Following from: http://www.vran.org/vaccines/pneumococcal/vaccine-pne.htm

http://www.whale.to/v/prevnar2.html

Independent statistical analysis of this new vaccine has uncovered a quagmire of very disturbing information. Dr. Erdem Cantekin presented his analysis at the recent National Vaccine Information Center Conference. "The alleged benefits are greatly exaggerated and the risks are significant." In examining the raw data and study methodology, Dr. Cantekin found that the vaccine is not effective for ear infections, or pneumonia and the data on meningitis prevention are inconclusive. Furthermore the FDA did not approve Prevnar for pneumonia or for otitis media. Dr. Cantekin asks "why does the American Academy of Pediatrics want our children to be immunized using Prevnar? Why are all those experts excited? I am afraid the answer is not in the scientific domain."

The vaccine trial had no placebo group, rather it had a control group of children who were given an experimental menigococcus C vaccine. Prevnar administered children had 4 times more seizures and they had 4 times more gastritis than the control group. Significantly, more children who received Prevnar developed asthma.

Says Dr. Cantekin - "The big push for Prevnar marketing comes from it s alleged benefits in otitis media although the FDA had clearly not approved it for this use." Consider these facts about ear infections About 60 percent of the cases are viral, less than 40 percent are bacterial, and perhaps 25 percent of ear infections are due to pneumococcus bacteria. Otitis media is a self-limiting disease and 90 percent of cases resolve within a few days, without treatment. With 7 million cases of ear infections occurring each year in the U.S. it has grown into a big business. For two decades the experts have treated ear infections with aggressive interventions, such as long duration antibiotic therapy with designer drugs, antibiotic prophylaxis, followed by aggressive surgery which "fuels our 5 billion dollar a year otitis medico-economics."

Pneumococcus is a common respiratory bacteria with more than 90 serotypes and causes various diseases. How it transmutes itself into a pathogen is not known, nor is the carriage rate and the serotype distribution in various population groups known. Of great concern explained Dr. Cantekin is that "the role of pneumococcus in the microecological balance is yet to be determined&.and that vaccination of all newborns with 7 pneumococcal serotypes and possible eradication of those serotypes (assumed to be the common pathogenic types) is an uninformed experiment at best."

The seven strains of pneumococcal bacteria this vaccine purports to ward off, are some of the antibiotic resistant strains that now account for the majority of bacterial infections in young children, an example of how the indiscriminate overuse of antibiotics has put pressure on pathogenic microbes to mutate and develop into highly aggressive bacterial strains impervious to antibiotic therapies. Says vaccine activist Dawn Richardson - "This situation begs for the question to be answered - that can't the indiscriminate widespread use of vaccines put the same kind of pressure on these bugs to mutate? We are already seeing evidence of this as there are already 8 different genotypes of wild strain measles identified."

Continuing with this line of thinking, Dr. Cantekin is worried about will happen to the other 80 serotypes when selective pressure is put on these few. "Pneumococcus is an aggressive organism that caused approximately 90,000 deaths lastyear because of antibiotic resistant pneumococcal pneumonia in older people. It is a deadly bacteria that killed many people before the invention of antibiotics in the 1940 s&&& we also need to know the environmental pressure due to Prevnar because it is not going to be a vaccination program where a given pathogen like small pox will be eradicated. It is going to be more like antibiotic use. Prevnar by changing serotype natural balance will exert selective pressure on microbial ecology." (More from Dr. Cantekin)

http://www.mercola.com/2001/feb/21/prevnar_vaccine.htm

Dawn Richardson founder of PROVE (Parents For Open Vaccine Education), shared these thoughts, "One study that has not beendone that I'm sure we all have a good hypothesis as to what the results are - who are the majority of children who are getting severe invasive infections with the pnuemococcal bacteria? Our experience is showing that it is the kids who are massively vaccinated and medicated with antibiotics. It is the poor children whose immune systems are being systematically destroyed by the medical profession but they do have a nice marketing gimmick going to create a constant widespread demand for their products and services."

In 1996 New Zealand researcher Hilary Butler wrote a fascinating paper entitled "The Perilous Haemophilus, or is it&..Pneumonia" (1) where she reported a disturbing trend following the widespread use of the combined haemophilus Influenza B conjugate vaccine and DPTP vaccine. Within a year of the introduction of this new combo, a dramatic and unexpected increase in hospital admissions of young children was observed. And although Hib disease had "fallen to rock bottom", doctors were noticing that "the proportion of very young children admitted is getting higher and that generally, children seem to be sicker when they arrive." This despite the public having been told that the new vaccine would ease the work load of paediatric staff, they were now seeing more, and sicker children than ever before.

Her attention was first drawn to this new trend when the New Zealand media began reporting the dramatic increase in hospitalization of young children presenting with severe cases of pneumonia, asthma, meningococcal diseases, fevers and bronchiolitis. On searching the medical literature, she found that the rise in pneumococcal disease had already been associated with the Hib vaccine.

Butler s search kept turning up associations between increases in pneumonia and meningitis, not only in the wake of the Hib vaccine but other vaccines as well. She refers to the "first Swedish study of the Japanese acellular pertussis vaccine which was abruptly stopped because a larger number of serious infections and deaths were occurring in the vaccinated group than the unvaccinated. The raw data repeatedly came up with PNEUMONIA and MENINGOCOCCAL MENINGITIS."

Then the June, 1992 issue of Newsletter from the Journal of Pediatric Infectious Disease stated "The Perilous Pneumococcus. We have great concern for the

increasing prevalence of relatively or absolutely penicillin resistant pneumococci coupled with the increased relative frequency of peneumococcal diseases as a result of universal Haemophilus vaccination."

Hilary Butler and Dr. J. Anthony Morris wrote a letter to the Pediatric Infectious Disease Journal newsletter and pointed out that a solution to one problem can give rise to another, perhaps more difficult problem. They expressed concern that the increase of pneumococcal disease as a result of universal Hib vaccination could result in greater difficulty in treating antibiotic resistant pneumococcal organisms.

"This apparent one step forward one step backward situation is reminiscent of similar problems that accompanied early use in the 1960 s of inactivated adenovirus vaccines to prevent respiratory diseases caused by adenovirus types 3, 4,and 7. The vaccines were highly effective in preventing disease caused by these types, but not effective in preventing respiratory diseases caused by the other 40 or more adenoviruses that moved in to replace types 3, 4 and 7. Soon after this situation was recognized, use of adenovirus vaccines , was abandoned, except for use in military personnel."

Then a Finnish study reported in the Lancet, 11 March, 1995, Volume 345, p.661 titled "Increase in Bacteraemic Pneumococcal Infections in Children" reported that "following the disappearance of invasive Hib disease in children bacteraemic pneumococcal infections have increased. A similar, although less striking increase has been reported in Philadelphia." They also speculated that while Hib vaccinations have reduced the carriage of the Hib organism, that "pneumococci may have found a new niche in colonizing children."

In her concluding remarks Hilary Butler forwards the idea that the "introduction of the vaccine (Hib conjugate) is the prime suspect for the increased number of sick children, either by suppressing the immune system allowing carriage of pneumococcal bacteria to become clinical disease, or by providing a new niche for the bacteria to increase its loading dose in children, resulting in disease. Either way, the result is undesirable."

Have we traded Hib disease for pneumococcal disease (which is far less treatable), and which now has taken up a predominant place in an increasing disease cycle? With over 90 pneumococcal organisms hovering, numbers of which are already intractable and antibiotic resistant, what new environmental pressure will be exerted on the microbial world when this new pneumococcal vaccine is unleashed into the community? What new and deadly organisms will evolve in retaliation to this reckless tampering with microbial ecology?

The haemophilus influenza B (Hib)vaccine has also been linked to increased rates of juvenile onset diabetes by Dr. Barthelow Classen who calculates it causes a 25% rise in the rate of diabetes. The incidence of diabetes in young children has been steadily rising since the mid 1960 s. It is a disease that shortens life expectancy, is the largest cause of blindness in the U.S. and the largest cause of non-traumatic amputations. The economic toll of diabetes is in the tens of billions of dollars.

In her search of the medical literature to find answers as to why her son developed life threatening anaphylaxis to every day foods, Rita Hoffman lays it squarely on Hib vaccine. About a decade ago, a sudden increase in children suffering from life

threatening food allergies was first noticed and started precisely when Hib vaccine was first added to the early infancy shots. Hib, along with additional boosters of MMR has increased the number of doses of vaccines given to children from 23 prior to 1987 to 30.

We start with healthy babies who are then bombarded with an arsenal of vaccines without any credence given to the natural ecology of the infant s immune system, or the time frame that is needed for it to unfold, strengthen and mature, or the natural non invasive, non-violent ways we have within our means to support this process. It is crucial that parents be enabled to evaluate the impact of vaccines on their children s health and future. It is not just a matter of suppressing this or that disease. It is a matter of understanding the much larger picture of microbial ecology and grasping the concept that when one organism, or group of organisms is thrown off kilter by powerful biological weapons like vaccines, that the fallout can create untold havoc - a cascade of events that in the long run will exert a far greater toll on health than the original disease it was meant to prevent.

Every mother has within her means the ability to protect her baby from Hib disease, ear infections, allergies, pneumonia, meningitis, and gastrointestinal illnesses a protection that reduces the risk of her baby contracting these diseases by 10 to 15 fold. By breastfeeding she enables her child to develop true and lasting health while providing the most critical foundation on which a strong neuro/immune system can form. When we reclaim our trust in nature, and embrace the big picture of health from the physical, emotional, nutritional, environmental and spiritual perspective, we become empowered to move beyond fear of disease that holds us captive to the vaccine paradigm - and move into harmony as co-creators with the greater evolutionary imperative.

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http://www.vran.org/vaccines/cpox/shingles-threat.htm

Goldman also reports that shortly after communicating on authorship issues with health officials associated with the Centers for Disease Control (CDC) concerning the shingles data and analysis, he was threatened with legal action if he published the manuscript in the medical literature. He said, "Whenever research data and information concerning potential adverse effects associated with a vaccine used in a human population are suppressed and/or misrepresented by health authorities, not only is this most disturbing, it goes against all accepted scientific norms and dangerously compromises professional ethics."

Between 1995 and 2000, shingles was not being studied, and positive aspects of vaccination contributed by Goldman were published in the Journal of the American Medical Association (JAMA) and other medical journals. In 2000, after hearing reports that school nurses were seeing cases of shingles in children for the first

time, Goldman suggested shingles be added to the active surveillance project. After two years of shingles data collection, Goldman documented the adverse effects that might well be associated with the universal varicella vaccination program. Currently, varicella immunization is mandated in thirty-eight states.

A study by Brisson et al conducted in England and Wales estimates universal varicella vaccination will contribute 21 million more shingles cases and 5,000 fatalaties due to shingles over the next 50 years. Universal varicella vaccination becomes cost-effective after most of the adult population (95% of which have had chickenpox) dies out. Another case-control study by Thomas et al, also from England, showed there was a protective effect among adults in households with children compared to those without children.

http://www.vran.org/vaccines/meningitis/men-parents.htm

In response to the deluge of information requests, we published a lengthy article in VRAN's Janurary-March, 2000 newsletter addressing some of these questions. Since then, new information has emerged indicating that the meningococcal organism is mutating, possibly in response to mass vaccination programs undertaken in various parts of the country. There is an undercurrent of anxiety emanating from health officials that the current vaccine may not only be completely ineffective in dealing with the outbreaks, but may be fueling them. Some regions have asked that Health Canada allow the introduction of a new as yet unlicensed "conjugate" vaccine that has been widely used in Britain, and has also been widely criticized for record amounts of adverse reactions. In this newsletter, we have reprinted British physician Dr. Jane Donegan's critique of the new type C conjugate meningococcal vaccine; her article offers a concrete perspective of the disease, the vaccine, and what makes children vulnerable to meningitis

Of all infectious diseases, perhaps none grips parents with greater fear than meningitis. Meningococcal disease can strike like lightning with potentially devastating consequences. A bacterial infection that causes an inflammation of the membranes that surround the brain and spinal cord, it can also lead to hearing loss, kidney failure, brain damage and in extreme cases limb amputation. Symptoms can include high fever, severe headaches, nausea, rashes and neck stiffness. The disease is primarily relegated to the late winter months and often hits teen populations. According to Health Canada, 200-300 cases of invasive meningococcal disease (IMD) occur each year. Mortality can range from 5%-15%.

Quebec experienced outbreaks of IMD in the early 90's. The province spent $30 million to vaccinate 1.6 million people of all ages, including 110,00 infants under two. It was the largest vaccination effort since the polio campaign of the 1950's and health officials have only recently admitted that they knew the vaccine given to children under the age of two risked making them more susceptible to meningitis. In fact eight infants who were vaccinated later developed meningococcal disease. Despite the sweeping vaccination campaign, outbreaks of meningitis continued to occur.

The Alberta outbreak first started in the Edmonton area in late 1999. Despite the injection of 168,000 children ages 2 to 19 over a 2-week period in Feb 2000, the disease continued to spread, seemingly unthwarted by the diligent and costly vaccination efforts of public health officials. Cases continued to occur through the spring and summer months of 2000, and well into 2001 in all age groups but primarily in those 19 years or less. According to Dr. Marcia Johnson, Deputy Medical Officer of Health in the Edmonton area, "The case occurrence accelerated in the Fall of 2000, resulting in a rate of 10.6/100 000 in the 20-24 year age group. In Oct 2000 quadrivalent vaccine was again offered to unimmunized 2-19 year olds and the vaccine campaign was expanded to all 20-24 year olds. A further 60,000 young people were immunized resulting in a coverage rate of 87% of 2 to 25 year olds." (1) Recent outbreaks have also been reported in Manitoba, British Columbia, Ontario and Quebec.

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Government claims that the vaccine has reduced the number of meningitis cases by as much as 85 percent, particularly among children aged 15-17 and infants less than a year old are being challenged. Figures compiled by The Observer appear to contradict those published by the government. "According to their statistics, there has been only an 18 percent drop in the total number of meningitis cases, from 713 cases during the first eight months of 1999 to 587 through the same time frame this year. Moreover, in parts of London, East Anglia and the West Midlands, there has even been a rise this year in the number of people diagnosed with the disease." (6)

http://www.vran.org/vaccines/mmr/rub-bull.htm

Rubella – A Benign Disease in Childhood

Downplayed by health officials and the media is the fact that rubella is a benign disease when contracted in childhood and confers lifelong immunity. In the pre-vaccine era, naturally occurring rubella epidemics produced immunity in about 80% of the population by 20 years of age with the added benefit that most adults, including women of childbearing age, sustained lifelong immunity to the disease.

Rather than meddling with the natural, widespread, disease-induced immunity, the vaccine could, instead, be offered to the remaining 20% who have not acquired natural immunity by adulthood. The double benefit with this strategy is that [1] we will then be able to retain the natural passive immunity gained over generations, to protect future generations, and [2] fewer people will be exposed to the genuine risks posed by indiscriminately vaccinating an entire population.

All Viruses Can Cause Birth Defects

"Medical people use an acronym called TORCH to define these defects" says Butler. This acronym stands for:

- T = Toxoplasma gondii
- O = Other viruses (HIV, herpes simplex, chicken pox, human parvovirus, Treponema pallidum, measles, mumps…)
- R = Rubella
- C = Cytomegalovirus
- H = Herpes simplex.

In order of severity of the first 5:

1. HIV
2. Cytomegalovirus,
3. Toxoplasma gondii,
4. Rubella,
5. Chickenpox, etc.

Butler explains "The reason all these different 'nasties' could cause almost identical defects is that viruses pull Vitamin A out of the system. If you feed a pregnant dog a diet deficient in Vitamin A (but no viruses) you will get TORCH defects in the puppies. If children in Africa who are malnourished get measles, they can go blind (as can babies born with congenital rubella effects, except in babies the blindness is permanent.). But the blindness in malnourished children is reversible with Vitamin A. The reason for these defects in babies is that in the first few weeks that a baby is forming, cells divide very quickly. One of the nutritional keys to proper cell division is vitamin A, and if a mother contracts any virus, the body uses that Vitamin A to fight the infection… but the baby keeps on forming – minus one essential building block.

The problem with this Vitamin A information is that the studies done on animals are old, and have not been recently corroborated, nor have any studies been done on pregnant women. I don't suppose they thought it worthy of study.

According to the medical literature, if a pregnant woman gets rubella in the first 4 weeks of gestation, 30 – 50% of babies run the risk of congenital malformations. Infection between the fifth and eighth week gives a risk of 25%; and during the ninth to twelfth weeks it is 8%, giving **an overall risk in the first trimester of 20%**.

The logical thought, to me, is not, "That is high, have the jab", but, "How is it that 80% of babies come through rubella in utero, in the first trimester, with no problems? What went wrong in the babies who had deformities?" I believe that diet and Vitamin A in the mother is the answer."

Why all the Chronic Diseases in Children? Canada Needs Rigorous Vaccine Studies

By Susan Fletcher

http://www.cmaj.ca/cgi/eletters/168/5/533

The Naus/Scheifele commentary, 'Canada needs a national immunization program…' [CMAJ Mar 4, 2003; 168(5)] states that government decision makers might fear "a never-ending demand for funding of new and increasingly expensive vaccines" if they adopted 'The National Immunization Strategy'. But, they say "this can be dealt with by agreeing on criteria – including economic considerations". It appears that the latter has already happened; most provinces have finally said enough is enough – with continually increasing demands for health care dollars due to an increasingly sickly population, supply can no longer meet demand.

The argument made by the editor [CMAJ Mar 4, 2003; 168(5)] that "Unless a large proportion (usually over 95%) of the population is vaccinated, herd immunity will not result and outbreaks will recur." has me scratching my head. In the same article he notes that "the near- complete immunization of whole populations in childhood has led, decades later, to whole populations of adults with waning immunity to some childhood diseases." and gives pertussis as an example saying that it "is now as common among adults as among children". Another article by John Hoey of the same CMAJ issue says there are "new concerns over the effectiveness of the varicella vaccine". Bear in mind that in the past there have been many other statements which question the efficacy of vaccines. For instance:

Dr Alan Hinman, former director of the Division of Immunization, Center for Preventative Medicine of the US CDC, said "there is virtually no epidemiological study with absolutely incontrovertible results that allow only one interpretation."; Edward Mortimer, staunch advocate of vaccinations, said "Clearly there are multiple reasons for the decline in mortality due to infectious disease in the United States in this century, and in many instances it is impossible to determine the relative contribution of different factors. There is little question that the natural history of some infectious diseases has changed spontaneously over the years for reasons not entirely clear."; a statement by L Dublin in Health Progess, 1935-1945 , publication of the Metropolitan Life Insurance Co. (pg 12), 1948 corroborates and elucidates Mortimer's thoughts: "…the combined death rate of diphtheria, measles, scarlet fever, and whooping cough declined 95 percent among children ages 1 to 14 from 1911 to 1945, before the mass immunization programs started in the United States."; and, according to the World Health Statistics Annual, 1973-1976, Vol 2, there has been a steady decline of infectious diseases "in most 'developing' countries regardless of the percentage of immunizations administered in these countries. It appears that generally improved conditions of sanitation are largely responsible for preventing 'infectious' diseases." "Herd immunity" was originally defined back in the early part of the last century as protection of any given population from a transmissible disease due to lifelong or long term immunity from having contracted and recovered from the disease. Immunity due to high standards of nutrition, cleanliness, sanitation, etc was a co-factor. (1)(2) As the editor's pertussis example and other examples above show, "herd immunity" through vaccination is a flawed concept; for various reasons vaccine efficacy is highly variable and never 100% and any immunity derived from vaccines is only short-lived. (3)

It wouldn't be so bad if all we had to worry about was lack of efficacy; after all, we managed to survive thousands of years with no vaccinations. The fact that these agents of dubious effect are also harmful is another matter. After almost 60 years of vaccinating against pertussis all we can say is that some children may have short-lived immunity due

to vaccinations but all the rest of us, especially newborns, are either pertussis immune cripples or have a family history of no vaccination but are increasingly at risk of new virulent pertussis strains being induced by decades of the vaccinations. (4) However, recent data from the US VAERS shows that deaths following pertussis vaccine far surpass deaths from pertussis (20 deaths yearly from the disease, 570 following vaccinations - and this is a gross understatement since, at most, only 10% of reactions are reported). (5)

Chickenpox, as the editor says, is one of those diseases that “only rarely have grave effects”; the main reason given for introducing varicella vaccine was to save parents the inconvenience and cost of care for sick children home from school. Just as with pertussis vaccine, the massive use of varicella vaccine for children in the US means much of that population will have no long-term immunity, either disease- or vaccine- induced. They will be at risk for serious cases of shingles later in life and their future unborn babies will be open to congenital varicella syndrome. The suggested use of adolescent/adult pertussis vaccine has already been made; no doubt varicella vaccine will also be prescribed for this age group as well as a poke to take care of the large outbreaks of shingles that are said to be due in 10 years time (6) – and so the vaccine merry-go-round continues.

I am very thankful that, according to Naus and Scheifele, underprivileged children are least likely to receive pricey new vaccines. CIDA research, the work of Dr Kalerinokos with Australian aborigines and common sense acknowledge that malnourished children, as many of these are likely to be, cannot withstand the assault of vaccines without disastrous results. (7)(8) That “vaccines are cost effective” is predicated on the fact that most disease that is probably vaccine related is not conceded to be, and even in the few cases when it is, no compensation is given.

I agree with Naus, Scheifele and the editor that we need national leadership on vaccination policy and a much improved national system of recording disease morbidity and mortality (witness my use of mainly US data). Much more pressing is the need for an adverse reaction reporting system which includes all possible adverse events and is easily accessed by the general public. What we don’t need is multitudes of new expensive vaccines on top of the many we already have, added to an already faltering health care system. Why should I, as a person who does not personally support vaccination but does support prevention through the use of healthy living and alternate therapies have to pay through taxes for vaccine programs for others when my choice for prevention is not subsidized? Universal health care in Canada is a myth.

In July 2002 a startling item appeared in a California newspaper: the NIH had just put aside US $2.5 million to create end-of-life care for infants. In the country that has the highest rate and longest history of vaccinations in the world, 53,000 infants per year were said to be dying from terminal diseases. (9)

It is heartening to see that Health Canada and public health authorities are now starting to show concern about the dismal state of Canadians’ health, especially young Canadians’, and actively promote lifestyle changes. But with all the autism, learning disabilities, asthma, diabetes, etc afflicting so many of our children today it is imperative that we go beyond that and find and rout the environmental and other factors that are causing this chronic disease. Vaccine information groups such as the one to which I belong have for many years suggested a connection between such disease and the use of vaccines, especially multi- dose vaccines. To date we have not seen any NIH reviews or vaccine trials that have had the validity to conclusively show that such a connection does not exist. In view of the tremendous amount of non-infectious disease in our children, I propose that, rather than lobby the federal government for additional universal vaccine programs, the CMAJ lobby the government to sponsor vaccine trials of unquestionable rigour so that once and for all we can determine whether or not vaccines are a source of chronic ill health in

our children. Such trials would have to be methodologically sound; rigorously controlled; involve large numbers of subjects; each be conducted over several years (one researcher who has found a correlation between vaccines and insulin dependent diabetes tells us the advent of the disease can take up to 10 years following vaccination) (10); compare similar size groups of highly vaccinated, lesser vaccinated and completely unvaccinated children; and measure all morbidity and mortality outcomes including pathological changes in immune and neurological function and genetic change in each trial subject over the entire course of the study of which he/she is a part. It's my guess that, if this were done, it might lead to a different "Enlightenment".

March 13, 2003 - Susan Fletcher, BSc Vaccination Risk Awareness Network Inc

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Source: http://www.vran.org/news-art/articles/sf01-mar03.htm

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Is MMR better than single antigen vaccines?

F. Edward Yazbak, MD, FAAP & Kathleen Yazbak, BA, MA

MMR and Monovalents, 16 January 2001

Professor Brent Taylor, head of the Department of Paediatrics and Child Health at the Royal Free and University College Medical School, recently asserted that, "Separate vaccines do not provide good protection for children." (January 14, 2001 Sunday Herald) http://www.sundayherald.com/news/newsi.hts?section=News&story_id=13747)

However, the medical literature begs to differ. Indeed, immunity in the era of single antigen vaccines-- before the widespread use of the triple MMR vaccine-- yielded extremely positive results. Quoting the CDC Manual "Epidemiology & Prevention of Vaccine-Preventable Diseases", 3rd edition, January 1996:

1. * Following licensure of the (Measles) vaccine in 1963, the incidence of measles decreased by more than 98% and 2-3 year epidemic cycles no longer occurred. p. 92
2. * Following vaccine licensure (1967), reported mumps decreased rapidly. p. 105
3. * Following vaccine licensure in 1969, rubella incidence fell rapidly. p. 117

In contrast, the medical literature post-MMR introduction and use is clearly less convincing.

Measles

Finland

Explosive School-based Measles Outbreak. Intense Exposure May Have Resulted in High Risk, Even among Re-vaccinees Mikko Paunio, Heikki Peltola, Martti Valle, Irja Davidkin, Martti Virtanen, and Olli P. Heinonen (University of Helsinki, Helsinki, Finland) Am J Epidemiol 1998;148:1103-10 "When siblings shared a bedroom with a measles case, a 78 percent risk (seven out of nine children) was observed among vaccinees. Vaccinated and unvaccinated students were equally able to infect their siblings. Total protection against measles might not be achievable, even among re-vaccinees, when children are confronted with intense exposure to measles virus." **NOTE**: This group's research is often sponsored by Merck, the vaccine manufacturer

Holland

A measles epidemic in an adequately vaccinated middle school population Van Eijndhoven MJ, et al. (Ned Tijdschr Geneeskd. 1994 Nov 26;138(48):2396-400. Dutch. PMID: 7990987; UI: 95082975. "Thirty-three of 37 patients with clinical or laboratory criteria of measles had been vaccinated... Primary failure of the measles vaccine might be the cause of the minor epidemic but the results do not cast doubt on the efficacy of the current measles vaccination."

Canada

Major measles epidemic in the region of Quebec despite a 99% vaccine coverage. Boulianne N, et al. Can J Public Health. 1991 May-Jun; 82(3):189-90. French. PMID: 1884314; UI: 91356447. "The vaccination coverage among cases was at least 84.5%. Vaccination coverage for the total population was 99.0%. Incomplete vaccination coverage is not a valid explanation for the Quebec City measles outbreak" (1989).

Outbreak of measles in a highly vaccinated secondary school population. (Toronto) Sutcliffe PA, et al. CMAJ. 1996 Nov 15;155(10):1407-13. PMID: 8943928; UI: 97099351. "Eighty-seven laboratory-confirmed or clinically confirmed cases of measles were identified (for an attack rate of 7.7%). The measles vaccination rate was 94.2%"

South Africa

The 1992 measles epidemic in Cape Town - a changing epidemiological pattern. Coetzee N, et al. S Afr Med J. 1994 Mar; 84(3):145-9. PMID: 7740350; UI: 95258851 "Immunisation coverage (at least one dose of any measles vaccine) was 91% and vaccine efficacy was estimated to be 79% (95% CI 55-90); it was highest for

monovalent measles (100%) and lowest for measles-mumps-rubella (74%)."

West Africa

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Egypt

Sero-epidemiological study of measles after 15 years of compulsory vaccination in Alexandria, Egypt. Tayil SE, et al. East Mediterr Health J. 1998 Dec;4(3):437-47. [MEDLINE record in process] PMID: 10415952; UI: 99344441. "Approximately 80% of the children with measles had been vaccinated."

United Kingdom

Reasons for non-uptake of measles, mumps, and rubella catch up immunization in a measles epidemic and side-effects of the vaccine. Roberts RJ, et al. BMJ. 1995 Jun 24;310(6995):1629-32. PMID: 7795447; UI: 95315783. "Many of the objections raised by parents could be overcome by emphasizing that primary immunization does not necessarily confer immunity and that diagnosis of measles is unreliable."

United States

Measles outbreak in a fully immunized secondary-school population. Gustafson TL, (1987) Lievens AW, Brunell PA, Moellenberg RG, Buttery CM, Sehulster LM. N Engl J Med 1987 Mar 26; 316(13):771-4 "We conclude that outbreaks of measles can occur in secondary schools, even when more than 99 percent of the students have been vaccinated and more than 95 percent are immune."

Measles Outbreak among Vaccinated High School Students-- Illinois MMWR: June 22, 1984 / 33 (24); 349 "The outbreak involved 16 high school students, all of whom had histories of measles vaccination after 15 months of age documented in their school health records"

Measles in an Immunized School-Aged Population -- New Mexico MMWR: February 01, 1985 / 34 (04); 052 The school system reported that 98% of students were vaccinated against measles before the outbreak began

Transmission of Measles Among a Highly Vaccinated School Population -- Anchorage, Alaska, 1998 MMWR: January 08, 1999 / 47(51); 1109-1111 The 33 case-patients ranged in age from 2 to 28 years (median: 16 years). Twenty-nine case-patients had received at least one dose of measles-containing vaccine (MCV) at or after age 12 months; one person with laboratory-confirmed measles had received two appropriately spaced doses of measles-mumps-rubella vaccine (MMR). At the high school where 17 cases occurred, based on school records, only one of 2186 students had not received at least one dose of MCV before the outbreak; 1057 (49%) had received one dose of MCV, and 1112 (51%) had received two or more doses.

(top)

Mumps

Singapore

Resurgence of mumps in Singapore caused by the Rubini mumps virus vaccine strain Goh, K T. Lancet Volume 354, Number 9187 16 October 1999. The measles, mumps, and rubella vaccine containing the highly attenuated Rubini mumps virus strain conferred no protection against acute parotitis in vaccinated children in Singapore. Its introduction into the national childhood immunisation programme has resulted in a reduction in the seroprevalence of mumps to pre-vaccination levels. Epidemiological investigations pointed to primary vaccine failure as the most likely cause for the resurgence of mumps. The seroprevalence of mumps in children less than 5 years of age was 22% in 1989, before the introduction of the MMR vaccine. It increased to 72·4% in 1993 after mumps vaccination (with the Urabe strain and Jeryl-Lynn strain) was introduced. In 1998, the seroprevalence of mumps again fell to 25·6%.

Switzerland

Mumps epidemic in vaccinated children in West Switzerland. Ströhle A; (1997) Eggenberger K; Steiner CA; Matter L; Germann D. Schweiz Med Wochenschr, 1997 Jun, 127:26, 1124-33 Since 1991, 6 years after the recommendation of universal childhood vaccination against measles, mumps, and rubella (MMR triple vaccine), Switzerland is confronted with a large number of mumps cases affecting both vaccinated and unvaccinated children. Up to 80% of the children suffering from mumps between 1991 and 1995 had previously been vaccinated, the majority with the Rubini vaccine strain.

Rubella

Switzerland

The incidence of rubella virus infections in Switzerland after the introduction of the MMR mass vaccination programme European Journal of Epidemiology, vol. 11, no. 3, June 1995, pp. 305-10): In evaluating the impact of the MMR mass vaccination program begun in Switzerland in 1985, "we conclude that MMR mass vaccination has not interrupted the circulation of rubella virus in Switzerland, and that improvements in the implementation and surveillance of the MMR vaccination campaign are necessary in order to avoid [the] untoward effects of it."

Conclusion

It is Professor Brent Taylor's personal opinion that the MMR provides 'better' protection to children. This view is not supported by medical literature, and does not add any useful insight to the current debate.

January 16, 2001

TL Autism Research, Falmouth, Massachusetts

http://www.vran.org/vaccines/dpt/pentacel-dpt.htm

In an article written in 1980, British professor Gordon Stewart says: "In some countries like the USA and Canada, pertussis vaccine was used intensively and it was claimed that whooping cough was a disappearing disease. Nevertheless, in both of these countries, outbreaks had been reported since 1974 in which (as in the UK) 30-50 per cent of cases were fully-vaccinated." Today, Health Canada tells us the increase in our pertussis cases arose largely since 1990. In a Sept 1, 2003 Canada Communicable Disease Report they explain: "The resurgence of pertussis was not due to poor vaccine coverage: coverage has consistently been found to be over 95% for three or more doses. The increase was largely attributable to the low efficacy of the combined adsorbed diphtheria-tetanus-pertussis whole cell vaccine used in Canada between 1980 and 1997. Its efficacy has been estimated to be in the range of 20% to 60% in children. The cohort of children immunized only with this vaccine was poorly protected and constitutes the population that has been most affected since 1990." In 1997 came the introduction of Pentacel with its pertussis portion in a new acellular form (ie containing only parts of the cells of Bordatella pertussis) and, in an attempt to counter the unfortunate increase in infected (and infectious) adolescents, Canadian provincial governments are now beginning to finance new programs for teens featuring yet another vaccine - Adacel™, dTap vaccine for adolescents. (The lower case "d" and "p" signify lower amounts of diphtheria and pertussis antigens than in the childhood vaccine.) Health Canada pins its hopes on mathematical modeling which "predicts that the overall incidence of pertussis in Canada will be lower in the next decade than it was between 1990 and 2000 because of the better protection in younger children vaccinated with the acellular vaccine." However, it admits: "The duration of protection afforded by acellular pertussis vaccines is not known".

So, if you are a parent looking for lifelong protection from pertussis for your child, that first shot of pertussis vaccine can lead to lifelong vaccine dependence which still carries no guarantee of protection but, for certain, carries risks. The problem manufacturers have always had is that in order to make a pertussis vaccine very effective in producing an antibody response, significant amounts of pertussis toxin and/or toxic adjuvant material must be used. In the Pentacel monograph only one study is cited for a claimed efficacy rate of 85.1% (meaning 85.1% of test subjects produced antibodies against pertussis). However, this must be considered the highest possible rate since the study, by Gustafsson et al published in 1996 in the New England Journal of Medicine, used only healthy subjects. And, as always, antibody production does not equal protection; Volume 46/ No RR-7, pg 4 of the March, 28, 1997 Morbidity and Mortality Weekly Report says "The findings of efficacy studies have not demonstrated a direct correlation between antibody response and protection against pertussis disease."

Vaccine researcher, Viera Scheibner, PhD and British professor Gordon Stewart have described how the spread of pertussis to infants, adolescents and adults was slowed for a few years in the United Kingdom when many parents stopped having their children vaccinated for fear of adverse reactions. Despite vaccination rates that had been averaging 80%, epidemics were still occurring every 3 to 4 yrs. After vaccination rates dropped below 40% in the mid-1970's a large epidemic followed, building gradually over a couple of years and peaking a little later than previous cycles. It caused fewer deaths than any previous pertussis epidemic, the usual age of infection having reverted back to 4 yrs. Similarly, in Sweden after vaccination against pertussis was discontinued in 1979, most new cases were in children 2 1/2 to 10 yrs old and there were no cases in infants younger than 6 mos. (4)

From a worldwide perspective, the more shots that are given, the more likely it is that the pertussis bacterium will mutate - after all, germs like to survive, too. In fact, this has already happened. Molecular surveillance of Bordatella pertussis strains carried out in Alberta and Quebec from 1985 to 1994 showed that in those two provinces at least, new strains were emerging. (5) Starting in 1994 in the Netherlands there was a greater increase in pertussis cases amongst the vaccinated than amongst the unvaccinated. Researchers concluded that the vaccine strains didn't match those circulating. Comparison of older samples of the bacterium with the most recent showed that at least two surface proteins had changed. Neither can current vaccines nor immunity derived from previous infections protect against pertussis mutants; when the bacterium changes form rapidly and/or very significantly, none of us will be immune. Considering poor and waning vaccine-derived immunity and vaccine provocation of mutation, **counter to standard beliefs, to a very large extent, continued vaccination with pertussis vaccine endangers the public rather than protects it.**

http://www.vran.org/vaccines/smallpox/sma-info.htm

Emerg Infect Dis. 2000 Jul-Aug;6(4):348-57.

Reemergence of pertussis in the highly vaccinated population of the Netherlands: observations on surveillance data.

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We analyzed pertussis reporting, death, hospitalization, and serodiagnostic data from 1976 to 1998 to help explain the cause of the 1996 pertussis outbreak in the Netherlands. The unexpected outbreak was detected by an increase in pertussis reporting and by other surveillance methods. In 1996, according to reporting and serologic data, the increase in pertussis incidence among (mostly unvaccinated) children less than 1 year of age was similar to the increase in hospital admissions. Among older (mostly vaccinated) persons, the increase in hospital admissions was relatively small. **The increase in pertussis incidence was higher among vaccinated than among unvaccinated persons of all ages.** This resulted in lower estimates of vaccine effectiveness. The proportion of pertussis infections resulting in recognizable symptoms may have increased among vaccinated persons because of a mismatch of the vaccine strain and circulating Bordetella pertussis strains. The small immunogenicity profile of the Dutch vaccine may have resulted in greater vulnerability to antigenic changes in B. pertussis.

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