**Are COVID Vaccines Accelerating Deadly Cancer Epidemics?**

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For over seventy years, the American public has been called upon annually to join the fight against cancer. We are urged to make donations with the assurance that progress is being made and innovative breakthrough treatments are just around the corner. Yet despite decades of financial and institutional investment, recent developments have cast a long shadow over this narrative. Since the onset of the COVID-19 pandemic, many of the nation’s most respected cancer institutions—including Memorial Sloan Kettering, Dana-Farber, MD Anderson, and the Mayo Clinic—have been reporting an alarming surge in cancer incidence. While some attribute this to pandemic-related disruptions in healthcare, including delayed screenings and overwhelmed hospitals, emerging patterns suggest that these factors alone do not explain the scale or nature of this increase. A more disturbing hypothesis gaining traction involves the potential biological effects of the SARS-CoV-2 virus itself, and more controversially, the experimental mRNA vaccines deployed globally by Pfizer and Moderna.

Among the most troubling observations from oncologists is the rise of what is being informally termed “turbo cancers”. These aggressive, fast-moving malignancies are appearing in individuals with no prior history of the disease. Often they were in complete remission. Moreover these cancers are striking younger demographics once considered very low-risk. These cancers, such as colorectal and pancreatic types in youth in their teens and twenties, display an accelerated growth previously unseen in clinical oncology. Even more perplexing are reports of remission reversals occurring within weeks of immune-triggering events from the mRNA booster shots. Leading oncologists, such as Professor Angus Dalgleish and Dr. Patrick Soon-Shiong, are sounding alarms about a possible link between immune suppression induced by these vaccines and the sudden proliferation of advanced-stage cancers. If these trends are indeed connected to the novel mRNA technology, as these experts contend, the implications are frightening. It raises urgent scientific, ethical, and legal questions that demand open inquiry and independent investigation.

It has only been during the past 2-3 years that the term “turbo cancer” has emerged in both clinical observations and in critical medical commentaries to describe a deeply disturbing trend. Since the start of the Covid-19 pandemic, there have been increasing numbers of cases of a rapid, aggressive onset of cancer in individuals who were previously healthy, in remission, or without prior cancer diagnoses. Although turbo cancer is not a formally recognized medical classification, such as the ICD-10 or the World Health Organization’s oncology taxonomies, the term has been increasingly used to characterize a distinct clinical pattern cancers observed since the onset of the pandemic and the widespread rollout of mRNA-based vaccines. Turbo cancers are being described as malignancies that manifest and metastasize within days, weeks, or a few months of first detection. These cancers develop far faster than conventional tumor growth patterns. Not only do these cancers display unexpected severity, they also seem to respond poorly to treatment. Another factor that seems to set them apart is their demographic profile. Otherwise healthy individuals, often much younger than expected, with no significant risk factors, present signs of this rapidly fatal disease shortly after an immune-triggering event such as SARS-CoV-2 infection or an mRNA COVID vaccination.

While there is no consensus on this phenomenon in the mainstream medical community, and there are no specific histological markers or biomolecular signatures to define a turbo cancer, this absence of classification should not be mistaken for evidence against it or that it is a purely speculative conspiracy. Medical history is replete with initially anecdotal observations that were later validated through rigorous scientific scrutiny. One such example is Helicobacter pylori’s role in ulcers. To the chagrin of oncologists and physicians, turbo cancer cases often appear shortly after immune system activation, which suggests a probable immunological or inflammatory mechanism. Some hypotheses are being proposed including impaired T-cell and/or NK-cell surveillance, persistent cytokine signals, and stress-induced oncogenesis. Scientific integrity now demands that these cancer trends be investigated regardless of whether or not they challenge prevailing pro-Covid vaccine narratives and pharmaceutical interests. This post-2020 pattern of highly aggressive cancers urgently demands open-minded and independent longitudinal research.

Professor Angus Dalgleish is a globally respected oncologist and professor emeritus at St George's Hospital Medical School, University of London. He has issued one of the strongest and most unambiguous warnings to date about the dangers of mRNA COVID-19 vaccines. Known for his groundbreaking co-discovery of the CD4 receptor's role in HIV infection and for authoring over 500 peer-reviewed studies, Dr. Dalgleish brings the weight of decades of virology, immunology, and cancer research to his critique. In his own words, the use of mRNA vaccine technology in healthy populations is “unbelievably dangerous” and “should never, ever have been thought of,” especially for a virus that primarily threatens individuals already at significant risk. His evaluation goes beyond theoretical speculation; rather it is grounded in clinical evidence, immunological assays, and first-hand patient cases. Dalgleish repeatedly asserts that the mRNA vaccines do not only fail to provide effective immunity but actively suppress key components of the immune response, most notably the T-cell system after booster doses.

During our recent interview with Dr. Dalgleish, he explained that in his laboratory research, published in Frontiers in Immunology, booster doses were shown to completely shut down the T-cell response thereby rendering patients immunologically vulnerable.(1) He warns of antibody-dependent enhancement: the phenomenon of vaccine-induced antibodies attaching themselves to viral variants without neutralizing them. But most concerning is the surge in highly aggressive and rapidly progressing cancers, which he colloquially calls “turbo cancers,” that arise in his long-term patients after receiving mRNA booster shots. He recounts melanoma patients who had been stable for years suddenly relapsing with metastatic disease within weeks of vaccination. Rather than dismiss these as coincidental, Dalgleish investigated the common denominator: all his patients had received mRNA booster shots shortly before the relapse. “I was the first to spot that my patients who were bullied into having booster messenger RNA viruses... started to relapse,” he stated. This pattern is not isolated. Many other oncologists and clinicians are now reporting similar aggressive cases of relapse and newly emergent cancers in patients post-vaccination.

In several detailed cases, Professor Dalgleish described how two of his personal friends, who were both healthy and cancer-free, developed explosive, metastatic cancers within weeks of receiving mRNA booster shots. Both men experienced unusual symptoms initially mistaken for long COVID, but quickly progressed to severe bone metastases. One of the patients was diagnosed with an aggressive recurrence of melanoma, while the other with rapidly advancing multiple myeloma. A third case developed widespread lymphoma shortly after a booster vaccination. Dalgleish emphasized that these were not typical cancer trajectories: “In 40 years of doing oncology, I've probably seen two explosive cancers. Now we're seeing lots of them.” These cancers, according to him, are unresponsive to conventional therapies, including immunotherapy that would normally offer an 80% response rate in melanoma. In one case there was no response whatsoever therefore further underscoring the abnormal nature of turbo cancers’ disease progression.

Emerging clinical reports and reviews support Dr. Dalgleish’s experience. For example, there is now warranted concern about a possible association between the mRNA vaccines and the onset or reactivation of hematologic malignancies, particularly lymphomas and leukemias. Several studies describe patients who developed aggressive B-cell lymphomas shortly after receiving mRNA vaccines.(2, 3) A systematic review conducted in 2024 identified multiple cases of cutaneous lymphoma recurrence following vaccination. The authors from the Medical University of Gdansk in Poland propose that vaccine-induced immune stimulation may reactivate dormant neoplastic cells in susceptible individuals.(4) To explain the sudden rise in cancers post-Covid vaccination, Drs. Angues and Bustos at Oregon Health and Sciences University School of Medicine have proposed the “multi-hit hypothesis,” which states that repeated immune activation via mRNA vaccines could induce oncogenic stress in genetically vulnerable individuals.(5) While much more needs to be done to belter understand the oncogenic characteristics of mRNA vaccines, these initial observations nevertheless underscore the urgent need for rigorous epidemiologic studies and long-term monitoring of vaccinated populations.

Dalgleish’s warnings extend beyond individual cases to systemic failures. He denounced the roles played by national health authorities, including the Centers for Disease Control and Prevention (CDC), National Institutes of Health (NIH), and the American Cancer Society, for their silence. “Not a word,” he said, referencing the absence of institutional acknowledgment despite mounting anecdotal evidence. He described the public health response as a “massive cover-up” where causes of death are systematically being mislabeled and exaggerated to sustain phony pandemic narratives. According to Dalgleish, the risk posed by mRNA vaccines stems not only from their long-term immunosuppressive effects but also from their very design. Stabilized synthetic RNA with contaminants such as DNA capsids and SV40 promoter sequences pose severe oncogenic risks. “This is no ordinary RNA,” he warned. “It is being stabilized… It shouldn't even be considered for another human being.”

Dr. Dalgleish concludes with a harsh moral judgment: “I basically think all these people I mentioned should be in jail… This is not just crimes against individuals or even a family. This is crimes against humanity.” His position, grounded in decades of scientific and clinical experience, is clear: the mRNA vaccines pose a real and immediate oncogenic danger, and their continued use especially in healthy, low-risk populations should be halted immediately.

Between 2022 and 2024, a marked and concerning rise in cancer incidence has been documented across numerous peer-reviewed studies with a mounting evidence that this trend may be linked to exposures unique to the SARS-CoV-2 virus and the widespread administration of mRNA vaccines produced by Pfizer-BioNTech and Moderna. These increases are not only significant in magnitude but also alarming in the demographics affected. Cancers are increasingly diagnosed in younger adults. This trend deviates sharply from historical baselines. Data from the UK, for instance, revealed a 6.7% rise in breast cancer diagnoses in 2022, particularly among women under 50.(6) In Canada, breast cancer diagnoses rose by 13% and colorectal cancers by 8% in 2022. Younger adults aged between 20–39 well surpassed pre-pandemic levels.(7) The US SEER registry and CDC data also report an accelerated increase in cancer incidence since 2021, especially among individuals aged 20–39 with overall rates growing 1.15% annually since 2005 but the rising more dramatically post-2020.(8). Similarly, a large Nordic registry analysis identified a significant increase in advanced-Stage III–IV cancers in 2021–2022 following diagnostic delays in 2020. Breast, lung, and colorectal cancers sharply exceeded pre-pandemic levels.(9) Finally, a Polish cohort study covering 3.5 million individuals reported a similar surge in late-stage breast, head and neck, and colorectal cancers by late 2022.(10)

Importantly, these alarming rebounds are not confined to high-risk or elderly populations but are disproportionately impacting younger cohorts who traditionally face lower cancer risk. In the US, men aged 30–50 are experiencing the sharpest increases in head and neck cancers.(11) Furthermore, a study analyzing Google Trends identified a surge in public internet searches for cancer symptoms beginning in 2022. This very likely reflects a very real increase in symptom burden or a rapid inexplicable onset of the disease.(12) This trend is being most observed in highly vaccinated nations with otherwise robust healthcare access. While the medical establishment’s and government health agencies’ explanations center around disrupted screening and delayed diagnosis, the continued rise in cancer cases—despite the official end of the pandemic—suggests the involvement of far more insidious biological drivers. The only globally ubiquitous novel exposures during this time were SARS-CoV-2 viral infections and the unprecedented deployment of mRNA vaccine platforms, which operate through systemic lipid nanoparticle delivery and synthetic RNA constructs that are capable of modifying host immune responses for unknown time durations.

The possibility that either or both of these agents are contributing to unusual cancer progressions and immune dysregulation must now be seriously entertained. Unfortunately, the health authorities at home and abroad fail consistently to acknowledge or act upon these red flags with the urgency they demand. The CDC and FDA has largely focused on vaccine safety in the short term, while neglecting long-term surveillance. They intentionally fail to initiate independent, unbiased investigations into potential links between mRNA vaccine technologies and cancer pathogenesis. The ongoing administration of mRNA COVID-19 boosters further compounds these concerns as cancer rates continue to climb. In this context, it is imperative that comprehensive, transparent, and corporate-independent research initiatives be launched immediately to evaluate the causal role of both SARS-CoV-2 infection and mRNA vaccine exposure in the ongoing cancer epidemic. The evidence can no longer be dismissed as coincidental or attributed solely to healthcare delays.

Dr. Patrick Soon-Shiong is a renowned cancer researcher, a former faculty member at UCLA’s medical school, biotechnology innovator and a pioneer in pancreatic and stem cell transplantation. In recent interview, he expressed deep concern over the unprecedented rise in aggressive cancers among younger populations, which he has observed firsthand in his clinical practice.(13) Dr. Soon-Shiong reports witnessing metastatic pancreatic cancer in a 13-year-old boy; it was a case he describes as "devastating" and historically unheard of in his decades of experience. The young boy had exhausted all available therapies despite widespread metastasis and finally passing away. These cases, he explains, are not isolated. He notes a significant increase in colon, ovarian and pancreatic cancers among individuals as young as 8, 10, and 11 years old, and women in their 30s and 40s. “We’re seeing now 30-year-old, 40-year-old ladies, young ladies with ovarian cancer,” he stated. These aggressive, fast-progressing malignancies bear the hallmarks of turbo cancers. According to Dr. Soon-Shiong, patients previously in remission are now returning with rapidly advancing cancers that resist standard treatment protocols. “I’m getting reports of that now… people that have been in remission before are now getting back cancers and very rapidly progressing.” His accounts neatly parallel what Dr. Dalgleish is observing on the other side of the Atlantic Ocean.

Dr. Soon-Shiong links this oncogenic phenomena to a fundamental breakdown in body’s immune regulation. In particular, we are witnessing the suppression of natural killer cells and T-cells, which are the key components of the body’s cancer-fighting arsenal. He warns that both SARS-CoV-2 infection and the mRNA vaccines developed by Moderna and Pfizer may be responsible for this immune suppression and the resulting cancer surge. “COVID is oncogenic,” he plainly stated while citing multiple mechanisms through which viral persistence and inflammation drive cancer growth. Dr. Soon-Shiong explains that persistent spike protein from either the virus or the vaccines enters cells via the ACE2 receptor that are present in the brain, lungs, colon, pancreas, heart. This can result in mitochondrial dysfunction, inflammation and immune cell suppression. This, he says, is no coincidence. “Is it by coincidence that post-COVID infection, post-COVID vaccine, we’re seeing all these events where we know the spike protein goes? I don’t think so. I think it’s not a coincidence.” Research from the University of California at San Francisco has revealed SARS-CoV-2 virus replicating in colon tissue up to two years post-infection in addition to the suppression of natural killer cells thereby contributing to unchecked tumor growth.

In addition to concerns over the mRNA vaccines’ probable oncogenic adverse effects, a growing body of peer-reviewed research also suggests links between SARS-CoV-2 infection and an uptick in cancers and their rapid progression. Evidence confirms Dr. Soon-Shiong’s own observations that the virus can promote oncogenic processes through immune dysregulation, chronic inflammation and epigenetic remodeling. Similar to the vaccines, the virus’s persistence in immune-compromised cancer patients also exacerbates hematologic malignancies.(14) In one study the impairment of DNA capacity to repair itself that has been observed in Covid infections resembles the mechanisms of established oncoviruses such as HPV and EBV.(15) Moreover the virus has been shown to significantly impair lymphocyte populations, particularly CD4+ and CD8+ T cells, through a variety of immunopathological mechanisms. By suppressing T cells, the body’s tumor immunosurveillance is weakened thereby increasing long-term cancer risks.(16) Given the now widespread consensus that the virus originated from engineered manipulation at the Wuhan Institute of Virology, the global surge in cancer cases may ultimately reflect the downstream consequences of a human-made virological crisis.

Dr. Soon-Shiong is sharply critical of the mRNA vaccine approach and the federal government’s regulatory process that approved them. He warns that mRNA vaccines convert into DNA; they can potentially continue to produce viral proteins long after administration. “The idea of giving an antibody vaccine and then creating another antibody vaccine… I don’t know what that’s doing,” he said. He denounced the decision to use the spike protein as the target for vaccination. In his analysis they “went after the wrong protein.” He believes that instead researchers should have focused on a product to stimulate T-cell responses by using a nucleocapsid protein. This approach he believes would have provided long-term immunity for up to 17 years, which is crucial for long term clearing of viruses and for preventing future immune suppression. “The only vaccine that’s important is a T-cell vaccine,” he insisted. In his own personal experience there has been institutional suppression of the medical science he is advocating. Federal health officials such as Francis Collins and Anthony Fauci have made efforts to prevent trials of his T-cell vaccines.

In his final assessment, Dr. Soon-Shiong underscores the dangerous intersection between an oncogenic virus and a vaccine strategy that may replicate and amplify its immune-suppressive properties. “You see young people with pancreatic cancer all of a sudden. You see young people with colon cancer all of a sudden,” he warned. In his view, both the virus and the mRNA vaccine may be driving a new, alarming epidemic of immune failure and new cancers. His call for halting immediately Pfizer’s and Moderna’s spike-based mRNA vaccines is implicit in his warnings because they are fundamentally flawed, poorly tested and probably responsible for the turbo cancers increasing globally and especially in younger populations.

Given the striking rise in cancer incidence and the emergence of turbo cancers, during the same period as the global rollout of mRNA COVID-19 vaccines, it is scientifically prudent and ethically imperative to mandate, at a bare minimum, a black box warning on these experimental products. The convergence of demographic shifts and geographic parallels across highly vaccinated countries raises serious concerns that the Pfizer and Moderna vaccines’ unprecedented biological mechanisms are very likely contributing to this growing oncogenic crisis. Although causality has yet to be definitively proven, the scale and severity of reported cases far exceed the safety thresholds that have triggered black box warnings and market withdrawals for other pharmaceutical products with far lower injury and death burdens. Public health credibility depends not on blind endorsement, but on data-driven vigilance. In this context, a black box warning would serve as an initial critical step toward restoring scientific accountability.

NOTES

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