Facility **A**utomation **M**anagement **E**ngineering Systems (*FAME* Systems)
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Friday, 22 August 2014

On 17 July 2014, Paul G. King, PhD, downloaded an on-line July 16, 2014 article, which was written by "*Markham Heid @markhamh*", titled "**Spacing Out Kids' Vaccines Can Hurt Their Health, Experts Say**", from http://time.com/2992222/spacing-out-kids-vaccines-can-hurt-their-health/.

Dr. King's response to that article follows these introductory remarks and two (2) "table of contents" pages.

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This assessment is titled, "**A Response to 'Spacing Out Kids' Vaccines Can Hurt Their Health, Experts Say'**".

Introductory Remarks

First, except for the "lead in", which is quoted in a grayed "Arial" font, each portion of the article's text is quoted in a grayed "Georgia" font.

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

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

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

Finally, should anyone find any significant factual error in this assessment 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 response.

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 assessment.

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A Response to
"Spacing Out Kids' Vaccines Can Hurt Their Health, Experts Say"

"All those shriek-inducing pokes may seem excessive but the rewards of following national vaccination guidelines far outweigh the risks, experts say"

Evaluation of the article's lead-in statement

In this article lead in, the writer, speaking for "*experts*" who appear to be unabashedly vaccination-supportive pediatricians and vaccination apologists, states, "*the rewards of following national vaccination guidelines far outweigh the risks*".

From the viewpoint of those pediatricians and vaccination apologists, Dr. Paul G. King, PhD, would agree that the compliance reinforcement rewards and increased medical visits to pediatricians and others, who provide care and medical products for our children, which accrue to those "*experts*" when parents are "*following national vaccination guidelines*", do "*far outweigh*" the non-existent risks that those vaccine proponents bear.

For such "experts", the "*rewards of following national vaccination guidelines far outweigh the risks*" because they are protected from being held liable for the adverse outcomes that may occur to those who are vaccinated by provisions in the National Vaccine Injury Compensation Program (NVICP) that was enacted in 1986 and is codified in 42 U.S.C. §§ 300aa-10 through 300aa-34.

However, remembering that the serious adverse outcomes[1] from vaccination reported in the Vaccine Adverse Events Reporting System (VAERS) database underestimate the true incidences by 90% to 99%, in 2012, the number of serious adverse-event reports was 595 (see **Table 1**).

Of those 595 reports, 353 (59.33%) of the serious adverse events occurred in those under three (3) years of age and 250 (42.02%) occurred in those under one (1) year of age.

Table 1 Serious Adverse Event Reports, in VAERS, for 2012

Event Category	< 18 Yrs of Age	< 3 Yrs of Age	< 1 Yrs of Age	% All (% < 1yr)
Total Deaths	65	56	47	10.92 (7.90)
Total Life Threatening	125	60	43	21.01 (7.23)
Total Permanent Disability	43	22	12	7.23 (2.02)
Total Hospitalized	340	204	142	57.14 (23.87)
Total Prolonged Hospitalized	22	11	6	3.70 (1.01)
OVERALL TOTAL	595	353	250	100.00 (42.02)

Based on that number of reports, between 5,950 and 59,500 serious

[1] In general, the serious adverse reactions include, life threatening reactions, hospitalization, prolonged hospitalization, permanent disability, and death).

post-vaccination adverse events occurred in 2012, including somewhere between approximately 650 and 6,500 post-vaccination-related deaths.

Turning to the infant mortality for the approximately four-million live births in 2012 ("3,952,841 registered live births"[2]), the reported 2014 estimate for infant mortality in the United States of America (USA) was 6.17 per 1,000 live births[3], which implies there were about 24,390 deaths, or 23,910 deaths, based on preliminary 2011 data[4] where the estimate for infant mortality was 6.05 deaths per 1,000 live births (for about 3,952,000 live births).

Presuming that the average of the preceding deaths of infants less than one year of age, 24,150, is an adequately accurate estimate for 2012, then the estimated range of vaccination-related deaths in infants less than one (1) year of age, 470 to 4,700 deaths, translates into 1.9% to 19% of the infant deaths in the first year of life.

Based on the preceding realities, for the families of the 1.9 to 19% of the newborns who were vaccinated in 2012 and, as a reported consequence of that vaccination, died before their first birthday, the "*the rewards of following national vaccination guidelines*" clearly did not outweigh the reality that those infants received no benefit from being vaccinated.

In addition, the hundreds[5] (estimated to be between 120 to 1,200 infants, but more probably between 600 and 1200) who reportedly were permanently disabled by a vaccination before their first birthday also received a life-long negative benefit.

In addition, the "rewarded" families also include the parents of the between 1,910 and 19,100 infants who had some other serious acute post-vaccination adverse event as well as those families of the unknown thousands who will later develop some long-term chronic disease condition caused by immune-system dysregulation, which seem to be affecting more than 25% of our children today, may have received negative rewards from "*following national vaccination guidelines*".

Furthermore, when the vaccines administered are live-virus-containing vaccines, most all of the millions of babies born each year who are vaccinated with them are abnormally infected with the selected vaccine strain(s) of the live virus(es) as well as with any adventitious viruses that may be present in such vaccines.

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2 http://www.cdc.gov/nchs/data/nvsr/nvsr62/nvsr62_09.pdf, Martin JA, Hamilton BE, Osterman MJK, et al. Births: Final Data for 2012. *National Vital Statistics Reports* 2013 Dec 30; 62(9): 1-87; page1, last accessed on 7 July 2014,

"Highlights

A total of 3,952,841 births were registered in the United States in 2012, slightly fewer births (749) than in 2011. …."

3 https://www.cia.gov/library/publications/the-world-factbook/rankorder/2091rank.html, last accessed on 17 July 2014.

4 http://mchb.hrsa.gov/chusa13/perinatal-health-status-indicators/p/infant-mortality.html, last accessed on 17 July 2014.

5 Based on estimates of the level of underreporting in VAERS, which increases with condition severity, the estimated number of permanent disabilities is between 120 to 1,200 infants, but it is more probably between 600 and 1200 infants in 2012 alone.

Moreover, through shedding by the vaccinees, all of the live viruses present in such vaccines can infect others.

Not to be outdone, *when the vaccine is an inactivated-virus or other disease-related antigen*, vaccination of our children with these vaccines apparently alters the immune system's function in such a manner that subsequently increases the inoculees' risk for contracting clinical infections[6,7] from:

- Related organisms,
- Other unrelated organisms that can occupy the biological niche formerly occupied by the vaccine-targeted organism(s), and/or
- Mutated strains of the very disease organism(s) against which disease protection is sought.

Therefore, based on a realistic assessment of the theoretical benefits and the very real risks associated with the current recommended vaccination schedule in the United States of America (USA), the touted benefits of vaccination, which accrue to only some percentage of those who are not harmed by them, certainly do not, as claimed, "*far outweigh the risks*".

"'Like any parent, I don't like to see my child get a shot,' says Dr. Michael J. Smith, a pediatrician at the University of Louisville who has studied immunizations and developmental health outcomes among kids. 'But these vaccine schedules are in place for a reason.' Smith compares skipping or postponing one of your child's vaccinations to not buckling him or her in during a car ride. 'You never know when you're going to get hit. And if you delay or space out your child's shots, not only are you putting your kids at risk, but you're [also] putting other people's kids at risk too.'"

Lack of vaccination schedule justification, a false analogy and misplaced blame for vaccination-program failures

First, Dr. King, a PhD Analytical Chemist, observes that even immunologists have recognized that injected vaccine inoculations given to developing children before they are developmentally one (1) year of age generally do not provide long-term disease protection.

This is the case because the infants' adaptive immune system has not sufficiently matured when the infant is less than one (1) year of developmental age.

Second, these same immunologists also recognize that, at best, vaccine inoculations only provide limited-duration disease protection to some percentage of those inoculated multiple times with the current vaccine types — they do not provide disease "immunity".

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6 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.

7 http://dr-king.com/docs/120806_PGKDrftRevu_Anti_vaccineMovementCausesTheWorstWhoopingCoughEpidemicIn70Yrs_fnlr2b.pdf.

However, those who are vaccine apologists and acolytes continue to use the term "immunization" as if, *though it is not*, its connotative meaning was the same as "vaccination".

This is the case because "immunization" implies "lifetime immunity from disease", a promise that not even the manufacturers of the current prophylactic ("disease protective") vaccines make.

Still, even pediatricians (who, like Dr. Smith, claim to have "*studied immunizations and developmental health outcomes among kids*") continue to go along with a vaccination schedule that administers multiple doses of multiple vaccines by injection before the child is one-(1)-year old.

Yet, they know, should know, or are responsible for knowing that such vaccine inoculations do not provide long-term protection from disease or, *when the vaccine is a live-virus vaccine*, from infection recurrence.

With respect to Dr. Smith's, "*But these vaccine schedules are in place for a reason*", in light of the preceding realities, Dr. King would welcome a scientifically sound immune-science-based explanation for the universal childhood vaccination schedule in the USA for:

- Hepatitis B vaccine (at birth, and 2 and 6 months of *physical* age) when most infants have zero risk of being infected by the hepatitis B virus and, *with pre-birth testing of their mothers*, the few infants who may be at risk can be easily identified and the post-vaccination risks, including death and permanent disability, in those children 18 months of age and younger seem to far outweigh the theoretical benefits from vaccination[8];
- DTaP (diphtheria, tetanus and acellular pertussis) vaccines (at 2, 4 and 6 months of *physical* age) where there are virtually zero notified cases of diphtheria and, *if infected*, there are antibiotics that are effective; the pertussis components in the vaccine have been proven not to be effective in providing durable protection against whooping cough, and vaccination on this schedule with this vaccine or the older, better studied, DTP vaccines significantly contributes to the vaccinated children's subsequent risk of developing asthma[9] or suddenly dying (historically, diagnosed as SIDS [sudden infant death syndrome] or, more recently as SIDS or SBS

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8 http://www.thinktwice.com/hepb.htm, apparently from 2010 based on the copyright date at the bottom of this web page, last accessed on 31 July 2014.

9 McDonald KL, Huq SI, Lix LM, Becker AB, Kozyrskyj AL. Delay in diphtheria, pertussis, tetanus vaccination is associated with a reduced risk of childhood asthma. *J Allergy Clin Immunol*. 2008 Mar; 121(3): 626-631. doi: 10.1016/j.jaci.2007.11.034. Epub 2008 Jan 18. http://www.ncbi.nlm.nih.gov/pubmed/18207561.

[shaken baby syndrome])[10];

- Hib (*Haemophilus influenza*e type b) vaccine (at 2, 4, 6 and 12 through 15 months of *physical* age) where the early doses provide no durable protection and the vaccine favors the observed increases in non-type B infections (see CDC's annual "Summary of Notifiable Diseases" reports that are published in the CDC's journal ***Morbidity and Mortality Weekly Report*** [***MMWR***] with a current delay of about 1.5-plus years after the year of interest);
- Inactivated polio vaccine (at 2, 4, and 6 through 18 months of *physical* age) in a nation where there have been no reported instances of paralytic polio in native-born infants since the late 1990s when the use of the live-virus paralytic-polio-causing oral poliovirus vaccine was abandoned in the USA;
- Two (2) quadrivalent meningococcal meningitis vaccines and one (1) divalent meningococcal meningitis plus Hib vaccine (at 2 months of *physical* age and older) where the vaccines provide no protection for the B serogroup disease which is the most common infectious *Neisseria meningitidis* agent in young children, the total number of cases from all serogroups is less than 1,000 a year even though 10-15% of the population carry one or more serogroups of viable *N. meningitidis* in their nasal and/or pharyngeal mucosa, and the protections provided miss at least 15% of those inoculated and they do not last;
- Two types of rotavirus vaccines (one at 2 and 4 months of *physical* age and the other at 2, 4, and 6 months of *physical* age) where the risk of life-threatening intussusception after inoculation appears to be several times that risk in natural disease cases (*before these vaccines were introduced, clinical cases of rotavirus were so uncommon [and naturally declining] that rotavirus has not been classified as a CDC-notifiable disease and, without having a clinical infection, most children were immune from rotavirus infection by five years of age*), and the price of the current vaccines makes universal vaccination not truly cost-effective in the USA except, perhaps, on Indian reservations and in inner-city slums, where sanitation and hygiene are compromised;

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10 See "131 Ways For An Infant to Die" by Neil Z. Miller, posted on 4 July 2014 at http://www.greenmedinfo.com/blog/131-ways-infant-die.

- Inactivated-influenza vaccines (at 6 and 7 months of *physical* age) where the studies show no real protective effect from vaccination of children under two years of age[11] and, based on a recent randomized, double-blind true-placebo-controlled clinical trial with nine (9) months of follow-up, those who received the inactivated-influenza vaccine had more than three (3) times the risk of developing a non-influenza viral respiratory illness than those who received a sterile saline placebo injection[12],[13];
- First MMR (measles, mumps, and rubella) live-virus vaccine (at 12 to 15 months of *physical* age) where there is both outcome[14] and legal[15] evidence that the mumps component fails to provide durable or adequate protection against mumps;
- First varicella live-virus vaccine (at 12 to 15 months of *physical* age), where there is strong evidence that this vaccination program is neither effective in preventing chickenpox or recurrence as shingles nor population cost-effective; and
- Hepatitis A vaccine (at 12 months of *physical* age) where the disease risk in young children is minimal in most of the USA,

which are either recommended to be given to all children before they are 12 *physical* and *developmentally* months of age or, *in the case of the MMR, varicella and hepatitis A vaccines*, recommended to be given to all children at 12 *physical* months of age and are, or can be, given to children before they are *developmentally* one (1) year of age.

Furthermore, Dr. Smith's disingenuous "seatbelt" analogy is fatally flawed.

This is the case because, *unlike seat-belt-buckling*, the act of vaccine inoculation is usually a bodily invasive medical procedure that carries with it the risk of not only serious adverse consequences, including permanent disability and death, but also the risk of long-term, chronic-disease-inducing, developing-immune-system damage.

Finally, with respect to Dr. Smith's assertions,

"'*… if you delay or space out your child's shots, not only are you putting your kids*

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11 Jefferson T, Rivetti A, Di Pietrantonj C, Demicheli V, Ferroni E, Vaccines for preventing influenza in healthy children (Review). The Cochrane Library (http://www.thecochranelibrary.com) in *Cochrane Library* 2012, Issue 8, http://www.update-software.com/pdf/CD004879.pdf.

12 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, http://cid.oxfordjournals.org/content/54/12/1778.full.

13 http://dr-king.com/docs/20140122_InfluenzaVaccines_VaccinationPrograms_Unsafe_NotEffective_IllnessCausing_Final_b.pdf.

14 Dayan GH, Rubin S, Plotkin S. Mumps Outbreaks in Vaccinated Populations: Are Available Mumps Vaccines Effective Enough to Prevent Outbreaks? Clin Infect Dis. (2008) 47 (11): 1458-1467. doi: 10.1086/591196. [http://cid.oxfordjournals.org/content/47/11/1458.full.]

15 See http://www.rescuepost.com/files/june-mumps-suit.pdf, last accessed on 24 July 2014.

at risk, but you're [also] putting other people's kids at risk too.'"

Dr. King knows of no studies that substantiate the first vaccination delay or spacing claim that you are "…*putting your kids at risk*, …".

In addition, Dr. King has found studies that show that delaying the kids' first DTP vaccination reduces the kids' risk of developing asthma[16] as well as their risk of dying[17].

Turning to Dr. Smith's other unsupported claim, "*but you're [also] putting other people's kids at risk*", Dr. King simply notes that those recently vaccinated with a live-virus vaccine can and do shed live virus for periods of up to 28 days, which can and does infect others.

Therefore, since most children are vaccinated (> 80%), those who have been recently vaccinated are a much more likely to be "*putting other people's kids at risk*" from being infected by the live viruses with which they have been vaccinated than the < 2% who have not been vaccinated because they or, if they are minors, their parents have medical, religious and/or philosophical exemptions from vaccination, unless they have recently returned from visiting a country where some viral disease is endemic or in which outbreaks were occurring.

Moreover, there is increasing evidence that vaccination with inactivated and artificial-particle vaccines induces increases in infection of those who have been inoculated and serve to spread these related diseases (see, for example, footnotes "**12**" and "**13**").

Thus, *if anyone*, it is the vaccinated who are "*putting other people's kids at risk*" – not the unvaccinated or, *more accurately*, the infection-spreading and infection-inducing outcomes of the current live-virus vaccination programs are "*putting other people's kids at risk*" of infection.

"The urgency of Smith's warnings are [sic; is] borne out in the recent outbreaks of measles and pertussis, diseases that had been almost totally eradicated in the U.S. but have made a frightening comeback since the turn of the century—right around the time two now-discredited scientific papers suggested a possible link between vaccines and autism."

Misrepresentations about measles and pertussis outbreaks

This article's assertions concerning "*diseases that had been almost totally eradicated in the U.S.*" are, *at best*, factually inaccurate.

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16 McDonald KL, Huq SI, Lix LM, Becker AB, Kozyrskyj AL. Delay in diphtheria, pertussis, tetanus vaccination is associated with a reduced risk of childhood asthma. *J Allergy Clinical Immunol* 2008; 121: 626-631.

17 For an in-depth report supporting giving the initial dose at 2 years of age, see "131 Ways For An Infant to Die" by Neil Z. Miller as posted on 4 July 2014 at http://www.greenmedinfo.com/blog/131-ways-infant-die, and the primary references cited in that paper regarding the changes in SIDS cases and infant mortality in Japan when the recommended age for the pertussis-components-containing vaccine was changed from two (2) months to two (2) years, "23. Noble GR., et al. Acellular and whole-cell pertussis vaccines in Japan: report of a visit by U.S. scientists. *JAMA* 1987; 257: 1351-1356. 24. Cherry JD., et al. Report of the task force on pertussis and pertussis immunization. Pediatr (Jun 1988); 81(6): 933-984. 25. Congressional Budget Office. Factors contributing to the infant mortality ranking of the United States. CBO Staff Memorandum (February 1992): Table 2, International Infant Mortality Rates by Ranking.

This is the case because, in spite of adding doses of DTP or the safer DTaP vaccine, which now include multiple doses of a Tdap vaccine after seven (7) years of age, "*pertussis*" cases in the USA have actually increased since 1981; exceeded six-thousand cases annually in 1996; and surpassed 48,000 CDC-notified cases in 2012.

Likewise, measles outbreaks have been increasing in an oscillatory pattern as explained by Heffernan and Keeling (2009)[18] because of the failure of the measles vaccine component of the MMR vaccine to provide long-term disease protection from measles infection to most who have been doubly inoculated with the MMR vaccine.

Moreover, Poland et al. (2011)[19] confirmed the deficiency in long-term measles-protection for most who were inoculated with measles-containing live-virus vaccines.

In addition, Dr. Obukhanych[20], a PhD Immunologist, has clearly shown that not only does vaccination not provide herd immunity but also that, *in specific*, the live-virus measles vaccine component does not provide those vaccinees with long-term disease protection from clinical measles re-infection.

Turning to the article's assertion concerning "*a possible link between vaccines and autism*",

> "*since the turn of the century—right around the time two now-discredited scientific papers suggested a possible link between vaccines and autism*",

Dr. King cannot address "*two now-discredited scientific papers*", which the article's author , "*Markham Heid*", does not identify and which he claims are "*now-discredited*".

However, Dr. King again notes that the first paper that he has found that suggested a possible link between vaccination and the subsequent development of classical autism (Kanner autism) outcome in a child was published in 1976[21] and, *as far as King can ascertain*, that

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18 Heffernan JM, Keeling MJ. Implication of vaccination and waning immunity. *Proc R. Soc. B* 2009; 276: 2071-2080, last accessed on 6 July 2014, accessible at http://royalsocietypublishing.org/content/276/1664/2071.full.

19 Poland GA, Kennedy RB, Ovsyannikova IG. Vaccinomics and Personalized Vaccinology: Is Science Leading Us Toward a New Path of Directed Vaccine Development and Discovery? *PLoS Pathog* 2011 Dec; 7(12): e1002344. http://doi:10.1371/journal.ppat.1002344.

20 Obukhanych, T. Herd Immunity: Myth or Reality?, which was posted at http://www.greenmedinfo.com/blog/herd-immunity-myth-or-reality?utm_source=Master+List&utm_campaign=004c39a42d-Greenmedinfo&utm_medium=email&utm_term=0_af50e1f25a-004c39a42d-87637245, which was last accessed on Sunday, June 29, 2014. The sections of that article titled, "The Boston University Measles Study", "Subsequent Measles Vaccine Observations" and "High Vaccination Compliance Is No Guarantee" clearly establish that, *for vaccination-generated measles antibody protection*, "herd immunity" cannot be attained with today's two-dose MMR vaccination schedule. Moreover, in the closing section of that article, "A Self-Defeating Public Venture", Dr. Obukhanych closes by stating,

> "The medical establishment got it all in reverse: it is not vaccine-exempt children who endanger us all, it is the effects of prolonged mass-vaccination campaigns that have done so. When would the medical establishment (and the media) start paying attention to the long-term consequences of mass-vaccination measures instead of hastily and unjustifiably blaming every out-break on the unvaccinated?"

21 Eggers C. [Autistic syndrome (Kanner) and vaccination against smallpox (author's transl)]. *Klin Padiatr*. 1976 Mar; 188(2): 172-180 [German] (emphasis added),

"Abstract

scientific paper, a detailed case report[22], has not been discredited.

"Dozens of subsequent studies have demonstrated there are no links between vaccinations and autism. But while stats show most parents understand the importance of immunizing their kids, research from the University of Michigan indicates plenty of moms and dads—roughly 1 in 4—worry that current immunization guidelines may overburden their babies' tiny immune systems."

Additional misrepresentations and distortions

With respect Markham Heid's next assertion,

"*Dozens of subsequent studies have demonstrated there are no links between vaccinations and autism*",

where the embedded link provided by Mr. Heid is to a ***Time*** magazine article, http://time.com/2942664/childhood-vaccines-are-safe-says-pediatrics-group/, not even to the published paper, Dr. King simply reports the following facts:

1. Public health officials, federal administrative arbitrators in what is euphemistically called the "vaccine court" in the USA and judicial courts outside the USA have recognized that vaccination-induced brain inflammation can, *in some instances*, lead to an affected child's being subsequently diagnosed with "*autism*".
2. Turning to the VAERS database, jointly maintained by the CDC and the U.S. Food and Drug Administration (FDA)], Dr. King has noted and, *reported on*[23], instances linking vaccination with a subsequent search (costart) term for "Autism" in the VAERS report entries from inoculations in August of

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3-4 weeks following an otherwise uncomplicated first vaccination against smallpox a boy, then aged 15 months and last seen at the age of 5 1/2 years, gradually developed a complete Kanner syndrome. The question whether vaccination and early infantile autism might be connected is being discussed. A causal relationship is considered extremely unlikely. But vaccination is recognized as having a starter function for the onset of autism".

22 This appears to be the first published "Kanner autism" case study of a male who was healthy at birth and developing in a nearly normal manner until 15 months of age).

Then, *at 15 months of age*, this male was given a smallpox inoculation and had no immediate serious negative reaction to it. However, three to four weeks later, his parents noticed he had lost all interest in his surroundings and them.

This boy became totally self-absorbed and continued to regress until, by 2.5 years of age, he lost all language and developed the other symptoms of what, at the time, was called Kanner autism.

With intensive holistic psychosomatic therapy (speech therapy, respiratory therapy, body self-awareness, body boundary training, and space relationship and perception training, at about 3 years of age, he began to speak again (described as "echolalia").

With continuing interventions, *by five and a half years of age at his last follow-up prior to this published case report*, although his behaviors and language had improved, he was still diagnosed with an autistic behavior disorder (Kanner autism), and his language was not yet age-appropriate (still at the level of a typical 3- to 4-year old).

Therefore, this article appears to be the first published case report of an instance of regressive autism, which was apparently triggered by a smallpox vaccination.

23 http://dr-king.com/docs/20130606_DrftRevuOf_Sticking_with_the_truth_b_r1.pdf, see "Table 1 VAERS Case Reports In Young Children (1 to 8 years of age) Receiving the MMR Vaccine and Later Being Diagnosed with Autism or a Related Neurodevelopmental Disorder (e.g., ASD or PDD,) from 19 Aug. 1988 through 15 Jan. 1997", page "3".

1988 onward.

3. Clearly, *based on point "**2.**"*, public health officials in the CDC and the FDA have accepted that vaccination can trigger adverse effects, including brain inflammation, which can result in some children's being given an "*autism*" diagnosis.
4. As shown in an Excel file[24], containing more than 165 entries, *which is posted on the web site*, Thimerosal-preserved vaccines and Thimerosal-containing solutions, delivering doses of Thimerosal in the range of 25 to 50 microgram per 0.5-mL dose in humans or the weight-adjusted equivalent in animals, or at tissues levels down to 0.01 micrograms of Thimerosal (or an equivalent level of an ethylmercury compound) per gram (g) of tissue or milliliter (mL) of cell culture medium, have been shown to:
    a. Cause the symptoms used to diagnose "*autism*" and other developmental disorders and/or impairments in humans, animals, and cell/tissue cultures, and/or
    b. Be neurotoxic at levels down to 0.01 microgram of Thimerosal exposure per g of tissue or mL of cell-culture medium.

    Finally, *in various epidemiological studies of Thimerosal-preserved-vaccine exposures*, a statistically significant association has been established between the level of Thimerosal-exposure in developing children and a subsequent increased risk that the Thimerosal-exposed children will be diagnosed with autism or some other neurodevelopmental, developmental or behavioral disorder[25].
5. Other peer-reviewed publications have established that the symptoms that are associated with autism are essentially the same indications as the symptoms associated with low-level mercury intoxication[26,27].
6. Three (3) independent peer-reviewed published studies evaluating datasets from the VAERS database and/or the "open" part of the CDC's Vaccine Safety Datalink (VSD) database have clearly established a statistically significant, causal

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24 http://mercury-freedrugs.org/docs/20140329_Kern_JK_ExcelFile_TM_sHarm_ReferenceList_v33.xlsx.

25 In some of those epidemiological studies, the subsequent risk of an adverse outcome (diagnosis with autism and other neurodevelopmental, developmental or behavioral disorders) was dependent upon the cumulative Thimerosal (organic mercury) dose to which the children were exposed.

26 http://www.ncbi.nlm.nih.gov/pubmed/19106436. Geier DA, King PG, Sykes LK, Geier MR. A comprehensive review of mercury provoked autism. *Indian J Med Res*. 2008 Oct; 128(4): 383-411.

27 http://www.ane.pl/linkout.php?pii=7212. 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.

linkage between children's exposure to Thimerosal-preserved vaccines and those exposed children's risk of later receiving an "*autism*" diagnosis,

a. "A two-phased population epidemiological study of the safety of thimerosal-containing vaccines: a follow-up analysis"[28],

b. "Thimerosal exposure in infants and neurodevelopmental disorders: an assessment of computerized medical records in the Vaccine Safety Datalink" database[29], and

c. "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"[30].

In addition, a recent independent peer-reviewed published study, "Methodological Issues and Evidence of Malfeasance in Research Purporting to Show Thimerosal in Vaccines Is Safe"[31], has established that the key non-independent published epidemiological studies[32] have significant methodological issues and evidence of scientific malfeasance.

Collectively, the preceding facts combine to establish that there is a causal linkage between the children's Thimerosal exposure from Thimerosal-preserved vaccine inoculations (vaccinations) and their subsequent risk of receiving a diagnosis of "*autism*".

Thus, Heid's generalization, "*there are no links between vaccinations and autism*", is clearly false.

Turning to Heid's assertion (emphasis added),

"*research from the University of Michigan indicates plenty of moms and dads—roughly 1 in 4—worry that current immunization guidelines may overburden their babies' tiny immune systems*",

Dr. King observes that the main parental concern is, *as it should be*, whether the current vaccination programs are actually **safe for their children** — an issue that Heid avoids addressing here — or, *as writer*

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28 http://www.ncbi.nlm.nih.gov/pubmed/15795695. 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 Apr; 11(4): CR160-CR170. Epub 2005 Mar 24.

29 http://www.ncbi.nlm.nih.gov/pubmed/18482737. 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 Aug 15; 271(1-2): 110-118. doi: 10.1016/j.jns.2008.04.002. Epub 2008 May 15.

30 http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3878266/. 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. *Transl Neurodegener*. 2013 Dec 19; 2(1):25 (12 pages). doi: 10.1186/2047-9158-2-25.

31 http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4065774/pdf/BMRI2014-247218.pdf. Hooker B, Kern J, Geier D, Haley B, Sykes L, King P, Geier M. Methodological Issues and Evidence of Malfeasance in Research Purporting to Show Thimerosal in Vaccines Is Safe. *Biomed Res Int*. 2014; 2014: 247218 (8 pages). Epub 2014 Jun 4.

32 These key conflicted published epidemiological studies are those publications: **a)** in which the CDC and/or the vaccine industry were involved and **b)** upon which the CDC, the FDA, the U.S. Department of Health and Human Services (HHS), the Institute of Medicine (IOM), and the Autism Omnibus proceedings in the "vaccine court" relied or rely to support their contention that there is no Thimerosal-preserved vaccine/autism linkage).

Alice Park put it in the ***Time*** *article, http://healthland.time.com/2011/10/03/more-than-1-in-10-parents-skip-or-delay-vaccines/ (with emphases added),*

> "… one in four who do adhere to current guidelines say they still feel that it may not be the best or safest way to immunize youngsters".

Moreover, the cited article confirms that safety was the most important issue in a passage that states (with emphases added),

> "Similarly, even parents who followed the CDC's immunization guidelines said they had doubts about the safety of the schedule, with 22% reporting that they disagreed or strongly disagreed that the plan was the best one to follow. A similar percentage believed that delaying vaccines was also safer than currently recommended dosing plans."

Furthermore, noting that this 2011 article is slightly dated, Dr. King found a 2013 slide presentation[33] given by Dennis Cooley, MD, FAAP in which Dr. Cooley presented a survey of parents' *safety* concerns in slide "12", titled, "PARENTAL CONCERNS", as follows:

"
- Too Many 36%
- Autism 30%
- Fevers 30%
- Unsafe ingredients 25%
- Not tested enough 15%
- Causes the disease 15%"

which cited "SOURCE: OPEL 2012", a survey whose results do not appear to have been published in a PubMed-reviewed publication.

Based on the preceding responses, it appears that, *depending on how the exact survey questions were phrased*, parents had a 15% to 36% concern (about 25.7% on average) about some aspect of the safety of the CDC-recommended vaccinations in the 2012 schedule.

This survey indicated that, *if anything*, the parental concerns about vaccine safety had increased from the 2011 level.

Furthermore, based on Dr. King's understanding of the current vaccination program[34,35,36], each of the parental concerns is a valid vaccine safety issue.

In addition, the current CDC-recommended vaccination programs do not "immunize" the children who are age appropriately vaccinated against the diseases for which disease protection is claimed.

Factually, *as the package inserts for the vaccines provided by the manufacturers of the current FDA-approved, CDC-recommended vaccines represent*, the manufacturers of these vaccines only claim that their vaccines provide some level of disease protection[37] to some

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33 http://www.kdheks.gov/immunize/2013_conference/dr_cooley--vaccinehes_10_14.13.pdf, last accessed on 21 July 2014.

34 http://dr-king.com/docs/130306_DrftRevu_Of_ForegoingImmunization___final_b.pdf.

35 http://dr-king.com/docs/20140416__Revu_ADoctor_sTakeOnTheAnti_VaccineMovement_final_b1.pdf.

36 http://dr-king.com/docs/20140716_Respnseto_ThankGodForVaccines_byDr_EmilyGibson_fnl_b_.pdf.

37 The level of disease protection is typically measured by some antibody-titer test (except for pertussis

percentage of those inoculated with them for some comparatively short period[38].

"The Centers for Disease Control and Prevention (CDC) currently recommend [sic; recommends] that all healthy babies be vaccinated against 12 different diseases or viruses during the first two years of life. That's compared to eight back in the early 1990s. Recently added to the list are vaccinations against potentially deadly illnesses like hepatitis and chicken pox.

But while the number of vaccines (and needle pricks) has grown during the last two decades, the amount of antigen in those shots, which is the substance that triggers a response from your child's immune system, has plummeted, Smith explains. "The actual burden on your child's immune system is far lower that it was 10 or 20 years ago, even though kids now receive more shots," he says. That's credited to advances in protein science and a better understanding of the way diseases and children's immune systems interact."

Recommended vaccines: misrepresentations and distortions

First, Mr. Heid's,

> "*… recommends that all healthy babies be vaccinated against 12 different diseases or viruses during the first two years of life.*",

is both incorrect and misleading.

Factually, as of 2014, the CDC currently recommends that "*all healthy babies*" be prophylactically vaccinated against clinical infection by **15** different disease organisms,

1. *Corynebacterium diphtheriae* (by means of vaccines containing a specific diphtheria toxoid antigen derived from killed *Corynebacterium diphtheriae* bacteria);
2. *Clostridium tetani* (by means of vaccines containing a specific tetanus toxoid antigen derived from the work-up of killed cultures of *Clostridium tetani* bacteria);
3. *Bordetella pertussis* (one cause of whooping cough; by means of vaccines containing multiple antigenic substances, including pertussis toxoid, derived from the killed cultures of *Bordetella pertussis* bacteria [**note**: there are four {4} human-infective species of *Bordetella*]);
4. *Haemophilis influenzae* type B (by means of vaccines which contain a protein-conjugated polysaccharide outer cell coating derived from the killed culture of *Haemophilis influenzae*

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38 [whooping cough], where some indirect assessment has been made).
Specifically, the durations of the disease protections provided by vaccination are short relative to the protection durations that are provided to those developing children who age-appropriately naturally contract the childhood contagious diseases (for which there is an FDA-approved vaccine and a CDC-recommended vaccination schedule) and naturally recover from those childhood diseases.

type B bacteria, one (1) of several human-infective types of *Haemophilis influenza* [**note:** there are six {6} generally recognized types of encapsulated *H. influenzae*: a, b, c, d, e, and f, and numerous non-encapsulated strains]);

5. Hepatitis B virus (by means of vaccines containing bioengineered hepatitis B surface antigen particles derived from the killed cultures of yeast cells that have been bioengineered to produce those particles);
6. Poliovirus (by means of vaccines containing a combination of three (3) types of inactivated poliovirus, where each type is derived from the workup of lysed polio-type-infected Vero cells, a continuous line of monkey kidney cells);
7. Measles virus (by means of vaccines containing a live measles virus strain isolated from the chicken embryo cell culture in which it was grown);
8. Mumps virus (by means of vaccines containing a live mumps-causing virus strain isolated from the chicken embryo cell culture in which it was grown);
9. Rubella virus (by means of vaccines containing a live rubella virus strain isolated from the WI-38 human diploid lung fibroblasts in which it was grown);
10. *Streptococcus pneumoniae* (by means of vaccines containing protein-conjugated polysaccharide coat entities for 13 specific strains or as polysaccharide coat entities for 23 strains of the killed *Streptococcus pneumoniae* cultures from which these polysaccharides are isolated [**note:** there more than 100 human-infective strains]);
11. *Neisseria meningitidis* (by means of vaccines containing the polysaccharide coat or the protein-conjugated-polysaccharide coat from four [4] strains [A, C, Y, and W-135] or protein-conjugated-polysaccharide coat from two [2] strains [C and Y] of killed *N. meningitidis* cultures from which these polysaccharides are isolated [**note:** there nine [9] human-infective strains]);
12. Alphaherpes varicella zoster virus (VZV) (by means of vaccines containing a live VZV strain derived from the work-up of the final cell cultures in which it propagated [**note:** when used for protection from chickenpox, childhood inoculations with a vaccine containing VZV ensures the inoculees will have a subsequent risk of recurrence as vaccine-strain shingles cases, as well as, if subsequently or previously infected

by a native VZV strain, shingles from a recurrence of the native strain]);

13. Hepatitis A virus (by means of vaccines containing an inactivated hepatitis A virus derived from the work-up of a viral culture in human MRC-5 diploid fibroblasts);

14. Rotavirus (by means of vaccines containing either a live human-strain rotavirus, derived from the work-up of cultures of a human 89-12 rotavirus strain, which belongs to the G1P[8] type, propagated on Vero cells, or five live bioengineered human-bovine hybridized "reassortant rotaviruses" derived from the work-up of cultures of these rotaviruses on Vero cells [**note:** four {4} of the reassortants express a human outer capsid protein and a bovine attachment protein {G1P7[5], G2P7[5], G3P7[5] and G1P7[5]} and the fifth one expresses a bovine outer capsid protein and a human attachment protein {G6P1A[8]}]); and

15. Influenza virus (by means of vaccines containing originally three [3] and now four [4] bioengineered ['cold-adapted'] reassortant strains of the influenza virus that are annually selected, which are grown in and harvested from eggs or, if inactivated, the purified split-viron protein antigens from three [3] or four [4] strains of influenza virus grown in eggs or a dog-kidney cell line or purified from recombinant hemagglutinin expressed in continuous insect cell line that is derived from Sf9 cells of the fall armyworm, *Spodoptera frugiperda,* using a baculovirus vector [Autographa californica nuclear polyhedrosis virus] insect cell system).

In addition, except for the influenza vaccines, these vaccines are recommended to be administered during defined windows in the period from birth to 18 months of age — during the first 1.5 years of life – not Heid's "*during the first two years of life*".

However, Heid did not address the number of doses that are now recommended against these diseases in the first 18 months of life – "35 or 36" dosings (one [1] to four [4] per disease).

Thus, the number of disease organisms for which there is a CDC-recommended early childhood vaccine has gone from eight (8) to 15, an 87% increase with a similar increase in the dosings administered.

Turning to Heid's next statement,

> "*Recently added to the list are vaccinations against potentially deadly illnesses like hepatitis and chicken pox*",

Dr. King notes that, given Heid's statement, the recent vaccines about which he is speaking are the inactivated-hepatitis-A virus

vaccine for "*hepatitis*" and the live-virus alphaherpes-varicella-zoster-virus [VZV] vaccine for "*chickenpox*", both of which are for diseases that are rarely "*deadly*".

Moreover, vaccines for various serogroups of the bacterium *N. meningitidis* have also recently been added to the early childhood vaccination schedule

Furthermore, *except for possibly the current vaccines against N. meningitidis*, the "*potentially deadly*" post-vaccination outcomes in inoculated children that are associated with these vaccines (the serious adverse events following inoculation) are much more likely to occur than such deadly outcomes in healthy children from these "*potentially deadly illnesses*".

Turning to Heid's next paragraph,

> "*But while the number of vaccines (and needle pricks) has grown during the last two decades, the amount of antigen in those shots, which is the substance that triggers a response from your child's immune system, has plummeted, Smith explains. 'The actual burden on your child's immune system is far lower that it was 10 or 20 years ago, even though kids now receive more shots,' he says. That's credited to advances in protein science and a better understanding of the way diseases and children's immune systems interact*",

Dr. King simply notes that the unsubstantiated statements made in the preceding text are clearly at odds with the reality that the percentage of children having chronic childhood diseases that are related to immune-system insults has more than doubled since 1994.

Specifically, the level of childhood chronic disease has increased from about "12.8%" who had at least one chronic disease at the end of the study of "cohort 1" in 1994 to about "26.6%" who had at least one chronic disease in 2006 at the end of the study of a similar group of children ("cohort 3")in the USA[39].

Furthermore, contrary to Heid's claim, with the approval of the "pentavalent" (5-disease) combination vaccines, the number of "*needle pricks*" may not have significantly increased provided the tetravalent live-virus (MMR-V) and pentavalent combination vaccines (DTaP-IPV-Hib or DTaP-IPV-HepB) are used when possible.

However, what has significantly increased has been the number of vaccine-component dosings given at the same time.

Those dosings have increased to the point that, *in the first year of life*, the level of vaccine-disease-component dosings at once has led to an increased risk of hospitalization in the child's first year of life.

Thus, *for two (2) through eight (8) components reported to have*

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39 "Prevalence of Chronic Illness in US Kids Has Increased", 16 Feb. 2010, http://www.medscape.com/viewarticle/717030, [**Note:** A MedScape account is needed to access this article], last accessed on 9 July 2014.

been given at once, hospitalization has been found to be linearly associated with the number of vaccine-disease-component dosings given in the same healthcare-provider visit[40].

Furthermore, *with the exception of the saline that serves as the basis for most vaccines*, almost any component in a vaccine dose is an antigen when it is administered parenterally as, *except for the live-virus influenza and rotavirus vaccines*, most vaccines are given.

Additionally, the nature of each antigen in a vaccine formulation influences the incremental magnitude of the harm to the immune system.

Also, as shown by Tsumiyama *et al*. (2012)[41], the cumulative effect of each dose of each antigen that is present in any injected vaccine formula incrementally harms the immune system of the recipient to some degree.

In addition, the recipient's immune system does not fully recover from that harm and, after some cumulative number of the "same antigen" insults, can induce a persistent autoimmune state in the recipient.

Therefore, it appears that the repetitive nature of the intermittent antigen exposures is a significant causal factor in the decrease in the ability of the inoculee's adaptive immune system to accurately differentiate between "self" (those substances to which it

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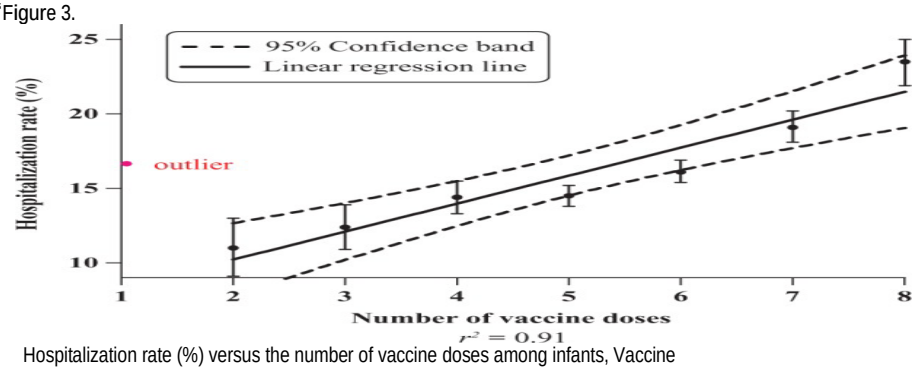
40 Goldman GS1, Miller NZ. Relative trends in hospitalizations and mortality among infants by the number of vaccine doses and age, based on the Vaccine Adverse Event Reporting System (VAERS), 1990-2010. *Hum Exp Toxicol*. 2012 Oct; 31(10):1012-1021. Epub 2012 Apr 24. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3547435/ .

"Figure 3.



Hospitalization rate (%) versus the number of vaccine doses among infants, Vaccine Adverse Event Reporting System (VAERS), 1990–2010."

41 Tsumiyama K, Miyazaki Y, Shiozawa S. Self-Organized Criticality Theory of Autoimmunity. *PLoS ONE* 2012 Dec 31; 4(12): e8382 (9 pages). doi:10.1371/journal.pone.0008382, http://www.plosone.org/article/info%3Adoi%2F10.1371%2Fjournal.pone.0008382, (emphasis added),

"Abstract

Background: The cause of autoimmunity, which is unknown, is investigated from a different angle, i.e., the defect in immune 'system', to explain the cause of autoimmunity.

Methodology/Principal Findings: Repeated immunization with antigen causes systemic autoimmunity in mice otherwise not prone to spontaneous autoimmune diseases. Overstimulation of CD4+ T cells led to the development of autoantibody-inducing CD4+ T (aiCD4+ T) cell which had undergone T cell receptor (TCR) revision and was capable of inducing autoantibodies. The aiCD4+ T cell was induced by de novo TCR revision but not by cross-reaction, and subsequently overstimulated CD8+ T cells, driving them to become antigen-specific cytotoxic T lymphocytes (CTL). These CTLs could be further matured by antigen cross-presentation, after which they caused autoimmune tissue injury akin to systemic lupus erythematosus (SLE).".

should not respond) and "not self" (those substances to which it should respond).

After some multiple of such antigen exposures, the result can be persistent autoimmune reactions in which the immune system mistakenly attacks a vaccine-antigen-related part of the inoculee's "self".

Furthermore, Heid's assertion,

> "*… a better understanding of the way diseases and children's immune systems interact*",

conceals several stark realities:

- The Establishment's germ-theory-based science does not accurately explain much less understand disease;
- Not only is the Establishment's vaccine-centric understanding of our "*children's immune systems*" incomplete but it also generally ignores important immune-system truths, including
  - The importance of exogenous boosting and subclinical infection, and
  - The fact that humans exist in and depend upon a sea of biological organisms for our survival and health; and
- The generally cooperative interaction between our immune system and the organisms upon which we depend for our health and well-being.

"In an effort to provide some answers for concerned parents, Smith and his colleagues looked at kids' scores on tests related to motor skill, verbal memory, attention span, and several other neuropsychological factor to see if vaccine timing had any impact—good or bad—on a child's brain development. His research shows kids vaccinated on time score the same or better than children who receive their vaccinations late or not at all."

A tobacco-science[42] study

Though the Smith study is not identified, based on the use of the term, "*neuropsychological*", Dr. King thinks that the study referred to was "On-time Vaccine Receipt in the First Year Does Not Adversely Affect Neuropsychological Outcomes"[43].

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42 In this context, the phrase "tobacco-science study" is meant to indicate a study knowingly conducted to cover up the harm from some practice. In the case of the tobacco industry, a comparable example would be studying whether smoking cigarettes before or after eating had any effect on the smokers' cognitive function. For an unbiased study, one would have to compare the studied outcomes for initially healthy children who were vaccinated at times near the recommended times to the same outcomes for a matched group of initially healthy children who were never vaccinated with any vaccine – not those who were not vaccinated with only certain vaccines.

43 Smith MJ, Woods CR. On-time Vaccine Receipt in the First Year Does Not Adversely Affect Neuropsychological Outcomes. *Pediatrics* 2010 Jun; 125(6): 1134 -1141. (doi: 10.1542/peds.2009-2489).

That study was a reanalysis of datasets from a previous study by Thompson et al. (2007)[44], where children who weighed less than 2.5 kilograms at birth, or had any encephalopathy and/or a wide range of other medical conditions, or who were not single births, or whose parents declined to participate were excluded from the datasets thereby probably removing from consideration many, if not most, of those children who had been seriously damaged by their vaccinations.

Also, the original study *apparently* did not assess the children's APGAR (Appearance, Pulse, Grimace, Activity and Respiration) scores to ensure that only initially healthy children were studied.

Given the information reported in the original study, only about 30.3% of the children initially selected were actually assessed[45].

Thus, the original study: **a)** excluded many who were damaged by vaccination, on-time or otherwise; **b)** apparently failed to ensure that all of those tested were healthy at birth; **c)** had only nine (9) children who had no record of receiving any vaccinations in the first year-plus of life but no information about their subsequent vaccination history; and **d)** only looked at certain vaccinations in the first year-plus of life while doing the evaluations when they were 7 to 10 years of age.

Given the preceding realities, Dr. King is neither surprised by the findings reported nor taken aback by the manner in which Heid, an apparent vaccine apologist, misportrayed the findings that were reported by Smith and Woods.

Since most all vaccinations were administered within 30 days of the recommended time windows, the probability of finding a statistically significant effect for late vaccination is reduced by the fact that most vaccine doses were given "on time".

Moreover, when there are fewer than 20 instances, as is the case for those nine (9) who received no vaccinations in their first year-plus of life, the small number of instances adversely affects the probability that any effect seen will be statistically significant.

Thus, the follow-up study mentioned can only *validly* be used to indicate that the deviation of the date of vaccination outside of the recommended timing windows was not a significant factor in the outcomes observed.

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44 Thompson WW, Price C, Goodson B, et al. Early thimerosal exposure and neuropsychological outcomes at 7 to 10 years. *N Engl J Med*. 2007; 357(13): 1281–1292. http://www.nejm.org/doi/full/10.1056/NEJMoa071434#t=articleTop.

45 Ibid., "RESULTS

Characteristics of the Children

Of 3648 children selected for recruitment, 1107 (30.3%) were tested. Among children who were not tested, 512 did not meet one or more of the eligibility criteria, 1026 could not be located, and 44 had scheduling difficulties; in addition, the mothers of 959 children declined to participate. Most of the mothers (68%) who declined to participate in the study and provided reasons for nonparticipation cited a lack of time; 13% reported distrust of or ambivalence toward research. Of the 1107 children who were tested, 60 were excluded from the final analysis for the following reasons: missing vaccination records, 1 child; missing prenatal records, 5; missing data regarding weight, 7; and discovery of an exclusionary medical condition during record abstraction, 47. Thus, 1047 children were included in the final analyses."

DTP vaccination: delaying initial vaccination improves outcomes

However, to see that delaying vaccination can improve the post-vaccination adverse outcomes that are observed after certain vaccinations, one need only examine a Canadian study[46] that found that delaying the initial DTP vaccination by more than two (2) months more than halved the vaccinated children's risk of developing asthma.

Additionally, in Japan in the late 1980s, delaying the first DTP vaccination until the child was two (2) years of age, virtually eliminated SIDS (sudden infant death syndrome) fatalities there.

Finally, the clinical cases of whooping cough in Japanese children less than one (1) year of age were *unexpectedly* reduced to the point that such clinical cases of whooping cough almost disappeared[47].

MMR vaccination: accelerating or delaying vaccination is problematic[48]

Though most of the research studying the timing of the initial vaccination are presented in terms of measles vaccination, the actual vaccination most often uses a combination measles, mumps and rubella (MMR) live-virus vaccine or a quadrivalent measles, mumps, rubella and "varicella" (alphaherpes varicella zoster virus [VZV], [MMR-V]) vaccine in the USA.

From the available data, giving the initial inoculation of either of those live-virus measles-containing vaccines earlier than 15 months reduces the duration of the protection provided to the point that, when the first dose is administered before the child is 12 months of

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46 McDonald KL, Huq SI, Lix LM, Becker AB, Kozyrskyj AL. Delay in diphtheria, pertussis, tetanus vaccination is associated with a reduced risk of childhood asthma. *J Allergy Clin Immunol*. 2008 Mar; 121(3): 626-631. doi: 10.1016/j.jaci.2007.11.034. Epub 2008 Jan 18. http://www.ncbi.nlm.nih.gov/pubmed/18207561, from the ABSTRACT (emphasis added),

"RESULTS: Among 11, 531 children who received at least 4 doses of DPT, the risk of asthma was reduced to (1/2) in children whose first dose of DPT was delayed by more than 2 months. The likelihood of asthma in children with delays in all 3 doses was 0.39 (95% CI, 0.18-0.86).

CONCLUSION: We found a negative association between delay in administration of the first dose of whole-cell DPT immunization in childhood and the development of asthma; the association was greater with delays in all of the first 3 doses. The mechanism for this phenomenon requires further research."

47 For an in-depth report supporting giving the initial dose at 2 years of age, see "131 Ways For An Infant to Die" by Neil Z. Miller as posted on 4 July 2014 at http://www.greenmedinfo.com/blog/131-ways-infant-die, and the primary references cited in that paper regarding the changes in SIDS cases and infant mortality in Japan when the recommended age for the pertussis-components-containing vaccine was changed from two (2) months to two (2) years, "23. Noble GR., et al. Acellular and whole-cell pertussis vaccines in Japan: report of a visit by U.S. scientists. *JAMA* 1987; 257: 1351-1356. 24. Cherry JD., et al. Report of the task force on pertussis and pertussis immunization. Pediatr (Jun 1988); 81(6): 933-984. 25. Congressional Budget Office. Factors contributing to the infant mortality ranking of the United States. CBO Staff Memorandum (February 1992): Table 2, International Infant Mortality Rates by Ranking."

48 In the interest of brevity, verification of the validity of the timing issues surrounding the initial MMR vaccination is being left up to the reader. For a more complete discussion of the issues surrounding the MMR vaccination program, Dr. King recommends his previous article addressing some of these issues http://dr-king.com/docs/130906_Mealses_MeaslesVaccinationRealities_AFormlRespnseToEndangeringTheHerd_final_br1.pdf and the appropriate portions in the second edition of Neil Z. Miller's book, "Vaccine Safety Manual For Concerned Families and Health Practitioners", ISBN: 978-188121737-4; or, *for an online source*, some of the information on the MMR-containing vaccines is published online by the National Vaccine Information Center (NVIC) at http://www.nvic.org/.

age, revaccination of that child when he or she is 12-to-15 months of age is recommended.

However, delaying the initial inoculation beyond 15 months in the window from 16 to 23 months of age reportedly increases the child's risk of febrile seizures, and even giving the MMR-V vaccine in that 12-to-15-month window doubles the child's risk of having febrile seizures.

Based on these findings, if an MMR-type live-virus vaccine must be administered and parents choose to delay inoculating their child against measles, then the parents may want to delay giving this vaccine until their children are at least 24 months of developmental age.

Moreover, *absent access to live-virus measles-only vaccines or live-virus measles-rubella vaccines*, the parents may want to only allow the MMR vaccine to be used to inoculate their children.

However, concerned parents should be aware that there is some evidence that the live-virus mumps component in Merck's M-M-R® II, live-virus measles, mumps and rubella vaccine is not truly effective in providing a significant level of durable protection to those inoculated with that vaccine (or with Merck's other mumps-containing live-virus vaccine, ProQuad® [an MMR-V vaccine]) from mumps infection[49].

"Related research from Canada looked specifically at the immunization decisions made by parents of children diagnosed with autism. 'Our study found that roughly 60 percent of parents who had a child with autism delayed or declined vaccinations for a later-born child,' says Dr. Jessica Brian, a developmental psychologist at the University of Toronto. According to Brian's research, those children who did not receive their shots on time or altogether were slightly more likely to develop autism. 'I don't want to suggest that vaccines offer some protection against autism,' she says. 'But our data show that there's no increased risk of autism among kids who are vaccinated on time.'"

A questionable vaccination timing study in families with children having an "autism spectrum disorder" (ASD) diagnosis

Again, though the article does not specifically identify the study, Dr. King thinks that the referenced Canadian paper is "Immunization uptake

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49 See http://www.rescuepost.com/files/june-mumps-suit.pdf, last accessed on 24 July 2014, "United States of America ex relators StephenA. Krahling and Joan L. Wlichowski, Plaintiffs, versus Merck & Co., Inc., Defendant, Case 2:10-cv-04373-CDJ, Document 12, AMENDED COMPLAINT FOR VIOLATIONS OF THE FEDERAL FALSE CLAIMS ACT" filed 04/27/2012 in the U.S. District Court for the Eastern District of Pennsylvania, which, *inter alia*, claims that Merck knowingly fabricated the reports purporting to claim 95% efficacy for the live mumps virus component in its combination live-virus vaccines to defraud the U.S. government. Dr. King briefly discusses this mumps-component efficacy issue in a section titled, "A knowing linguistic misrepresentation – Portraying 'vaccination' as if it provides disease 'immunity'" in one of his earlier review articles, which can be accessed at http://dr-king.com/docs/131101_FormalResponseToLetter_MakeNoExemptionsForChildhoodVaccinations_fnl_br1.pdf. For an update on the 'false claims' case involving the lack of efficacy of Merck & Co., Inc.'s mumps-component in their combination vaccines that reflects the pre-trail legal maneuvering actions though mid-2013, see http://www.beyondconformity.org.nz/hilarys-desk/mercks-illegal-mmr-smokescreen-continues.

in younger siblings of children with autism spectrum disorder" [50], which was published in the journal ***Autism*** in 2014.

Examining the abstract, Dr. King notes that the only statistically significant difference reported was

> "A significant group difference emerged for overall immunization status (Fisher's exact test = 62.70, p < .001)".

Tellingly, the abstract also stated (emphasis added),

> "The rates of autism spectrum disorder diagnosis did not differ between immunized and nonimmunized younger sib groups, although small sample size limits interpretability of this result".

Based on the abstract, all of the "controls" were apparently "fully" vaccinated ("All controls were fully immunized, ..."); almost all (97/98) of the older siblings were vaccinated ("immunizations were delayed in 16/98 probands (16.3%) and declined in only one"); and one (1) or more of the recommended vaccinations were declined in only 12 of 98 children in the younger siblings group.

Moreover, because of the small size of the groups, the variability in the ages of the members in the groups, and the similarity of their vaccination status at the time of the study, the only scientifically supported "Conclusion" was "Parents who already have one child with autism spectrum disorder may delay or decline immunization for their younger children".

Furthermore, the abstract's closing remark, "potentially placing them at increased risk of preventable infectious diseases" was not backed by any study in the younger siblings of children with an ASD diagnosis that established that they had a significantly higher risk of contracting "preventable infectious diseases" than their older siblings or a similarly vaccinated control group of children.

Thus, ignoring the fact that the study lacked the statistical power to do more than assert,

> "The rates of autism spectrum disorder diagnosis did not differ between immunized and nonimmunized younger sib groups, ...",

Heid nevertheless misleadingly and erroneously claims,

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50 http://www.ncbi.nlm.nih.gov/pubmed/23045216. Abu Kuwaik G, Roberts W, Zwaigenbaum L, Bryson S, Smith IM, Szatmari P, Modi BM, Tanel N, Brian J. Immunization uptake in younger siblings of children with autism spectrum disorder. *Autism.* 2014 Feb;18(2):148-55. doi: 10.1177/1362361312459111. Epub 2012 Oct 8. The article's abstract states (emphasis added),

> "Background: Parental concerns persist that immunization increases the risk of autism spectrum disorder, resulting in the potential for reduced uptake by parents of younger siblings of children with autism spectrum disorder ("younger sibs"). Objective: To compare immunization uptake by parents for their younger child relative to their older child with autism spectrum disorder ("proband") and controls. Design: Immunization status was obtained for 98 "younger sibs," 98 "probands," and 65 controls. Results: A significant group difference emerged for overall immunization status (Fisher's exact test = 62.70, p < .001). One or more immunizations in 59/98 younger sibs were delayed (47/98; 48%) or declined (12/98; 12.2%); immunizations were delayed in 16/98 probands (16.3%) and declined in only one. All controls were fully immunized, with only 6 (9.2%) delayed. Within the "younger sibs" group, 25/98 received an autism spectrum disorder diagnosis; 7 of whom (28%) were fully immunized. The rates of autism spectrum disorder diagnosis did not differ between immunized and nonimmunized younger sib groups, although small sample size limits interpretability of this result. Conclusion: Parents who already have one child with autism spectrum disorder may delay or decline immunization for their younger children, potentially placing them at increased risk of preventable infectious diseases."

> "*According to Brian's research, those children who did not receive their shots on time or altogether were slightly more likely to develop autism*"

and concludes with a quote he attributed to Dr. Brian,

> "'*But our data show that there's no increased risk of autism among kids who are vaccinated on time*'",

which misleadingly speaks of the risk of having an ASD diagnosis as the "*risk of autism*" (where, during the time the subjects were evaluated, this risk was "100%" in the ASD-diagnosed older siblings and, when they were assessed, "0%" in the controls).

This essentially leaves only the younger siblings group (which is reportedly divided into three categories (39/98 "fully vaccinated on time"; "delayed" [implicitly "fully vaccinated" with a variety of delay periods] 47/98; and 12/98 "declined" [implicitly never vaccinated]) from which to try to ascertain a relative risk, where the fact that their older siblings had an ASD diagnosis is, *to the extent that genetics and epigenetics influence the risk of an ASD diagnosis*, a serious confounding factor.

Moreover, based on the abstract's "small sample size limits interpretability" reality, the numbers in each of the subgroups in the group of younger siblings were insufficient to ascertain whether the delay or lack of vaccination actually changed the rate of diagnosed ASD in the younger siblings of children who had an ASD diagnosis.

Turning to the paper, Dr. King notes that this "inter- and intra-group" study was problematic in other respects.

For example, *as shown in a recent case-control study*[51], to ensure unbiased classification, all of the children in the "younger siblings" group and in the "controls" group should have been studied <u>until</u> the youngest children in each of those groups were more than seven and a half (> 7.5) years of age.

Because those children were followed for a much shorter period than the seven-and-a-half-plus (> 7.5) years needed to ensure proper diagnosis with respect to "ASD" (emphasis added),

> "The sample consisted of parents of 261 children (176 boys and 85 girls); of whom 98 were the younger siblings of children with ASD (hereafter, "younger sibs"), 98 were their older siblings with ASD (probands), and 65 were "low-risk" controls (with no family history of ASD). Control babies were roughly group matched to the younger sib group based on age and sex, and only the younger of any sibling pairs in the control group were included in the current analyses. Most participants were recruited when their younger children were 6 months (91/98 younger sibs and 59/65 controls), the remainder enrolled when their children were 12 months; <u>all have been followed up to at least the age of 3 years</u>.",

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51 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). [http://www.biomedcentral.com/content/pdf/2047-9158-2-25.pdf.]

there was a greater than 50% risk that some of the children in the "younger siblings" and "control" groups were misclassified as not affected when, *had those children been followed up until all were more than 7.5 years of age*, some additional subjects in both the "younger sibs" and the "control" groups would have probably been subsequently identified as children with an "ASD" diagnosis.

Thus, the results observed are even more limited in "interpretability" than that paper stated.

Finally, in that paper, the groups were less well defined than the abstract suggested according to narrative in the paper's "*Study design and procedures*" section which stated (emphasis added),

> "Immunization status was divided into three predefined categories: (a) ***Fully immunized***: Children with four doses of DPTP (2, 4, 6, and 18 months) and the initial MMR dose at 12 months, (b) ***Partial/delayed immunizations***: Children with any missing dose of DPTP or MMR at any age or a delay of 3 months or more for at least one of the doses of DPTP or MMR, and (c) ***Not immunized/declined***: Children for whom all immunizations had been withheld as of 3 years of age".

Furthermore, vaccinations with other than the initial "MMR" vaccine and four (4) doses of the "DPTP" vaccines that some would have received (e.g., four (4) Hib vaccine inoculations and three (3) hepatitis B vaccine inoculations as well as, *for those older than four (4) years of age*, a second MMR dose) were not considered.

Additionally, had the study truly been designed to ascertain the rate of a diagnosis of an ASD in those who are "fully immunized" that is attributable to on-time vaccination, then:

- The "on-time test" group should have been a randomly selected group of initially healthy children who:
  - **a.** Were at least eight years of age of sufficient size to ensure that at least 100 children in the group would have an ASD diagnosis (on the order of 10,000 to 15,000 Canadian children who were 8 to 18 years of age),
  - **b.** Were "fully immunized" at the schedule-recommended times, and
  - **c.** Had a complete medical history from birth until they were selected for the study;
- The "delayed test" group should have been a matched, similarly sized group of initially healthy "fully vaccinated" children:
  - **a.** Who were not the siblings of those in the on-time group, and
  - **b.** Whose vaccinations were all delayed by a minimum

of 60 days from the schedule's timings; and

- ❑ The "control" group should have been a randomly selected age-matched group of initially healthy never-vaccinated children of the same size as the "test" groups, who:
  - **a.** Were <u>not</u> related to any of the members in the previous "test" groups,
  - **b.** Were at least eight years of age, and
  - **c.** Had a complete medical history from birth until they were chosen for this study.

Then, a case-control study could have validly ascertained the relative risk of an ASD diagnosis in those who had an "on-time, fully vaccinated" status to the risk of autism in those who had a "delayed, fully vaccinated" status; and to the risk of an ASD diagnosis in those who had a "never vaccinated" status.

Based on the rate of ASD diagnosis in the "on-time, fully vaccinated" group, the rate of autism in the "delayed, fully vaccinated" group, and the rate of ASD diagnosis in the "never vaccinated" (control) group, valid assertions could be made among the groups about the relative risks for an ASD diagnosis.

IF the rate of ASD diagnosis in the "on-time, fully vaccinated" group were <u>not</u> significantly different than the rate of ASD diagnosis in the "delayed, fully vaccinated" group, THEN, a scientifically sound assertion could be made that, among kids who were at least eight years of age, there was "*no increased risk of autism among kids who are vaccinated on time* as compared to the risk of autism among those kids with delayed vaccination".

Moreover, IF the rates for an ASD diagnosis were statistically the "same" in all three (3) groups, THEN, the researchers could validly assert that, among those children who were eight years of age or older, there was "*no increased risk of*" an ASD diagnosis "*among kids who are vaccinated on time* or had their vaccinations delayed compared to those children who were never vaccinated".

However, though the number of initially healthy children who have never been vaccinated and are eight (8) years of age or older [born in 1992 through 2006] probably easily exceeds 600,000 in the USA — where there are certainly enough initially healthy, "never vaccinated" children, the rarest group, for a "fully-vaccinated versus never-vaccinated" retrospective case-control study in the USA — the CDC has steadfastly refused to even attempt to conduct that study.

Instead, confounded tobacco-science studies, *such as the one that was referred to in the passage being reviewed here*, are continually being published.

Moreover, *as was the case here*, their findings are continually being misrepresented both in peer-reviewed published papers and in the mainstream media articles that attempt to utilize such tobacco-science studies to dismiss any post-vaccination safety concerns.

"Brian, Smith and other vaccine researchers repeatedly point to the Internet as a source of misinformation and, in some cases, unsubstantiated fear mongering when it comes to vaccines." "Not uncommon are conspiracy theories involving pharmaceutical companies and the CDC. But travel overseas, and the picture changes slightly."

Internet: *"source of misinformation and … unsubstantiated fear mongering"*

Here, Dr. King is bemused to find that, *in an article published on the Internet*, Heid is reporting the views of certain "*vaccine researchers*" that the delivery medium ("*the Internet*") is to blame because it is "*a source of misinformation and, in some cases, unsubstantiated fear mongering when it comes to vaccines*".

Factually, most publications addressing the issues pertinent to vaccines, and other drugs, and their usage, be they published studies in peer-reviewed journals, mainstream media articles such as the article to which Dr. King is responding, and articles from other sources, including the peer-reviewed ones that Dr. King directly publishes on his web site, are Internet accessible.

Moreover, as underscored in a recent publication[52], even peer-reviewed vaccine-related articles that have been published in journals where the research was overseen or conducted by CDC investigators can have serious methodological issues and evidence of malfeasance.

Thus, *as with the other unsubstantiated claims made by Heid in this article*, the reader should, *to the extent possible*, critical review the assertions made and the directly cited or indirectly referenced publications that support those assertions.

Then, and only then, should the reader accept those claims based on the validity of evidence supporting those claims, or dismiss or ignore those claims for which:

a. There is no scientifically sound supporting evidence or

b. The scientifically sound evidence that the reader can access does not support the claims being made.

Finally, Dr. King observes that, *as was the case here*, some, if not many, of the statements in the Heid-authored article appear to provide "*misinformation and, in some cases, unsubstantiated fear mongering*".

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52 Hooker B, Kern J, Geier D, Haley B, Sykes L, King P, Geier M. Methodological Issues and Evidence of Malfeasance in Research Purporting to Show Thimerosal in Vaccines Is Safe. *Biomed Res Int*. 2014; 2014: 247218 (12 pages). Epub 2014 Jun 4. [Available at http://www.hindawi.com/journals/bmri/2014/247218/ and http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4065774/.]

Thus, it would appear that such statements are intended to support the *status quo* in vaccination without regard to the facts.

"Not uncommon are conspiracy theories involving pharmaceutical companies and the CDC. But travel overseas, and the picture changes slightly."

Obvious collusion miscast as "*conspiracy theories*"

Since the CDC publishes the vaccination recommendations that its Advisory Committee on Immunization Practice (ACIP) makes and that ACIP is packed with vaccine-industry consultants and vaccine industry employees who all have "conflict of interest" waivers and those industry personnel, consultants and CDC personnel have a "revolving door" employment history with the CDC and the pharmaceutical industry, any prudent person would know that the relationships between the CDC, the vaccine makers, and the consultants to both are incestuous and collusive.

As an example of the apparent degree of influence of the vaccine makers over the CDC, the now-withdrawn rotavirus vaccine, Lederle's Rotashield®, a bioengineered, human-monkey-hybrid-virus rotavirus vaccine, was recommended for mass use in infants by the CDC's ACIP in March of 1999 after its FDA approval for marketing on August 31, 1998 (http://www.cdc.gov/mmwr/preview/mmwrhtml/00056669.htm).

Though not statistically significant because of the limited size of the phase III clinical trial conducted, the incidence of a life-threatening adverse reaction, intussusception, in the clinical trial subjects was several times the one (1) reported case in the control subjects.

In addition, the CDC's ACIP was, or should have been, aware of the troubling jump in reports of intussusception cases to VAERS, a database jointly maintained by the CDC and the FDA, after FDA approval but before the ACIP's recommendation for population use was published (see **Table 2** on the next page) – reports which significantly exceeded the apparent "background" level of one (1) case per year in 1993 through 1997.

Moreover, after the CDC's mass vaccination recommendation was suspended, VAERS "intussusception" reports following RotaShield inoculation dropped from greater than 20 a month to "none" for the last five months of 1999, two (2) for all of 2000; and five (5) for all of 2001.

Troublingly, the FDA did not demand a class I recall of all of the RotaShield vaccine doses; and neither the CDC nor the FDA forbade using the vaccine.

Based on the preceding facts, there was some suspicion that the

clinical data on which the approval was granted may have been altered by the sponsor, *or one of the sponsor's agents*, to misclassify one (1) of the intussusception cases in the "Rotavirus inoculation" arm of the phase III clinical trials as an intussusception case in the "control" arm of those trials.

Table 2. U.S. Reports Of Intussusception In VAERS, 1993-2001

Month of Vaccination[1]	RotaShield's Status	Reports
1994-02	Before RotaShield Approval by the FDA	1
1995-01		1
1996-06		1
1997-03		1
1998-11	After RotaShield approval by the FDA, but before CDC ACIP Recommendation for Population USE	4
1998-12		7
1999-01		8
1999-02		7
1999-03	Transition month	9
1999-04	After CDC ACIP Recommendation for Population Use	16
1999-05		19
1999-06		32
1999-07		22
2000-05	After CDC ACIP Withdrawal of Recommendation and Voluntary Withdrawal from the Market by the Vaccine's Manufacturer **NOTE**: Vaccine not banned	1
2000-11		1
2001-04		3
2001-06		1
2001-07		1
TOTAL		135

[1] Vaccination-date month entries are discontinuous before approval RoaShield as well as after its withdrawal.

Finally, on May 4, 2004, roughly five (5) years after the CDC's withdrawal of its recommendation for mass use, the National Institute of Allergy and Infectious Diseases (NIAID) awarded a new license agreement for RotaShield, "an oral rotavirus vaccine, created by NIAID scientists in the 1980s", to BIOVIRx, Inc., of Minneapolis, MN, which planned global commercialization of RotaShield[53].

So, not only have our federal government agencies been colluding

[53] http://www.immunize.org/timeline/, last accessed on 25 July 2014.

with vaccine makers to approve vaccines and recommend vaccine-maker-friendly vaccination programs but one of them was also actually the primary developer of RotaShield – our tax dollars at work for the vaccine makers' interests.

As another clear example of today's collusion between the CDC and the vaccine makers, *in spite of the intussusception problem with Wyeth's RotaShield® rotavirus vaccine*, whenever a new prophylactic vaccine is approved by the FDA, *without waiting for general population use to confirm that the vaccine is as safe as the vaccine maker claims*, the CDC's ACIP almost immediately recommends its population use.

The CDC does this because, *by recommending it for universal use*, that vaccine is added to the list of vaccines that are covered by the NVICP even though that vaccine's actual safety, efficacy and adverse-reaction profile are unknowns for the general targeted population(s).

Clearly, because any vaccine recommended for population-wide use immediately falls under the vaccine maker's umbrella NVICP liability protections, this CDC practice shields the vaccine's maker and the vaccination providers from liability even when use in the general population finds that the vaccine is unsafe, has virtually no general-population efficacy, or has too great a risk for serious post-vaccination adverse events to justify its continued marketing.

Moreover, as has been the case for the pertussis-component in the DTP/DTaP/Tdap vaccines and the vaccines for measles and varicella, whenever an initially recommended vaccination or vaccination series fails to provide the CDC-promised "disease prevention"[54], the CDC simply recommends another dose of the vaccine whenever it can.

Thus, instead of stopping an obviously failed vaccination program, the CDC seeks to reward the vaccine maker by recommending an additional dose or doses of the problematic vaccine.

This CDC practice increases the vaccine manufacturer's sales and profits as well as ensures that the federal government will get more tax revenue from the increased doses administered.

Finally, adding additional doses also ensures that more people will have a serious adverse reaction thereby increasing the revenues for the products that treat those serious adverse reactions and for the "health care" providers who diagnose, prescribe for, and/or care for those who have these serious adverse reactions.

Furthermore, the FDA and the vaccine makers have a comparable

[54] The irony is that the CDC's "disease prevention" assertion is a claim that the vaccine maker's package insert does not even attempt to make.

collusive relationship.

For example, the FDA essentially serves as a "rubber stamp" for vaccines because it approves vaccines based on the information that the vaccine makers submit without:

1. Requiring that all preclinical testing required to prove the vaccine is not carcinogenic, mutagenic or in any manner reproductively toxic was conducted and proved that the vaccine could not cause those problems in humans before any doses were given to any human being[55];
2. Rigorously auditing the vaccine maker's records to ensure that all of the information collected was submitted;
3. Rigorously verifying that neither the requisite records nor the original datasets have been fabricated or altered;
4. Conducting any independent randomized double-blind true-placebo-controlled studies to verify that vaccine inoculations do not cause a significantly higher level of, and/or much more severe, adverse effects than true placebo inoculations; and
5. Putting the vaccine maker on notice that the government will, *using its statutory authority to suspend or revoke any human biological drug product license*, immediately exercise that authority whenever
   a. Any post-approval audit finds evidence of a pattern of falsification of any of the requisite records and/or the records' supporting datasets and ancillary information, or
   b. Independent researchers find and confirm that the vaccine has any contamination (e.g., adventitious viruses or possibly bioactive viral contaminants or recombinant DNA or DNA fragments), which the vaccine maker did not fully disclose and/or did not prove that the highest possible level of that contamination cannot cause any inoculee safety issues in its submission documents.

Moreover, the FDA does not rigorously enforce the parenteral-drug-labeling requirements (as set forth in 21 C.F.R. § 201.100) for all vaccines and recently colluded with the manufacturer of a meningococcal meningitis vaccine, Novartis' MenVeo®, to hide the complete

[55] As the vaccine makers' package inserts for their approved vaccines do not deny or freely admit. [Note: http://dr-king.com/docs/20130501_Vaccines_The_Safest_of_Medicines_or_the_Biggest_Liequstn_e_b_r1.pdf discusses this issue in detail and contains an appendix that lists the pertinent package-insert information.

composition of the vaccine behind a "trade secret" claim even though the pertinent labeling regulations require the composition of parenteral drugs to be fully disclosed in the consumer-available labeling.

Finally, the current good manufacturing practice (CGMP) regulations for vaccine drug products, as set forth in 21 C.F.R. § 600 through § 680, are supposed to establish clear legally binding minimum requirements below which no manufacturer may operate and with which the FDA is required to establish compliance before allowing any vaccine to be marketed or, if marketed, to remain on the market.

However, when the requirement to prove that Thimerosal, still used as a preservative in vaccines, was safe to the standard "sufficiently nontoxic", as required in CGMP regulation set forth in 21 C.F.R. § 610.15(a),

> "Any preservative used shall be sufficiently nontoxic so that the amount present in the recommended dose of the product will not be toxic to the recipient",

became inconvenient, the FDA *extra legally* modified § 600.15 Constituent materials by adding a § 610.15(d) [76 *FR* 20518, Apr. 13, 2011], which simply states,

> "The Director of the Center for Biologics Evaluation and Research or the Director of the Center for Drug Evaluation and Research may approve an exception or alternative to any requirement in this section. Requests for such exceptions or alternatives must be in writing".

Obviously, the FDA made this change to protect itself and the vaccine makers even though it plainly violates the legal requirement that all such CGMP regulations must be a clearly defined minimum.

Moreover, that change permits there to be no standard or differing standards for each vaccine (or other biological drug product) for a vaccine maker's compliance with any part of § 610.15(a) based on some administrators whim, provided the request for any such exception or alteration is made in writing.

Furthermore, federal regulation changes *legally* only apply after their effective date as published in the *Federal Register*.

However, the FDA has continued to ignore and taken no action to address the pre-existing reality that the FDA had continually approved Thimerosal-preserved vaccines from 1973, *when it assumed responsibility for vaccines*, onwards for which the vaccine manufacturers have supplied no proof of compliance with the clear CGMP safety minimum ("sufficiently nontoxic") set forth in 21 C.F.R. § 610.15(a) to the FDA for the Thimerosal level used in their Thimerosal-preserved vaccines.

Based on the preceding realities, any prudent person would be forced to conclude that the federal governmental agencies and the vaccine makers are colluding to advance the approval of vaccines and the sales of the vaccine makers' vaccines with little or no regard for

the potential or realized harm from the vaccinations and/or the net negative costs to the physical and/or fiscal health of the children and other residents of the USA.

Here, the reality of Dr. King's assertion is supported by two (2) recent independent peer-reviewed publications, where he is the co-author, on the problematic nature of the U.S. chickenpox ("varicella") vaccination program[56].

As the "Summary" in the published "Abstract" of the second paper (footnote "**56.b.**") states (emphasis added), "When the costs of the booster dose for varicella and the increased shingles recurrences are included, the universal varicella vaccination program is neither effective nor cost-effective").

Given the preceding facts, where collusion has been clearly established, the time for vaccine apologists, like Heid, to abandon the use of the "*conspiracy theories*" phrase has long passed.

"In Europe, where some diseases were never eradicated as thoroughly as they were in the U.S., health officials say there isn't as much 'too much, too soon' concern among parents when it comes to immunizations."

In Europe: fewer vaccines dosings, higher levels of natural disease, and elevated circulation of non-vaccinating travelers

Here, Heid begins by misleadingly speaking of "*some diseases*" as if they were the specific organisms that cause clinical cases of his "*some diseases*".

Obviously, no disease can be "*eradicated*", but what can possibly be reduced to the point of "oblivion" are clinical cases of those medical conditions that define a disease case.

However, vaccination programs that use live-viruses to reduce clinical disease cases are actually infecting most who are inoculated with the live-virus vaccines as well as some number of others who collectively are exposed to the viruses being shed by the recently inoculated vaccinees and/or to their live-virus-laden excretions

Yet, the countries' public health surveillance systems only monitor the general population for disease cases.

Most countries' public health systems do not rigorously, or at all in some countries, attempt to monitor the inoculees and those who may be infected by their excretions for some period to ascertain the

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a. 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".]

b. 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* 2014 Aug; 33: 886-893. First published online as *Hum Exp Toxicol*. 2013 Nov 25; 33(8): 886-893. Abstract is available at: http://het.sagepub.com/content/33/8/886.abstract.

number of cases where vaccine-strain infections have directly or indirectly caused vaccine-strain clinical disease cases.

At some level, for the live-virus vaccines, people should realize that the claimed antibody-level-based "disease protections" can only arise when the live viruses in those vaccines infect the inoculees in a manner that provokes the inoculee's or the inoculees' contacts' adaptive immune system to recognize the virus as an unwanted intruder and mount an effective adaptive-immune-system response.

Moreover, the measure of a vaccine program's apparent "success" that is used by the Establishment is whether the generation of clinical disease cases can be interrupted in a manner that permits the disease to be classified as "non-endemic" in a given area, state, nation or continent, or hemisphere.

Thus, the reality in Europe is that some diseases, like measles, which has been declared "non-endemic" in the USA, are still endemic there.

Moreover., to the extent that, *for the 2008-2009 schedules*, fewer ("18" to 24") to many fewer ("12" to "18") vaccines were recommended in the first year of life in Europe versus "26" in the USA and, in 2009, the infant mortality levels per 1,000 live births in most of the developed European countries were lower ("5.5"; San Marino and Italy) to significantly lower ("2.75" [Sweden] to "3.99" [Germany]) than the corresponding infant mortality in the USA ("6.22")[57], those factors (fewer vaccines and a significantly lower infant mortality), *and <u>not</u> the clinical disease levels per se*, serve to explain the lesser "*too many*, *too soon*" parental concern in Europe as expressed by unidentified European "*health officials*".

"'Still, European moms and dads do harbor fears about potential vaccine side effects,' says Niklas Danielsson, deputy head of the vaccine-preventable diseases program for the European Centre for Disease Prevention and Control. Danielsson says the 'unprecedented success' of vaccination programs has created a generation of young parents who aren't familiar with the reality of something like a measles outbreak, so they're [sic; their] focus is on a shot's rare risks as opposed to its many proven benefits."

Classic vaccine apologia[58]

Here, Heid begins by quoting "*Niklas Danielsson, deputy head of the vaccine-preventable diseases program for the European Centre for Disease Prevention and*

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57 Miller NZ, Goldman GS. Infant mortality rates regressed against number of vaccine doses routinely given: is there a biochemical or synergistic toxicity? *Hum Exp Toxicol*. 2011 Sep; 30(9):1420-1428. [http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3170075/.]

58 Apologia "ap•o•lo•gi•a (ˌæp əˈloʊ dʒi ə) *n., pl.* -gi•as. A defense or justification of one's beliefs, attitudes, or actions. [1775–85; < Late Latin < Greek]"

Control", who, as vaccine apologists do, speaks of parents "*fears*" when what the "*European moms and dads*" have are valid concerns and their fear, *if any*, is that the information they are being provided is designed to obscure the vaccination-related risks to the overall health and well-being of their children.

Moreover, as parents in the USA, what they are truly concerned about is the ***risk to their children*** for the very serious post-vaccination "adverse events" (clinical harm, including permanent disability and death that do occur) — not about vague "*potential side effects*", which may occur.

Furthermore, "*the 'unprecedented success' of vaccination programs*", which is attributed to Danielson, is an unsubstantiated claim that, *for most vaccines*, conceals the reality that these vaccination have absolutely failed to provide the "disease immunity" benefits repeatedly promised by vaccination-program apologists and acolytes with each new prophylactic ("disease protective") vaccination program.

In addition, Dr. King observes that the vaccination propaganda machine and not the actual performance of the vaccination programs is what "*has created a generation of young parents who aren't familiar with the reality of something like a measles outbreak*" — a machine that blatantly uses fear mongering, disease severity exaggeration and disease risk inflation to shape the views of the people.

Furthermore, the closing remark,

"*so [their] focus is on a shot's rare risks as opposed to its many proven benefits*",

with respect to the vague "*a shot's rare risks*":

a. Admits that a single vaccine inoculation carries with it multiple post-vaccination-associated risks, but

b. Conceals the reality that little or no real pre-vaccination effort is generally expended or mandated to assess each child's individual risk for each of those vaccine hazards that are serious and may be lethal before the child is given any vaccine inoculation.

Furthermore, *absent subsequent exposure to the disease-causing organisms for which the vaccine is claimed to provide some protection*, there can be no benefit to giving that child that vaccine.

In addition, vaccines provide a range of "benefits" to those who are inoculated with them.

That range of "benefits" runs from no protection whatsoever from the disease(s) for which protection is claimed to a waning level of disease protection that, *while it may be initially sufficient to protect many inoculated children from contracting clinical disease*, will, after

some relatively short period of time (a few years to, at best, a decade-plus), cease to be disease protective.

Consequently, all of the claimed "*benefits*" of vaccination are, at best, theoretical and, *when the real risks of post-vaccination adverse events are included*, are certainly negative for those who are seriously harmed by, or die from, the post-vaccination adverse events associated with a given vaccine.

Finally, there is no proof of "disease prevention" because no randomized double-blind true-placebo-controlled disease-exposure post-vaccination clinical trials are conducted using informed volunteers.

In such clinical trials, *after inoculation with a vaccine or a sterile isotonic pH-balanced saline placebo and waiting the weeks required for the disease-protections to develop*, the entire group of healthy volunteers is challenged with the most virulent strains of the disease organism(s) for which disease prevention is claimed.

Then, if the vaccine were "disease protective", *after an appropriate time for disease resolution*, the study codes would be broken and most all of the vaccinated individuals would be found to have not contracted the disease(es) while most of those given a placebo injection would have contracted the disease(es).

Absent the preceding post-vaccination disease-challenge studies, the fundamental "disease prevention" benefits will remain claims that even the manufacturers of the vaccines do not make in their vaccines' package inserts.

Therefore, the only completely "*proven benefits*" are those that accrue to all who, directly or indirectly, profit from the development, approval, recommendation, marketing, dispensing and taxation of vaccines.

As Dr. King has shown, the claimed "health" and "disease prevention" benefits from the current CDC-recommended vaccination programs are either apparently illusory (when it comes to long-term health) or scientifically unproven (when it comes to ***disease prevention***).

"The lingering presence of diseases in other countries is one of the big reasons having your children vaccinated on time is so important, says Dr. Simon Hambidge, a professor of pediatrics and epidemiology at the University of Colorado. 'We live in a world of international travel, and people are coming into our country all the time who may be carrying these diseases,' Hambidge says. 'Unfortunately, the vast majority of the new outbreaks we're seeing involve unvaccinated children.'"

Another apologist's views on vaccination and King's response

Here, Heid introduced the views of "*Dr. Simon Hambidge, a professor of*

pediatrics and epidemiology at the University of Colorado".

Dr. Hambridge' statement begins by using the "*presence of diseases in other countries*" to justify the importance of "*having … children vaccinated on time*" in the USA.

Next, he reminds us that "*people are coming into our country all the time who may be carrying these diseases*".

Finally, *omitting the hyperbole*, Heid closes this passage with a quotation, inferentially attributed to Hambridge, that states,

"*the … majority of the new outbreaks we're seeing involve unvaccinated children*".

First of all, Dr. King observes that the "*vaccinated on time*" issue is, as King has shown earlier in his responses, **a)** a complex issue and **b)** a vaccine-specific issue that should <u>not</u> be generalized.

Second, before addressing the issue of timing, the issues of the long-term safety, effectiveness and cost-effectiveness of each vaccine need to be actively addressed in comparison to the overall long-term safety, effectiveness and cost-effectiveness of the natural disease cycle in healthy individuals living in a healthy society.

Third, Dr. King accepts the reality that "*people are coming into our country all the time who may be carrying these diseases*", but observes:

- IF our government and our public health officials were *truly* concerned about that reality,
- THEN, the USA would have real border security and all arriving at the borders of the USA — those arriving at our borders, ports or airports:
  - **a.** Whose itinerary <u>cannot</u> be verified or
  - **b.** Who departed from foreign destinations where one or more contagious diseases are endemic or there are currently contagious disease outbreaks

  would be quarantined until the appropriate tests could confirm that they were <u>neither</u> infected by <u>nor</u> carrying any highly contagious disease or diseases.

Since <u>no</u> such public-health quarantine system is in place and we continually have these importation-triggered contagious disease outbreaks, Dr. King must conclude that our government and our public health officials have decided that having these importation-triggered disease outbreaks is desirable.

Perhaps, this is the case because these outbreaks provide the fodder for their vaccination fear mongering and help provide job security for the participants in our outbreak-accepting, vaccination-based, insurance-driven, allopathic, disease-management system, which is euphemistically called a "health care" system in the USA.

Furthermore, *for those specific contagious diseases covered by a*

universal vaccination recommendation, Dr. King knows that most outbreaks "*usually involve unvaccinated children*".

However, the real problem is that most of those outbreaks also involve older children and adults who have been age-appropriately vaccinated but still contract a clinical case of the disease or, *worse*, have a silent case of the disease, which they spread to others with whom they have contact.

Furthermore, as vaccination coverage levels increase, the risk of contracting a covered disease disproportionately increases most in those who are too young to be vaccinated.

Additionally, because of their small size and lack of a fully developed immune system, the too-young-to-vaccinate infants are more likely to succumb to either the disease itself or other adverse medical conditions that having the disease facilitates or exacerbates.

Finally, though not mentioned in this article, there is a growing body of evidence that our ever-increasing vaccination programs are significantly reducing the overall health of our children and ourselves by greatly increasing the level of chronic disease in those who are age-appropriately up-to-date with all of the CDC's ACIP recommendations for vaccination.

"Hambidge has looked closely at one possible vaccine side effect that has parents worried: seizures. The CDC recommends that all healthy infants receive their first measles vaccination between the ages of 12 and 15 months, and some research has linked the measles vaccine to higher rates of febrile seizures. Though frightening for parents, seizures of this type are relatively common and almost never cause lasting damage, Hambidge explains. 'About one in 2,000 to 4,000 kids will experience one of these febrile seizures after receiving the measles vaccine,' he says. 'But we found that that seizure rate rises to one in 1,000 or 2,000 if the measles vaccine is given late, or between 16 and 23 months of age.' Hambidge says this is just one example of how a slight deviation from the CDC's vaccination schedule can put your child's health at risk."

MMR vaccination seizure issues: a one-sided view of inoculation timing

First, noting that the specific study is not identified by Heid, Dr. King thinks that the study in question is "Timely versus delayed early childhood vaccination and seizures"[59].

Second, though the narrative continually speaks of "*measles*", the actual live-virus measles-component-containing vaccines studied were a live-virus MMR (measles, mumps & rubella) vaccine (Merck's M-M-

[59] Hambidge SJ, Newcomer SR, Narwaney KJ, Glanz JM, Daley MF, Xu S, Shoup JA, Rowhani-Rahbar A, P Klein N, Lee GM, Nelson JC, Lugg M, Naleway AL, Nordin JD, Weintraub E, DeStefano F. Timely versus delayed early childhood vaccination and seizures. *Pediatrics*. 2014 Jun; 133(6): e1492-e14999. doi: 10.1542/peds.2013-3429. [http://pediatrics.aappublications.org/content/133/6/e1492.long]

R® II) and a live-virus MMR-V (measles, mumps and rubella with an elevated level of varicella) vaccine (Merck's ProQuad®).

While the results stated partially reflect the findings from a retrospective review of certain unaudited records in the VSD database covering the period from 2004 through 2010 for certain vaccinated children born in 2004 through 2008, Heid's narrative did not disclose:

a. The reality that giving the MMR-V vaccine to infants at 16 to 23 months of age appeared to double the risk for febrile seizures as compared to giving the MMR-V vaccine to children at 12-15 months of age,

b. The fact that giving the MMR-V vaccine to infants at 16 to 23 months of age appears to quadruple the risk of febrile seizures as compared to giving the MMR vaccine to children at 12 to 15 months of age.

c. There was actually insufficient data to study the effect of the age of initial inoculation on the risk of febrile seizures beyond 21 months of age, and the absence of vaccination records in the period from 24 months of age through 48 months of age precluded the study's including children 24 months of age and older.

d. The paucity of febrile seizure data precluded narrowing the comparison windows.

e. "Of note, ~2% of children in the VSD population have a seizure in the first 2 years of life." [**Note:** Remember that almost all of the children in the VSD have received most, *if not all*, of the recommended vaccine doses.]

f. "Regardless of vaccination, young children are at their greatest risk for febrile seizures at ~16 to 18 months of age.[34,35] [34] Waruiru C, Appleton R. Febrile seizures: an update. Arch Dis Child.2004; 89(8): 751–756. Abstract/FREE Full Text. [35] Jones T, Jacobsen SJ. Childhood febrile seizures: overview and implications. Int J Med Sci. 2007;4(2):110–114. Medline Google Scholar."

g. "The stronger association of seizures with both MMR and MMRV vaccines administered after 15 months of age, compared with 12 to 15 months, is likely due to a complex interplay between the immunogenicity of the vaccines, the genetic and physiologic susceptibility of the child, and the age-based maturation of the child's immune system; as the immune system matures in the second year of life[36] it also becomes capable of greater febrile response to immune stimulants, such as vaccines. [36] Gasparoni A, Ciardelli L, Avanzini A, et al. Age-related changes in intracellular TH1/TH2 cytokine production, immunoproliferative T lymphocyte response and natural killer cell activity in newborns, children and adults. *Biol Neonate*. 2003; 84(4): 297–303. CrossRef Medline Web of Science Google Scholar".

h. "The relationship between the reactogenicity and the immunogenicity of vaccines was suggested in a recent study that demonstrated a greater risk of measles disease among school-aged children who had received 2 doses of MMR vaccine with the first dose at 12 to 13 months versus at least 15 months of age.[37] [37] Defay F, De Serres G, Skowronski DM, et al. Measles in children vaccinated with 2 doses of MMR. Pediatrics. 2013 [Nov 1]; 132(5): [e1126-

e1133]. Available at: www.pediatrics.org/cgi/content/full/132/5/e1126. Abstract/FREE Full Text" [http://pediatrics.aappublications.org/content/132/5/e1126.full.pdf+html.]

Based on all of the preceding,

- IF a parent in the USA elects to vaccinate his or her child against measles,
- THEN, with respect to minimizing the risk of febrile seizures and maximizing the probable protection against measles and the duration of that protection, parents who accepts the validity of the assertions made in points "**f.**" and "**h.**", should ensure that the vaccine is administered when their children are older than 18 months of age and may want to wait until their children are 24 months of age (or older when their children are being breastfed for *not less than* two [2] years).

Turning to the last statement in this passage,

"*Hambidge says this is just one example of how a slight deviation from the CDC's vaccination schedule can put your child's health at risk*",

Dr. King notes that the febrile-seizures risk finding in this example does not translate to all vaccinations as, for example, the delay of the initial DTP vaccinations by more than two (2) months from the recommended two-month initial vaccination date has been shown to halve the risk of a vaccinated child's subsequently developing asthma[60] and delaying initial DPT vaccination from two (2) months to 24 months drastically reduced the incidence of SIDS in children (by more than an order of magnitude) as well as practically eliminated pertussis cases in children who were less than one (1) year of age[61].

In addition, a 2005 report[62] on an older (1992) comparative study of 226 vaccinated children and 269 unvaccinated children in New Zealand (of the differences in health between initially healthy children who were vaccinated with a live-virus measles vaccine and those who were not vaccinated with it) found that those given the live-virus measles vaccine had a significantly increased post-vaccination risk of tonsillitis and tonsillectomy (26 cases of tonsillitis [11.5%] and 3 tonsillectomies [1.3%] in the 226 vaccinated children) as compared to those who were not vaccinated with that live-virus measles vaccine (3

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60 McDonald KL, Huq SI, Lix LM, Becker AB, Kozyrskyj AL. Delay in diphtheria, pertussis, tetanus vaccination is associated with a reduced risk of childhood asthma. *J Allergy Clinical Immunol* 2008; 121: 626-631.

61 For an in-depth report supporting giving the initial dose at 2 years of age, see "131 Ways For An Infant to Die" by Neil Z. Miller as posted on 4 July 2014 at http://www.greenmedinfo.com/blog/131-ways-infant-die, and the primary references cited in that paper regarding the changes in SIDS cases and infant mortality in Japan when the recommended age for the pertussis-components-containing vaccine was changed from two (2) months to two (2) years, "23. Noble GR., et al. Acellular and whole-cell pertussis vaccines in Japan: report of a visit by U.S. scientists. *JAMA* 1987; 257: 1351-1356. 24. Cherry JD., et al. Report of the task force on pertussis and pertussis immunization. Pediatr (Jun 1988); 81(6): 933-984. 25. Congressional Budget Office. Factors contributing to the infant mortality ranking of the United States. CBO Staff Memorandum (February 1992): Table 2, International Infant Mortality Rates by Ranking."

62 http://www.mednat.org/vaccini/dannivacc_study.pdf, last accessed on 27 July 2014.

cases of tonsillitis [1.1%] and no tonsillectomies [0%] in the 269 who were not vaccinated with that measles vaccine)[63].

That report also contained the following relevant passage,

> "In other research, a study of 1265 Christchurch children born in 1977 found that none of the unvaccinated children had asthma or had had doctors consultations for asthma or allergic conditions.
>
> 'The 23 children who received no diphtheria/pertussis/tetanus (DPT) and polio immunizations had no recorded asthma episodes or consultations for asthma or other allergic illness before age 10 years; in the immunized children, 23.1% had asthma episodes, 22.5% asthma consultations, and 30.0% consultations for other allergic illness. Similar differences were observed at ages 5 and 16 years'[1] [1] Kemp T, Pearce N, Fitzharris P, Crane J, Fergusson D, St George I, Wickens K, Beasley R. Is infant immunization a risk factor for childhood asthma or allergy? Epidemiology. 1997 Nov; 8(6): 678-80'".

When the preceding realities are considered with other findings of increased incidence of chronic disease in those who were age-appropriately vaccinated in comparison to those who have not been vaccinated[64], the reported findings show that the post-vaccination risks for adverse medical conditions and childhood chronic disease should be properly included in any "benefits of vaccination" assessment.

"The risk of measles is far, far more serious than the risk for febrile seizures," Hambidge says. "Even if your child is unlucky enough to have a seizure after a vaccination, these seizures are short-lived and don't lead to any long-term issues, while measles is a life-threatening disease."

Disinformation and obfuscation: measles and febrile seizures

First, Dr. King accepts that a given risk can be larger or smaller than some other risk.

For example, in the USA, the risk of dying from being struck by lightning is far less than the risk of being killed in a car crash.

In addition, the outcome associated with a given risk may be more, or less, serious than an outcome associated with some other related or non-related risk.

For example, being permanently disabled in a car wreck is more serious than simply being injured in a car wreck or in a bicycle crash.

However, the risk of condition "a" cannot be "*more serious*" than the risk of condition "b" – much less, "*far, far more serious*".

Thus, the quotation attributed to "*Hambridge*" here,

"*The risk of measles is far, far more serious than the risk for febrile seizures*",

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63 Ibid, page "4", "In the vaccinated, 73% of the cases of tonsillitis" [21 of "29"] "and 92% of the tonsillectomies" [11 of "12"] "were in children who had received the measles vaccines. As only 52% of the total vaccinated children received a measles vaccine, one would expect about 52% of the tonsillitis/tonsillectomies to occur in children to have had the vaccine. The higher rate of tonsillitis and tonsillectomy in recipients of the measles vaccine suggests that the vaccine made some children more susceptible to tonsillitis".

64 http://www.whale.to/a/children1.html, last accessed on 21 August 2014.

is, intentionally or unintentionally, disinformative.

Moreover, the quotation,

> "*Even if your child is unlucky enough to have a seizure after a vaccination, these seizures are short-lived and don't lead to any long-term issues, while measles is a life-threatening disease*"

is not only condescending but also not supported by the factual record that clearly shows that some febrile seizures are anything but "*short-lived*" and do lead to "*long-term issues*" in some instances (see VAERS reports of adverse events following inoculation with a measles-containing vaccine).

Furthermore, Hambridge's claim that "*measles is a life-threatening disease*" is not supported by the facts.

For example, under the heading "How is it treated?", a WebMD article on "*measles*" states[65] (emphasis added),

> "Measles usually gets better with home care. You can take medicine to lower your fever, if needed. Read and follow all instructions on the label. Also, get plenty of rest and drink lots of fluids. Stay away from other people as much as you can so that you don't spread the disease. Anyone who has measles should stay out of school, day care, work, and public places until at least 4 days after the rash first appeared.
>
> Your doctor may suggest vitamin A supplements if your child has measles.
>
> Most people get better within 2 weeks. But measles can sometimes cause dangerous problems, such as lung infection (pneumonia) or brain swelling (encephalitis). In rare cases, it can even cause seizures or meningitis.
>
> If you have been exposed to measles and you have not had the vaccine, you may be able to prevent the infection by getting a shot of immunoglobulin (IG) or the measles vaccine as soon as possible. Babies who are younger than 12 months, pregnant women, and people who have impaired immune systems that can't fight infection may need to get IG if they are exposed to measles".

Thus, *in initially healthy children*, measles is generally a mild disease from which, *when appropriate supportive care and nutrition are provided*, most children recover with no lasting ill effects.

Furthermore, it is the complications that some who have measles experience that can be life threatening.

However, vaccination against measles using a measles-component containing live-virus vaccine carries similar complications risks as measles as well as the risk of rare but much more serious medical conditions that is not associated with natural measles infection.

Thus, Hambridge is clearly fear mongering the uncommon risks associated with other medical conditions that some persons who contract a clinical case of measles ***may*** develop[66] while failing to mention

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65 http://www.webmd.com/children/tc/measles-rubeola-topic-overview, last accessed on 27 July 2014.

66 http://www.webmd.com/children/tc/measles-rubeola-topic-overview, last accessed on 27 July 2014.

that inoculation with the vaccine-strain of the virus that causes measles carries with it similar risks for those other serious but rare medical conditions as being naturally infected by measles as well as some serious adverse effects (e.g., atypical measles[67]), which are <u>not</u> causally associated with natural measles infection.

"Despite the overwhelming amount of research and real-world evidence that points to the reliable safety of vaccines, experts acknowledge that parents will continue to worry about the chemicals and additives in immunization shots. To those who have doubts, Dr. Smith says, 'Vaccines are one of the most rigorously tested and effective health products on the planet. Nothing involving them is done lightly.'"

Claims of safety <u>not</u> supported by the facts

Here, Heid begins by quoting "*Dr. Smith*", a university pediatrician, about the "*safety of vaccines*" supposedly based on "*the overwhelming amount of research*" and "*real-world evidence*".

However, Dr. King's research has established that the facts are that the "disease protective" vaccines approved by the FDA and recommended for universal use by the CDC do <u>not</u> meet their minimum standards for "safety"[68].

For example, as the package inserts for the FDA-approved vaccines typically state or, in a few instances, do <u>not</u> even address, the reality that the requisite preclinical toxicological safety studies required to prove the vaccine is <u>neither</u> mutagenic <u>nor</u> carcinogenic in humans were <u>not</u> conducted.

Absent these preclinical proofs of safety (nonmutagenicity and noncarcinogenicity) and in light of the increasing levels of various cancers and leukemia cases in vaccinated children, Dr. King can only conclude that the administration of these vaccines to children is probably a significant causal factor in the rise in childhood cancers and childhood leukemia cases.

Thus, the current FDA-approved vaccines that lack these proofs (and others) are *inherently* unsafe or, *as the U.S. Supreme Court put*

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67 http://www.fda.gov/downloads/biologicsbloodvaccines/vaccines/approvedproducts/ucm123789.pdf, page "6" of the 2014 copyrighted Merck package insert for Merck's M-M-R II measles, mumps and rubella vaccine (emphasis added),

"ADVERSE REACTIONS

The following adverse reactions are listed in decreasing order of severity, without regard to causality, within each body system category and have been reported during clinical trials, with use of the marketed vaccine, or with use of monovalent or bivalent vaccine containing measles, mumps, or rubella:

Body as a Whole

Panniculitis; <u>atypical measles</u>; fever; syncope; headache; dizziness; malaise; irritability.

…."

last accessed on 28 July 2014.

68 http://dr-king.com/docs/20130501_Vaccines_The_Safest_of_Medicines_or_the_Biggest_Liegustn_e_b_r1.pdf.

it in Bruesewitz v. Wyeth, "unavoidably unsafe", a term that the Supreme Court Justices on both sides of that split decision used 29 times[69].

Therefore, given the choice, as Dr. King expressed it in a 2013 essay, "Vaccines: 'The Safest of Medicines' or 'the Biggest Lie'"[70], the lack of proof that the current vaccines: **a)** cannot cause human mutations or cancers, and/or **b)** are not reproductively toxic to humans (both male and female) make vaccines "unsafe" as do the other applicable "proof of vaccine safety" deficits outlined in King's essay.

In addition, since these vaccines are supposedly given to healthy children as a preventive measure for a future exposure that the vaccinated child in today's USA may never have.

Then, *unlike the reality of harm confirmed by the documented serious post-vaccination adverse reactions, including death*, for a vaccine to be safe under the applicable definition of "safety" as set forth in 21 U.S.C. § 600(3)(p),

> "The word safety means the relative freedom from harmful effect to persons affected, directly or indirectly, by a product when prudently administered, taking into consideration the character of the product in relation to the condition of the recipient at the time",

that vaccine would have to have essentially no risk of causing cancer, mutation, reproductive toxicity, permanent disability or death that exceeds the projected risk for such events were there no vaccination program including the altered-immune-system-related chronic disease events that seem attributable to our current vaccination programs.

Unfortunately, the preceding requirements are levels of safety that the current vaccines do not meet

Furthermore, *if those levels of safety were met*, our federal government would not have been "compelled" to enact the National Vaccine Injury Compensation Program (NVICP, as codified in 42 U.S.C. § 300aa-10 through § 300aa-34 as amended).

Therefore, Dr. King finds that the closing quotation attributed to Smith,

> "*Vaccines are one of the most rigorously tested and effective health products on the planet. Nothing involving them is done lightly*",

is not supported by the facts.

To begin with, as Dr. King has shown and the vaccine makers' package inserts admit or, *by omission*, do not deny, the prerequisite preclinical toxicological, "proof of safety", carcinogenicity and mutagenicity studies have not been conducted.

In addition, all of the studies required to prove that a given vaccine is not reproductively toxic to males or females are also not con-

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69 *Bruesewitz v. Wyeth*, 562 U.S., 131 S.Ct. 1068 (2011).

70 http://dr-king.com/docs/20130501_Vaccines_The_Safest_of_Medicines_or_the_Biggest_Liequstn_e_b_r1.pdf.

ducted — at most, incomplete reproductive toxicity studies have been conducted.

Also, the clinical studies conducted to establish vaccine safety in healthy humans are much less rigorous than the studies required for the development of new drug products that are not vaccines.

Moreover, no randomized, double-blind, true-placebo-controlled studies are required for all vaccine safety assessments and neither the safety studies nor the efficacy studies have the decade-plus follow-up necessary to identify long-term outcomes.

Furthermore, there are no randomized, double-blind, true-placebo-controlled vaccine-effectiveness studies with volunteers that study the outcomes of post-inoculation disease challenge.

Without such studies there is no proof that vaccine inoculation is effective in preventing the disease for which disease "prevention" is claimed by today's vaccine advocates, apologists and acolytes

Tellingly, the vaccine makers' package inserts do not claim that inoculation with their vaccines will prevent those who are inoculated with their vaccine from contracting the covered diseases.

Instead, the vaccine makers use levels of antibody titers or, *in the case of the pertussis-protective vaccine components*, other measures to show that their vaccines are effective in providing some level of disease "protection" – not disease "prevention".

Moreover, the follow-up periods for the vaccine "efficacy" (phase III) clinical trials are not sufficient to assess the long-term (beyond 10 years) performance of the administered vaccine inoculations.

Thus, as the information in the vaccine manufacturers' package inserts clearly confirm, vaccines are much less rigorously tested than conventional drug products and make no claims for "disease prevention" effectiveness.

Furthermore, fewer phase III clinical trials are required for vaccine candidates than for most conventional drug products and the post-approval (phase IV clinical monitoring) studies used to justify the phase III short cuts are not, *as they should be*, required to be conducted for *not less than* 10 years (typically, the monitoring periods are less than 3 years in duration.

Therefore, based on all of the preceding realities, relative to conventional drug products, everything "*involving them is done lightly*".

And when it comes to the CDC's recommendations regarding vaccination schedules, he adds, 'As a pediatrician and as a parent, if my family's on vacation and we have to put off my daughter's doctor visit, I get anxious each day that she goes unvaccinated. I think the timing is that important.'"

A scientist's and a pediatrician's contrasting views of *"the CDC's recommendations regarding vaccination schedules"*

Presuming Heid's quotations are accurate, when speaking about his daughter, Smith, both as "*a pediatrician and as a parent*", gets "*anxious each day that she goes unvaccinated*" and thinks "*the timing is that important*".

In contrast, based on his study and understanding of children's developing immune systems, Dr. King thinks that, *for those vaccines a parent chooses to administer*, vaccine inoculations should not be given until: **a)** the child's developmental age is that of a full-term properly nourished 12-month-old or older child; or **b)**, whenever the child is breastfed for an extended period of 24 months or longer, the child is at least 24 months of age.

Dr. King's reasons for adopting this position are:

- Before the full-term child is 12 months of age, the child's adaptive immune system has not matured to the point that vaccine inoculations will provide other than short-term disease-protection — "as the immune system matures in the second year of life[36] it also becomes capable of greater febrile response to immune stimulants, such as vaccines" (see footnote "**59**"), where the cited text's internal footnote, "[36]", refers to "Gasparoni A, Ciardelli L, Avanzini A, et al. Age-related changes in intracellular TH1/TH2 cytokine production, immunoproliferative T lymphocyte response and natural killer cell activity in newborns, children and adults. *Biol Neonate*. 2003; 84(4): 297–303 CrossRefMedlineWeb of ScienceGoogle Scholar"[71].
- Through false imprinting, early immune-system challenges can damage the immune system's future capability to properly differentiate between what is "self" and what is not "self".
- For "pertussis", the combined Canadian and Japanese experiences, which was presented earlier in this discussion, clearly show that any medically sound vaccination program for "pertussis" should be delayed – probably to 24 months of age because such a delay would: **a)** significantly reduce the

[71] The "Abstract" of the cited article states (emphasis added),

"To evaluate the development of the neonatal immune system, we measured T lymphocyte response to Con A, intracellular IL-2, IL-4, IFN-γ and IL-10 production, and natural killer cell (NKC) activity in 12 very preterm, 12 preterm and 20 term neonates, 10 children and 10 adults. Immunoproliferation to Con A was significantly lower in cord blood than in children or adults. The percentage of CD4+ lymphocytes was significantly higher in newborns while CD8+ cells were higher at older ages, with a resulting gradual decline of the CD4+/CD8+ ratio. The percentage of IL-2-producing CD4+ and CD8+ cells was higher in all newborn groups than in children and adults, while the percentage of IL-4-producing cells was higher for CD8+ and lower for CD4+ cells in cord blood than in children and adults. Neonates had substantially lower percentages of CD4+ and CD8+ IFN-γ-producing cells. A significant negative correlation was observed between gestational age and IFN-γ-CD4+-, IL-2-CD8+-, and IL-10- CD4+-producing cells. In addition, a positive correlation was found between gestational age and IL-10-CD8+-producing cells. Percentages of CD4+/CD45RA+ cells were higher and CD4+/CD45RO+ percentages were lower in newborns than in children and adults. NKC activity in infants was significantly correlated with gestational age and significantly impaired compared to children and adults. On the whole, these results suggest a gradual development of immunity during gestation and show significant immaturity of cellular immune response at birth. The reduction of NKC activity, the lower proliferative response of T cells, the reduced cytotoxic response and a dysregulated cytokine production may contribute to the neonatal increased risk of infection and to the low incidence of graft-versus-host disease after cord blood transplantation."

child's subsequent risk of subsequently developing asthma; **b)** eliminate most all SIDS fatalities in children under one (1) year of age; and **c)** possibly eliminate, or at least greatly reduce, clinical cases of "pertussis" in children under 12 months of age.

- In most healthy breastfed children who are being nursed by healthy mothers in the USA, it is unusual for an infant to have any clinical disease until after breastfeeding stops, which, in natural healthy civilizations usually does not occur before the child is 24 months of age.

Of course, Dr. King realizes that such changes in the "*CDC's recommendations regarding vaccination schedules*" would

a. Drastically reduce the revenues of the vaccine makers for their sales in the USA or any other country adopting King's suggestions, and,

b. *Given the extremely rigid position against any changes in vaccination timing advocated by the CDC, state health departments, public health officials, mainstream pediatricians, and others who actively support the current vaccination schedules*, would shatter the remaining blind trust in the current vaccination program schedules and the vaccination programs' supporters.

Additionally, Dr. King thinks that 25% to 50% of all health care services would be become superfluous over the next century if:

- All of the current state vaccination mandates were repealed;
- The vaccination timings were revised to eliminate all vaccination inoculations before children are 12 developmental months of age;
- Comprehensive family histories (collected prior to birth) and the infant's adaptive immune type (appropriately assessed just before, at or after birth) were used to identify those who should not be given certain or any childhood vaccines; and
- The CDC's recommendations for all vaccine programs that are not medically cost-effective were revoked.

Of course, natural cycles of childhood infections would return for those natural rite-of-passage contagious diseases (e.g., chickenpox, measles, mumps, rubella, rotavirus and "pertussis" [whooping cough]) for which there is an FDA-approved vaccine that, *for healthy children who are breastfed for at least 12 months*, should not be life threatening.

In addition, those children who recovered from those diseases would again have the long-term or lifetime protections from disease

recurrence and, if female, be able to pass those protections to the children they later bear as well as again benefit from the other general health protections that being infected by these diseases naturally and neutralizing those infections provide.

Furthermore, *for those who wanted them*, the approvals for most all of the current vaccines would not be affected and those vaccines should remain available to those individuals who believe that those risks are worth taking for themselves or their children or wards.

Finally, those who have similar vaccination program concerns in other countries need to independently weigh the vaccination program realities in their country and revise their vaccination recommendations/mandates appropriately because Dr. King's suggested changes are only directly applicable to today's USA.

Dr. King's closing remarks about the "success" of the current CDC-recommended vaccination programs in the USA

The "success" of our current CDC-recommended vaccination programs depends upon the metrics (measures) that are used to define "success" or "failure" and the viewpoint of those who are making the measurements.

From the viewpoint of the vaccine makers, which are driven by the profit motive,

- The ever-growing vaccination-program-related revenues,
- Much lower developmental costs,
- Shorter time-to-approval timelines,
- Ability to avoid having to prove their vaccines do not cause cancer and/or mutations, and are not reproductively toxic,
- The lack of "generic" vaccine manufacturers whose lower prices would put pressure on their vaccines' pricing,
- Their almost complete freedom from liability for any harm from their vaccines might cause, and
- The apparent increase in damaged-immune-system-related childhood chronic diseases from which their other divisions can profit by providing treatments

have combined to make vaccines an over whelming success.

At the other end of the "success" spectrum, those who bear the costs, those whose children died or were significantly damaged by the CDC-recommended vaccination program as well as those who have chronically ill children whose chronic childhood illnesses appear to have resulted from their children's having been vaccinated in accordance with the CDC recommendations are forced to bear most of the

fiscal, physical, emotional and social costs associated with the harm caused by such vaccine inoculations.

Given a history where vaccines have been repeatedly found not to live up to the false promises of "immunity" (lifetime protection from disease) used by the CDC and the other vaccination activists, apologists and acolytes to justify each new vaccine to the public, Dr. King thinks that those who study the facts understand that, *at best*, vaccines are false panaceas.

Factually, our current prophylactic ("disease preventive") vaccines:

- Do not provide long-term (near lifetime or lifetime) disease protection that they were initially claimed to provide;
- At levels generally up to 100 times higher than claimed by vaccine proponents, harm, maim or kill some of those inoculated with those vaccines; and
- Have long-term immune-system-damage consequences that:
  - Are contributing to, or causing, the rise in chronic childhood adverse medical conditions that in 1950 were rare or unknown and, by 2006, appear to have translated into more than half of our children having one or more of these chronic adverse medical conditions at some time during childhood and one-fourth of those USA children of the having one or more than one of those as lifetime chronic adverse medical conditions and
  - Have significantly degraded, and are degrading, the quality of our lives and
  - To the delight of those who profit from the medicines and practices promoted by the Establishment, cause us to spend an ever-increasing portion of our wealth on ever-more-expensive treatments for those chronic medical conditions.

Thus, the reality is that the current CDC-recommended vaccination programs are the foundation upon which our disease-treatment-centric medical system, which is euphemistically called a "health care" system, currently rests.

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About Markham Heid, Author of the Article Being Reviewed

Source: http://time.com/author/markham-heid/

"Markham Heid writes about health, nutrition, fitness, and lifestyle topics for TIME.com and other national magazines and media outlets. A cyclist and (one-time) triathlete, he lives in Philadelphia."

Source: http://www.linkedin.com/pub/markham-heid/19/a05/945

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About Paul G. King, PhD, Author of this Review

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

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[72].

Moreover, Dr. King was also one of the authors of a paper in *Int. J. Environ. Res. Public Health*, where the lead author was Janet K. Kern, PhD.

That peer-reviewed paper reviewed Thimerosal exposure and the roles of sulfation chemistry and thiol availability in autism[73].

Furthermore, Dr. King was one of the authors in a review chapter, "Mercury Induced Autism"[74] (pages 1411-1432), in Comprehensive Guide

[72] 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".]

[73] 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

[74] See, http://www.researchgate.net/publication/258009647_Mercury_Induced_Autism/file/60b7d526955a643330.pdf for this chapter.

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.

Additionally, Dr. King was one of the authors of the 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.

That open-access paper contributed more evidence to the actuality that there is a causal relationship between the level of Thimerosal-preserved vaccine exposure and the subsequent risk of the inoculated children's ending up with a diagnosis of "autism" in the USA[75].

Furthermore, Dr. King is one of the authors of a paper titled, "Methodological Issues and Evidence of Malfeasance in Research Purporting to Show Thimerosal in Vaccines Is Safe"[76], where Dr. Brian Hooker was the lead author. That open-access paper established that the six (6) key epidemiological studies, which the CDC uses to support its assertion that Thimerosal-containing vaccines are safe to give to pregnant women and developing children, have significant methodological issues and evidence of intentional malfeasance that renders them scientifically unreliable.

Finally, Dr. King is the co-author of a paper with Dr. Gary S. Goldman that is titled, "Vaccination to prevent varicella: Goldman and King's response to Myers' interpretation of Varicella Active Surveillance Project data"[77], which, as the abstract's "Summary" states, clearly established that "[w]hen the costs of the booster dose for varicella and the increased shingles recurrences are included, the universal varicella vaccination program is neither effective nor cost-effective" in the USA.

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[75] 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). [http://www.biomedcentral.com/content/pdf/2047-9158-2-25.pdf.] In the first month after publication, it was accessed more than 10,500 times.

[76] Hooker B, Kern J, Geier D, Haley B, Sykes L, King P, Geier M. Methodological Issues and Evidence of Malfeasance in Research Purporting to Show Thimerosal in Vaccines Is Safe. *Biomed Res Int*. 2014; 2014: 247218 (8 pages). http://www.hindawi.com/journals/bmri/2014/247218/.

[77] 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* 2014 Aug; 33(8): 886-893. Abstract: http://het.sagepub.com/content/33/8/886.abstract.