
Hospitalized? No

Administered by: Private Purchased by: Private

Symptoms: Acute disseminated encephalomyelitis, Coma, Confusional state, Death,Lumbar puncture, Nuclear magnetic resonance imaging, Pyrexia, Subacute sclerosing panencephalitis
SMQs:, Hyperglycaemia/new onset diabetes mellitus (broad), Neuroleptic malignant syndrome (broad), Anticholinergic syndrome (broad), Dementia (broad), Noninfectious encephalitis (narrow), Noninfectious encephalopathy/delirium (broad), Noninfectious meningitis (broad), Demyelination (narrow)

Write-up: ADEM secondary to agency from administration of live virus flu vaccine to patient following interferon confusion, fever, coma, death. Contact hospital doctor for details.

Previous Vaccinations:

Other Medications: Peg Infron; Isoprinosine

Current Illness: SSPE

Preexisting Conditions:

Diagnostic Lab Data: MRI & LP at Clinic and Hospital

CDC 'Split Type':

14. 21-yr-old male – died 3 days after vaccination by military – FluMist vaccination probably was a causal factor – autopsy results missing

VAERS ID: 435707 (history) Vaccinated: 2011-09-22
Age: 21.0 Onset: 2011-09-25, Days after vaccination: 3
Gender: Male Submitted: 2011-09-26, Days after onset: 1
Location: Washington Entered: 2011-09-26

Vaccination	Manufacturer	Lot	Dose	Route	Site
FLUN3: INFLUENZA (SEASONAL) (FLUMIST)	MEDIMMUNE VACCINES, INC.	501096P	2	IN	

Administered by: Military Purchased by: Military

Symptoms: Chest pain, Death, Malaise, Resuscitation, Vomiting
SMQs:, Acute pancreatitis (broad), Gastrointestinal nonspecific symptoms and therapeutic procedures (narrow), Cardiomyopathy (broad)

Write-up: Member was given the Flumist on 09/22/2011. On 09/25/2011, member was feeling chest pain and not feeling well after dinner and going to the Club. Member was found down face in vomit by his friends. CPR was started and 911 activated. Paramedics arrived and continued CPR en route to Hospital where CPR was continued unsuccesfully. Member was pronounced dead at 0215 by Dr.

Life Threatening? No

Died? Yes
Date died: 2011-09-25
Days after onset: 0

Permanent Disability? No

Recovered? No

ER or Doctor Visit? No

Hospitalized? No

Previous Vaccinations:

Other Medications:

Current Illness: No

Preexisting Conditions: None noted

Diagnostic Lab Data: Autopsy has been ordered

CDC 'Split Type':

15. 2-yr-old female – died 1 day after vaccination – given infection with both influenza A and influenza B strains, FluMist vaccination definitely causal.

VAERS ID: 483215 (history) Vaccinated: 2013-01-16
Age: 2.0 Onset: 2013-01-17, Days after vaccination: 1
Gender: Female Submitted: 2013-02-01, Days after onset: 15
Location: Minnesota Entered: 2013-02-01

Vaccination	Manufacturer	Lot	Dose	Route	Site
FLUN3: INFLUENZA (SEASONAL) (FLUMIST)	MEDIMMUNE VACCINES, INC.	AL2156	3	IN	

Administered by: Private Purchased by: Private

Symptoms: Aspartate aminotransferase increased, Basophil count increased,Basophil percentage increased, Blood calcium decreased, Blood culture negative,Blood gases abnormal, Blood glucose increased, Blood lactic acid increased, Blood potassium increased, Blood pressure decreased, Blood pressure increased, Breath sounds abnormal, CSF culture negative, Convulsion, Cough, Death, Endotracheal intubation, Influenza, Influenza A virus test positive, Influenza B virus test positive,Lethargy, Lymphocyte count increased, Lymphocyte percentage increased, Malaise,Monocyte count increased, Monocyte percentage increased, Muscle twitching,Neutrophil percentage decreased, Oropharyngeal pain, Oxygen saturation decreased, Pharyngeal erythema, Postictal state, Pyrexia, Red blood cells urine positive, Respiratory failure, Respiratory rate decreased, Resuscitation, Rhonchi,Specific gravity urine increased, Sputum culture positive, Streptococcus test negative, Streptococcus test positive, Tonic clonic movements, Urine ketone body present, Urine odour abnormal, Viral infection, Vomiting, White blood cell count increased
SMQs:, Rhabdomyolysis/myopathy (broad), Liver related investigations, signs and symptoms (narrow), Anaphylactic reaction (narrow), Acute pancreatitis (broad), Angioedema (broad), Haematopoietic leukopenia (broad), Lactic acidosis (narrow), Hyperglycaemia/new onset diabetes mellitus (narrow), Neuroleptic malignant syndrome (broad), Systemic lupus erythematosus (broad), Anticholinergic syndrome (broad), Shock-associated circulatory or cardiac conditions (excl torsade de pointes) (broad), Torsade de pointes, shock-associated conditions (broad), Hypovolaemic shock conditions (broad), Toxic-septic shock conditions (broad), Anaphylactic/anaphylactoid shock conditions (broad), Hypoglycaemic and neurogenic shock

Life Threatening? No

Died? Yes
Date died: 2013-01-17
Days after onset: 0

Permanent Disability? No

Recovered? No

ER or Doctor Visit? No

Hospitalized? No

Previous Vaccinations:

Other Medications:

Current Illness: No The following information was obtained through follow-up and/or provided by the government. Family member w/ flu.

Preexisting Conditions: The following information was obtained through follow-up and/or provided by the government. 2nd hand cigarrette smoke exposure in home.

Diagnostic Lab Data: The following information was obtained through follow-up and/or provided by the government. 2/11/2013 lab/diagnostic records received for DOS 1/17-18/2013. Strep, blood cx (-). Blood: WBC 19.2 K/uL (H), neutros 38.1% (L), lymphocytes 45.2% & 8.7 K/uL (H), monocytes 9.9% & 1.9 K/uL (H), basophils 6.8% & 1.3 K/uL (H),

conditions (broad), Convulsions (narrow), Dyskinesia (broad), Dystonia (broad), Oropharyngeal conditions (excl neoplasms, infections and allergies) (narrow), Acute central respiratory depression (narrow), Guillain-Barre syndrome (broad), Noninfectious encephalitis (broad), Noninfectious encephalopathy/delirium (broad), Noninfectious meningitis (broad), Gastrointestinal nonspecific symptoms and therapeutic procedures (narrow), Hypertension (narrow), Generalised convulsive seizures following immunisation (narrow), Chronic kidney disease (broad), Hypersensitivity (broad), Tumour lysis syndrome (broad)

Write-up: Patient deceased. The following information was obtained through follow-up and/or provided by the government. 2/11/2013 ER records received for DOS 1/17/2013. Dx: viral syndrome. Pt w/ 2 day hx fevers, cough, sore throat, vomiting, 1 episode of feeling "droopy", foul smelling urine. PE: fever, mild erythema pharynx. Tx"d @ home w/ alternating ibuprofen & acetaminophen. D/c"d home w/ care & f/u instructions. 2/11/2013 ER records received for DOS 1/18/2013. Impression: 1) seizure, likely febrile in nature; 2) pulmonary failure w/ unsuccessful resuscitation efforts, suspect underlying fulminate influenza infection. Pt developed 1 min seizure. EMS activated. Upon arrival no longer seizing, pt transported to ER. PE: fever (102 F), postictal, lethargic, elevated BP, decreased air entry to lung bases. Tx"t: ice packs to neck & groin, acetaminophen, IVF. Temperature dropped to 99-100 F, lt foot began twitching, followed by tonic clonic activity. Tx"t: diazepam. Seizure activity lasted <1 min. Pt to be intubated & transferred for higher level care. BP dropping, respirations slowed, O2 sats 70-80%; followed by respiratory failure. Intubated, rhonchi noted, CPR performed. Lungs developed progressively more rhonchi. CPR stopped, death declared. 3/6 & 14/2013 autopsy report received for DOS 1/19/2013, DOD 1/18/2013. COD: seizure activity. Final Dx: clinical hx of seizure activity w/ associated respiratory arrest & death, febrile state 2^ to influenza.

End of audit

Ca 8.7 mg/dL (L), K 7.3 mEq/L (H), glucose 226 mg/dL (H), AST 96 U/L (H), lactic acid 2.9 mmol/L (H). UA: sp gravity $g1.03 (H), RBC 5-10 (H), ketones $g160 (H). Blood gas abnormal. 2/11/2013 autopsy lab/diagnostic records received for DOS 1/19-21/2013. Flu A/B (+). Lung cx (+) for gamma & alpha strep, gram + cocci. CSF cx (-).

CDC 'Split Type':

APPENDIX B

Definition of the Disease "FLU", What Influenza Vaccines Really Seem to Do for those Inoculated with Them, and Other Musings

Definition of the "FLU"

"FLU" is a disease defined by symptoms and the time of the year in which those symptoms are observed.

For example, using http://www.webmd.com/cold-and-flu/cold-guide/flu-cold-symptoms, pages "2" and "3" (emphasis added)

> "What are common flu symptoms?
>
> Flu symptoms are usually more severe than cold symptoms and come on quickly. Symptoms of flu include sore throat, fever, headache, muscle aches and soreness, congestion, and cough. Swine flu in particular is also associated with vomiting and diarrhea.
>
> Most flu symptoms gradually improve over two to five days, but it's not uncommon to feel run down for a week or more. A common complication of the flu is pneumonia, particularly in the young, elderly, or people with lung or heart problems. If you notice shortness of breath, let your doctor know. Another common sign of pneumonia is fever that comes back after having been gone for a day or two.
>
> Just like cold viruses, flu viruses enter your body through the mucous membranes of the nose, eyes, or mouth. Every time you touch your hand to one of these areas, you could be infecting yourself with a virus, which makes it very important to keep hands germ-free with frequent washing to prevent both flu and cold symptoms.
>
> Is it flu or cold symptoms?
>
> How do you know if you have flu or cold symptoms? Take your temperature, say many experts. Flu symptoms often mimic cold symptoms with nasal congestion, cough, aches, and malaise. But a common cold rarely has symptoms of fever above 101 degrees. With flu symptoms, you will probably have a fever initially with the flu virus and you will feel miserable. Body and muscle aches are also more common with the flu. This table can help determine if you have cold or flu symptoms.

Symptoms	Cold	Flu
Fever	Sometimes, usually mild	Usual; higher (100-102 F; occasionally higher, especially in young children); lasts 3 to 4 days
Headache	Occasionally	Common
General Aches, Pains	Slight	Usual; often severe
Fatigue, Weakness	Sometimes	Usual; can last 2 to 3 weeks
Extreme Exhaustion	Never	Usual; at the beginning of the illness
Stuffy Nose	Common	Sometimes
Sneezing	Usual	Sometimes
Sore Throat	Common	Sometimes
Chest Discomfort, Cough	Mild to moderate; hacking cough	Common; can become severe
…	…	…

> Usually, the time of year will give you some sense of what you're dealing with. The standard flu season runs from fall to spring of the next year."

Clearly "flu" is any disease exhibiting the preceding symptoms and, though the ***Web*MD** article does not use this terminology, a "flu" infection can be characterized as acute respiratory infection (ARI), as the cited paper does or as a respiratory-tract infection (RTI) or an upper respiratory-tract infection (URTI) as some others have done, which, in its initial phase, usually begins as a viral infection of some type in the respiratory tract.

Here, Dr. King's definitions are based on those implicit definitions provided in **1)** Cowling BJ, Fang VJ, Nishiura H, et al. Increased Risk of Noninfluenza Respiratory Virus Infections Associated with Receipt of Inactivated Influenza Vaccine. ***Clin Infect Dis.*** 2012 June 15; **54**(12): 1778-1783, which addresses influenza and noninfluenza virus infections, which collectively would be called "flu" cases, and Dr. King's view of the relative contribution of "influenza" infections to clinically reported "flu" cases is based on **2)** Doshi P, Influenza: marketing vaccine by marketing disease. ***British Med J. [BMJ]*** 2013; **346** doi: http://dx.doi.org/10.1136/bmj.f3037 (Published 16 May 2013), which seemingly establishes that, on average, no more than about 20% of "flu" cases are "influenza" infections.

From "**1)**", the disease "flu" can be defined as any acute respiratory infection (ARI) that is characterized by a patient's exhibiting two (2) or more of the following symptoms, "body temperature ≥37.8°C [≥ 99.5°F], cough, sore throat, headache, runny nose, phlegm, and myalgia [muscle pain/ache]".

Also from "**1)**", the "flu" (an ARI exhibiting the listed symptoms) can be caused by "influenza types A and B (including 2009-H1N1), RSV types A and B, parainfluenza types 1–4, metapneumovirus, rhinovirus, coxsackievirus/echovirus, adenovirus types B and E, bocavirus, and coronavirus types NL63, HKU1, 229E, and OC43" as well as possibly other viruses.

From "**2)**", on average, *no more than* about 20% of the "flu" cases in the USA each year seem to be caused by influenza viruses. [**Note**: If the influenza vaccines were effective, then, on average, the percentage of clinical cases identified as influenza infections would have declined over time as the percentage of the total population vaccinated has continued to rise since 1997, if not before; but that trend was not been seen in the data reported in "**2)**".]

In "**1)**", the identified noninfluenza viruses were rhinovirus, coxsackie/-echovirus, coronavirus, human metapneumovirus, parainfluenza, and respiratory syncytial virus (RSV) in the 20 flu cases in the double-blind randomly selected vaccinated group of 69 individuals and the 3 flu cases in the corresponding true-placebo-injected group of 46 individuals. [**Note**: Both of the groups each had three (3) cases of post-inoculation, laboratory-confirmed, influenza infection.]

Thus, influenza was and is a minor subset of the cases of “flu” that typically occur and are labeled “flu” in the “flu season” that starts in the Fall, usually in late September or early October of a given year and usually ends in late March to early April of the following year, although acute viral respiratory infections that exhibit the symptoms of “flu” do, in fact, occur year round at a lower incidence rate.

Given the preceding, there are NO “flu” vaccines, where, to be a “flu” vaccine, the vaccine would have to be made to provide protection from ALL of the viruses that have been found to cause the symptoms of “flu” in humans!

There are the “inactivated-influenza vaccines” that ONLY provide limited protection from getting influenza for a few (the three or, beginning in 2013, four strains in some vaccine formulations) strains of influenza A (two strains) and influenza B (one or, starting in 2013, 2014, two strains).

In addition, the inactivated-influenza vaccine has been found, in at least two studies, to increase the risk that those who are vaccinated with it will subsequently contract a noninfluenza viral respiratory infection (with a 3.4- to 4.0-fold higher risk in healthy children ages 6 to 15 years of age who were vaccinated as compared to a matched randomly selected similar group who were given a sterile saline (true placebo) injection in the double-blind study (“**1)**”).

In the double-blind, true-placebo-controlled study with 9 months of follow-up, the level of protection from influenza in the vaccinated group was small compared to the true-placebo group but the level of protection for “flu” was highly negative because the vaccinated group subsequently had 20 cases of a noninfluenza viral respiratory infection to 3 cases in the true-placebo group. Thus, the vaccine caused many more cases of “flu” (20 more) than it provided protection from “influenza” (correcting for the relative size of the groups, vaccination may have prevented “1 case” to, at most, “2” cases of influenza). In terms of the outcomes observed, influenza vaccination resulted in about “4” times as many cases of “flu” as would have been observed in a same-size placebo group.

Based on this study influenza vaccination caused a statistically significant increase in the cases of the “flu”!

For the live-virus influenza vaccine formulation to “work”, the person inoculated with it must first be infected by the now four (4), live, cold-adapted (genetically engineered) influenza virus strains (two “A” and two “B” strains) in the vaccine so that the person will, for a period of no more than a year, based on recommendations for an annual inoculation, have some protection against being re-infected by the covered vaccine strains of the influenza virus and some that are “closely related”. Therefore, the live-virus influenza vaccine does not protect most from getting a case of influenza when they are given it.

Thus, influenza vaccination probably causes more cases of "flu" each year than the number of cases of influenza it prevents even if the inactivated-influenza vaccines do slightly reduce the number of influenza cases in a year where there is a good match between the predominate circulating strains of influenza and those in all of the vaccine formulations.

False Advertising

For the Inactivated-influenza Vaccines

Now, everyone should understand that influenza vaccines appear to be intentionally mislabeled as "Flu Shots" to deceive the public into believing that they protect the public from getting the "flu" when, in fact, influenza inoculations are only labeled as providing some protection to some who are inoculated with them from some strains of influenza A and influenza B, which collectively seem to cause no more than 20 % of the cases of the "flu" annually.

Who, except those who were duped by the preceding misrepresentation would want to get a vaccine inoculation that provides no protection whatsoever from roughly 80% of the cases of the "flu"?

For the Live-virus Influenza Vaccine

For the live-virus influenza vaccine, there is no "shot" but rather a squirt of a liquid formulation of live influenza viruses up each nostril, which infects:

a. Most of those who are inoculated with it;

b. In some instances, some of those who are doing the inoculation or helping the inoculators; and

c. While those infected in "**a.**" and "**b.**" are shedding these four (4) live viruses for up to 21 days, some others with whom those who are directly or indirectly inoculated have contact

with now up to (4) strains of influenza.

From the viewpoint of "influenza", these vaccines are direct influenza-causing vaccines that would be contributing to the cases on influenza each year if they were properly counted. However, when viewed from the viewpoint of the "flu", the live virus vaccine provides little or no immediate protection from the "flu" because it causes influenza-derived "flu" in most all of those inoculated with it and, at best, it provides no protection from the other viruses that cause the "flu".

Truth in Advertising?

For the Inactivated-influenza Vaccines

So imagine if those pushing influenza vaccines had begun their advertising with the following factual simplistic assertions:

"Getting an influenza vaccination MAY protect some percentage of those inoculated with an inactivated-influenza vaccine each year from getting an influenza A or influenza B infection.

However, it does NOT provide any protection from the other viruses that are known to cause, on average, more than 80% of the cases of 'flu'.

In addition, influenza vaccination more than triples your risk of having a noninfluenza viral respiratory infection (a 'flu' case).

Finally, inactivated-influenza vaccine inoculation may cause a serious adverse reaction in some unknown percentage of those inoculated with it, which, in rare instances, may cause permanent disability and death."

How many would have wanted to get an inactivated-influenza vaccine inoculation?

Why, given the preceding realities, would anyone want one now?

For the Live-virus Influenza Vaccine

Imagine, after decades of the inactivated-influenza vaccines, introducing an advertising campaign for the live-virus influenza vaccines that begins with the following simplistic factual assertions:

"Getting an influenza vaccination MAY protect some percentage of those inoculated with an inactivated-influenza vaccine each year from subsequently getting an influenza A or influenza B infection but ONLY if you are initially infected by those influenza viruses, which, *in most instances*, will give you mild infections from three genetically engineered, cold-adapted influenza viruses that are most often non-invasive.

However, it does NOT provide any protection from the other viruses that appear to cause, on average, more than 80% of the cases of 'flu'.

In addition, how much the live-virus influenza vaccine inoculation increases your risk of having a noninfluenza viral respiratory infection (a 'flu' case) is NOT known.

Finally, live-virus influenza vaccine inoculation may cause a serious adverse reaction in some unknown percentage of those inoculated with it, which, in rare instances, may cause permanent disability and death."

How many would have wanted to get an live-virus influenza vaccine inoculation?

Why, given the preceding realities, would anyone want one now?

The Bottom Line

Clearly, influenza vaccines are not effective in protecting those inoculated with them from subsequently contracting the "flu" because they only protect some of those inoculated with them from some strains of influenza when more than 75% of the cases of "flu" are apparently caused by other than an influenza virus

Moreover, beyond being minimally to marginally protecting those who are vaccinated from subsequently getting influenza, all of the current influenza vaccines, inactivated and live-virus, are causal factors for cases of the "flu".

In the case of the inactivated-influenza vaccines we have an indication that vaccination with inactivated-influenza vaccines may cause more cases of noninfluenza-derived "flu" than it prevents cases of influenza-derived "flu".

In the case of the live-virus influenza vaccine, inoculation with the vaccine clearly causes almost everyone inoculated with it to contract a case of influenza-derived "flu" in order to protect some of them from catching one or more of the live influenza viruses in it again as well as causes these infected inoculees to shed live-virus that may infect others. Unfortunately, we do not know what the increased risk is, for those who have been inoculated with the live-virus, of their subsequently contracting a noninfluenza-derived "flu" as the randomized, double-blind, true-placebo-controlled study with 9 months of follow-up and rigorous identification of the causes for all acute respiratory infections does not appear to have been conducted.

However, based on the current understanding that the influenza vaccines do not protect from the noninfluenza "flu"-causing agents that account for the majority of the "flu" cases and the live-virus influenza vaccine cause influenza in most all inoculees,

- The current CDC-recommended influenza vaccination program should be stopped immediately, and
- All mandates, or recommendations, for giving the influenza vaccines to anyone should be immediately voided on the legal grounds that the current influenza vaccination program is apparently a health fraud.