

# Facility Automation Management Engineering (FAME) Systems

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Wednesday, 30 July 2008

To All:

The text following this page is a draft review of the excerpted text from “**As Diseases Make Comeback, Why Aren't All Kids Vaccinated?**” by Glenn Harlan Reynolds that was published in the “August 2008” issue of *Popular Mechanics Magazine* and downloaded from:

[http://www.popularmechanics.com/science/health\\_medicine/4273262.html](http://www.popularmechanics.com/science/health_medicine/4273262.html)

on 16 July 2008.

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The formal review, which is titled “**A Review of: ‘As Diseases Make Comeback, Why Aren't All Kids Vaccinated?’**”, begins on the next page.

## Introductory Remarks

First, *to simplify this review*, the statements in the article by the author, Glenn Harlan Reynolds, will be quoted in a “Times New Roman” font.

Second, remarks by this reviewer, Paul G. King, PhD, will be presented in indented text following each of the writer’s quoted remarks.

In addition, this reviewer’s remarks will be in a dark blue “News Gothic MT” font except, when he quotes: **a)** from or refers to any federal statute or regulation, the text will be in a “Lydian” font or **b)** from other sources, the quotations will be in an “Arial Narrow” font.

When this reviewer quotes from statements made in the author’s article, this reviewer will use an *italicized “Times New Roman”* font.

Finally, should anyone find any significant factual error for which they have published substantiating documents, please submit that information to this reviewer so that he can improve his understanding of factual reality and appropriately revise his views and the final review.

Respectfully,

<S>

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## **Review of: “As Diseases Make Comeback, Why Aren't All Kids Vaccinated?”**

Since vaccine apologists, including this writer, are able to continually present their views, this reviewer, an advocate for: a) the safening of vaccines by banning the use of Thimerosal, or any other mercury compound, in the manufacture of any medicine and b) vaccine safety as well as for: c) government-supported vaccination programs only for vaccines that have been proven to be safe and medically cost-effective, will address both the “*As Diseases Make Comeback*” and the “*Why Aren't All Kids Vaccinated?*” issues in this review from these viewpoints.

Consequently, this review presents factual information that exposes the weaknesses in, and/or exposes the apparent falseness of, the broad generalizations framed in the article’s title.

Lest any take this reviewer’s remarks as those of someone who is anti-vaccine, this reviewer again reiterates that, *given the scientific information available*, he currently supports national vaccination programs for those vaccines that have truly been proven to be both generally safe and medically cost-effective, provided the individual parent’s constitutional right to “due process of law” is not abridged or ignored.

Having made his position as an advocate for:

- a. Banning the use of mercury compounds in medicine to safen vaccines,
- b. Vaccine safety, and
- c. Medically cost-effective vaccines

clear, this reviewer will now assess the statements made by the writer of the article, “*As Diseases Make Comeback, Why Aren't All Kids Vaccinated?*”

**“The measles, whooping cough and even polio have returned.** Why? Because of a new breed of vaccine deniers who are ignoring campaigns for awareness, and ultimately might live shorter—not longer—lives.”

This reviewer is amazed by either:

- a. The naiveté, or
- b. The knowing disregard of reality,

which the writer’s first statement, “*measles, whooping cough and even polio have returned*”, displays.

This is the case because measles and whooping cough have never left the United States of America.

Further, there is no apparent trend indicating that polio has returned because:

- a. The single case of paralytic polio that was found in 2005 was a live-oral-polio-vaccine-associated case and
- b. The 4 non-paralytic polio cases, found in a Minnesota cluster, *coincidentally* in 2005, were polio-vaccine-derived infections,

as the CDC’s reporting shows (**see: Summary of Notifiable Diseases – U.S. 2005** [*MMWR* 2007 March 30; **54**(53): 2-92; “**Poliomyelitis, Paralytic**”]).

Thus, polio has not returned.

For measles, every year we inoculate about 8-plus million children (currently, about 4-plus million at 12-15 months [1<sup>st</sup> dose] and about another 4-plus million at 4-6 years [2<sup>nd</sup> dose] of age) mostly with Merck's MMR<sup>®</sup> II, a man-made live-virus measles, mumps and rubella vaccine.

In the process, these inoculations create about 8-plus million uncounted cases of man-made measles, mumps and rubella infections annually.

Of these 8-plus million uncounted vaccine measles infections, some become "clinical" cases, *requiring medical intervention*, and cause serious adversities, *including death*, in some small percentage of those infected.

In addition to these uncounted vaccine-measles cases, there were other reported cases of measles each year, based on the paragraphs that follow:

### **Notifiable Measles Cases and Deaths in the USA – 2002-2006**

For example for the 5-year period from 2002 through 2006, the Center for Disease Control and Prevention (CDC) summary information reported<sup>1</sup> the following in ***Morbidity and Mortality Weekly Reporter (MMWR)***, with added **bolding**, underlining and double underlining for emphasis:

#### **1. Summary of Notifiable Diseases – U.S. 2002 (MMWR 2004 April 30; 51(53): 1-84).**

##### **"Measles**

A record low of 44 confirmed measles cases was reported in 2002, with cases occurring in 17 states. Eighteen cases were internationally imported, and exposure to these cases resulted in 15 additional cases. Three other cases had only virologic evidence of importation (i.e., genotypic analysis of measles viruses indicated an imported source). The remaining eight cases were classified as unknown source cases because no link to importation was detected. [18%] "The majority of cases were either in infants aged <12 months (18 cases) or persons aged >20 years (19 cases); only three cases occurred among children aged <5 years, and four cases among those aged 5-19 years. Three outbreaks, ranging in size from 3 to 13 cases, accounted for 43% of cases (n=19). In two of these outbreaks, the source cases were imported." [But what of the source case for the third?]

#### **2. Summary of Notifiable Diseases – U.S. 2003 (MMWR 2005 April 22; 52(54): 1-85).**

##### **"Measles**

A total of 56 confirmed measles cases, two of them fatal, were reported during 2003 by 15 states. Of the 56 cases, 24 were internationally imported, and 19 resulted from exposure to persons with imported infections. In two other cases, virologic evidence indicated an imported source. The sources for the remaining 11 cases were classified as unknown because no link to importation was detected. [20%] "Three outbreaks occurred in 2003 (size range: 3-12 cases) (1,2). The 12-case outbreak was in Hawaii and included persons aged 3 months-21 years; this outbreak began simultaneously with a measles outbreak in the Republic of the Marshall Islands, which resulted in 826 cases and three deaths (3).

1. CDC. Epidemiology of measles---United States, 2001-2003. *MMWR* 2004;53:713-5.
2. CDC. Measles, mumps, and rubella--vaccine use and strategies for elimination of measles, rubella, congenital rubella syndrome and control of mumps: recommendations of the Advisory Committee on Immunization Practices (ACIP). *MMWR* 1998;47(No. RR-8).
3. CDC. Measles epidemic--Majuro Atoll, Republic of the Marshall Islands, July 13-September 13, 2003. *MMWR* 2003;52:888-9."

#### **3. Summary of Notifiable Diseases – U.S. 2004 (MMWR 2006 June 16; 53(53): 1-79).**

##### **"Measles**

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<sup>1</sup> For those who are not familiar with disease reporting jargon, an "outbreak" is supposed to be 3 or more cases in a given location, although, in 2008, the CDC has apparently ignored this in Arkansas where 2 cases were reported as an outbreak.]

During 2004, the number of confirmed cases of measles reported in the United States was a record low. Cases occurred in 13 states; 27 cases were internationally imported and resulted in six secondary cases. For four cases, the sources are classified as unknown because no link to importation could be detected.” [15% of 37 cases] “The majority of infected persons were aged <5 years. Two outbreaks occurred, both from imported sources. In one outbreak that involved nine persons, measles occurred among nine adopted children from China; a secondary case occurred in an unvaccinated U.S. resident. In a second outbreak that involved three persons, an unvaccinated U.S. resident aged 19 years with a nonmedical exemption returned to the United States from India while infectious (1,2). Two secondary cases resulted, including one in an airline passenger who was seated directly beside the index patient. Measles can be prevented by adhering to recommendations for vaccination, including guidelines for travelers (3,4).

1. Dayan GH, Ortega-Sanchez IR, LeBaron CW. The cost of containing one case of measles: the economic impact on the public health infrastructure, Iowa, 2004. *Pediatrics* 2005;116:1–4.
2. CDC. Imported measles case associated with nonmedical vaccine exemption—Iowa, March 2004. *MMWR* 2004;53:244–6.
3. CDC. Preventable measles among U.S. residents, 2001–2004. *MMWR* 2005;54:817–20.
4. CDC. Measles, mumps, and rubella—vaccine use and strategies for elimination of measles, rubella, and congenital rubella syndrome and control of mumps: recommendations of the Advisory Committee on Immunization practices (ACIP). *MMWR* 1998;47(No. RR-8): 38–9.”

#### **4. Summary of Notifiable Diseases – U.S. 2005 (MMWR 2007 March 30; 54(53): 2–92).**

##### **“Measles**

Nearly all of confirmed measles cases reported in 2005” [66] “were import-associated.” [“32 – 23” = 9\* (CBS News: ATLANTA, Dec. 21, 2006, “Measles Outbreak Traced To One Person Girl Who Visited Romania Is Linked To Largest U.S. Measles Outbreak In A Decade”); 14%] “Half of all cases occurred among children aged 5–19 years. Overall measles morbidity increased 79% after a record low number of cases in 2004. The increase was the result primarily of an outbreak in Indiana among a group of members of a single church who had not been vaccinated for measles. This outbreak was the largest outbreak in the United States since 1996 and the largest in Indiana since 1990. The source of the outbreak was an unvaccinated U.S. resident who had acquired measles infection while traveling in Romania (1). The majority of all cases among U.S. residents can be prevented by following current recommendations for vaccination, including specific guidelines for travelers (2,3). Although the elimination of endemic measles in the United States has been achieved, and population immunity remains high (4), an outbreak can occur when measles is introduced into a susceptible group. Indiana public health officials estimated that the cost of containing the disease was approximately \$168,000 (5).”

\* The probable number of “sources are classified as unknown” cases.

- “1. CDC. Import-associated measles outbreak—Indiana, May–June 2005. *MMWR* 2005;54:1073–5.
2. CDC. Preventable measles among U.S. residents, 2001–2004. *MMWR* 2005;54:817–20.
3. CDC. Measles, mumps, and rubella—vaccine use and strategies for elimination of measles, rubella, and congenital rubella syndrome and control of mumps: recommendations of the advisory committee on immunization practices (ACIP). *MMWR* 1998;47(No. RR-8).
4. Hutchins SS, Bellini WJ, Coronado V, et al. Population immunity to measles in the United States. *J Infect Dis* 2004;189(Suppl 1):S91–7.
5. Parker AA, Staggs W, Dayan G, et al. Implications of a 2005 measles outbreak in Indiana for sustained elimination of measles in the United States. *N Engl J Med* 2006;355:447–55.

#### **5. Summary of Notifiable Diseases – U.S. 2006 (MMWR 2008 March 21; 55(53): 1–94).**

##### **“Measles**

In 2006, the Council of State and Territorial Epidemiologists (CSTE) approved a modified case classification for measles, simultaneously with those for rubella and congenital rubella syndrome (1). Because measles is no longer endemic in the United States, its future epidemiology in the U.S. will reflect its global epidemiology. The modification of the case classification clearly identifies the origin of each case and will help define the impact of imported cases on the epidemiology of measles in the United States.

As in recent years, 95% of confirmed measles cases” [55] “reported during 2006 were import-associated. Of these, 31 cases were internationally imported, 20 resulted from exposure to persons with imported infections, and in one case, virologic evidence indicated an imported source. The sources for the remaining three cases were classified as unknown because no link to importation was detected.” [5.4%] “Nearly half of all cases occurred among adults aged 20–39 years, and 20% occurred in adults aged >40 years. Four outbreaks occurred during 2006 (size range: 3–18 cases), all from imported sources. Three imported cases occurred in each of two outbreaks, with no secondary transmission. In another outbreak; one imported case and two secondary cases occurred in an immigrant community. In the fourth outbreak, 18 cases occurred among persons aged 25–46 years, most of whom had unknown vaccination histories. The primary exposure setting for this outbreak was a

large office building and nearby businesses. Five case-patients were foreign born, including the index case-patient, who had arrived in the United States 9 days before onset of symptoms.

Measles can be prevented by adhering to recommendations for vaccination, including guidelines for travelers (2,3). Although the elimination of endemic measles in the United States has been achieved, and population immunity remains high (4), an outbreak can occur when measles is introduced into a susceptible group, often at significant cost to control (5).

1. Council of State and Territorial Epidemiologists. Revision of measles, rubella, and congenital rubella syndrome case classifications as part of elimination goals in the United States. Position statement 2006-ID-16. Available at <http://www.cste.org/position%20statements/searchbyyear2006.asp>.
2. CDC. Preventable measles among U.S. residents, 2001--2004. MMWR 2005;54:817--20.
3. CDC. Measles, mumps, and rubella--vaccine use and strategies for elimination of measles, rubella, and congenital rubella syndrome and control of mumps: recommendations of the Advisory Committee On Immunization Practices (ACIP). MMWR 1998;47(No. RR-8).
4. Hutchins SS, Bellini W, Coronado V, et al. Population immunity to measles in the United States. J Infect Dis 2004;189(Suppl 1):S91--S97.
5. Parker AA, Staggs W, Dayan G, et al. Implications of a 2005 measles outbreak in Indiana for sustained elimination of measles in the United States. N Engl J Med 2006;355: 447--55."

<http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5553a1.htm>

**Reviewer's Table 1. Measles Data 2002—2006**

| Year    | Measles Cases | N (%) of Cases with an unassigned source | Measles Deaths |
|---------|---------------|--|----------------|
| 2002    | 44            | 8 (18)                                   | 0              |
| 2003    | 56            | 11 (20)                                  | 2              |
| 2004    | 37            | 4 (15)                                   | 0              |
| 2005    | 66            | 9 (14)                                   | 0              |
| 2006    | 55            | 3 (5.4)                                  | 0              |
| Average | 51.6          | 7 (13.5)                                 | ----           |

Based on the measles cases, as summarized in **Reviewer's Table 1**, there is no evidence of a significant increasing time-trend in measles cases that would be needed to support a claim that measles has returned.

Thus, the CDC's data demonstrates that measles has neither left the USA nor does this disease appear to have returned.

Turning to the man-made measles-virus infections, based on a simple category search of the Vaccine Adverse Event Reporting System (VAERS) database by a knowledgeable epidemiologist,

<http://wonder.cdc.gov/controller/datarequest/D8;jsessionid=3B462407EBBE8A5627809C...>,

this reviewer reports the results shown in **Reviewer's Table 2** on the next page.

In addition, since: **a)** the reporting to VAERS is strictly voluntary, **b)** studies on the percentage of adverse events that are reported to the U.S. Center for Disease Control and Prevention (CDC) have found that there was significant underreporting, and **c)** "less than 10%" is the general level of reporting used by many researchers when estimating the actual level of the adverse events reported in VAERS, this reviewer has simply multiplied the results found by 10 to get his guestimated numbers of total adverse events occurring in a given year and entered them in braces, "[ ]", in **Reviewer's Table 2**, in a column that is labeled "'Guestimated' Total Count".

Reviewing the reported data for "measles" in VAERS, this reviewer can only wonder why, at a minimum, the CDC is not required to report all VAERS measles-vaccine deaths as a notifiable death and all unique severe adverse events as a measles case unless the investigation of the VAERS report proves that the measles virus was not a

causal factor – perhaps in separate columns labeled “Measles-vaccine-related measles Deaths” and “Measles-vaccine-related Cases”, respectively.

Beyond that, this reviewer has only presented the reported information and his gues-  
timated total count data:

- To prove the validity of this reviewer’s claim that measles have never left America and
- As food for thought for those who read this review to ponder.

In conclusion, all of the information provided here demonstrates that measles has never left and is not, based on this data, returning (increasing at a significant rate).

**Reviewer’s Table 2. VAERS Search – Any Measles Vaccine & Adverse Reports By Category 2002—2006**

| Year Vaccinated | Event Category          | Count | “Guestimated” Total Count |
|-----------------|-------------------------|-------|---------------------------|
| 2002            | Death                   | 8     | [80]                      |
|                 | Life Threatening        | 41    | [410]                     |
|                 | Permanent Disability    | 41    | [410]                     |
|                 | Hospitalized            | 143   | [1,430]                   |
|                 | Hospitalized, Prolonged | 1     | [10]                      |
|                 | Emergency Room          | 1,502 | [15,020]                  |
|                 | Not Serious             | 2,490 | -----                     |
| 2003            | Death                   | 5     | [50]                      |
|                 | Life Threatening        | 30    | [300]                     |
|                 | Permanent Disability    | 36    | [360]                     |
|                 | Hospitalized            | 143   | [1,430]                   |
|                 | Hospitalized, Prolonged | 6     | [60]                      |
|                 | Emergency Room          | 1,545 | [15,450]                  |
|                 | Not Serious             | 3,482 | -----                     |
| 2004            | Death                   | 5     | [50]                      |
|                 | Life Threatening        | 43    | [430]                     |
|                 | Permanent Disability    | 30    | [300]                     |
|                 | Hospitalized            | 132   | [1320]                    |
|                 | Hospitalized, Prolonged | 6     | [60]                      |
|                 | Emergency Room          | 1,483 | [14,830]                  |
|                 | Not Serious             | 3,358 | -----                     |
| 2005            | Death                   | 6     | [60]                      |
|                 | Life Threatening        | 35    | [350]                     |
|                 | Permanent Disability    | 17    | [170]                     |
|                 | Hospitalized            | 122   | [1,220]                   |
|                 | Hospitalized, Prolonged | 6     | [60]                      |
|                 | Emergency Room          | 1,347 | [13,470]                  |
|                 | Not Serious             | 3,021 | -----                     |
| 2006            | Death                   | 8     | [80]                      |
|                 | Life Threatening        | 42    | [420]                     |
|                 | Permanent Disability    | 30    | [300]                     |
|                 | Hospitalized            | 165   | [1,650]                   |
|                 | Hospitalized, Prolonged | 8     | [80]                      |
|                 | Emergency Room          | 1,443 | [14,430]                  |
|                 | Not Serious             | 3,001 | -----                     |

**Notifiable Whooping Cough (Pertussis) Cases and Deaths in the USA – 2002-2006**

For the 5-year period from 2002 through 2006, the Center for Disease Control and Prevention (CDC) summary information reported the following in ***Morbidity and Mortality Weekly Reporter (MMWR)***, with added underlining and double underlining for emphasis:

## **1. Summary of Notifiable Diseases – U.S. 2002 (MMWR 2004 April 30; 51(53): 1–84).**

### **“Pertussis**

During 2002, 9,771 cases of pertussis were reported (rate: 3.4/100,000), the highest number of reported cases since 1964. Of these cases, 21% occurred among infants aged <6 months (108.8/100,000), who were too young to have received the first 3 of the 5 doses of diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine recommended by age 6; 3% occurred among children aged 6–11 months (15.4/100,000); 14% among children aged 1–4 years (8.9/100,000); 10% among children aged 5–9 years (4.8/100,000); 29% among persons aged 10–19 years (7.0/100,000); and 23% among persons aged >20 years (1.2/100,000).

Since 1995, the coverage rate with >3 doses of pertussis vaccine has been >94% among U.S. children aged 19–35 months (1). Since 1980, the number of reported cases of pertussis in infants aged <6 months and in adolescents and adults has increased in some states (2). The reasons for this increase are unknown but could include increased awareness of pertussis among health-care providers, better reporting of cases to health departments (3), and possibly an increase in circulating Bordetella pertussis. The true number of pertussis cases in adolescents and adults has likely been underreported because the pertussis cough is not pathognomonic for pertussis, persons may not seek medical care for a cough illness, and (if medical care is sought) diagnostic tests are not sufficiently sensitive. Adolescents and adults can become susceptible to disease when vaccine-induced immunity wanes, approximately 5–10 years after pertussis vaccination. The incidence of reported pertussis among children aged 7 months to 9 years has been relatively stable, suggesting protection against pertussis by routine vaccination according to the recommended schedule.

1. CDC. National, state, and urban area vaccination levels among children aged 19–35 months—United States, 2002. MMWR 2003;52:728–32.
2. CDC. Pertussis—United States, 1997–2000. MMWR 2002;51:73–6.
3. Cherry JD. The science and fiction of the “resurgence” of pertussis. Pediatrics 2003;112:405–6.”

## **2. Summary of Notifiable Diseases – U.S. 2003 (MMWR 2005 April 22; 52(54): 1–85).**

### **“Pertussis**

During 2003, a total of 11,647 cases of pertussis were reported (incidence: 4.0 per 100,000 population), the highest number of reported cases since 1964. Of the cases for which age was reported, 1,982 (17%) occurred among infants aged <6 months, who were too young to have received the first 3 of the 5 doses of diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine recommended by age 6 years. This age group had the highest reported incidence (103.1 per 100,000 population). Among the other pertussis cases, 235 occurred among children aged 6–11 months (12.2 per 100,000); 1,138 among children aged 1–4 years (7.5 per 100,000); 852 among children aged 5–9 years (4.4 per 100,000); 4,540 among persons aged 10–19 years (11.1 per 100,000); and 2,854 among persons aged >20 years (1.4 per 100,000).

Pertussis continues to cause morbidity in the United States despite high coverage levels for childhood pertussis vaccine. The incidence of reported pertussis has increased from 2.5 per 100,000 population in 1993 to 4.0 per 100,000 in 2003. How much of this increase is caused by increased recognition and better reporting of cases is unclear (1,2). Although infants have the highest morbidity associated with pertussis (during the 1990s, approximately 18,500 cases were reported among infants, of whom 67% were hospitalized [3]), adolescents now account for the majority of reported cases. Adolescents and adults can become susceptible to disease when vaccine-induced immunity wanes, approximately 5–10 years after pertussis vaccination (2).

The actual number of pertussis cases (especially among adolescents and adults) continues to be substantially underreported because the pertussis cough illness resembles other conditions, infected persons might not seek medical care, and availability of reliable diagnostic tests is limited. Culture for Bordetella pertussis is highly specific but has low sensitivity. Polymerase chain reaction is not standardized, and its use has led to overdiagnosis of pertussis during certain outbreaks (4). New strategies are needed to reduce the burden of pertussis disease in the United States; pertussis vaccines for adolescents and adults are under review by the Food and Drug Administration.

1. CDC. Pertussis—United States, 1997–2000. MMWR 2002;51:73–6.
2. Guris D, Strebel PM, Bardenheier B et al. Changing epidemiology of pertussis in the United States: increased reported incidence among adolescents and adults, 1990–1996. Clin Infect Dis 1999;28:1230–7.

3. Tanaka M, Vitek CR, Pascual B et al. Trends in pertussis among infants in the United States, 1980–1999. *JAMA* 2003;290:2968–75.
4. Lievano FA, Reynolds MA, Waring AL, et al. Issues associated with and recommendations for using PCR to detect outbreaks of pertussis. *J Clin Microbiol* 2002;40:2801–5.”

### **3. Summary of Notifiable Diseases – U.S. 2004 (*MMWR* 2006 June 16; **53**(53): 1–79).**

#### **“Pertussis**

In 2004, incidence of reported pertussis increased for the third year in a row, to 8.9 cases per 100,000 population, more than twice the rate reported in 2003.” [25,827 cases] “The number of cases was the highest reported since 1959. Of the cases for which age was reported, 10% occurred among infants aged <6 months who were too young to have received the first 3 of the 5 doses of diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine recommended by age 6 years. This age group had the highest reported rate (136.5 per 100,000 population). Among older infants aged 6–11 months, the rate was 31.8 per 100,000. Among older children and adults, rates were 16.9 among children aged 1–4 years, 12.6 among children aged 5–9 years, 23.9 among children and adolescents aged 10–19 years, and 3.5 among adults aged >20 years.

Pertussis continues to cause morbidity in the United States despite high coverage levels for childhood pertussis vaccine. During 1994–2004, the reported pertussis rate per 100,000 population increased from 1.8 to 8.9. How much of this increase reflects greater recognition and better reporting of cases is unclear (1,2). Although infants have the highest morbidity associated with pertussis, adolescents and adults now account for the majority (67%) of reported cases. They become susceptible to disease when vaccine-induced immunity wanes, approximately 5–10 years after pertussis vaccination (2).

Two tetanus toxoid, reduced diphtheria toxoid and acellular pertussis vaccine, adsorbed (Tdap) products were licensed by the Food and Drug Administration in 2005 as single-dose booster vaccines to provide protection against tetanus, diphtheria, and pertussis. CDC's Advisory Committee on Immunization Practices (ACIP) recommends the routine use of Tdap vaccines among adolescents aged 11–18 years in place of tetanus and diphtheria toxoids (Td) vaccines (3). ACIP also has made a provisional recommendation that adults aged 19–64 years receive a single dose of Tdap to replace the next dose (4). The primary objective of administering the adolescent pertussis booster is to protect adolescents and adults against pertussis. Strategies for use of Tdap in adults are under review.

1. CDC. Pertussis—United States, 1997–2000. *MMWR* 2002;51:73–6.
2. Guris D, Strebel PM, Bardenheier B, et al. Changing epidemiology of pertussis in the United States: increased reported incidence among adolescents and adults, 1990–1996. *Clin Infect Dis* 1999;28:1230–7.
3. CDC. Preventing tetanus, diphtheria, and pertussis among adolescents; use of tetanus toxoid, reduced diphtheria toxoid and acellular pertussis vaccines; recommendations of the Advisory Committee on Immunization Practices (ACIP). *MMWR* 2006;55(No. RR-3):1–45.
4. CDC. ACIP votes to recommend use of combined tetanus, diphtheria, and pertussis vaccine for adults. Atlanta, GA: US Department of Health and Human Services, CDC; 2005. Available at <http://wwwdev.cdc.gov/nip/vaccine/tdap/tdap-adult-recs.pdf>.”

### **4. Summary of Notifiable Diseases – U.S. 2005 (*MMWR* 2007 March 30; **54**(53): 2–92).**

#### **“Pertussis**

In 2005, incidence of reported pertussis remained stable at 8.7 cases per 100,000 population after doubling during 2003–2004.” [25,616 cases] “Infants aged <6 months, who are too young to be fully vaccinated, had the highest reported rate of pertussis (160.81 per 100,000 population), but adolescents aged 10–19 years and adults aged >20 years contributed the greatest number of reported cases (60%). Adolescents and adults might be a source of transmission of pertussis to young infants who are at higher risk for severe disease and death (1). In addition to routine use of tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis vaccine (Tdap) in adolescents aged 11–18 years as recommended by the Advisory Committee on Immunization Practices (ACIP) in 2005, ACIP recommends use of Tdap for a single dose to replace the next dose of Td for adults aged 19–64 years (2,3). Use of Tdap also is recommended for certain populations of adults, including health-care workers and persons in close contact with infants aged <12 months (3,4).

1. Bisgard KM, Pascual FB, Ehresmann KR, et al. Infant pertussis: who was the source? *Pediatr Infect Dis J* 2004;23:985–9.
2. CDC. Preventing tetanus, diphtheria, and pertussis among adolescents; use of tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis vaccines; recommendations of the Advisory Committee on Immunization Practices (ACIP). *MMWR* 2006;55(No. RR-3).
3. CDC. ACIP votes to recommend use of combined tetanus, diphtheria and pertussis (Tdap) vaccine for adults. Atlanta, GA: US Department of Health and Human Services, CDC; 2006. Available at [http://www.cdc.gov/nip/vaccine/tdap/tdap\\_adult\\_recgs.pdf](http://www.cdc.gov/nip/vaccine/tdap/tdap_adult_recgs.pdf).

4. CDC. Prevention of tetanus, diphtheria and pertussis among pregnant women: provisional ACIP recommendations for the use of Tdap vaccine. Atlanta, GA: US Department of Health and Human Services, CDC; 2006. Available at [http://www.cdc.gov/nip/recs/provisional\\_rec/tdap-preg.pdf](http://www.cdc.gov/nip/recs/provisional_rec/tdap-preg.pdf).”

## 5. Summary of Notifiable Diseases – U.S. 2006 (MMWR 2008 March 21; 55(53): 1–94).

### “Pertussis

In 2006, incidence of reported pertussis decreased to 5.35 cases per 100,000 population after peaking during 2004–2005 at 8.9 per 100,000.” [15,632 cases] “Infants aged <6 months, who are too young to be fully vaccinated, had the highest reported rate of pertussis (84.21 per 100,000 population), but adolescents aged 10–19 years and adults aged >20 years contributed the greatest number of reported cases. Adolescents and adults might be a source of transmission of pertussis to young infants who are at higher risk for severe disease and death and are recommended to be vaccinated with tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis vaccine (Tdap) (1,2). In 2006, coverage with Tdap in adolescents aged 13–17 years was 10.8%, compared with 49.4% coverage with tetanus and diphtheria toxoids vaccine (Td) (3). The decrease in reported pertussis incidence in 2006 is unlikely to be related to use of Tdap and is more likely related to the cyclical nature of disease.

1. CDC. Preventing tetanus, diphtheria, and pertussis among adolescents; use of tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis vaccines: recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR 2006;55(No. RR-3).
2. CDC. Preventing tetanus, diphtheria, and pertussis among adults: use of tetanus toxoid, reduced diphtheria toxoid and acellular pertussis vaccine: recommendations of the Advisory Committee on Immunization Practices (ACIP) and Recommendation of ACIP, supported by the Healthcare Infection Control Practices Advisory Committee (HICPAC), for use of Tdap among health-care personnel. MMWR 2006;55 (No. RR-17).
3. CDC. National vaccination coverage among adolescents aged 13–17 years—United States, 2006. MMWR 2007;56:885–8.”

Tabulating the preceding cases and earlier year’s cases data in **Reviewer’s Table 3**, it appears that, *as the 2006 CDC report stated:*

“The decrease in reported pertussis incidence in 2006 is unlikely to be related to use of Tdap and is more likely related to the cyclical nature of disease.”

the change in the cases and incidence rates are part of a periodic cycle in disease intensity.

**Reviewer’s Table 3. Pertussis Data 1999—2006**

| Year | Pertussis Cases | Overall Incidence per 100,000 | Incidence in Children < 6 months Old |
|------|-----------------|-------------------------------|--------------------------------------|
| 1999 | 7,288           | -----                         | -----                                |
| 2000 | 7,867           | -----                         | -----                                |
| 2001 | 7,580           | -----                         | -----                                |
| 2002 | 9,771           | 3.4                           | 108.8                                |
| 2003 | 11,697          | 4.0                           | 103.1                                |
| 2004 | 25,827          | 8.9                           | 136.5                                |
| 2005 | 25,616          | 8.7                           | 160.81                               |
| 2006 | 15,632          | 5.35                          | 84.21                                |

Given: **a)** the tens of thousands of cases reported annually and **b)** the fact that the vaccines do not contain live bacteria, this reviewer sees no need to address adverse reactions associated with the DTaP and Tdap vaccines in the context of disease-related cases of pertussis.

However, this reviewer does suggest that interested parties may want to look into the incidence rates for severe adverse reactions to the “aP” (acellular pertussis) component in the DTaP and Tdap vaccines.

In any case, *based on the information available from the CDC*, it is clear that whooping cough (pertussis) has also never left the USA.

Finally, based on: **a)** the CDC's reporting that the disease level is cyclical and **b)** the 39% drop in cases (for 2006 cases as compared to 2005 cases), pertussis has not returned (significantly increased year to year for every year from 1999 through 2006).

### **Poliomyelitis Cases and Deaths in the USA – 2002-2006**

For the 5-year period from 2002 through 2006, the Center for Disease Control and Prevention (CDC) summary information reported the following in ***Morbidity and Mortality Weekly Reporter (MMWR)***, with added underlining and double underlining for emphasis:

#### **1. Summary of Notifiable Diseases – U.S. 2002 (MMWR 2004 April 30; 51(53): 1–84).**

##### ***Poliomyelitis***

“Part 1 contains tables showing incidence data for each of the nationally notifiable diseases during 2002.\*

\* Because no cases of paralytic poliomyelitis and western equine encephalitis were reported in the United States during 2002, these diseases do not appear in the tables in Part 1.”

#### **2. Summary of Notifiable Diseases – U.S. 2003 (MMWR 2005 April 22; 52(54): 1–85).**

##### ***Poliomyelitis***

“Part 1 contains tables showing incidence data for the nationally notifiable diseases during 2003.\*

\* Because no cases of anthrax, Powassan encephalitis/meningitis, western equine encephalitis, paralytic poliomyelitis, or yellow fever were reported in the United States during 2003, these diseases do not appear in the tables in Part 1.”

#### **3. Summary of Notifiable Diseases – U.S. 2004 (MMWR 2006 June 16; 53(53): 1–79).**

##### ***Poliomyelitis***

“Part 1 contains tables showing incidence data for the nationally notifiable diseases during 2004.\*

\* Because no cases of anthrax; diphtheria; influenza-associated pediatric mortality; paralytic poliomyelitis; rubella, congenital syndrome; severe acute respiratory syndrome--associated coronavirus (SARS-CoV) disease; smallpox; vancomycin-intermediate Staphylococcus aureus; western equine encephalitis; or yellow fever were reported in the United States during 2004, these diseases do not appear in the tables in Part 1.”

#### **4. Summary of Notifiable Diseases – U.S. 2005 (MMWR 2007 March 30; 54(53): 2–92).**

##### ***Poliomyelitis, Paralytic***

In 2005, an imported case of vaccine-associated paralytic poliomyelitis (VAPP) was reported to the National Notifiable Diseases Surveillance System. In addition, type 1 vaccine-derived poliovirus (VDPV) infections were reported to CDC. The VAPP case occurred in an unvaccinated U.S. college student aged 22 years who was residing temporarily in Costa Rica, where she likely was exposed through contact with an infant who had recently been vaccinated with oral polio vaccine (OPV) (1). Although the risk is extremely low, health-care providers should be aware of contact VAPP; be alert to the diagnosis of polio, especially in unvaccinated persons with onset of acute flaccid paralysis; and obtain stool cultures for poliovirus testing. Electrodiagnostic studies can assist in differentiating polio from demyelinating conditions such as Guillain-Barré syndrome. The VDPV infections occurred among an Amish population in Minnesota. The index case-patient was an Amish infant with severe combined immune deficiency who underwent stool culture examination for diarrhea and failure to thrive. Community investigations demonstrated circulation of VDPV infection in the local Amish community but not in other related communities in the United States and Canada. No cases of paralytic disease or other clinically compatible illnesses caused by poliovirus were identified (2). VDPVs emerge from OPV viruses as a result of continuous replication in immune-deficient persons or their circulation in populations with low vaccination coverage. Because OPV has not been used in the United States since 2000 and in Canada since 1997, the original source of the VDPV infection was likely a person who received OPV in another country. Both situations highlight the risks for U.S. citizens of not being vaccinated and the importance of continued polio surveillance.

1. CDC. Imported vaccine-associated paralytic poliomyelitis---United States, 2005. MMWR 2006;55:97--9.

2. CDC. Poliovirus infections in four unvaccinated children---Minnesota, August--October 2005. MMWR 2005;54:1053--5.”

## 5. Summary of Notifiable Diseases – U.S. 2006 (*MMWR* 2008 March 21; 55(53): 1–94).

### *Poliomyelitis*

“Part 1 contains tables showing incidence data for the nationally notifiable infectious diseases during 2006.\*

\*No cases of diphtheria, neuroinvasive or nonneuroinvasive western equine encephalitis virus disease, paralytic poliomyelitis, severe acute respiratory syndrome–associated coronavirus (SARS-CoV), smallpox, yellow fever, or varicella deaths were reported in the United States in 2006; these conditions do not appear in the tables in Part 1.”

Based on the CDC’s reports, it appears that clinical paralytic poliomyelitis cases are very rare in the USA today but, *because there is no ongoing monitoring program to routinely check for the presence of the polio virus in all cases where un-resolved viral immunodeficiency issues are noticed*, there are no good population studies that verify the complete elimination of the polo virus.

Given the one (1) vaccine-associated paralytic polio case “VAPP” in a 20-year-old college student and the 4 “type 1” vaccine-derived poliovirus (VDPV) infections reported in Minnesota among the Amish, it appears that the wild polio viruses have been displaced by the vaccine-strain polio viruses.

Moreover, given the high level of vaccination with the inactivated polio vaccine and the probable residual oral-polio viruses, the polio virus cases that sporadically occur are probably from a vaccine-derived strain.

While the wild poliovirus strains seem to have been displaced, the information provided clearly indicates that neither wild polio strains nor the vaccine strains have returned.

Thus, the reality is that none of these diseases has “returned”.

Further, measles and pertussis have clearly never been entirely eliminated.

- ❑ For measles, though the true number of cases of measles, including the vaccine-measles strain cases (**see Reviewer’s Table 2**), which are not counted), and the native-measles-strain cases (probably concealed by the CDC’s purposely obtuse “classified as unknown because no link to importation was detected”) [**see Reviewer’s Table 1; “Cases with an unassigned source”**], has remained relatively stable, the CDC appears to have concealed the annual number of these cases from the general public.
- ❑ Moreover, as the measles reporting in the summary section of the annual summary reports indicates, the CDC has apparently also moved in the period from 2002 through 2008 (in the reports for the period 2000 through 2006) to even make it harder for the average researcher to easily discern the number of “confirmed” measles cases from reading the annual summary information.
- ❑ For pertussis, the information provided by the CDC clearly indicates that, *in spite of 94-plus % uptake (that appears to be increasing) for three or, now more, doses recommended*, there are thousands of “confirmed” cases annually.

Lest anyone accuse this reviewer of being anti-vaccine *per se*:

- ❑ For polio, this reviewer’s reality is that the polio vaccination program has been and, because it has adapted as our understanding of the risks has increased, is a qualified success because, in the United States, the switch to the reformulated inactivated polio virus (IPV) vaccine that has apparently eliminated the contamination with non-human primate viruses, like SV-40 that is linked to human glioblastomas, *a once very rare brain cancer*, in the brain “30-60” years

post inoculation, has eliminated the risk of paralytic polio for all Americans except the rare unvaccinated American who travels to a country that is still using a live-virus oral vaccine (OPV) and is exposed, *based on the one confirmed vaccine-associated paralytic polio case since 1999*, by close contact with a recently OPV-vaccinated baby shedding the OVP viruses.

- ❑ For measles, *provided the program adapts to safer vaccination by requiring the patient be given a single large dose of oil-soluble contaminant-free vitamin A just before vaccination; the risks for a serious adverse reactions are disclosed; and, for those who want it, single measles only and measles-rubella vaccines remain available*, this reviewer currently thinks the current measles vaccination program is, *on balance*, a successful program.
- ❑ For pertussis, this reviewer can only accept the probable need for effective pertussis interventions and accept that the current “no Thimerosal” acellular pertussis vaccines (DTaP and Tdap) probably reduce the risk of serious adverse outcomes – but thinks that, since there are serious vaccine risks and vaccination does not confer “lifetime” (5-plus-decade) immunity, the true risks, *including a possible increased risk of asthma linked to the early vaccination with DTaP (which may be Thimerosal-related)*, should be fully disclosed to the American public.

Having exhaustively addressed the deceptiveness of the writer’s first statement, this reviewer now addresses the rest of this article.

“Because of a new breed of vaccine deniers who are ignoring campaigns for awareness, and ultimately might live shorter—not longer—lives.”

Give the preceding realities, this reviewer finds that the writer’s statement here:

- Introduces a non-existent and undefined group of people, the writer’s “*new breed of vaccine deniers*”,
- Euphemistically defines the current pro-vaccine propaganda campaigns, funded by the vaccine makers, healthcare establishment, and the government, as “*campaigns for awareness*” and
- Blatantly threatens not only this writer-fabricated “*new breed of vaccine deniers*” but also the reviewer and any reader with the writer’s “*who ... ultimately might live shorter—not longer—lives*”.

Overall, this reviewer finds the writer’s statement boils down to Orwellian newspeak that disregards factual reality and fabricates whatever it needs to suit the writer’s agenda.

“Progress is easy to take for granted. When I was a child in the ’60s, polio was history, measles was on the way out, and diphtheria and whooping cough were maladies out of old movies. Now these contagious diseases are making a comeback. Take measles, for instance. The disease used to infect 3 to 4 million Americans per year, hospitalizing nearly 50,000 people and causing 400 to 500 deaths. In 2000 a panel of experts convened by the Centers for Disease Control and Prevention proclaimed that measles transmission had been eradicated in the United States, except for imported cases. But that caveat is important. An unvaccinated 7-year-old from San Diego became infected with measles while traveling with his family in Switzerland and ended up transmitting the disease

back home to two siblings, five schoolmates and four other children at his doctor's office—all of them unvaccinated.

Given the facts reported by this reviewer, this reviewer must first dismiss the writer's statements here as an Orwellian rant, where unsupported "historical" measles information (which is probably inflated by a factor of 10 for the claimed annual measles infections) that is not relevant to today's America (the writer's "*used to infect 3 to 4 million Americans per year, hospitalizing nearly 50,000 people and causing 400 to 500 deaths*", which refers to the pre-measles-vaccine era), a 2000 proclamation by a panel of CDC-selected experts, and an isolated imported-measles outbreak where those affected were unvaccinated are used to support a statement, "*Now these contagious diseases are making a comeback*" that the facts, *as this reviewer has shown*, simply do not support the writer's "*comeback*" claim for measles or whooping cough (pertussis).

"Whooping cough has also seen a resurgence: A school in the East Bay area near San Francisco was closed recently when some 16 students fell ill."

Based on the cases data for the period from 1999 through 2006 and the CDC's evaluations thereof, as stated in the "Summary of Notifiable Diseases --- United States, 2006" (published in 2008), there has been no "*resurgence*" in pertussis only a cyclic increase and, *perhaps*, because of the current "pertussis" vaccination program, a shift toward more cases in the young-adult age groups because:

- a. As the CDC: admits, "vaccine-induced immunity wanes, approximately 5--10 years after pertussis vaccination" and
- b. The immunity-loss issue has been addressed by the replacement of the use of a "DT" vaccine for boosting the immunity to diphtheria and tetanus acquired from the early childhood vaccination program with a new no-Thimerosal "Tdap" vaccine that, *in theory*, also boosts immunity to pertussis toxin.

Moreover, based on the number of "DTaP" doses now recommended and the addition of the more expensive "Tdap" vaccine for older children and adults, this reviewer must question the lifetime societal cost-effectiveness of adding more and more doses when the true costs of doing so, including the adverse-events costs, are considered – though the cost-effectiveness of adding more doses of a higher-priced vaccine, the Tdap vaccines, are clear to the vaccine makers who market these vaccines.

"The reason for these incidents—and for recent outbreaks of polio—is that the percentage of parents vaccinating their children has fallen, perhaps because some parents see no point in warding off diseases they've never encountered"

First, because there have been no "*recent outbreaks of*" wild-virus polio and the only polio outbreaks since the late 1990s, *when the use of the live oral polio virus vaccine (OVP) was phased out the USA*, were:

- Two (2), 2005 vaccine-poliovirus-related incidents,
- One incidence of only 1 case of vaccine-acquired paralytic polio from an over-seas exposure, and
- One report of four interrelated "type 1 vaccine-derived poliovirus (VDPV) infections",

this reviewer must reject the writer's misrepresenting these two isolated 2005 polio-case reports as "*outbreaks*" rather than as one incident and one time-isolated vaccine-derived outbreak as the two so obviously were.

Second, since:

- The cases of measles and pertussis occurred in children that are too young to be vaccinated and in children or adults that had been vaccinated as well as in the unvaccinated who were old enough to be vaccinated,
  - There was no significant (10-fold increase) increase needed to justify a claim of a disease “*resurgence*”:
    - In the case of measles (where no real increase was found during the 2002-2006 period or, *even if the current “outbreaks” eventually total 200-plus cases, in 2008*) or
    - In the case of pertussis (where:
      - a. The 2006 cases indicate a 60-plus percent drop from the cases in the 2004-2005 period,
      - b. 20 to 25 % of cases are in children are too young to be inoculated, and
      - c. Pertussis is known to be a disease whose incidence has cyclical increases and decreases),
- and
- *In the case of measles*, the reported cases are mostly vaccine-measles-related cases in the vaccinated, and the real, *but uncounted*, vaccine-measles cases in the measles-vaccinated population,

the reasons for the writer’s “*incidents*” and “*outbreaks*” cannot, *based on the truth*, be solely attributed to “*the percentage of parents vaccinating their children has fallen*” as the writer does here.

If nothing else, the 60-plus % decline in pertussis cases in 2006, *if considered in isolation*, points to a decrease in cases as “*the percentage of parents vaccinating their children has fallen*”.

Thus, this reviewer must reject the writer’s attempt to blame the disease outcomes observed solely on the decrease in “*the percentage of parents vaccinating their children*”.

“Religious or new-age beliefs may also factor into the decision: The San Diego outbreak spread in a school where nearly 10 percent of the students had been given personal-belief exemptions from the vaccination requirement. The East Bay outbreak started at a school that emphasizes nature-based therapy over mainstream medicine; fewer than half of the students were vaccinated.”

Here, returning to pertussis outbreaks, the writer shifts the focus from the decrease “*the percentage of parents vaccinating their children*” to “*the decision*” and, *in the San Diego school’s case*, knowingly misrepresents the lawful exemptions affirmatively chosen by the parents as if they were “*gifts*” (the writer’s “*students had been given personal-belief exemptions*”).

Further, this reviewer finds the writer’s East Bay outbreak focus on the “*fewer than half of the students were vaccinated*”, ignores several realities:

- Without exposure to the disease organism, there would have been no outbreak,
- Most of the cases were in only some of the unvaccinated children, so that most of the unvaccinated children were not clinically infected, and

- Had vaccination been fully protective, none of the vaccinated would have contracted pertussis (whooping cough), but some did.

All in all, this reviewer finds that this passage is a thinly veiled attack on the parents right to make an informed medical choice and on the fundamental right to “bodily integrity” recognized in the **Constitution of the United States of America’s** guarantee of “**due process of law**” (in Amendment V. with underlining added for emphasis:

“No person shall ... be deprived of life, liberty, or property, without due process of law; nor shall private property be taken for public use without just compensation.”

and this “**due process of law**” right to bodily integrity has been repeatedly upheld in key cases before the courts in cases dating from the 1800s.

“Why would parents refuse to vaccinate their children against dangerous diseases? Many are skeptical of modern science and medicine in general. (And it is true that most vaccines carry exceedingly tiny—but real—risks of serious illness or even death.)”

In the writer’s “why” question, the writer employs one of the tried and true devices of vaccine apologists – the writer begins by portraying the parents as “vaccination refusers” (the writer’s “*parents refuse to vaccinate their children*”) rather than the guardians of their children’s health.

Factually, caring parents, as the guardians of their children’s health should weigh:

- Each vaccine’s risks:
  - The acute risks of serious harm and death associated with the vaccine and the odds for each,
  - The risk that vaccination may contribute to or, in some cases, causes, some long-term chronic disease (e.g., increased risk of childhood MS from hepatitis B) and,
  - *In most cases*, less than lifetime immunity, and
- The vaccine’s theoretical protective benefits

against:

- a. The risk of their children’s contracting an acute childhood communicable disease and
- b. *In most cases*, thereby acquire lifetime immunity to that disease, as well as
- c. The risk that their infected children may be seriously injured or die and the odds for each risk of these risks, and
- d. The risk that the child may develop a vaccine-related/induced chronic disease.

Moreover, though the writer ignores this reality, parents must make their decision in a climate that:

- Obscures, hides or even denies the risks associated with each vaccine as the writer’s parenthetical statement: “*And it is true that most vaccines carry exceedingly tiny—but real—risks of serious illness or even death*”, which:
  - a. Uses the vague phrase, “*exceedingly tiny*” in an obvious attempt to minimize the “*but real—risks*” carried by “*most vaccines*” and
  - b. Given the writer’s “*most vaccines*” language, recognizes that some vaccines carry significant risks,

- Touts and inflates the possible benefits of each vaccine, and
- Has refused to:
  - a. Carefully study the long term risks and the risks of administering combinations of vaccines as well as
  - b. Conduct the preservative safety tests mandated for vaccines preserved with Thimerosal to prove, *as required by law*, that the preservative level of Thimerosal in each vaccine formulation is “sufficiently nontoxic so that the amount present in the recommended dose of the product will not be toxic to the recipient,” as required by 21 C.F.R. Sec. 610.15(a).

“But I think most are responding to the widespread belief that vaccines are linked to autism.”

Here, this reviewer can only agree that the writer, speaking in the first person, is entitled to:

- His thoughts and
  - Cast the realities that:
    - Autism has been repeatedly linked to some vaccines, and
    - Government medical professionals in the Department of Health and Human Services have conceded that vaccinations caused autism (*Hannah Poling v. Sec. HHS*, case 02-01466V in the U.S. Court of Federal Claims, November 2007)
- as a “widespread belief”.

“Recent studies have soundly dispelled that notion.”

Here, this reviewer only notes that the writer has obviously not read all of the recent published studies that link autism and/or other neurodevelopmental, developmental and behavioral disorders to Thimerosal-containing vaccines.

“And a simple glance at health statistics shows that autism cases continued to rise even after thimerosal, the mercury-based preservative widely blamed for the supposed autism link, was largely phased out of U.S. vaccines by 2001.”

This reviewer must first congratulate the writer for his ingenuity and cunning in fabricating a classical example of Orwellian newspeak here.

Factually, since:

- The federal “*health statistics*” are out-of-date (2002 is the latest) selected-region survey estimates of autism spectrum disorders (ASDs, *typically*, autism [autistic disorder], pervasive developmental disorders — not otherwise defined [PDD-NOS], and Asperger’s in the United States) – not autism, apparently without any attempt to correct for missed cases (underascertainment) or possible sampling bias,
- The California Department of Developmental Services data, which are for “DSM IV” autism cases and continue to grow, also suffers from the failure to: **a)** correct for underascertainment bias or **b)** explain the continued growth in the number of “children with autism” in the older age groups,

- Most of the other data are raw “school count” numbers, not “health statistics”, from the data collected by education departments with no underascertainment correction or, *in some cases*, without health-provider verification,

there are no valid nationwide “health statistics” on “autism cases”, even though the incidence rates for ASDs are currently estimated as being about 1 in 150 (66.7 per 10,000) and, *in spite of these estimated rates*, the federal government has not added autism, PDD-NOS and Asperger’s to the notifiable diseases so that all cases would have to be reported and valid the rates for each could be generated. [Note: By comparison, pertussis is a notifiable disease even though its incidence rate (0.34 to 0.89 per 10,000) is roughly 100-fold lower than the crude “2002” estimated rate for ASDs.]

Further, the writer’s assertion that “thimerosal, the mercury-based preservative widely blamed for the supposed autism link, was largely phased out of U.S. vaccines by 2001” is not supported by the following facts:

1. Of the about 50 currently (2008) U.S.-licensed vaccines, 17 of these vaccines (~ 34%) still contain some level of Thimerosal and 10 (~ 20%) of that 17 are still preserved with Thimerosal (**see Reviewer’s Table 4** on the next page),
2. The tabulation of FDA-approved vaccines from 2003 contained entries also contained entries for 18 Thimerosal-containing vaccine formulations and, *though some were different vaccines*, 10 of that 18 were also Thimerosal preserved, and
3. Of the current 17 U.S.-licensed Thimerosal-containing vaccines:
  - a. All but 2 (Sanofi’s “reduced Thimerosal” Tripedia® and TriHIBit®) are approved to be given to pregnant women and,
  - b. All but 4 of the Thimerosal-preserved influenza vaccines (3 human inactivated-influenza vaccines [CSL Limited’s Afluria®, GlaxoSmithKline Biologicals’ Fluarix®, and ID Biomedical Corporation of Quebec’ FluLaval®] and Sanofi’s bird-flu vaccine) are approved for administration to some group of children (**see Reviewer’s Table 5** on the page following **Reviewer’s Table 4**).

Therefore, because these 17 vaccines still contain some level of Thimerosal, 10 are Thimerosal-preserved vaccines, and all of the Thimerosal-preserved vaccines, except the H5N1 (bird-flu) vaccine, are approved to be directly or, *by inoculating women during pregnancy with them*, indirectly administered to developing children at some point before their 18<sup>th</sup> birthday, this reviewer finds that the writer is, *at best*, mistaken when he states that Thimerosal “*was largely phased out of U.S. vaccines by 2001.*”

Finally, since: **a)** the current “rates” for autism are, at best, only crude estimates that have not been corrected for missed cases or survey bias, **b)** Thimerosal, *contrary to the writer’s statement*, is still present in a significant percentage of U.S.-licensed vaccines, and **c)** after 2001, the FDA has continued to license both Thimerosal-containing and Thimerosal-preserved vaccines, this reviewer finds the writer’s statement here is not supported by the facts and should, *therefore*, be ignored.

#### Reviewer’s Table 4. March 2008 FDA-licensed Thimerosal-containing Vaccines

[Taken From: FDA’s “Table 3: Thimerosal and Expanded List of Vaccines - (updated 3/14/2008) Thimerosal Content in Currently Manufactured U.S. Licensed Vaccines” & recent approvals]

| No.<br>[8] | Vaccine | Trade Name  | Manufacturer        | Thimerosal Concentration[1] | Mercury         |
|------------|---------|-------------|---------------------|-----------------------------|-----------------|
| 1          | DTaP    | Tripedia[2] | Sanofi Pasteur, Inc | ≤ 0.00012%                  | ≤ 0.3 µg/0.5 mL |

|       |                                     |                                   |  |  |   |
|-------|-------------------------------------|-----------------------------------|--|--|---|
| 2     | DTaPH (Tripedia + ActHIB [2])       | TriHIBit                          | Sanofi Pasteur, Inc/SA   | ≤ 0.00012%                             | ≤ 0.3 µg/0.5 mL   |
| 3     | DT                                  | No Trade Name                     | Sanofi Pasteur, Inc  | < 0.00012% (single ds)                 | < 0.3 µg/0.5 mL   |
| 4/1   | DT (available but not marketed [3]) | No Trade Name                     | Sanofi Pasteur, Ltd [3]  | 0.01%                                  | <b>25 µg/0.5 mL</b>   |
| 5/2   | Td                                  | No Trade Name                     | Mass Public Health   | 0.0033%                                | <b>8.3 µg/0.5 mL</b>  |
| 6     | Td                                  | Decavac                           | Sanofi Pasteur, Inc  | ≤ 0.00012%                             | ≤ 0.3 µg /0.5 mL  |
| 7/3   | TT                                  | No Trade Name                     | Sanofi Pasteur, Inc  | 0.01%                                  | <b>25 µg/0.5 mL</b>   |
| 8     | HepA/HepB                           | Twinrix                           | GlaxoSmithKline Biologicals                                    | < 0.0002%                              | < 1.0 µg/1.0 mL   |
| 9/4   | Influenza                           | Afluria                           | CSL Limited  | 0.01% (multidose)                      | <b>24.5 µg /0.5 mL</b>  |
| 10/5  | Influenza                           | Fluzone [6]                       | Sanofi Pasteur, Inc  | 0.01%                                  | <b>25 µg/0.5 mL</b><br>(3 yrs & older)<br><b>12.5 µg/0.5 mL</b><br>(6- 35- months old)- |
| 11/6  | Influenza                           | Fluvirin                          | Novartis Vaccines and Diagnostics Ltd                          | 0.01%                                  | <b>25 µg/0.5 ml</b>   |
| 12    | Influenza                           | Fluvirin (Preservative Free)      | Novartis Vaccines and Diagnostics Ltd                          | < 0.0004%                              | < 1 µg/0.5 mL   |
| 13    | Influenza                           | Fluarix                           | GlaxoSmithKline Biologicals                                    | < 0.0004%                              | < 1 µg/0.5 mL   |
| 14/7  | Influenza                           | FluLaval                          | ID Biomedical Corporation of Quebec                            | 0.01%                                  | <b>25 µg/0.5 mL</b>   |
| 15/8  | Japanese Encephalitis [7]           | JE-VAX                            | Research Foundation for Microbial Diseases of Osaka University | 0.007%                                 | <b>35 µg/1.0mL</b><br>(>3 years of age)<br><b>17.5 µg/0.5 mL</b><br>(1 to 3 yrs of age) |
| 16/9  | Meningococcal                       | Menomune A, C, AC and A/C/Y/W-135 | Sanofi Pasteur, Inc  | 0.01% (multidose)                      | <b>25 µg/0.5.mL</b>   |
| 17/10 | Avian Influenza [9]                 | Influenza Virus Vaccine, H5N1     | Sanofi Pasteur Inc.  | 0.0098% (multi-ds with dss at 0 & 2 m) | <b>49 µg/1.0.mL</b><br>( <b>98 µg</b> in 2-dose regimen; <b>18 to 64 yrs of age</b> )   |

**Table Footnotes**

1. Thimerosal is approximately 50% mercury (Hg) by weight. A 0.01% solution (1 part per 10,000) of thimerosal contains 50 µg of Hg per 1 ml dose or 25 µg of Hg per 0.5 ml dose. Vaccines with a nominal "preservative" level of mercury have **bolded** mercury values.
2. Sanofi Pasteur's Tripedia may be used to reconstitute ActHib to form TriHIBit. TriHIBit is indicated for use in children 15 to 18 months of age.
3. This vaccine is not marketed in the US **but it is available**.
4. ....
5. ...
6. Children under 3 years of age receive a half-dose of vaccine, i.e., 0.25 mL (12.5 µg mercury/dose.)
7. JE-VAX is distributed by Aventis Pasteur. Children 1 to 3 years of age receive a half-dose of vaccine, i.e., 0.5 mL (17.5 µg mercury/dose).
8. The numbers in **red** are the count for the current Thimerosal-preserved vaccine formulations that have FDA approval.
9. Approved April, 17 but not in "Table 3" as it is currently only licensed for use in a pandemic outbreak; approvals for children are pending or deferred.)

“Nevertheless, these unsubstantiated fears have led some people to say that getting vaccinated should be a matter of individual choice: If you want to be protected, just get yourself and your children vaccinated.”

Here, again, the writer, *ignoring the previously established realities and his own lack of standing to speak for even “some people”*, again plays the “fear” card (the writer’s “*these unsubstantiated fears have led some people to say*”) to link what he thinks has led “*some people that getting vaccinated should be a matter of individual choice*”.

Factually, the Constitution of the United States of America under the “due process” clause in “Amendment V” has established the right of bodily integrity that inherently gives each citizen of the USA the right to hold that the issue of getting vaccinated is meant to be a matter of individual choice; and, *in general*, the U.S. courts have upheld that view as this reviewer stated previously.

Thus, this reviewer finds the writer’s attempt to reduce this “due process of law” right to a fear-driven individual choice of some people is reprehensible, beneath contempt, and, *to the extent this statement seeks to undermine the rule of law and the Constitution of the United States of America*, a statement that should be concern of all Americans.

**Reviewer’s Table 5. March 2008 FDA-licensed Thimerosal-preserved Vaccines for Children Revisited**

[Taken From: FDA CBER **Table 3:** Thimerosal and Expanded List of Vaccines - (updated 3/14/2008)  
Thimerosal Content in Currently Manufactured U.S. Licensed Vaccines]

| No. | Vaccine                             | Trade Name                        | Manufacturer   | Thimerosal Concentration[1] | Mercury   |
|-----|-------------------------------------|-----------------------------------|--|-----------------------------|---|
| 1   | DT (available but not marketed [3]) | No Trade Name                     | Sanofi Pasteur, Ltd [3]  | 0.01%                       | 25 µg/0.5 mL  |
| 2   | Td                                  | No Trade Name                     | Mass Public Health   | 0.0033%                     | 8.3 µg/0.5 mL   |
| 3   | TT                                  | No Trade Name                     | Sanofi Pasteur, Inc  | 0.01%                       | 25 µg/0.5 mL  |
| 4   | Influenza                           | Fluzone [6]                       | Sanofi Pasteur, Inc  | 0.01%                       | 25 µg/0.5 mL<br>(3 to 18 years of age)<br>12.5 µg/0.5 mL<br>(6- to 35- months old)- |
| 5   | Influenza                           | Fluvirin                          | Novartis Vaccines and Diagnostics Ltd                          | 0.01%                       | 25 µg/0.5 ml<br>(4 to 18 years of age)  |
| 6   | Japanese Encephalitis [7]           | JE-VAX                            | Research Foundation for Microbial Diseases of Osaka University | 0.007%                      | 35 µg/1.0mL<br>(>3 years of age)<br>17.5 µg/0.5 mL<br>(1 to 3 years of age)         |
| 7   | Meningococcal                       | Menomune A, C, AC and A/C/Y/W-135 | Sanofi Pasteur, Inc  | 0.01%<br>(multidose)        | 25 µg/0.5 mL<br>(9 to 18 years of age)  |

**Table Footnotes**

1. Thimerosal is approximately 50% mercury (Hg) by weight. A 0.01% solution (1 part per 10,000) of Thimerosal, which nominally contains 50 µg of Hg per 1 mL dose, 25 µg of Hg per 0.5 mL dose or 12.5 µg of Hg per 0.25 mL dose.
2. Sanofi Pasteur's Tripedia may be used to reconstitute ActHib to form TriHIBit. TriHIBit is indicated for use in children 15 to 18 months of age.
3. This vaccine is not marketed in the US **but it is available.**
4. ....
5. ...
6. Children under 3 years of age receive a half-dose of vaccine, i.e., 0.25 mL (12.5 µg mercury/dose.)
7. JE-VAX is distributed by Aventis Pasteur. Children 1 to 3 years of age receive a half-dose of vaccine, i.e., 0.5 mL (17.5 µg mercury/dose).

Finally, the writer’s, “*If you want to be protected, just get yourself and your children vaccinated,*” simply states a factual reality for all those who live in one of the about 20 states that, *in addition to a medical exemption and, in all but Mississippi and West Virginia, a religious exemption*, have a legal “philosophical exemption” clause in their state’s vaccination laws.

For those who do not live in such states, medical reality and each person’s personal religious beliefs limit choices of those who:

- Live outside of states with a “philosophical exemption”, and
- Are unwilling or unable to:
  - Move to a nearby state that has a legal “philosophical exemption” clause in their state’s vaccination laws or
  - Become part of a grassroots movement in their state to change the vaccination laws to provide a “philosophical exemption” before they need to make another vaccination decision.

“Only it’s not that easy.”

Here, this reviewer obviously disagrees with the writer.

“While the measles vaccine protects virtually everyone who is inoculated, not all vaccines have the same rate of success.”

Here, this reviewer generally agrees with the writer but notes that, *in use*, some of the current FDA-licensed vaccines have been found to be ineffective (e.g., the human influenza vaccines) or to have marginal effectiveness (e.g., the pneumococcal vaccines for children and adults).

“But even if a vaccine is effective for only 70, 80 or 90 percent of those who take it, the other 30, 20 or 10 percent who don’t get the full benefit of the vaccine are usually still not at risk.”

Here, the writer’s version of the “herd immunity” argument is much too simplistic.

This is the case because the writer’s statement ignores:

- Those who are not vaccinated,
- The adverse effects that the vaccine can have on the immune system’s of those who are inoculated but who, *as a group*, are known not develop effective immunity (e.g. the hepatitis B vaccine [ $< 2$  years of age] or the influenza vaccine in every young children ( $< 3$  years of age),
- Those who develop a partial immunity that imbalances their immune system (e.g., the effect of inoculation with Sanofi’s Menactra meningococcal vaccine that appears to trigger autoimmune disease expression), and
- Those in whom the vaccine inoculation increases their susceptibility to strains of the disease that are not addressed by the vaccine (e.g., the recent HPV vaccine cases where young women with no previous HPV-related skin infections who break out with non-vaccine-covered HPV-related skin infections shortly after being vaccinated with Merck’s Gardasil® HPV vaccine).

In addition, this writer also ignores the reality that, *in some the newer vaccines*, all that the vaccinations may do is identify those whose immune systems will, *if exposed*, be capable of fighting off the disease without damaging the body.

“That’s because most of the people around the partially protected are immune, so the disease can’t sustain transmission long enough to spread.”

Here, the writer’s remark is again too simplistic because it ignores the non-viral diseases (e.g., tetanus, pertussis, and diphtheria) and, *with Merck’s Rotateq®, a new multi-strain bioengineered live-virus rotavirus vaccine*, instances where the infectious pathogen is already widely distributed in the environment or, *in the case of RotaTeg and formerly the live oral poliovirus vaccines*, is being continually shed into an environment where the pathogen can remain infectious upon contact for extended periods of time.

The writer’s statement also conceals the reality that, *when the vaccine is a live-virus vaccine that is shed into the environment and the virus can mutate*, those who are vaccinated may infect not only those who were not vaccinated but also a significant percentage of those who were vaccinated but did not develop immunity.

“But when people decide to forgo vaccination, they threaten the entire system.”

Here, the writer appears to have abandoned his “herd” model, where some significant percentage of the people (the author’s “*the other 30, 20 or 10 percent*”, who do not have effective immunity either because the vaccine fails to trigger it or the people are not vaccinated) may not have vaccine-induced protection but the others around those people protect them by interrupting the “*transmission*” of the disease.

Here the writer’s unstated model seems to reduce to: Even if vaccinating them will kill or maim some of those who are vaccinated, all should be vaccinated so that they will not “*threaten the entire system*”.

Thus, the writer’s core motive here appears to be protecting the entire vaccination system and not the public’s health.

Again, this reviewer must oppose the writer’s “*threaten the entire system*” because it ignores the core American goal that demands that, *above all*, our healthcare systems should protect the physical, financial, emotional and spiritual health of the American people and not “*the entire*” vaccination “*system*” as the writer’s, perhaps, Freudian slip so clearly states.

“They increase their own risk and the risk of those in the community, including babies too young to be vaccinated and people with immune systems impaired by disease or chemotherapy.”

### **Re: Those Who Choose Not To Vaccinate**

Here, this reviewer agrees that “parents”, *the group of which the writer has purported been speaking previously*, who elect, *as the law permits for medical or, where permitted, religious or philosophical reasons*, to withhold vaccination from themselves and/or their children incur certain risks, responsibilities and possible rewards.

#### ***Risks for Those Who Elect Not To Vaccinate***

- Some risk of their and/or their children’s contracting a disease that the vaccine may, *but is not guaranteed to*, have prevented,
- Some risk that they or their children may contract a vaccine-related strain of a disease from children recently vaccinated with a live-virus vaccine,
- An increased risk that they or their children may be barred from their job or school in the event of a disease outbreak in the workplace or school,
- Some risk that they may have to battle for the rights that the law provides them and will have to put up with the negative stereotypes that those who chose not to vaccinate see in the mainstream media that is essentially owned by the pro-vaccine vaccinate-no-matter-what Establishment, and
- For highly contagious aggressive childhood diseases:
  - Some increased risk of permanent harm and/or death to some fraction of those infected (e.g., measles, mumps, rubella, polio, pertussis, and diphtheria), and
  - Some risk that they or their infected children may infect others if they or their children are not kept from contacting others while infectious.

#### ***Responsibilities for Those Who Elect Not To Vaccinate***

For those who chose not to vaccinate, of course, comes the responsibility to:

- Have heightened hygiene and increased vigilance to minimize the risk that they or their children may be exposed to a disease at an inappropriate time,
- Restrict the unprotected contact they and their less than two-year-old children have with outsiders
- Withhold their children from school, group activities, unintentional contact with others, and other community activities if there is any possibility that they or their children have been exposed to a communicable disease or may be exhibiting the first symptoms of a communicable disease,
- Implement stringent hygiene, heightened sanitation, and appropriate quarantine procedures if they or their children contract a communicable disease, and
- Notify their neighbors, healthcare providers, children's schools, and other organizations that they or their children have been exposed, or, *if they or their children are infected*, that they have the disease.

In addition, for those who do not vaccinate their children and choose to let their children naturally contract certain “vaccine preventable” childhood diseases, like mumps, rubella, and chickenpox, after their child is two years of age or, *when nursed longer*, after weaning, besides increasing the levels of certain nutrients needed by the body to handle the disease, the parents should be prepared for the extra time required for childcare and the need to carefully monitor and document their child's journey from exposure to infection resolution and recovery.

#### ***Possible Benefits for Those Who Elect Not To Vaccinate***

Finally, though allowing themselves or their children to have certain “childhood” diseases will, *if lucky*, only cause them a short period of acute symptoms and pain, and, *when they recover from these childhood diseases*, they should probably have lifetime immunity against all of the childhood diseases that they contract, except for chickenpox (which requires periodic post-disease re-exposure [*exogenous boosting*] to *herpes varicella zoster* to maintain immunity), and, *if they are females*, should be able to pass a full spectrum of maternal immune factors for the diseases they have contracted naturally to their offspring provided they nurse them.

In addition, they and their children may have a lessened risk for developing the long-term chronic health conditions (e.g., asthma and allergies) that seem to be much more prevalent in those who are fully vaccinated with all of today's vaccines.

However, since the preceding presentation only addresses issues facing those who elect not to vaccinate, this reviewer would be remiss if he did not also, *to be fair*, address the issues facing those who choose to vaccinate themselves or their children or wards.

#### **Re: Those Who Choose To Vaccinate**

However, there are also risks, responsibilities and probable rewards that those who choose to vaccinate may also face, even though the writer does not even mention most of them except for his earlier cryptic and dismissive parenthetical comment: “*And it is true that most vaccines carry exceedingly tiny—but real—risks of serious illness or even death.*”

### ***Risks for Those Who Elect To Vaccinate***

- Some risk for a serious vaccine-associated adverse reaction, including permanent injury or, worse, vaccine-associated death,
- If female, some risk that the immunity factors that may be transmitted to their offspring if they choose to nurse them after birth may be incomplete or nonexistent,
- Some risk that they or their children may develop one or more lifetime chronic medical conditions that was exacerbated or caused by vaccination,
- Some risk that they or their children may not be protected against the disease even when “fully” vaccinated,
- When the vaccine contains Thimerosal as a preservative or at a lower level, some risk of their or their children’s being subacutely mercury poisoned to some degree and then, *in some cases*, develop the symptoms associated with a neurodevelopmental (e.g., autism), developmental (e.g., chronic constipation or diarrhea) or behavioral disorder (e.g., ADHD and OCD)
- For acellular pertussis vaccines, some risk of vaccine-induced serious brain injury and
- For live-virus vaccines,
  - Some risk that the vaccinee’s immune system may not properly cope with the live virus leading to some risk of permanent harm and/or death to some fraction of those vaccinated with such (e.g., live-virus vaccines containing measles, mumps, rubella, varicella [chickenpox], polio, and rotavirus),
  - Some risk for the measles vaccine of significant adverse neurological and gastrointestinal outcomes, and
  - Some risk that the inoculated person(s) may infect others if they are not kept from contacting others while infectious (actively shedding virus).

### ***Responsibilities for Those Who Elect To Vaccinate***

For those who chose to vaccinate, of course, comes the responsibility to:

- Have heightened hygiene and increased vigilance to minimize the risk that they or their children and/or their wards may be exposed to a disease before they or their children or their wards are fully vaccinated for a given disease,
- Control and manage the timing of the vaccinations they and their children and/or wards receive to ensure that their or their children’s and/or wards’ immune systems are not compromised by another infection and/or overwhelmed by too many vaccinations at one time.
- Carefully read the information card and, *if concerned about the composition of the vaccine and the known adverse reactions for the vaccine*, the package insert for each vaccine that is scheduled to be administered before consenting to inoculation to ensure that:
  - There is no allergy risk from any vaccine component,
  - They understand the possible post-inoculation adverse reactions and their risks, and
  - They are comfortable with each of the vaccines that are to be administered,

- Make certain that they have affirmatively signed an appropriate consent form before allowing the vaccine to be administered and that, *after inoculation*, the name of the vaccine and the vaccine's manufacturer, the vaccine's correct lot number and its expiration date, the date administered and the name of the person giving it have been properly entered into the appropriate medical records and,
- After the vaccine(s) is(are) administered, make sure that they have a copy of each completed vaccination record, the telephone number for reporting any adverse reaction to VAERS, and the contact information for the "National Vaccine Injury Compensation Program (NVICP) in case they need to contact the U.S. Court of Federal Claims to file a vaccine injury claim should they or their children and/or wards have any serious adverse reaction that appears to be possibly temporally associated with a given vaccination,
- *For live-virus vaccines*, since there is some risk of secondary transmission to others by the person who has been vaccinated,
  - Appropriately "quarantine"/restrict the person(s) vaccinated from all unnecessary contacts for at least the period specified in the package insert for the vaccine(s) administered,
  - Implement stringent hygiene, and heightened sanitation procedures for those who have been vaccinated, and
  - Notify their neighbors, children's and/or wards' schools, and other organizations that they or their children and/or wards have been vaccinated with a live-virus vaccine that may keep them at home for a short period and make sure they have the work or school assignments for all the topics being covered during the period they or their children and/or wards are observing self quarantine, and
- Monitor, record and track the health of those vaccinated until they appear to have fully recovered from being vaccinated and appropriately include this information in the records you keep for the vaccine(s).

In addition, for those who vaccinate their children and/or wards but choose to let their children and/or wards naturally contract certain "vaccine preventable" childhood diseases, like mumps, rubella, and chickenpox, after their child and/or ward is two years of age or, *when nursed longer*, after weaning, besides increasing the levels of certain nutrients needed by the body to handle the disease, the parents or guardians should be prepared for the extra time required for childcare and the need to carefully monitor and document their child's and/or ward's journey from exposure to infection resolution and recovery.

#### ***Possible Benefits for Those Who Elect To Vaccinate***

- For contagious diseases, a lowered risk of contracting the wild/native disease (except for varicella),
- No need to seek exemptions to work or have their children and/or wards have access to school (or the hassles of seeking and maintaining these exemptions),
- For live-virus diseases (currently, measles, mumps, rubella, varicella, rotavirus, influenza and, *for some persons*, vaccinia [cowpox] and polio), general control over the date they, their children and/or their wards are infected with the disease, and

- Except for varicella, a lower risk that their children or wards will actually have a childhood disease before the age of 18 years.

Thus, *on balance*, the differences in the effort required and the overall risks, responsibilities and rewards seem to be similar for both groups.

“They are also free-riding on the willingness of others to get vaccinated, which makes a decision to avoid vaccines out of fear or personal belief a lot safer.”

First, the writer’s views ignore the reality that parents inherently make decisions for themselves and their children and/or wards based upon what they think, *based on their knowledge and experience*, is in their best interests.

Second, while the writer’s pro-vaccine views accurately portray the situation as seen from the point of view of the vaccine apologists of the world, they ignore the reality that those who choose not to vaccinate are accepting the risk for themselves and their children and/or wards that they or their children and/or wards may contract:

- Some wild/native strain disease, or
- The man-made strain of disease when exposed to others who have recently been inoculated with a live-virus vaccine (currently, measles, mumps, rubella, varicella, rotavirus, influenza and, for some, vaccine [cowpox] and polio).

Because of the high level of vaccination and the current levels of sanitation, hygiene, poverty and health, the risk of contracting a wild/native strain of a live virus is very low but the risk of contracting a man-made “vaccine” strain of a virus is, *except for varicella*, much higher than for the vaccinated children.

However, though secondary infection by the vaccine strain of the live viruses used in some vaccines is “low”, it is sufficiently high that, in the USA, the use of the live-virus oral polio vaccine was phased out in the late 1990s and, for polio, most all cases of the virus detected in humans in America in the 2000s have been vaccine-strain-related cases, typically, originating from vaccine-derived strains or strains still being used in the oral polio vaccines in other countries.

Thus, the “free ride” that those Americans who choose not to vaccinate are getting is anything but free.

“Of course it is the very success of modern vaccines that makes this complacency possible.”

Rather than rebut the writer’s simplistic and pro-vaccine-biased view of “*modern vaccines*”, this reviewer lets the recent words<sup>2</sup> of Jay Gordon, MD, who is currently an assistant professor of Pediatrics at the UCLA Medical School, address “*the very success of modern vaccines*” (with underlining added for emphasis):

Questioner: “***What are some of the side effects you've seen besides fever and bruises?***”

Dr. Gordon: “I've seen kids who developed autism shortly after vaccination. When I first went into practice in the '80s, I would get a lot of phone calls from moms, and they would say, ‘You know, after the shots, she's just acting a little different. Is that normal?’ And I'd say, ‘Yes it is.’ And they'd call back a week later and say, ‘He's still a little bit off. I can't quite describe it.’ That scared me.”

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<sup>2</sup> [http://www.cookieimag.com/entertainment/2008/07/vaccine\\_experts?currentPage=2](http://www.cookieimag.com/entertainment/2008/07/vaccine_experts?currentPage=2)

Now, many people would argue that vaccines are only for the better. I would say that there's no free lunch; it is lovely to be immune to whooping cough, but if I have to diminish your health a little bit to do that, I have to hesitate. Integrity demands that I tell you other parts of the story: I saw one child who developed seizures two days after her two-month appointment, and she didn't get any shots. It's true that the onset of autism often coincides with the time that kids are getting their shots. But the vast majority of times that I see a temporal relationship, I'm assuming it's not a coincidence.

I am 100 percent convinced that vaccines, while creating some excellent public health benefits, also create problems. I've been doing this for 29 years. I've watched it really closely, and I've seen kids who get shots undergo changes.”

Moreover, this reviewer notes that the writer has failed to mention, much less address, the failures of “*modern vaccines*” including the recent, *but now withdrawn*, LymeRx and RotaShield vaccines and the in-use ineffectiveness, *except to profit the vaccine makers and the healthcare establishment*, of the human influenza and the varicella vaccines.

“In previous generations, when epidemic disease swept through schools and neighborhoods, it was easy to persuade parents that the small risks associated with vaccination were worth it.”

While this reviewer does not disagree with the writer about the reality that a disease epidemic or outbreak makes it easier “*to persuade parents that the small risks associated with vaccination were worth it*”, this reviewer notes that many of today’s vaccines (e.g., hepatitis B and HPV) are for diseases that are not epidemic in the USA and, *in the youngest members of the population first being vaccinated*, are almost non-existent.

Moreover, vaccines are being recommended for general use when, *in the USA today*, the only groups that have a significant risk of having a clinical case of the disease are in the lower socioeconomic groups (e.g., the rotavirus vaccines).

Finally, rather than persuading parents by providing them with accurate information about both the value and the risk of vaccination, today coercive mandates, fear mongering, and misrepresentation of the benefits as real and the risks as theoretical (when the benefits are theoretical and the risks are real) are the tools that the pro-vaccination groups are using to promote vaccination – regardless of the long-term costs.

“When those epidemics stopped—because of widespread vaccinations—it became easy to forget that we still live in a dangerous world.”

Because, *in most cases*, the current vaccination programs in America seem to have traded epidemics of acute disease for epidemics of a variety of chronic diseases, this reviewer finds that not only have the epidemics of disease not stopped but also the costs of today’s chronic-disease epidemics far outweighs those of the prior childhood disease epidemics that American children born after the World War II experienced.

This is the case because increases in sanitation, food and water quality, hygiene, and adequate housing coupled with antibiotics to stave off bacterial infection had combined to decrease the annual level of deaths from, *for example*, measles from 10,000 to 2,000 in the period from 1912 – 1944 to “1,000” to “200” in the period from 1945 – 1962 (before the first measles vaccine was introduced)<sup>3</sup> – a time when the population of the USA was rapidly growing.

Finally, since fear is the most-favored tool of this writer and his fellow vaccine apologists and the American public is continually bombarded with fear-based propaganda about vaccines and the risk of vaccine epidemics, it is almost impossible for the average American “*to forget that we still live in a dangerous world*”.

“It happens all the time: University of Tennessee law professor Gregory Stein examined the relation between building codes and accidents since the infamous 1911 Triangle Shirtwaist factory fire in New York and discovered a pattern: accident followed by a period of tightened regulations, followed by a gradual slackening of oversight until the next accident. It often takes a dramatic event to focus our minds.

The problem is that modern society requires constant, not episodic, attention to keep it running. In his book **The Escape from Hunger and Premature Death 1700–2100** Nobel Prize-winning historian Robert Fogel notes the incredible improvement in the lives of ordinary people since 1700 as a result of modern sanitation, agriculture and public health. It takes steady work to keep water clean, prevent the spread of contagious disease and ensure an adequate food supply. As long as things go well, there’s a tendency to take these conditions for granted and treat them as a given. But they’re not: As Fogel notes, they represent a dramatic departure from the normal state of human existence over history, in which people typically lived nasty, sickly and short lives.

This departure didn’t happen on its own, and things don’t stay better on their own. Keeping a society functioning requires a lot of behind-the-scenes work by people who don’t usually get a lot of attention—sanitation engineers, utility linemen, public health nurses, farmers, agricultural chemists and so on. Because the efforts of these workers are often undramatic, they are underappreciated and frequently underfunded. Politicians like to cut ribbons on new bridges or schools, but there’s no fanfare for the everyday maintenance that keeps the bridges standing and the schools working. As a result, critical parts of society are quietly decaying, victims of complacency or of active neglect. (See PM’s special report on the nation’s infrastructure, “Rebuilding America”) It’s not just vaccinations or bridges, either. A few years ago, I attended an Environmental Protection Agency Science Advisory Board meeting, and the water-treatment discussion was enough to make me think about switching to beer.”

This reviewer sees no need to review the writer’s examples because, while valid, they are not applicable to vaccines and vaccination programs because the American government, healthcare establishment, public health officials and the vaccine makers are all continually propagandizing the public with messages that sell the need for more and more vaccines and tout the “wonders” of the current vaccination programs while downplaying, hiding and, *in some cases*, lying about, the problems with our current vaccines and vaccination programs.

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<sup>3</sup> Centers for Disease Control (CDC). Reported Measles Cases, Deaths, Deaths-to-Cases Ratio and Estimated Population in the United States, 1912-1984. Provisional Data; Doc #0051m

Thus, the resistance to vaccines and our current ever-increasing vaccination programs are not “*victims of complacency or of active neglect*”.

Increasingly, the American public is becoming aware that vaccines and vaccination programs are trading the risk of epidemics of childhood diseases and increased cases of certain lifestyle diseases for the reality of epidemic increases in chronic diseases, some of which were unknown as little as 30 years ago, that are destroying the fabric of our society while enriching the federal government (through a tax of \$ 0.75 on each dose of each disease component), healthcare establishment, public health officials, the vaccine makers, and others who are rewarded for their pro-vaccine fervor.

As this reviewer has repeatedly stated, he is not anti-vaccine but rather pro-vaccine safety.

Moreover, this reviewer can only support general vaccination programs for those vaccines that are truly safe and long-term medically cost-effective.

Further, this reviewer notes that Japan, a country with a much more flexible vaccination schedule, many fewer recommended vaccines, and no coercive vaccination mandates for work and schooling, today has an infant mortality rate that is less than half that of the infant mortality rate in the USA and a significantly longer life expectancy.

Obviously, if lessons are to be learned from the experience of others, America needs to learn the lessons that the Japanese vaccination programs offer rather than to continue pursuing an ever-more-coercive, ever-growing vaccination program that is increasingly turning America into the land of the chronically diseased.

“What do we do about this? To some degree, we have to do what the reformers of the 19th and early 20th centuries did: Hector people about the importance of paying attention to our society’s upkeep.

Alas, our main allies in persuasion will probably be the epidemics and other disasters that take place when too few pay attention. Sometimes, people have to trip and fall to be reminded that it’s important to watch their step.”

Rather than tolerating the increasing harassment to vaccinate or the increasingly coercive vaccination mandates, cast by the writer here in the imperative (“*we have to ...(h)ector people ...*”<sup>4</sup>), which pay little or no attention to the overall health (physical, emotional, spiritual or financial) of Americans, the American public needs to demand that the government should only:

- License and approve those vaccines that can independently be proven to be long-term safe and
- Recommend those vaccination programs that are truly medically cost-effective when all of their costs, including those associated with serious adverse events and the risk of chronic disease, or other health impairment are considered.

Moreover, this reviewer cannot help but notice the implied threat in this writer’s last statement which, *given the ability of the Establishment to create and deploy highly infectious diseases*, warns of the possible epidemics to come if the American public

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<sup>4</sup> The synonyms for “hector” are: “bully”, “intimidate”, “harass”, “push around”, “hassle” and “badger”.

does not stop resisting giving up the constitutional right of “**due process**” when it comes to vaccination.

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### **Reviewer’s Postscript**

On June 27, 2008, the Special Masters in the Omnibus Autism Proceeding in the United States Court of Federal Claims granted<sup>5</sup> the Justice Department’s request to withdraw the expert reports of the two recognized toxicologists (Drs. Magos and Clarkson), which were the key reports upon which the government was heretofore relying to rebut the petitioners’ toxicological evidence that Thimerosal in vaccines causes mercury poisoning that manifests as autism and other neurodevelopmental disorders.

This action is another, *albeit indirect*, admission by key toxicology experts (who were nominated to testify against “**THEORY 2**” [the proposition that Thimerosal {49.55-wt% mercury} in vaccines is causally linked to autism] and filed expert reports supporting this view) that the ever-growing body of scientifically sound toxicological evidence clearly supports the causal link between Thimerosal-containing vaccines and autism.

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### **About the Writer:**

Wikipedia contains the following text for the writer, Glenn Harlan Reynolds<sup>6</sup>:

“Glenn Harlan Reynolds (born 1960) is Beauchamp Brogan Distinguished Professor of Law at the University of Tennessee, and is best known for his weblog, Instapundit, one of the most widely read American political weblogs.[1]

Reynolds is often described as conservative, but in fact holds liberal views on social issues such as abortion[2], the War on Drugs and gay marriage. He describes himself as a libertarian[3] and more specifically a libertarian transhumanist.[4] He once illustrated his combination of views by stating: "I'd be delighted to live in a country where happily married gay couples had closets full of assault weapons." [5] He is a strong supporter of Porkbusters and the Iraq War.

On October 25, 2007, Reynolds wrote that he was a former member of the Libertarian Party.[6]

In 2006, he released the book *An Army of Davids: How Markets and Technology Empower Ordinary People to Beat Big Media, Big Government, and Other Goliaths*, which covered the various ways in which modern technology is changing society by allowing amateur individuals to do things that previously only large, well-funded organizations were equipped to do.

Reynolds was a finalist for the World Technology Network's 2004 Media and Journalism award. In his remarks, he said:

*Changes in technology are producing major changes in media and journalism. Journalism is becoming an activity, not simply a profession. In my InstaPundit.com weblog I have tried to foster the growth of amateurism in that field, by encouraging people to get involved and to make use of the new tools—from Web publishing to inexpensive digital still and video cameras—to bring news and perspectives to the world stage that were previously lacking.[7]*

Reynolds is a frequent contributor to *Popular Mechanics Magazine*, where he writes about broad legal and practical issues in the digital age, and sometimes participates in their coverage of events such as

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<sup>5</sup> [http://www.uscfc.uscourts.gov/sites/default/files/autism/7\\_03\\_08\\_autism.pdf](http://www.uscfc.uscourts.gov/sites/default/files/autism/7_03_08_autism.pdf) “**AUTISM MASTER FILE ORDER CONCERNING THEORY 2 GENERAL CAUSATION REBUTTAL**”.

<sup>6</sup> [http://en.wikipedia.org/wiki/Glenn\\_Reynolds](http://en.wikipedia.org/wiki/Glenn_Reynolds)

the Consumer Electronics Show.

Reynolds also ran his own music label WonderDog Records, for which he also served as a record producer.”

**“References**

1. ^ The Truth Laid Bear
2. ^ Reynolds: The mommy wars - Glenn Reynolds - MSNBC.com
3. ^ ,[1]
4. ^ Instapundit.com
5. ^ Instapundit.com
6. ^ Instapundit.com
7. ^ Background: Glenn Reynolds - The World Technology Network”

**About the Reviewer:**

Information about this reviewer, Paul G. King, PhD, can be found on the Internet at:

<http://www.dr-king.com>,

and other reviews of similar articles are posted on the “**Documents**” web page of:

<http://www.mercury-freedrugs.org>.

This reviewer received no compensation for this review; and, other than his advocacies, has no conflicts of interest.