# Vaccination: An Analysis of the Health Risks – Part I

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For more than a hundred years, two basic assumptions have been put forth by public health officials. One is that vaccines are safe. The second is that vaccines are effective for the conditions for which they're given. The public and our legislators have, by and large, accepted these assumptions as true, and as a result it is now compulsory in many states that children have as many as 33 separate inoculations before entering school. Some of these are given as early as the first few weeks of life.

We've been told that the end of polio, for example, as a serious health threat is due to mass inoculation programs, and again we have accepted the official dogma without question. But as we shall see, this is not exactly the truth. What's more, a disturbing reality that generally has gone unrecognized is the ever-growing number of people suffering adverse reactions to vaccinations. These individuals are predominantly infants and children, and the problems they've incurred as a result of vaccination go far beyond sore arms and transitory fever: Conditions such as autism, attention deficit disorder, *minimal* brain dysfunction, and other biochemical and neurological abnormalities have been linked to the effects of vaccines. Most tragically, so has SIDS – sudden infant death syndrome.

Because of underreporting of these troubling statistical links, however, a full picture of the effects of vaccination has not emerged. The problem of underreporting is a deep-seated one. Yet the official line is that a small minority must accept negative consequences for the greater good of the majority.

This investigation is an attempt to uncover the truth. In three parts, we will, discuss facts that challenge our assumptions about vaccine safety and effectiveness, look at the effects associated with specific vaccines, and summarize some of the legal, political and economic issues surrounding the use of vaccines. The series has required a review of thousands of articles. We are presenting information based upon hard science; hundreds of references are included here for those who want to read further. For people challenging mandatory vaccination policies, the reference section will be particularly helpful.

## Why We Should Question Our Assumptions

We think of vaccinations as panaceas and look to science to develop new ones for every known affliction, from the common cold to AIDS. Jamie Murphy, author of *What Every Parent Should Know About Childhood Immunization,*[1] attributes society's general acceptance of vaccinations, in large part, to state laws that dictate children must receive vaccines before they can attend school.

However, we must take a close look at our assumptions and ask, are we seeing the full picture? The reasons we should challenge our beliefs include the following:

**Safety issues.** Significant adverse effects have been reported with every type of vaccine. These reactions can occur soon after vaccination (short-term reactions) or several months to years later (long-term). Delayed reactions are more insidious and less obviously linked to vaccination, and thus necessitate large-scale epidemiological studies to be proven.

One would think that before injecting children worldwide with hundreds of millions of doses of vaccines, enough clinical trials would be performed to determine exactly what the effects of this large-scale human genetic experiment would be. Lack of funding is not the problem. Each year, more than $1 billion is appropriated by Congress to federal health agencies to develop, purchase, and promote the mass use of vaccines in the US but not to fund independent researchers to investigate vaccine-related health problems.

In the meantime, as an example of the volume of adverse reactions reported to the Vaccine Adverse Event Reporting System (VAERS), there were 38,787 such events between 1991 and 1994. Of these, 45% occurred on the day of vaccination, 20% on the following day, and 93% within two weeks of vaccination. Deaths were most prevalent in children 1 to 3 months old and were defined as sudden infant deaths.[2] Since, as has been amply documented, only one-tenth of vaccine-induced reactions are reported to the VAERS, this number vastly underestimates the real incidence of vaccine-associated complications. Furthermore, no link has been established when the adverse event occurs long after the time of vaccination.

Another area of concern is that many doctors refuse to vaccinate themselves and their families,[3,4] even though physicians belong to a high-risk category and are urged to accept vaccinations because of their continued, exposure to infectious disease. A 1981 article in the *Journal of the American Medical Association* reports that the lowest vaccination rate among medical personnel for the German measles vaccine occurred among obstetrician/gynecologists and the next lowest rate occurred among pediatricians.[5,6] The authors conclude, "The fear of unforeseen vaccination reactions was the main reason for the low uptake rate of physicians to be vaccinated." In the *British Medical Journal,* a 1990 article tells us that of 598 doctors questioned about hepatitis B vaccine, 86% believe that all general practitioners should be vaccinated against this disease. Yet 309 of those practitioners had not been vaccinated themselves.[7]

**Vaccinations Are Based on Unsound Principles**. According to Jamie Murphy, "Vaccines are portrayed as being indispensable and somehow better at disease protection than what our innate biological defenses and nutritional resources have accomplished for thousands of years..... Before the introduction of the measles and mumps vaccines, children got measles and they got mumps, and in the great majority of cases those diseases were benign."[8]

Walene James, author of *Immunization: The Reality Behind the Myth,*[9] explains that the full inflammatory response is necessary to create real immunity.[10] James quotes Dr. Richard Moskowitz, past president of the National Institute of Homeopathy, as stating, "Vaccines trick the body so that it will no longer initiate a generalized inflammatory response. They thereby accomplish what the entire immune system seems to have evolved to prevent. They place the virus directly into the blood and give it access to the major immune organs and tissues without any obvious way of getting rid of it. These attenuated viruses and virus elements persist in the blood for a long time, perhaps permanently. This, in turn, implies a systematic weakening of the ability to mount an effective response, not only to childhood diseases but to other acute infections as well."

Murphy observes that vaccines, unlike childhood diseases, do not produce permanent immunity. "The medical profession does not know how long vaccine immunity lasts because it is artificial immunity. If you get measles naturally, in 99% of the cases, you have lifelong immunity. If you have German measles you will have lifelong immunity. The chances of getting measles twice, German measles twice, or even whooping cough twice [are remote].... However, if you get a measles vaccine or a DPT vaccine, it does not mean that the vaccine will prevent you from getting the disease."[11]

In "Vaccination: Dispelling the Myths," Alan Phillips writes, "The clinical evidence for vaccination is their ability to stimulate antibody production in the recipient, a fact which is not disputed. What is not clear, however, is whether or not such antibody production constitutes immunity. For example, a-gamma globulinemic children are incapable of producing antibodies, yet they recover from infectious diseases almost as quickly as other children.... Natural immunization is a complex phenomenon involving many organs and systems; it cannot be fully replicated by the artificial stimulation of antibody production.... Our immunological reserve may thus actually be reduced, causing a generally lowered resistance."[12]

Phillips adds: "Another component of immunization theory is 'herd immunity,' which states that when enough people in a community are immunized, all are protected. There are many documented instances showing just the opposite – fully vaccinated populations do contract diseases; with measles, this actually seems to be the direct result of high vaccination rates...."[13,14]

Writing in *Nexus,* Phillips makes the point that immunization practice assumes that all children, regardless of age and size, are virtually the same. "An 8-pound 2-month-old receives the same dosage as a 40-pound five-year-old," Phillips points out. "Infants with immature, undeveloped immune systems may receive five or more times the dosage (relative to body weight) as older children." What's more, random testing has revealed that the number of "units" within doses has been found to range up to three times what the label indicates, with quality control tolerating a rather large margin of error,

James notes that people sometimes confuse the principle of vaccination with the principle of homeopathy, when in fact they are very different.[15] One of the differences she cites is that mass compulsory vaccinations are based upon the mistaken notion that one size fits all. Another difference is the amount of toxins given. "The homeopathic dose is minute. It is so small, in fact, that there is only an energy field left. Through a method called potentization, you are only left with a pattern; there is no trace of the substance. This is not true of an allopathic vaccine. Also, when you are taking homeopathic treatments, you are taking just one treatment, not a whole lot of them. Further, in classical homeopathy, you are never supposed to violate the body by piercing the skin."

**Questionable Science**. Many scientific studies tell us that vaccines are safe and effective when this is not necessarily the case.[16,17] Doctors and vaccine proponents often quote studies done solely on antibody production in the blood, not taking into account clinical experiences.[18,19]

Dr. Dean Black, author of *Immunizations: Compulsion or Choice,* brings up an issue that needs more attention – what if we stopped compulsory vaccination? "By looking at what happens in countries where vaccinations are no longer required," he says, "we can get an idea of what would truly happen if we were to cease demanding compulsory immunization in America. In 1975, Germany stopped requiring pertussis [whooping cough] vaccinations, and the number of children vaccinated promptly began to drop. Today, it has dropped to well below 10%. What has happened in Germany from pertussis over that period of time? The mortality rate has continued to decrease."[20]

**The Natural Evolution of Disease**. Immunization supposedly puts an end to disease. We attribute the decline in polio to the polio vaccine, the "disappearance" of smallpox to the smallpox vaccine, and so forth.[21-26]

But are vaccinations the magic bullets we believe them to be? Dr. Harris Coulter, an expert on the pertussis vaccine, co-author of *A Shot in the Dark*,[27] and author of *Vaccination, Social Violence, and Criminality*,[28] concludes otherwise.[29] Regarding infectious diseases of the past, he states, "The incidence of all of these infectious diseases was dropping very rapidly, starting in the 1930s. After World War II, the incidence continued to drop as living conditions improved. Clean water, central heating...these are the factors that really affected people's tendencies to come down with infectious diseases much more than vaccines. The vaccines might have added a little bit to that downward curve, but the curve was going down all the time anyway."

Dr. Coulter's view is supported by the *Australian Nurses Journal:* "A careful. study of the decline in disease will show that up to 90% of the so-called 'killer diseases' had all but disappeared when we introduced immunization on a large scale during the late thirties and early forties."[30] A similar statement is made by the *Medical Journal of Australia:* "The decline of tetanus as a disease began before the introduction of tetanus toxoid to the general population. The reasons for this decline are the same for the decline in all other infectious diseases: improved hygiene, improved sanitation, better nutrition, healthier living conditions, etc."

Alan Phillips elaborates on this theme: "We just assume that vaccinations are responsible for disease decline, which is not the case. For if you check the statistics, you will find that the vast majority of disease decline preceded vaccines. In the case of measles, for example, there was a 97% decline preceding vaccination; in the case of pertussis, 79%. When you look at the graph of the decline in death rate over the course of the century, you see that the rate of decline, post-immunization, was virtually the same as the decline pre-immunization, suggesting that it's difficult to tell whether or not the vaccine had any effect on an already well-established decline in disease deaths."[31,32]

Phillips attacks the notion that vaccines are responsible for the dramatic reduction in infectious disease during this and past centuries. "According to the British Association for the Advancement of Science, childhood diseases decreased 90% between 1850 and 1940, paralleling improved sanitation and hygienic practices, well before mandatory vaccination programs. Infectious disease deaths in the US and England declined steadily by an average of about 80% during this century (measles mortality declined over 97%) prior to vaccinations. In Great Britain, the polio epidemics peaked in 1950, and had declined 82% by the time the vaccine was introduced there in 1956. Thus, at best, vaccinations can be credited with only a small percentage of the overall decline in disease-related deaths this century."[33]

**Toxic Vaccine Ingredients and Manufacturing Processes**. Walene James urges parents to think about the effects the ingredients of vaccines could ➤

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have on their children's health: "There are three categories of ingredients. The first are cultured bacteria and viruses.... The second ingredient in vaccinations is the medium in which they are cultivated. This can include...dog kidney tissue, monkey kidney tissue, chicken or duck egg protein, chick embryo, calf serum, pig or horse blood, and cowpox pus. These foreign proteins are injected directly.... They are very toxic since they do not get filtered through the digestive process or pass through the liver.

"These proteins are foreign to the body, and are in a state of decomposition. They are composed of animal cells, and therefore contain animal genetic material. It is possible for the genes in these cells to be picked up by the live, attenuated viruses used in vaccines. These viruses then implant a foreign alien genetic material from animal tissue cultures into the human genetic system...."

The last category of vaccine ingredients, James says, includes stabilizers, neutralizers, carrying agents, and preservatives. "Many people feed their children healthy foods. They would never think of giving their children formaldehyde...or aluminum phosphate to eat.... These are preservatives and carrying agents that are injected... without buffering by the digestive process, or censoring by the liver."[34]

As examples of the ingredients used in vaccines, we list the contents of five common childhood vaccines below. These ingredients arc current according to the latest information, available to us, but they arc subject to change at any time:

**Hepatitis B vaccine**: This genetically engineered, noninfectious viral vaccine is derived from hepatitis B surface antigen produced in yeast cells, The Recombivax HB vaccine (Merck & Co.) uses a fermentation medium consisting of a yeast extract, soy peptone, dextrose, amino acids and mineral salts. The protein is purified, then treated with formaldehyde and coprecipitated with alum (potassium aluminum sulfate) to form bulk vaccine adjuvanted with amorphous aluminum hydroxyphosphate sulfate. There is no detectable yeast DNA in the vaccine, but it may contain not more than 1% yeast protein.[35] For the Engerix-B vaccine (SmithKline Beecham), the antigen is absorbed on aluminum hydroxide, and the product contains no more than 5% yeast protein. The product also contains sodium chloride and phosphate buffers. The pediatric/adolescent and adult formulations of Engerix-B do not have preservatives but may contain a trace amount of thimerosal (a mercury derivative) from the manufacturing process.[36] Recombivax HB is supplied in pediatric/adolescent and adult formulations with and without a preservative.[37]

**DPT vaccine**: This vaccine includes diphtheria and tetanus toxoids and acellular pertussis vaccine absorbed. The components of the acellular pertussis vaccine are isolated from phase 1 *Bordetella pertussis* culture grown in a modified Stainer-Scholte medium. They are treated with formaldehyde. For the Tripedia vaccine (Aventis Pasteur), the *Corynebacterium diphtheriae* cultures are grown in a modified Mueller and Miller medium, while the *Clostridium tetani* cultures are grown in a peptone-based medium containing a bovine (meat) extract. Both are treated with formaldehyde, and the detoxified materials are purified by serial ammonium sulfate fractionation and diafiltration. The toxoids are absorbed using aluminum potassium sulfate (alum). The product contains sodium chloride, gelatin, and polysorbate 80. The one-dose vial does not have a preservative but contains a trace amount of thimerosal from the manufacturing process; the multidose vial contains thimerosal as a preservative.[38] For the Infanrix vaccine (SmithKline Beecham), the diphtheria toxin is produced in a Linggoud and Fenton medium containing a bovine extract, and the tetanus toxin is produced in a modified Latham medium. Both are treated with formaldehyde, and each is absorbed onto aluminum hydroxide. The product contains 2-phenoxyethanol as a preservative, sodium chloride, and polysorbate 80.[39]

**Inactivated polio vaccine**: The IPOL product (Aventis Pasteur) is a highly purified, inactivated vaccine that contains three types of poliovirus. The viruses are grown in cultures of VERO cells, a continuous line of monkey kidney cells. The cells are grown in Eagle MEM modified medium, supplemented with newborn calf serum that is tested for adventitious agents before use and originates from countries free of bovine spongiform encephalopathy. For viral growth, the culture medium is M-199, without calf serum. (The residual calf serum protein is less than 1 ppm in the final vaccine.) Neomycin, streptomycin and polymyxin B are used in the production process. The vaccine also contains 2-phenoxyethanol and formaldehyde (0.02% maximum) as preservatives.[40]

**MMR vaccine**: The M-M-R II live virus vaccine (Merck & Co.) contains (1) Attenuvax, a more attenuated line of measles virus propagated in chick embryo cell culture; (2) Mumpsvax, a strain of mumps virus propagated in chick embryo cell culture; and (3) Meruvax II, the Wistar RA 27/3 strain of live attenuated rubella virus propagated in WI-38 human diploid lung fibroblasts. The product contains sorbitol, sodium phosphate, sucrose, sodium chloride, hydrolyzed gelatin, human albumin, fetal bovine serum, and neomycin. It does not contain a preservative.[41]

**Chickenpox vaccine**: The Varivax vaccine (Merck & Co.) is prepared from the Oka/Merck strain of live, attenuated varicella virus. The virus originated from a child with natural varicella. It was introduced into human embryonic lung cell, cultures, adapted to and propagated in embryonic guinea pig cell cultures and propagated in human diploid cell cultures (WI-38). The vaccine contains sucrose, hydrolyzed gelatin, sodium chloride, monosodium L-glutamate, sodium phosphate dibasic, potassium phosphate monobasic, potassium chloride, residual components of MRC-5 (human diploid) cells including DNA and protein, and trace amounts of sodium phosphate monobasic, EDTA, neomycin, and fetal bovine serum. There is no preservative.[42]

Noting that vaccines include a host of undisputed toxins, such as aluminum phosphate and formaldehyde, Alan Phillips reminds us that many of the ill effects of vaccines did not exist at anywhere near today's levels 30 years ago. He cites autism, ADD, hyperactivity, dyslexia, and a host of allergies as examples.[43]

In his book *What Every Parent Should Know About Childhood Immunization,* Jamie Murphy seconds the views of Phillips: "What could formaldehyde, aluminum, phenol...or any number of other deadly chemical substances used in vaccines possibly have to do with preventing disease in children? The fact that they are needed at all in the vaccine formula argues that the product is toxic, unstable and unreliable with or without their presence."[44]

**The Use of Thimerosal**. In July 1999, the American Academy of Pediatrics (AAP) issued a statement urging the removal of the mercury-containing preservative thimerosal from vaccines.[45] The Centers for Disease

Control and Prevention (CDC) reports that as of April 2001, all seven of the vaccines recommended for use in all children contain either no thimerosal or trace amounts only. These vaccines include hepatitis B, Haemophilus influenzae B, and DTaP (which formerly contained thimerosal as a preservative) and MMR, polio, varicella and pneumococcal (which have never contained thimerosal).[46]

The FDA explains that the vaccines are now being produced as either thimerosal-free or thimerosal-reduced products. The term *thimerosal-reduced,* it says, usually indicates that trace amounts of mercury – less than 0.5 micrograms per 0.5 mL vaccine dose – may remain from the use of thimerosal in the manufacturing process, but that thimerosal is *not* added as a preservative. The term *preservative-free* means the vaccine does not have a preservative but, again, that trace amounts may remain from the manufacturing process.[47]

The reason for the AAP's strong recommendation in 1999 was a growing concern about the risk of exposing the developing brains of infants to mercury. As more vaccines were being mandated for children, the cumulative level of mercury exceeded that deemed safe by guidelines. With the new pediatric vaccines, the FDA. says, "the most likely *maximum* amount of ethyl mercury that an infant may be exposed to from the routine vaccination schedule has been reduced from approximately 187.5 mcg to <3 mcg."[48]

While this change is certainly welcomed, we should ask why such a dangerous, known neurotoxin was allowed to be used in vaccines in the first place. Mercury exposure has been associated with nerve cell degeneration,[49] adverse behavioral effects,[50] and impaired brain development.[51] It has also been linked to degenerative chronic conditions such as Alzheimer's disease. The developing fetal nervous system is the most sensitive to its toxic effects, and prenatal exposure to high doses of mercury has been shown to cause mental retardation and cerebral palsy.[52]

Yet the CDC recommends the influenza vaccine, which for the most part still contained mercury in late 2002, to all pregnant women, despite the 2001 urging from the Institute of Medicine that "full consideration be given to removing thimerosal from any biological product to which infants, children, and pregnant women are exposed." In 2001 the FDA was in discussions with manufacturers of influenza virus vaccines regarding the development of thimerosal-free or -reduced products.[53] According to the CDC, one manufacturer of influenza vaccine, Evans Vaccines, will in fact have reduced-thimerosal influenza vaccines available for the 2002-2003 flu season. This Fluvirin product has less than 1 mcg of thimerosal per dose; other influenza vaccines have 25 mcg.[54] For the pediatric market, another manufacturer, Aventis Pasteur, announced in September 2002 that the FDA had approved a license to market a preservative-free influenza vaccine for infants aged six to 35 months. A supply of the preservative-free Fluzone was to be available for the 2002-2003 flu season.[55]

It should be noted that while the mercury content of childhood vaccines has been eliminated or greatly reduced, vaccines may still contain formaldehyde (a highly carcinogenic material used to embalm corpses) and/or aluminum.

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# Vaccination

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**Vaccine Failures**. According to Phillips, "The medical literature has a surprising number of studies documenting vaccine failure. Measles, mumps, smallpox, and polio outbreaks have all occurred in vaccinated populations. In 1989, the CDC reported: Among school-aged children, [measles] outbreaks have occurred in schools with vaccination levels of greater than 98 percent. They have occurred in all parts of the country, including areas that had not reported measles for years. The CDC even reported a measles outbreak in a documented 100%-vaccinated population. A study examining this phenomenon concluded, 'The apparent paradox is that as measles immunization rates rise to high levels in a population, measles becomes a disease of immunized persons....These studies suggest that the goal of complete immunization is actually counterproductive, a notion underscored by instances in which epidemics followed complete immunization of entire countries.... In the US in 1986, 90% of 1,300 pertussis cases in Kansas were 'adequately vaccinated.' Seventy-two percent of pertussis cases in the 1993 Chicago outbreak were fully up to date with their vaccinations."[56-64]

### Effects of Specific Vaccines

With this section, we begin an examination of the effects of specific vaccines. Seven vaccines will be covered in this and the next two installments of this series: diphtheria, pertussis and tetanus, polio, chickenpox, hepatitis B, measles, mumps and rubella, smallpox, and the now-withdrawn rotavirus vaccine.

## Diphtheria, Pertussis, and Tetanus Vaccines

### Diphtheria Vaccine

In the 15 years following the introduction of the diphtheria vaccine in 1894, the number of deaths in England and Wales rose 20%. Between 1895 and 1907, there were 63,249 cases of diphtheria in individuals treated with anti-toxin; 8,917 people died, a fatality rate of 14%. In the same time period, there were 11,716 cases not treated with anti-toxin; only 703 died, a fatality rate of 6%.

### Acellular Pertussis Vaccine

Until 1996 the whole-cell vaccine was the only whooping cough vaccine available in the US for children in their first year of life. This vaccine included all the components of the bacterium Bordetella pertussis, including the toxic ones, and was associated with high rates of adverse reactions. In Japan, a lack of trust among the public of the whole-cell vaccine led to the development of a new, purified acellular vaccine that has been used exclusively in the country since 1981.[65]

Even though a safer vaccine was widely used in Europe and Japan, it wasn't until 15 years later that the purified acellular pertussis vaccine was approved by the US FDA for use in combination with the diphtheria and tetanus toxoids for all doses in the vaccination series.[66] A 1996 study showed that the rate of adverse reactions reported to VAERS in 1991 to 1993 dropped from 9.8 per 100,000 vaccine doses to 2.9 per 100,000 after substitution of the acellular pertussis vaccine for the whole-cell vaccine for the fourth and fifth dose of DPT vaccination.[67]

**Vaccine Failure**. Ninety-one percent of pertussis cases in Nova Scotia, Canada, had received at least three doses of vaccine. Researchers concluded that "pertussis remains a significant health problem in Nova Scotia despite nearly universal vaccination,"[68] In this case, the pertussis vaccination proved ineffective.

Pertussis vaccination also has been shown to increase the susceptibility of certain individuals to the infection, as a 1997 report by the CDC clearly describes. In the Netherlands, 96% of children have received at least three shots of pertussis vaccine by the age of 12 months. Yet pertussis has been endemic in the country for the past two decades.[69]

**Increasing Cases of Pertussis in Infants and Adults**. After the United States mandated pertussis vaccination in 1978, the incidence of the disease in the following eight years trebled. While cases of pertussis were increasingly seen among every age group, the highest incidence was registered in infants less than 1 year old, and the highest relative increase was seen in adolescents and adults. It is important to note that infants suffered from the most complications, with rates of hospitalization, pneumonia, convulsions, and encephalopathy being the highest in children less than 6 months old.[70]

According to one article, the incidence of pertussis increased each year in England and Wales after an accelerated immunization schedule was introduced.[71] Since the immunity provided by the vaccine, unlike that derived from natural infection, is only temporary, more adults are now contracting the disease and are transmitting it to infants, where the infection manifests with particular severity and can often lead to death.

Epidemics of pertussis striking infants have also been reported in Australia, despite extensive vaccination coverage.[72]

**DPT Safety**. The US Department of Health and Human Services estimates that every year approximately half a million DPT shots are followed by reactions severe enough to contraindicate the administration of more pertussis vaccine. One in seven children should be turned away for further pertussis vaccine. In practice, though, this does not happen. And, as pointed out by Alan Phillips, "The FDA's VAERS (Vaccine Adverse Effects Reporting System) receives about 11,000 reports of serious adverse reactions to vaccination annually, some 1 percent (112+) of which are deaths from vaccine reactions. The majority of these deaths are attributed to the pertussis (whooping cough) vaccine, the 'P' in DPT. This figure alone is alarming, yet it is only the tip of the iceberg. The FDA estimates that only about 10% of adverse reactions are reported...."

**DPT Vaccination and Neurological Damage**. The scientific literature contains documentation of the damaging effects of DPT vaccination on the nervous system. Neurological complications include convulsions, hypotonic-hyporesponsive episodes (a collapse-shock-like status), paralysis, and encephalopathy. Articles in the literature associate DPT vaccinations with neurological problems[75,76] and convulsions.[77-80]

**DPT Vaccination and Asthma.** In a 1994 study published in the *Journal of the American Medical Association,* Dr. Michel Odent found that children immunized against whooping cough were five times more likely to suffer from asthma than those who did not receive the vaccine.[81]

Dr. Odent's is not a solitary voice. Another study, performed by Farooqi et al. on almost 2,000 children born between 1974 and 1984, showed that vaccination against whooping cough is associated with a 76% increased risk of developing asthma and other allergic diseases later in life.[82]

**DPT Vaccination and SIDS.** Sudden infant death syndrome (SIDS) is the unexpected death of a child occurring

without any apparent explanation, and for which autopsy cannot reveal a determining cause. Every year 5,000 to 6,000 children die from SIDS. The incidence peaks in infants aged 2-4 months, which correlates with the introduction of a majority of vaccine injections. It is worth noting that approximately 85% of SIDS cases occur during the first six months of life, and that the first three DPT shots were given to children at 2, 4, and 6 months of age when these studies were conducted.

A study conducted by researchers at the Mayo Clinic looked at the incidence of SIDS in Olmsted County, Minnesota, over several decades and found that it increased steadily from a rate of 0.55 per 1,000 live births in 1953 to 128 in 1992. That's a great increase in this 40-year study period. However, when the authors compared mortality from SIDS to overall infant mortality, they came up with an even more distressing finding. The increase of SIDS as a percentage of total infant deaths increased from 2.5 in 1953 to 17.9 in 1992.[83] So from 1950 to 1990, a combination of lifestyle changes, improved sanitary conditions, and progress in medical technology resulted in a reduction of practically all causes of infant death except one - sudden infant death.

In 1982, at the 34th Annual Meeting of the American Academy of Pediatrics, Dr. W. Torch presented an abstract entitled "Diphtheria-Pertussis-Tetanus (DPT) Immunization: A Potential Cause of the Sudden Infant Death Syndrome (SIDS)." Triggered by a report of 12 such deaths occurring within 3-1/2 to 19 hours of DPT vaccination, Torch's investigation looked at 70 SIDS cases. He found that two-thirds of the victims had been vaccinated from a half day to three weeks prior to death.[84]

Torch reaffirmed a link between DPT and SIDS in 1986, when he presented 11 new cases of SIDS and one of near-miss syndrome (NMS) occurring within 24 hours of DPT injection. All cases presented with SIDS pathology, yet none were diagnosed as "postvaccinal" death.[85] Analysis of these and more than 150 other cases of DPT postvaccinal deaths reported in the literature – about half of which were sudden or anaphylactic – led Torch to conclude that "Although many feel that the DPT-SIDS relationship is temporal, this author and others maintain a causal relationship exists in a yet-to-be-determined SIDS fraction."[86]

## Vaccination

Other researchers also have uncovered a relationship between DTP immunization and SIDS.[87,88]

**Tetanus Vaccination and Neurological Damage.** The literature includes articles on neurological reactions to the tetanus vaccination[89-94] and other adverse reactions.[95-97]

**In Part 2: The effects of vaccines for polio, chickenpox, hepatitis B, and measles, mumps and rubella.**

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# Vaccination


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