THE *informed* PARENT

SUMMER 1997 THE BULLETIN OF 'THE INFORMED PARENT GROUP' *ISSUE 19/20*

ORPHANS USED FOR 3 IN ONE DRUG TEST

Extract taken from a front-page article in the Irish Independent, 5/7/97

Children from five Dublin orphanages were used as guinea pigs in trials of the 3-in-one vaccine, the Irish Independent can disclose today.

The tests took place in the early 1960s, when they were also given the polio vaccine.

Further trials of new 3-in-one vaccines were carried out at two Dublin children's homes in 1973. At least three of the babies vaccinated were either mentally or physically handicapped.

In further disturbing renelations, we can disclose how children suffered a harrowing range of side effects, including convulsions, infantile spasms and brain damage, after they were given the 3-in-one vaccine in the 1970s.

While governments and the Dept of Health have consistently played down the extent of adverse reactions to the vaccine, we can reveal that drug manufacturers Wellcome admitted to a disturbing increase in reactions in 1973.

To date, the DoH has not responded formally to a series of questions put to it by the Irish Independent on June16 last. Glaxo Wellcome has also been asked to reply to the issues raised in our coverage of the controversy.

The Eastern Health Board, which specially monitored 80 children who were vaccinated at Dublin health clinics in 1972 and 1973, was so concerned about the extent of reactions that it asked if it was possible to reduce or alter the pertussis element in the vaccine.

The pertussis component had long been suspected as responsible for the adverse reactions.

CHILD DIED

A report sent to the DoH by another health board described the death of a one year old as "an apparent adverse reaction following immunisation".

Health board chiefs admitted privately that the absence of a proper reporting system was leaving them in the dark about the full extent of the reactions. At a meeting of the country's top health administrators in Dublin in 1977 experts clashed over the future direction of whooping cough policy.

Among other disturbing revelations:

- In 1982 the government acknowledged that 14 children had 'probably' suffered brain damage as a result of the vaccine. but tried to 'buy off' their parents with ex-gratia offers of £10,000.
- This was despite strong advice by DoH officials stating that it would be 'inconsistent and inconclusive' not to concede compensation. The establishment of a board of assessors to decide on proper compensation for the brain damage victims was urged by the officials but rejected by the government.
- Efforts by families of other alleged vaccine damaged children to take legal action for damages have been frustrated by the DoH and healthe boards insisting that proper vaccination records are not available.

Editor - In the same edition, the Irish Independent's supplement 'Weekender" featured a more in-depth coverage of the above article, in which Prof. Meenan, who was head at the Dept of Medical Microbiology, University College. Dublin, is reported as not quite recalling the '73-'74 trial. "By that time I had pretty well pulled out. I was still head of the department at that time - it was run on a very loose rein. I might not have known what was being done there at the time." There has also been recent reports regarding Australian babies involved in similar vaccine trials between 1947and 1970!

16-PAGE DOUBLE ISSUE !

CERTIFICATION OF ELIMINATION OF POLIOMYELITIS

Taken from: CMO's Update, DoH, 14/5/97

In 1988, the World Health Assembly of the World Health Organisation (WHO) announced the goal of the global eradication of poliomyelitis by the year 2000. The world will be considered free of wild virus poliomyelitis when all countries are able to demonstrate, beyond doubt, that they have had no cases of wild virus poliomyelitis for a period of at least three years, despite surveillance sufficiently sensitive to demonstrate wild virus poliomyelitis if it were to occur. Thereafter, routine polio immunisation will be discontinued.

The Americas (from Alaska to Argentina) has already been certified by an international commission to have eliminated wild virus poliomyelitis. The Western Pacific is the next WHO region likely to be similarly certified.

A European Certification Commission has been appointed, and the United Kingdom is among the first tranche of countries that the Commission will consider for certification. The Commission will expect to see evidence of absence of circulation of wild polio viruses and that mechanisms exist to ensure the identification of cases of poliomyelitis should they occur.

All doctors are reminded that it is a statutory obligation to notify suspected cases of poliomyelitis.

VIRUS-HOST RELATIONSHIP

Taken from: Preface by R M Zinkernagel, Intervirology 1993

There is no such thing as a 'virus' or a 'virus-induced disease'. There are virus-host relationships that have co-evolved and depend upon many host and virus parameters, most of which we do not know or understand.

While few cytocidal viruses cause disease by destroying infected cells, mostly acutely and directly, many other viruses are noncytopathic and therefore cause no disease, or trigger disease only indirectly and often very slowly. This symposium was focused on those groups of viruses that may or may not induce disease. It also attempted to analyse disease etiologies and pathogeneses, which are unclear and where viruses may be suspected to play some role. This task is rendered difficult by the fact that viruses, particularly RNA viruses, mutate continuously, that host resistance depends upon many parameters (including interferons), and that the host immune response is variable and depends upon antibodies and/or T cells to varying extents.

The panel of speakers and discussants covered many of these variable parameters and they explained in general and very detailed terms some of the issues addressed. We cannot expect to find solutions to all the questions raised, but we shall learn a bit from each of the many model diseases or animal models.

This quest to understand some diseases of unclear etiology and pathogenesis is further complicated by the fact that most biological processes and phenomena are not absolute in physical terms; what is found in 95-97% of examples, cases, doses and experimental situations does not apply in the same way to the few remaining percentages. What may then be a more or less generalised explanation for the 3-5% of examples that are not reasonably explained by the general rules may again be explained to 90-95% by one major pathogenetic mechanism, leaving another few cases unexplained. Take for example hepatitis B virus infections, most patients will overcome an acute infection, few will develop aggressive hepatitis, even fewer will become virus carriers, and fewer again may develop liver cell carcinoma; it still remains unclear in this spectrum where auto immune hepatitis really fits in?

These many open questions are a challenge to us all, and this meeting and the book resulting from it hopefully may enhance and further our efforts to understand the role of unknown or unrecognised old or new viruses in known, often called chronic or degenerative diseases of unclear pathogenesis.

SCHOOLS SWEPT BY ME PLAGUE

An article on the front page of the Guardian, (22/5/97), reported on the results of the largest study ever made of the controversial illness ME, the modern plague doctors call chronic fatigue syndrome (CFS). The study showed that ME was responsible for 51% of long term sickness absence among schoolchildren.

Jane Colby, a former head teacher recovering from ME who is one of the authors, said:"The figures are shocking... This disease shows a sinister pattern right across the school population. No one can deny how serious it is."

In 392 schools long-term sickness absence was reported out of which 224 blamed ME. Next came cancer and leukaemia, reported by 161 schools. The last part of the article reports:

The Royal College of Physicians disputed the assertion from Ms Colby and Dr Dowsett that "the clustering pattern suggests that ME results from an infection". The authors claimed the biggest cluster extended over a number of schools "in an area containing recreational water heavily polluted with sewage".

The college retorted: "There is no scientific evidence that common viral infections are a risk factor."

Editor - What about common childhood vaccinations as a risk factor?

ALERT OVER CANCEROUS CAT JABS

Taken from: The Daily Telegraph, 4/6/97

Cat owners and vets are being urged to avoid vaccinations in certain cases because of a risk of cancer associated with the injection.

Though scientists in America who have been studying the problem say the benefits of a jab usually outweigh the risks, they believe house-bound cats in particular need not be vaccinated for certain diseases.

The American Vaccine-Associated Feline Sarcoma Task Force gives warning that as many as four out of every 10.000 vaccinations result in cancerous tumours.

Vets call it vaccine-associated feline sarcoma, where a higher than expected number of tumours develop in cats that have been vaccinated.

Dr James Richards, director of the Feline Health Centre at the Cornell University, said: "The low risk of contracting certain diseases may not warrant vaccination.

"If we have a cat that spends time outside, then that animal presents a different risk of feline leukaemia, compared to a cat that stays exclusively indoors and is never around cats that go outdoors.

"It may be appropriate to omit the feline leukaemia vaccination for an indoor cat.

He added: "The benefits of vaccination still outweigh the risks in the vast majority of situations. But when we find a situation where we can omit a vaccination, that's what we want to do."

Vets began noticing sarcomas at vaccination sites on cats' bodies in 1991, and since then research has shown that they are most frequently associated with vaccinations against feline leukaemia virus and, to a lesser extinct against rabies virus.

So far the problem has mostly affected America though there have been cases in Britain, according to Dr Malcolm Bennett of Liverpool University.

He said people ought to be aware of the problem.

SIX IN ONE!

Taken from: The Daily Mail, 6/5/97

A combination vaccine for children that protects against six diseases is set to become available next year. Developed by SmithKline Beecham, the vaccine will mean only one injection is necessary for complete immunisation against diphtheria, tetanus, whooping cough, polio, hepatitis B and haemophilus influenza B (Hib) - the six most commonly contracted childhood illnesses. The vaccine, to be called Infanrix plus, will also avoid the side-effects, such as fever and headaches, that children commonly experience after taking the whooping cough vaccine.

Jenny Hope

SCIENTISTS BREED MICE WITH FULL HUMAN CHROMOSOMES

An article in The Guardian, 4/6/97 reported on a new milestone in genetic engineering with the transfer to mice of entire human chromosomes. This complex procedure resulted in mice being born with human genes in their thyroid glands, hearts and livers.

The article ends by stating: 'Importantly, genes for human defence cells (antibodies) were retained, raising the possibility of the technique being used to make vaccines.

Steve Jones, a leading genetics expert from University College London, said of the work: "In theory, there's no reason you should stick to mice. You could do the same with sheep or elephants. You could use them as antibody factories."

MEASLES VACCINE IN QUESTION

Taken from: She, May 1997

There's growing evidence of a link between the MMR vaccine and autism. In the US, Dr Bernard Rimland of the Autism Research Institute, is backing parent groups' demands for studies to be carried out.

And in the UK, Dawbarns Solicitors, who are handling the cases of some 600 children who had developed normally until their MMR vaccinations, believe it is also implicated in cases of Crohn's disease (an inflammatory bowel disease) and epilepsy.

"These children developed one of these three conditions suddenly after their MMR vaccinations," says Kirsten Limb, researcher at Dawbarns. "There has also been a huge increase in cases of diabetes in under-5s since the vaccine was introduced. Acute pancreatitis has been linked to the vaccine and this can cause diabetes. These cases should be investigated."

The Committee on the Safety of Medicine has now asked for details of Dawbarns' cases, and research on the link between the measles vaccine and Crohn's disease is under way at London's Royal Free Hospital.

Meanwhile, says Kirsten Limb, "There should be urgent reconsideration, or even suspension, of the MMR vaccine policy until studies of its safety are thoroughly carried out."

Parents should consult their GP before making vaccination decisions.

For a copy of Dawbarns' factsheet on MMR vaccines, send a large 38p SAE to:

Kirsten Limb,
Dawbarns Solicitors,
Bank House,
King's Staithe Square,
King's Lynn, Norfolk,
PE30 1RD.

Editor - The MMR factsheet consists of 38 informative pages and references are quoted throughout. An extremely interesting document to obtain!

JUSTIFYING DISHONESTY

Taken from: Pediatrics 1996; 98(3):409

John Byrom, a minor eighteenth century poet, wrote some verse about a couple of likeable scoundrels discussing what to do about their lack of transport. Stealing a horse would be clearly be wrong; filching one would be a little better. Could they pilfer one? No, that would be less than honest. Yet, by the end of the poem, they decide that they need not think too badly of themselves if they nim a horse. Scientists practice the same sort of semantic sleight-of -hand.

Inventing data would clearly be wrong; suppression of inconvenient results would be less than honest.Yet they need not think too badly of themselves if they gloss over the study's methodological shortcomings, optimise the statistical analysis, cite published selectively, or perhaps make someone a gift of authorship.

Editorial. Shall we nim a horse? Lancet, 1995; 345:1585-1586
Submitted by Student

FREAK REACTION TO FLU VACCINE LED TO MAN'S AGONISING DEATH

Taken from: The Guardian, 9/5/97

A father-of-three described as "a fit and lively chap" died in agony nearly four years after being given an influenza vaccination, an inquest heard yesterday.

Harry Richardson, from Bury in Lancashire, had been advised to have the injection in October 1992, but within days of being given the Flu Virin vaccine he experienced a 'pins and needles' sensation in his legs and was taken to hospital with paralysis, the hearing in Bury was told.

According to neuropathologist Helen Reed, the vaccination resulted in transverse myelitis - a swelling that badly damaged the spinal cord and left Mr Richardson, aged 60, paralysed from the chest down. He also developed massive pressure sores.

The cause of death was given as septicaemia, broncho-pneumonia and infected trophic ulcer as a result of spinal cord damage caused by the vaccine.

Coroner Barrie Williams recorded a verdict of misadventure, but said that doctors should not be put off giving the vaccine to those who needed it. He added: "I have no doubt Mr Richardson was well advised and that Flu Virin was used in good faith. While it is an undoubted tragedy for his family the odds against this happening were huge."

The court heard that although Mr Richardson's reaction to the injection was rare, other cases have been reported and five people are known to have died from similar conditions.

The makers of Flu Virin, Surrey-based Evans Medical, said that since its production in the early 1980s some 65 million doses had been distributed throughout the world.

But Mr Richardson's family plan to take legal action against the firm. Sylvia Pilsworth, his common law wife for 16 years, said: "I have waited for doctors to say that there are side-effects to this vaccination for a long time. Harry suffered horrendously and others should be warned about the hidden dangers.

"There may only be five recorded cases like Harry's, but that is five too many."

Chris Mihill,
Medical Correspondent.

NEW GULF SYNDROME INQUIRY

The Guardian, 15/7/97, reported that a new £2.5 million research programme into the causes of Gulf War syndrome will focus on multiple vaccinations which were alarming the DoH even before the desert war.

Because the anthrax vaccine is slow to take effect, it was given in conjunction with whooping cough vaccine as an accelerator. Yet in late 1990 the department reported that this combination, when given experimentally to mice, produced a "serious loss of condition and weight loss".

Graham Rook, a medical microbiologist at University College, London and Alimuddin Zumla, director of the college's infectious diseases unit, believe that multiple vaccinations, vaccinating individuals under stress and using insecticides may have altered the balance of lymphocyte cells, which control the body's response to disease.

FIRST-DOSE MMR UPTAKE FALLING *Taken from: Pulse, 12/4/97*

First-dose MMR vaccine coverage figures are slightly lower in children aged under two than previously recorded, according to national statistics.

Dr Mary Ramsey, a consultant in public health medicine at the PHLS, said national figures for this quarter showed 150 fewer infants out of 150,000 had received first-dose MMR vaccine compared with previous surveillance figures.

"Although this represents a drop of just 0.1% from 91% national coverage of 600,000 infants we will be concerned if the downward trend continues over the next few quarters," she added.

BMJ SNIPPETS

People who choose to have an annual immunisation against influenza should consider having a booster after six months if they want to travel abroad, says a note in the Canadian Medical Association Journal (1997;156:677). The vaccine gives protection for only six months or so, but this is usually enough to cover the whole winter season. Someone who crosses the equator may arrive in the opposite hemisphere to meet a winter outbreak of influenza in full spate.
BMJ,Vol 314:1210, 19/4/97

Two anecdotal reports of improvement in patients with multiple sclerosis after attacks of varicella (chickenpox) stimulated a pilot study in Canada (Journal of Clinical Epidemiology 1997;50:63-8) of treatment with varicella virus vaccine. The vaccine was given to 50 patients with chronic progressive multiple sclerosis. Fourteen improved, four got worse, and 29 were unchanged. There was no major side effects.
BMJ, Vol 314: 762, 8/3/97
Editor - If there was an improvement after naturally contracting chickenpox , then surely using a varicella vaccine would produce different results anyway.

Here in the West the emphasis is on vaccines. The Sri Lanka Prescriber (1996;4 (3):1-2) gives another perspective. Its review of the management of typhoid fever warns that "undue haste in starting antibiotic therapy early in the course of a febrile illness could hamper the diagnosis by altering the clinical picture, preventing the isolation of bacteria, and suppressing the antibody response."
BMJ, Vol 314: 616, 22/2/97

Social deprivation and bacterial meningitis in North East Thames region: three year study using small area statistics.

The conclusion drawn from this study was:

'In spite of the difficulties with ascribing socio-economic characteristics of geographic areas to individuals living in those areas, we believe that these data show that rates of meningococcal and pneumococcal meningitis are related to measures of area deprivation.....Our findings suggest that effective action to tackle social deprivation will have an effect on rates of bacterial meningitis.
BMJ, Vol314: 794-5, 15/3/97

TO VACCINATE OR NOT TO VACCINATE?!?!?!?

Many readers of this newsletter will wonder and worry about what might happen if you don't have your child immunised. It is for you that I decided to write this article.

You might feel uneasy about the whole business of immunisation. Or you may think it is a bad idea to interfere with a babies delicate immune system and decide that you want to wait till the child is older before subjecting them to the jab.

I also felt these things, and after doing my own research, I became aware of many more reasons not to vaccinate. I decided to go the whole hog and have kept all my six children completely vaccine free. They can always decide to get vaccinated themselves should they want to. (None of them has as yet and two are over 21 now.) I can always change my mind and have them vaccinated at any time, but once they are vaccinated it cannot be undone.

By Eva Tombs-Heirman. B Hom Med - RS Hom

Below follow a few questions people often ask me when they hear that the children are not immunised:

Do they catch all the illnesses that they are not immunised against?

"No. In fact the opposite - they seem to be ill a lot less frequently than their classmates. Any illnesses they have had have been thrown off quickly and without too much bother using natural remedies (herbal and homœopathic) and TLC (tender loving care). Not one of them has ever needed an antibiotic!"

Do you have to keep them isolated from other children at times of vaccination drives and epidemics?

"No, I have never done this. I know they have strong immune systems I also know that the immune system is made even stronger by confrontation."

Are your children not a threat to the community because they haven't been immunised?

"No, the opposite. They are an asset to the community. There are not a great many people left in the community whose immune systems have not been polluted by immunisations. Who knows, some day they might be needed to provide the natural antibodies to diseases that have become untreatable with drugs."

There are obviously many more questions and worries parents have on this very emotive subject. But, study the facts and leave your fear out of the decision and you might also decide like I did. My children are just normal children, no different from any others. except perhaps that they are all very strong, all very much individuals. I think perhaps we should begin to look at the more subtle effects that vaccination have on people. Besides the physical effects such as the increase in eczema, the upward trend in asthma, what about the suppression of the individual that I sense in the vaccinated populations?

There is a wonderful Maxim I often remind myself of:
Don't fix it if it is not broken. (If you do you'll weaken the object.)

Eva Tombs-Heirman. B Hom Med - RS Hom

Eva runs a homœopathic mother, baby and childrens clinic in Edinburgh, offering:

Homœopathic advice and treatment for all health problems in pregnancy, childbirth and the first 12 years of life.

Vaccination alternatives.

Classes for parents in: homœopathy, baby massage, active birth, home nursing with natural remedies, cooking for babies and toddlers.

Books, remedies, natural creams and oils, vitamins and lots of information.

For appointments or further details contact Eva at:

Cherubim
The Natural Health Centre
9 Gillespie Place
Edinburgh
Scotland
EH10 4HS

AIDS VACCINE HOPE

Taken from: The Guardian, 3/6/97

Chimpanzees inoculated with an experimental Aids vaccine have successfully fought off repeated exposure to the Aids virus for a year, a United States research team has reported, according to today's Washington Post.

The vaccine is given in a series of nasal sprays, followed by a booster shot in the arm. Although scientists warn that other vaccines have looked similarly effective in chimpanzees only to fail in human trials, the researchers said they were encouraged by the strength of the immune response triggered and its long term protection, the paper said.

Reuter, Washingtor

THE LADY IN RED

The Mail on Sunday (23/3/97) featured an article on Kelly Le Brock, the former British model and Hollywood star, regarding her move to homœopathic medicine. She was quoted as saying:

"I didn't vaccinate my last child. When you're given a shot of a disease straight into your bloodstream it doesn't seem right.

"You get sick only if your immune system is not working. What messes up your immune system is drugs.

"If you have a strong immune system you can fight pretty well anything. And you can opt for homœopathy to fight diphtheria and many other things."

VACCINATION AND ASTHMA - IS THERE A LINK? - A SECOND LOOK

In 1994 Dr Michel Odent published a study regarding a possible link between the whooping cough vaccination and the onset of asthma.

To the question: has your child ever been diagnosed as asthmatic? there were 26 positive answers in the immunised group (10.69%) compared with 4 in the non-immunised group (1.97%). The difference was highly significant (P=0.0005, 95% confidence interval 1.93 - 15.30).

Since then Dr Odent has carried out a second study. The children were aged between 5-17 years and the size of the groups (classified according to whooping cough vaccination) were almost equal. 125 had been immunised and 149 had not been immunised. Among the 125 pupils vaccinated against whooping cough, 23 were diagnose as asthmatic (18.4%). This is the rate of asthma one might currently expect for this age group in Great Britain. Among the 149 non-immunised children 6 were diagnosed as asthmatic (4.02%). The difference is statistically very significant ($p<0.001$).

Among the 149 who had no whooping cough vaccination 41 had no vaccinations at all, and 108 had other vaccinations. Among the 41 there was one case of asthma (2.4%) and among the 108 there were therefore 5 cases of asthma (4.63%).

These results were combined with the previous study. Among 134 subjects who had no vaccination at all there were 2 cases of asthma (1.51%), whereas among the 220 who had no pertussis vaccination but had had other vaccinations there were 8 cases (3.64%). The difference is not statistically significant and Dr Odent comments:

'We would need greater numbers (a third study...but where?) to conclude that - in terms of risks of asthma - there is a difference between no vaccination at all and early vaccinations excluding pertussis vaccination. Another difficulty is that whooping cough vaccination is never received in isolation.'

For a copy of the full study and interpretations of the results please contact: Primal Health Research, 59 Roderick Road, London NW3 2NP. Fax: 0171 267 5123
Or visit there home page at: WWW. PRIMAL/HEALTH. ORG

PNEUMOCOCCAL VACCINE CAMPAIGN BASED IN GENERAL PRACTICE

BMJ, Vol 314:1094-98, 19/4/9

The object of this study was to show whether a general practice setting is a practical and effective medium for increasing uptake of pneumococcal vaccine.

The conclusion was that a practice based campaign is an effective method of increasing uptake of pneumococcal vaccine by high risk groups.

Reproduced below are a few snippets from the study:

Pneumococcal vaccine has been available in Britain since 1979. The current 23 valent vaccine covers 96% of serious pneumococcal infections in Britain, "is safe" and is cost effective. Its efficacy is 50-80% in older and high risk patients. It is ineffective in children under 2 years old, and it is less effective in immunocompromised people, though may still be of value.....
.....There is at present little incentive for general practices in this country to offer pneumococcal vaccine. No item-of-service fee is available, and the vaccine costs about £10 per dose, so purchasing a large number can lead to cash flow problems for the practice.....
.....Side effects from the vaccine were commonly reported, but most were minor and were well tolerated.....
.....More severe local and systematic side effects were reported than expected, but patient satisfaction was also high. Patients' willingness to accept side effects of vaccines that are not life threatening has been reported elsewhere. (eg The surprisingly high acceptability of low-efficacy vaccines for otitis media: a study of patients using hypothetical scenarios. Paediatrics 1995:95;350-4.)

Editor - In the package insert of a pneumococcal vaccine produced by Merck Sharp & Dohme the following adverse reactions are listed:

COMMON ADVERSE REACTIONS:
Local injection site soreness,
Erythema (abnormal flushing of the skin caused by dilation of the blood capillaries - it is often a sign of inflammation and infection).
Induration (abnormal hardening of a tissue or organ.)

ADVERSE REACTIONS OCCURRING OCCASIONALLY ARE:
Low grade fever (<100.9F/38.3C)

ADVERSE REACTIONS OCCURRING RARELY ARE:
Headache, fever (>102F/38.9C), malaise, asthenia (weakness or loss of strength)
Adenitis (inflammation of a gland or a group of glands)
Anaphylactoid reactions, serum sickness
Arthralgia, myalgia, arthritis
Rash, urticaria (hives, nettle rash)

Reactions of greater severity, duration, or extent are unusual. Neurological disorders such as paraesthesiae and acute radiculoneuropathy, including the Guillain-Barre syndrome have rarely been reported at the time of vaccination, but with no established cause-and-effect relationship.

DISCOVERING THE CAUSES OF ATOPY

The above heading was the title of an article featured in the BMJ (Vol 314, 987-8) on the 5th April this year. The opening two paragraphs stated:

'The marked increase in the prevalence of childhood asthma, eczema, and hay fever in Britain over the past 30 years or more is largely unexplained. However, it is likely to be attributable to a rise in the prevalence of atopy. This is characterised by exaggerated Th2 cell responses to common allergens with production of raised concentrations of allergen specific IgE. Although we now understand more about the genetics of atopy and the role of Th1 and Th2 cells in the control of IgE, the environmental causes of atopy have eluded us. Of increasing interest is the potential roles that patterns of childhood infection and fetal growth and maturation might have in the inception of atopy.

The number of older siblings has been shown to be inversely related to the prevalence of adult hay fever and infant eczema. This observation led Strachan to propose in the BMJ in 1989 that atopy may have increased because of a fall in exposure to infections in early childhood through improved hygiene and reductions in family size and overcrowding in the home. Children are likely to experience more severe infections at an earlier age when the number of their older siblings is greater. Thus, it was suggested that infections in early childhood might protect against atopy and that successive cohorts of children have progressively lost this protection.....

It then goes on to say:

'More direct evidence that childhood infection might prevent atopy comes from a recent historical cohort study in Guinea-Bissau, West Africa, which found that young adults who had experienced measles in childhood during a severe epidemic were significantly less likely to be atopic than those who had been vaccinated and not had measles.....

.....There are several puzzles concerning the "infection hypothesis." It is not clear, for example, why studies have not found consistent associations between family size and asthma, nor why pre-school nursery attendance, which is known to promote cross infection and more severe infection, does not seem to be associated with a reduction in atopy. Further insights may be gained by more detailed studies in countries where there is greater variation in the burden of childhood infectious disease. Virologists and immunologists must collaborate with epidemiologists if we are to really understand the role of infections in the development of atopy.

Editor - Dare I suggest that perhaps the marked increase in allergies over the past 30 years or more has something to do with the introduction of mass vaccination programmes, or is it merely a coincidence?

VOODOO OR WITCHCRAFT!

A certain form of unscientific attitude is illustrated by a comment found in "Combined vaccines and simultaneous administration", published in 1995 by the New York Academy of Sciences. According to Kenneth Brown "the body of knowledge regarding mechanisms of adjuvancy or adjuvant effect could better be described as voodoo or witchcraft."

Taken from: Primal Health Research, May 1997.

WOUND CLEANSING - MOST IMPORTANT

In an article regarding sports injuries in the Guardian, 10/5/97, Dr Douglas Carnall discusses how to treat skin lacerations. He says:

"All particles of dirt and grass must be thoroughly flushed out of the wound - a more important aspect of tetanus prevention, by the way, than having a tetanus booster."

GP TARGET PAYMENTS 1997/8

CHILDHOOD IMMUNISATIONS:

HIGHER £2,340
LOWER £780

PRESCHOOL BOOSTERS:

HIGHER £690
LOWER £230

TAKEN FROM: FINANCIAL PULSE, 22/2/97

VIERA SCHEIBNER will be visiting the UK in mid-September and possibly a few days in October, also. If anyone is interested in setting up a talk in their area (large or small), please contact Magda ASAP! Tel: 0181 861 1022

See back page for one confirmed date!

HIB AND DTP VACCINES

From May 1997, the combined product (DTP and Hib vaccines) manufactured by Pasteur Mérieux MSD is being distributed in a new dual-chamber pre-filled syringe. Information about the use of this novel syringe has already been distributed to general practioners and pharmacists during April, and full instructions appear in the package insert.

Taken from: CMO's Update, DoH, 14/5/97

DEALING WITH COUGHS

A cough is the result of irritation in the air passages; when irritated the membranes produce mucus. Mucus from the nose can also drip down the back of the throat to collect into a glob of mucous which needs to be coughed up. The purpose of coughing is to expel foreign particles and mucus from the airways. Cough mixtures aren't much help because they just suppress the cough reflex. Over the counter drugs from chemists may be more harmful than helpful, and evidence shows that antibiotics are virtually useless at clearing up cough or purulent sputum. I'll be talking more about antibiotics in the next issue, but basically you shouldn't give them for your child's coughs and colds.

Many cases of what GPs seem to be calling bronchitis are nothing worse than phlegmy coughs which may sound chesty but are actually a result of mucous dripping down the back of the nose and accumulating. So don't immediately jump to the conclusion your child has bronchitis and needs antibiotics - question your doctor!

By Cassandra Marks, homœopath and health journalist

According to a letter from the Wellington Asthma Research Group in The Lancet, "a child presenting with an episode of wheezing is now more likely to receive a diagnosis of asthma and be given treatment with bronchodilators ...
Potentially this could lead to a deterioration in symptoms, prolongation of the episode and the requirement for yet more bronchodilator therapy."

In other words, because of the current medical fashion of calling any cough that goes on longer than a few weeks asthma, your child runs the risk of developing chronic asthma as a result of wrongly medicating a prolonged cough.

The other thing I've seen a lot is a spasmodic cough that looks and sounds very much like whooping cough - but because it hasn't got an audible whoop when the child breathes in it's not diagnosed as whooping cough because immunisation is supposed to have wiped it out! This spasmodic cough, which leaves your child retching up slimy mucous, or red in the face and gasping for air, is sometimes called viral asthma instead. Whatever kind of virus it's caused by, the antibiotics commonly prescribed will do no good at all because they can't help infections caused by viruses rather than bacteria.

For all these situations, homeopathic remedies come into their own. If your child has a nasty cough, you'll need to seek the advice of a professional homeopath, but you can treat the milder forms yourself with one of the remedies described below.

Choose the remedy whose picture best covers your child's symptoms.

QUICK COUGH REMEDY SPOTTER:

Loose, wet, rattling; Pulsatilla
Throaty; Pulsatilla or Rhus tox.
Dry, chesty; Bryonia or Phosphorous.
Croup (or a dry, tight cough); Aconite or Spongia.
Whooping type cough: Ipecac or Drosera.

REMEDY PICTURES

PHLEGMY COUGH PULSATILLA

The no.1 cough remedy for children.
The cough is loose (with lots of mucus); there's a lot of thick snot and from both throat and nose, usually yellow-greeny in colour.
It's the main remedy for a cough which is much worse on lying down to sleep (because mucus accumulates), and in the morning on waking (when the cough starts up to clear it out).
Earache; ears feel sore.
Not very thirsty.
Better in fresh air. Uncomfortable in heated rooms.
Like to be cuddled and made a fuss of.

SILICA: Use it when a rattly cough doesn't clear up on Pulsatilla.
They usually look pale and are quiet or floppy. Glands in the neck may be quite swollen and their head may feel sweaty. They feel chilly and might like a scarf around their neck.
Nose blocked with yellowish mucous.
Hearing is often diminished after a cold and cough.
Throaty, teasing cough.

RHUS TOX

Phlegmy cough, which sounds like it's coming from just inside the throat.
Especially if it's come on after snuffles when the weather has changed from dry to damp weather, whether warm or cold.
Wants warm drinks, and often milk (which is not the best thing for a phlegmy child to drink!)
They may get fever blisters around the mouth at the same time.
Sometimes has chill or a flu as the cough develops.

CHESTY COUGH BRYONIA

Dry cough which hurts the chest, or causes the head to pound. Cough more on coming into a warm room.
They can hold their chest when coughing (because it hurts). Can even help in bronchitis. Chest sounds a bit wheezy.
Thirsty; want plenty of cold water. Lips dry.
Irritable. Don't like to be fussed over.

PHOSPHOROUS

Tickling cough in delicate people with weak chests. When your child is exhausted by a constant cough.
The cough is hard with a barking sound, worse talking, laughing, in open air.
Cough can be triggered by any change in temperature
Very thirsty, especially for iced drinks.
Because of the nasal congestion they can have spontaneous nosebleeds, or traces of fresh blood in the phlegm. (NB. Check with the doctor whenever blood appears.)

DRY COUGH/ CROUP ACONITE

Hoarse voice with dry hard croupy cough. Cough sounds hard and dry, or 'barking'. Breathing in cold air tends to bring on the cough. Breathing out seems much more comfortable.
Thirsty. Behaviour is anxious and restless. In a state which needs Aconite, the child is often restless, with sudden heat and fever, which can alternate with chills. Their face is hot and flushed while their feet are cold.

SPONGIA

Use for croup if a few doses of Aconite haven't helped. Or for a croaky cough with hoarseness. Again, the cough sounds like a hollow bark (like a seal), sometimes with a rasping saw-like sound in between. They bend forward to cough.
They may wake up at midnight with a cough. Excitement can bring on a bout of coughing.
Cough seems better from eating or drinking.

SPASMODIC OR WHEEZY COUGH IPECAC

When wheezy and breathless from coughing. They seem to make a big performance of coughing - which can end in retching. Hacking cough with retching of frothy sputum or vomiting.

Cough continues to trouble them during sleep.

DROSERA

For intense, spasmodic cough.
Whooping cough.
The spasms of cough seem to literally take their breath away. Child holds their chest when coughing. Coughs and retches.
Cough so strong the nose bleeds.
It seems to be triggered by drinking, talking, laughing, and sometimes on lying down.

RECOMMENDATIONS:

- Encourage your child to drink plenty of water, or hot lemon drinks.
- Don't force your child to eat if they're not hungry. The body needs energy for self-healing rather than digesting.
- Cut out junk food, sugar, and reduce wheat and dairy products which are mucus-producing.

For dry coughs - Turn down the central heating and leave it off at night.
- Use humidifiers at night if the atmosphere is still dry.

NB - If your child has a lingering cough for weeks, or they are getting frequent coughs and colds they would benefit from seeing a homeopath for constitutional treatment to strengthen their immune system.

Cassandra Marks RSHom is available at:
North End Practice,
8a Burghley Road, NW5.
Tel 0171 485 9362.

Next issue.....Antibiotics

DOSAGE

One tablet of the 6 potency three or four times daily for mild infections.

One tablet of the 30 potency every two or three hours only if your child seems very distressed by the symptoms. Reduce the frequency as soon as they start feeling better.

Be flexible regarding how often you give the remedy. Generally the worse the condition the more frequently it should be given. In less urgent problems, give a 6 potency three times a day until improvement sets in, and then quickly tail off the remedy.

Don't forget - the minimum dose that can achieve a cure is always the best.

A MEMBERS COMMENTS

I have two children - Elouise who is 6 1/2 years old received those early jabs at 2,3, and 4 months and then I well remember reading that article in the Evening Standard magazine which sent alarm bells ringing - around the time when she was due for her MMR - she never had it and has not had another jab since.

I became a member of the Informed Parent around the birth of my second child. obviously feeling nervous about the DPT/Polio. But my gut feeling was not to go ahead and I have never regretted that decision. He is now a healthy 4 year old - has had measles (at around 18 mths) suffered slightly worse effects with chickenpox at 3 years and, I suspect, German Measles recently. They both have healthy fevers when they are sick (thus increasing their white blood count when it is needed most) and I rarely take them to the doctors for what I know are viruses, which their bodies' own natural defence system will deal with, strengthening their immune system.

All around me I see friends' children suffering with constant ear infections, glue ear, diabetes; one friend has an 11 year old who has just been diagnosed with Aspergers Syndrome - a kind of autism - he convulsed following his MMR (is there a connection I wonder). Another acquaintance has a 7 year old who just stopped normal progression around 13 months and is now a 'special needs' pupil in mainstream school. However, although many of my friends know my stance on vaccination, not one of them wants to believe in my views. Therefore, I remain mostly silent - putting in a gentle reminder occasionally - but they know where to come if they want more information.

It is my view that the question of wholesale vaccination is an explosive subject - there may be suspicions amongst some quarters of the medical profession as to their efficacy and long term effects, but can you imagine the catastrophic uproar that would arise if the WHO were suddenly to turn around and say - well we're sorry but we've been wrong for the last century and actually we're not sure what effect vaccinations are having on the human race - who would pay the compensation claims?!!

DOCTOR PATIENT PARTNERSHIP TARGETS CHILD IMMUNISATIONS

Taken from: BMA News Review, 7/5/97

The Doctor Patient Partnership breaks new ground this week with a campaign aimed at encouraging patients to have their children immunised.

Don't Delay, Immunise Today highlights the benefits of childhood immunisations against whooping cough, polio, and measles, mumps and rubella, and reassures parents about the side-effects.

Agony aunt Claire Rayner has pledged her support for the campaign and helped launch the initiative at BMA House in London.

Posters and leaflets are being sent out to GP surgeries and the bunny star of the Enjoying Easter initiative plays a central role again.

GP negotiator Simon Fradd said he was delighted at the involvement of patients' organisations. 'We have managed to reassure them that we are not about reducing services, we just want services to be used more effectively.

The campaign will benefit doctors and patients. In the short term it will be less difficult for GPs to meet quotas and people will come voluntarily for immunisations. In the long term immunisation can eradicate polio, which could disappear in three years."

Dr Fradd said he hoped Health Department and Royal College of General Practitioners representatives would join community health councils on the board co-ordinating the campaign.

Caroline Ryan

"AN INSULT TO DEDICATED HEALTH AND SCIENTIFIC PROFESSIONALS .....CONTINUED

In the first article I examined the 'discovery' of vaccination and how detrimental data was ignored. In this issue I will show how that procedure was perpetuated together with the manipulation of figures to further its cause.

This deception is clearly seen in the incidence of smallpox in the 1700's. Official figures from the Bills of Mortality for London showed that under 2,000 died annually, with the last two decades recording an average of 1,751 and 1,786. But when Dr Lettsom gave evidence to the Parliamentary Committee in 1802 he used the figure of 3,000 - an exaggeration of 68%. He took that figure and multiplied it by 12 to get a comparison (?) for the country as a whole. As before, this extrapolation ignored the fact that smallpox was rare in the countryside and small towns. For example in 1782 Mr Connah, a surgeon of Seaford, Sussex, reported only 1 case of smallpox in the last eleven years in a population of 700. Likewise Mr Cross, a historian of Norwich, said that prior to 1805 smallpox was little known in that city with its population of 40,000.

Dr Lettsom's generous figure that 3,000 died in a population of nearly 1 million gave a death rate of 3 per 1,000. Yet in 1806 he further compounded his error by stating that 89 per 1,000 died annually . Such exaggerations favour vaccination.

Much was made, in those days, of the *dreadful* disease but how much did placing smallpox pus in open cuts (inoculation) contribute to it's spread?

After all vaccination with cowpox was introduced precisely to overcome the illness and deaths resulting from inoculations.

Not that vaccination was without side effects and deaths but then as now, the figures were ignored and hidden. In Dr Maclean's article in the 1810 Medical Observer he said: "very few deaths from cowpox appear in the Bills of Mortality, owing to the means which have been used to suppress a knowledge of them. Neither were deaths, diseases and failures transmitted in great abundance from the country, not because they did not happen, but because some practitioners were interested in not seeing them, and others who did see them were afraid of announcing what they knew. For example, Mr C Fox, a medical man of Cardiff, published 56 cases of illness from vaccination including 17 deaths. Yet he only certified 2 as caused by vaccination. Of those who survived several were permanently injured and most endured great and prolonged suffering. If one medical man recorded such injury and deaths what was the total of unrecorded vaccine damage for the whole country?

The diseases that were spread/caused by vaccines included diarrhoea, bronchitis, leprosy, syphilis and convulsions. The vaccinators continued unabated aided by the National Vaccine Establishment (set up in 1807) who in 1812 and 1818 gave the loaded figure of deaths in London, prior to vaccination, as 2,000 per year. In 1826 they quoted 4,000 and in 1836 that had become 5,000. This from a body supported by public funds!

MICHAEL HENRY, FATHER OF FOUR AND A GRANDFATHER WRITES A PERSONAL VIEW BASED ON HIS OWN FINDINGS AND EXPERIENCES

This all helped the vaccinators, who had become a majority, to gain wider acceptance and further their desire to dominate. As vaccinations were paid for out of public rates they persuaded Parliament to pass an Act in 1840 prohibiting inoculation with smallpox. The penalty for which was one month's imprisonment. Its interesting to note that Jenner before his (penniless) death in 1823 had declared that cowpox was smallpox of the cow and non-infectious. A view shared by the *high priest of the vaccine cult*, sir John Simon who said "cowpox is smallpox, and that a person who has had cowpox has really passed through smallpox." So were not vaccinators also breaking the law?

The vaccinators efforts were completely rewarded in 1853 when they convinced Parliament to pass the Compulsory Vaccination Act.

Did it have any effect?

Despite rigorous enforcement 14,244 people died in the 1857-59 epidemic followed by 20,059 in the one between 1863-65. An increase of 40.8% whilst the population only rose 7%. This was followed by 44,840 deaths in the 1870-72 epidemic, a dramatic increase of 123% over the last one whilst the population grew just 9%. The London Bills of Mortality show that this epidemic achieved death rates not seen since 1838, and in Bristol of the 740 fully vaccinated children in the Muller's Orphanage 292 caught smallpox (40%) and 17 died - 22,973/million. So after 70 years of vaccination and nearly 20 years of compulsion smallpox was rife and back with a vengeance.

The same damning evidence was echoed in other official records both here and abroad:

- The 1882 Report of the Hospital Commission stated that the percentage of vaccinated people in London Smallpox Hospitals increased from 40% in 1838 to 95% in 1879.
- In Ireland where only 11% of the population lived in towns of over 100,000 people, and vaccination was regarded as imperfect, the smallpox death rate in the 1871-73 epidemic was 800/million. Whereas in England 54% lived likewise, 95% were vaccinated and yet the death rate was 2.5x greater - 2,000/million.
- Sweden, regarded as one of the best-vaccinated countries, was held up to parliament by Sir John

Simons in 1857 as an example of success. He claimed that by 1810 "a quarter of all births were vaccinated." But according to the 1857 Swedish Board of Health Report the first successful vaccination in densely populated Stockholm was at the end of 1810. Sir John also ignored the huge rise in deaths in the major epidemics of 1825, '33, '39 and '51! These were followed by ones in 1859, '65, '68 and a doubling of deaths in the 1874 epidemic.

• Prussia (Germany) had greater mortality from 1846 to '71 than England but this was overlooked by Dr Seaton when testifying to the Committee on Vaccination. He said that he knew "Prussia was well protected."

Against what? If that were true then why did the death rate soar in the 1871-72 epidemic by 5x more than the worst one that century? In the same epidemic in Bavaria 95.7% of the 30,742 cases were vaccinated.

• Our own Army and Navy, where vaccination was vigorously enforced, had a death rate of 64.3/million between 1865-95. As this was lower than the general public it was used in favour. The fact that they were better fed, housed and medically cared for seems of little importance. As does the fact that Ireland had a similar death rate (65.8/m) but, in stark contrast, were known to be imperfectly vaccinated.

There were several Commissions set up in the 1800's to examine vaccination and their Reports were always found in favour. In doing so they disregarded the wealth of detrimental statistics, diagrams and testimonies some of which were given by eminent doctors. A clue to their decision is given in the Final Report wording "the question that we are now discussing must be argued on the hypothesis (assumption) that vaccination affords protection against smallpox."

Was it not the commission's duty to examine the whole issue impartially and without the extent of bias shown?

With the exception of frequent major epidemics there was a gradual decline through the 1800's - in fact since 1760. But the same applied to the overall death rate including all other Zymotics (infectious diseases like measles, whooping cough, diphtheria, fevers etc.). No account was taken as to why they fell - no vaccines were available. No doubt the steady improvements in sewage disposal, less cramped living conditions, fresh water and food made an extremely important contribution. But the Final Report ignored this with the dismissive reference to sanitation, "the experiment has never been tried." Little account either was taken of the mass of cases and deaths in fully protected (vaccinated) groups. If the theory works why were there failures? Its no good holding up the Armed Forces as an example of success when they were still dying of the disease. They also defused the impact Leicester had on their findings. The people of Leicester fed up with epidemics and higher mortality than London, despite being 95% vaccinated, decided to reject the practice from 1872. This led to a greater decline in deaths and severity of epidemics than elsewhere. For instance Leicester went from having an equal death rate to Birmingham to having 78% less deaths in 1891-94 and 70% less cases. And between 1873-94 61% less deaths than the well protected Armed Forces. Instead of taking the rare example set by low vaccinated Leicester (fewer than 10% from 1887) and comparing it to fully covered groups the Commission scattered and dismissed the information in their Final Report.

Did "herd immunity" grow its roots in those days as a means of eliminating comparison?

Perhaps the modern day "habit" of denying side effects likewise evolved from those times? The 1894 National Health Society booklet 'Facts concerning Vaccination for Heads of Families' stated that: "with due care no risk of any *injurious effect* from it need be feared." But the year before, after investigating injurious effects, the Medical Officer of Health for Congleton reported that 50% suffered *abnormalities* and a large number were *gravely injured.*

The other modern "habit" that stems from those days is the one of assuming vaccination as an established fact rather than one based on science.

Next issue.....new century - old habit

A REFORM A DAY KEEPS THE DOCTORS AWAY

Extract from: 'Doctor at large' column by Luisa Dillner, The Guardian, 8/7/97.

The future of medicine, it is now apparent, is in public health (once it used to be in general practice).

More specifically it is about getting tough not just on illness but on the causes of it. And as Tessa Jowell announced in the Government's brand new public health strategy, one of the main causes of ill health is poverty. Closely behind poverty are its big mates unemployment, bad housing, social isolation, pollution and belonging to a certain ethnic minority or gender group.

.....If you are born poor, of course, you are less likely to make it into adulthood anyway - a child in the lowest social class is twice as likely to die before the age of 15 as a child in the highest group.

To be anything other than a public health doctor would now seem to be missing the point. Public health interventions have, historically, done more than most modern therapies, to improve the nation's health. Dramatically, in 1854 Dr John Snow interrupted the death march of Cholera by removing the handle from the Broad Street water pump. It wasn't a terribly popular measure at the time.....

HOW TO INJECT EXTRA CASH FROM VACCINATIONS AND IMMUNISATIONS

Taken from: Financial Pulse, 8/2/97

THE PROBLEM

We recently analysed our accounts and found our earnings from vaccinations and immunisations are well below the national average. We are an urban practice of six partners with a list size of 11,800.

How can we improve in this area?

Money from vaccinations and immunisations should represent between 5 and 10% of item-of-service income, writes Dr Ian Gold. It is therefore an important source of earnings.

This practice should look at the different areas in which this income is derived so it can devise strategies to boost earnings.

Immunisations can be split into three categories:

1. childhood and pre-school
2. public policy
3. travel

CHILDHOOD IMMUNISATIONS

Childhood and pre-school immunisations contribute to target payments, of which there are two levels. You achieve the lower level if 70% of the eligible children on your practice list have received completed courses of the immunisations and the higher level if 90% have.

The maximum annual lower target payments for a GP with a national average of 22 children under two years of age and 22 children under five years of age are £745 for childhood immunisations and £220 for pre-school boosters. The maximum annual higher target payments are £2,235 for childhood immunisations and £660 for pre-school boosters.

(In the Financial Pulse, 22/2/1997, the target payments were reported to be: Childhood immunisations: higher £2,340 lower £780 Pre-school boosters: higher £690 lower £230.)

Within these targets the actual payments depend on the proportion of the immunisations given by the GPs as part of GMS as opposed to those given at, say, health authority clinics.

This practice has not achieved any target payments. If the GPs reach the lower target for next year they could potentially receive £5,790. If they could reach the higher target this would bring them an extra £11,580. Certainly most practices would feel that improving their income by a total of £17,370 was worth a considerable amount of effort.

What can they do to improve uptake? First, the practice must calculate well in advance of the due date for claiming (the first day of each quarter) whether it is likely to achieve the targets.

There are four groups of immunisations to complete for target payments for children aged two:

- •diphtheria, tetanus and polio x 3
- •pertussis x 3
- •measles, mumps and rubella
- •hib x 3

For children aged five you need to complete reinforcing doses of diphtheria, tetanus and polio.

Currently the pre-school booster dose of MMR attracts an item-of-service payment, but it will eventually be included as part of the target payments.

Identify any children that have not been immunised so you can invite them to complete their course. This could be by letter but it is usually more effective to phone or involve the health visitor who will visit the family.

Make it easy for your patients by offering an appointment time to suit them. As a last resort it might even be worth giving the immunisation at home if it means hitting a target.

If a parent refuses immunisation, explore the reasons and determine whether the parents have all the facts needed for an informed decision.

Discuss immunisations with parents at the six-week development check so the programmes are started in the right place. Use other contacts with the children to check on immunisation status and pick up defaulters.

PUBLIC POLICY IMMUNISATIONS

Most immunisations in this category attract an item-of-service fee - see schedule 1 of paragraph 27 of the Red Book.

If your immunisation income is below the national average, offer tetanus boosters for adults who have not received one in the preceding 10 years. Also pick up those who have never had a primary course.

You could do this opportunistically during consultations or by recall from the computer. Check on immunisation status at new patient checks.

With tetanus (as well as typhoid and infectious hepatitis), you can generate income from reimbursement for personally administered vaccine under paragraph 44.5 of the Red Book. It is important to offer oral polio to previously unimmunised parents of children being immunised.

There is no item-of-service fee for some public policy immunisations, for example influenza, pneumococcus and hepatitis B. It is still worth generating income from these through the reimbursement scheme.

This practice could generate up to £3,700 from an effective annual influenza vaccination campaign if it immunised 10% of the practice.

Targeting patients for pneumococcal vaccination would mean immunising 5% and would bring in around £3,000.

But unlike influenza this is not repeated annually.

Influenza immunisation is strongly recommended for people of all ages, but especially the elderly, with the following:

chronic respiratory disease
chronic heart disease
chronic renal failure

diabetes mellitus, and other endocrine disorders

immunosuppression due to disease or treatment.

These are also indications for pneumococcal vaccine but splenectomised patients should be included. Influenza immunisation is also recommended for residents of nursing homes, residential homes for the elderly and other long-stay facilities. Current recommendations now include everyone over 65 years of age.

FOREIGN TRAVEL

Many practices are finding this a growth area, so it could be costly to ignore. Some attract item-of-service fees and can also be claimed for reimbursement of any personally administered drugs. Others may be a source of private income, but remember you cannot charge for the immunisation and claim an item-of-service fee or reimbursement. But you can charge for issuing an immunisation certificate.

Travel immunisations attracting item-of-service payments are:

TYPHOID - outside UK, except Canada, the US, Australia, New Zealand and Northern Europe

CHOLERA - Africa, Asia or an infected area

(Editor- In the DoH 1996 edition of Immunisation against Infectious Disease, HMSO, it states: 'No cholera vaccine is currently available in the UK. Cholera vaccine has no role in the management of contacts of any cases, or in controlling the spread of infection. Control of the disease depends on public health measures rather than immunisation.....Contacts should maintain high standards of personal hygiene to avoid becoming infected.'

POLIO - outside Europe, except Canada, the US, Australia and New Zealand

INFECTIOUS HEPATITIS - outside Northern Europe, Australia or New Zealand.

The GPs in this practice should consider starting a travel clinic, run by the practice nurse. They should first direct this at their own patients, but there might be scope later to expand it to a private service for patients registered with other practices.

They could also consider becoming a yellow fever centre authorised by the Dept. of Health.

Good marketing is the secret of increasing uptake in this area so they should advertise the clinic via posters in the surgery and the practice leaflet. Again they should make appointments as convenient as possible.

Ian Gold is a GP in Radlett, Herts.

Editor - Another article in the same edition of Financial Pulse was entitled - "Travel vaccines - broaden your earnings. Dr Mike Townsend explains how GPs can take advantage of patients' trips to exotic destinations."

Shouldn't the priority be 'health' not 'wealth'?

LETTER FROM A MEMBER

Dear Informed Parent

Like all parents, we want the best health for our son Samuel. When he was born, we went for all the usual vaccinations including the then new Hib vaccine. Up to the age of 4, Sam had continuous coughs and colds and unexplained sudden high temperatures. When he was 3, he had the most frightening cough which the doctor later diagnosed as croup. At one stage, our GP prescribed Ventilin, saying that Sam was 'probably' asthmatic. We refused the Ventilin and asked to see a specialist. After a number of tests, the consultant told us that Sam had had whooping cough which caused this recurring cough every time he was down with a cold. There was no asthma. It made me wonder how many parents naturally accept their doctors diagnosis of asthma and give their children a drug they do not need. The consultant also said that Sam's immune system was not very strong but should improve as he got older.

Then we found 'The Informed Parent', which helped us to make the decision not to have any further vaccinations. Our GP has tried to convince us that it is irresponsible not to go ahead with the doses that all 4 year old are given. I have to admit, I am worried that Sam might catch Polio, or Tetanus. But he has been so well over the past year, hardly catching a cold; and when he does catch a cold he is over it in a very short time, with no persistent cough.

In contrast, many of Sam's friends have had sicknesses and bugs which he doesn't catch from them. It may just be coincidence and nothing to do with vaccinations, but I feel I have witnessed enough to believe that they do mess up the immune system.

I still worry when Sam comes home from school with a plaster on his knee. Children get lots of grazes and cuts, and we live in the country. Are we really putting Sam at risk of tetanus? Our GP seems to think so.

How are we to know if Sam happens to be in a swimming pool at the same time as a baby who has just had the polio vaccine? How likely is he to contract the illness? I am sure these are normal fears of any parent who has made the decision we have made. It doesn't rest easy with us.

Are there any other parents living in the Ashford area of Kent who feel as we do? I would be keen to set up a local group to share the concerns and be more informed. Would it be possible to do this through 'The Informed Parent' by people contacting you and then you putting them in touch with us?

J. Wood

If you are interested in responding to this letter, please write c/o 'The Informed Parent'.

Don't forget about the link-up lists available to members, which list local members who are happy to be contacted. Please send a SAE to 'The Informed Parent', for a copy of the lists, indicating the counties you are interested in.

HAEMOPHILUS INFLUENZA B - THE DISEASE AND THE VACCINE

YOUR QUESTIONS ANSWERED BY DR JAYNE DONEGAN

1. Are the symptoms the same as those from other forms of meningitis?

The symptoms of Haemophilus Influenza B (Hib) meningitis are similar to those of other forms of meningitis in children. Hib meningitis occurs more often after colds, coughs and ear infections in young children. Seizures are more common. The disease tends to have a slower onset than Neisseria meningitidis type B meningitis and is less likely to cause a rash. It also occurs less commonly in epidemics.

2. What other diseases does the vaccine prevent and how does it cover more than one?

Haemophilus influenzae is a bacterium that infects humans only. It comes in an unencapsulated form which causes mostly coughs, colds. sinusitis and ear infections. There is an encapsulated form that has six types (A-F). Type B is the commonest type and can cause ' invasive' disease. It may spread directly and inflame the skin of the face or cause epiglottitis or it may invade the blood stream and cause infections further away - meningitis, joint infection, pneumonia. 90% of healthy individuals carry Haemophilus influenzae in their noses. 5% of these organisms will be type B.

The vaccine is only against type B so it will only affect infections caused by Haemophilus influenzae type B (Hib). It is also likely that, as infections by type B are suppressed, the other types A, C-F will eventually take over and produce them instead.

3. Is my child less likely to get Hib meningitis because other children are vaccinated or more likely to because the other children are carrying Hib without signs of illness?

Invasive Haemophilus influenzae disease is more likely in children aged 3-48 months. The peak age is ten to eleven months. Antibodies form against the encapsulated form (of which type B is one) and may be the result of carrying the organism, without symptoms, in the nose or the pharynx. Antibodies may also be formed as a result of infections with other organisms that have similar capsules (such as E. coli k100, found in the gut).

The vaccine will presumably cause less children to meet the organism and less children to carry it in their nose. This means that less children will gain natural immunity to Haemophilus influenzae and this will increase the likelihood of their contracting severe forms of the disease at a later age.

The incidence of disease caused by invasive forms of Haemophilus influenzae (encapsulated forms A-F) has been rising since the introduction of mass vaccination in the 1950s and excessive use of antibiotics.

In answer to the question, your child may be less likely to get natural immunity from meeting the infection in other children but, hopefully, should still meet it in healthy adult carriers. As this latter group disappears with the vaccination of sucessive generations, the chance of gaining natural immunity at an early age will also disappear with all the consequent complications that this causes.

4. What studies have been done on reactions and long term effects? How long has the vaccine been available?

Studies have been carried out on reactions but none of them are long term. The original vaccines were 'unconjugated' and did not produce an immune response in children less than 18 months of age. The current 'conjugated' vaccines are made of a purified part of the capsule of Hib and are joined (conjugated) to another material with the aim of provoking an immune rezponse at a younger age.

The conjugated vaccines have been around for less than ten years and were not licensed for use in two month old children until 1990 (in the USA). There are many different types, depending on the material to which they are conjugated:

PRP-D	Conjugated to Diphtheria Toxoid
PRP-T	Conjugated to Tetanus Toxoid (Pasteur Merieux - ActHib and ActHIbDPT) (SmithKline Beecham-Hiberix)
PRP-CRM	Conjugated to Cross Reacting Mutant Diphtheria Toxoid (Lederle Praxis CRM197 HibTITER)
PRP-OMP	Conjugated to Outer Membrane Protein of Group B Neisseria meningitidis
HbOC	Conjugated to Oligosaccharide

The Handbook of Immunisation against infectious diseases 1996 mentions large field trials in Finland, the USA and the UK. The trials showing the highest efficacy and given as references in the Handbook are for the vaccines PRP-OMP and HbOC, neither of which are used in this country. The trials were all over a one to two year period so no data as to long term efficacy are available. As for reactions, studies on reactions and incidence of Hib disease post vaccination have been mainly in children who were given Hib vaccine and DPT and Polio compared with children given DPT and Polio alone. This is not a very good control group, bearing in mind the high incidence of adverse effects

that these vaccines have on immunity, particularly in young babies.

Some studies suggest that the Hib vaccine may reduce the ability of a child to fight infection in the two to three weeks after administration.

The Handbook on Immunisation mentions swelling and redness at the injection site in 10% of doses. The British National Formulary lists: fever, headache, malaise. irritability, prolonged crying, loss of appetite, vomiting, diarrhoea, rash, allergic urticaria, convulsions, erythema multiforme, and transient cyanosis (blueness) of the lower limbs. Other reactions which have been reported through the Vaccine Adverse Event Reporting System (VAERS) of the USA are:

Guillain-Barré Syndrome (a neurological disease which may eventually cause paralysis of the muscles needed for breathing and necessitates artificial ventilation in intensive care. The symptoms may gradually improve), Transverse Myelitis (a paralysing disease that mainly involves the legs), Death (which may have been caused by the Hib vaccine or by other vaccines that were given at the same time).

5. At what age is one less likely to contract a Hib disease? Is this because of a more developed immune system?

Hib disease is unlikely to occur after the age of five years because by this age the organism will have been encountered and symptomatic or asymptomatic disease with subsequent immunity will have occured, but this age will rise as vaccination becomes more prevalent. 70% of all cases of Hib and menigococcal type B meningitis currently occur in children less than five years of age. Boys are more likely to be affected than girls. The highest seasonal incidence is between autumn and spring. The incidence is much higher in daycare institutions.

6. What can I do to boost my child's immune system? I want to give them vitamins but can only find inadequate synthetic ones.

To boost your child's immune system you need to give them love, time (ordinary time not just 'quality' time), fresh air, fresh fruit and vegetables, home cooked, unprocessed food, water (uncontaminated by sewage, heavy metals and agrochemicals), exercise and the space to assimilate all that is going on around them in this increasingly hectic, unchildlike world.

VITAMINS. Because of intensive farming methods and pollution, it is probable that even a healthy, well balanced diet is lacking in nutrients. Vitamin supplementation is, therefore, probably advisable. Nature's Own (Tel 01684 310022) make what they call 'food state' vitamins which are supposed to be more bioavailable. Unfortunately, they charge more for their children's multivitamin/mineral supplements than they do for their adult ones (even though there is less in them!) because of their odd package sizes. If you do wish to order comething from them, ask to speak to the managing director, Peter Wallace, and insist that you get 100 childrens vitamins for the same price as 100 adult ones.

Jayne L M Donegan, July 1997

References:

- Handbook of Immunisation against Infectious Disease -1996 HMSO
- British National Formulary, Number 33 - March 1997 BMA and Royal Pharmaceutical Society of Gt Britain
- Harrison's Principles of Internal Medicine, 11th Edition -1987 McGraw Hill
- Vaccination, Viera Scheibner -1993 Australian Print Group, Victoria, Australia
- The Vaccination Guide, Randall Neustaedter - 1996 North Atlantic Books, Homœopathic Educational Services, Berkley, California, USA

FUTURE SEMINAR

BEYOND INFORMATION...

Trevor Gunn - Graduate in medical biochemistry, practising homœopath, author of 'Mass Immunisation - A Point In Question.

Nick Smith - Personal development coach, corporate health program consultant.

Immunisation continues to be an emotionally charged subject, with opinions varying amongst orthodox and holistic therapists. Given much of the basic information and statistics, difficulties still arise when trying to reach conclusions with regard to the safety and effectiveness , especially whilst operating within a framework of risk analysis and fear.

Trevor and Nick will present data along with an overview of how current models of thinking have developed with regard to immunisation, immunity and infectious diseases. With the added perspective of holistic health practitioners, it is possible to gain new insights into the issue of immunisation.

They will demonstrate how a shift in perception can open up new possibilities and enable individuals to overcome apparent difficulties and limitations.

With new insight and more information we are left facing the consequences of our findings. At such times, many people still experience insecurity, hesitancy and fear. Often attributing this to lack of information, i.e. lack of specific information about the subject matter; adverse effects, % of effectiveness, risk of disease etc. etc.. However, obtaining more information frequently leads to more feelings of inadequacy and an insatiable need for even more information.

We will therefore look at what it involves to take action according to our findings. Helping us to overcome some of the many obstacles encountered when faced with the prospect of change. Beyond the point at which more information is never enough and to a place where it is possible to act with confidence and safety.

Beyond Information.....For people with health concerns for themselves and their loved ones, a seminar that aims to impart information....and an insight into how to use it.

Date and venue to be confirmed, full details in next issue!

HOMŒOPATHIC CHILDREN'S CLINIC ST JOHNS PRACTICE 2 ST JOHNS ROAD, ISLEWORTH

TEL: 0181 560 7073

Cathy Bland LCH
Shanagh Forsyth LCH
Kathy Scott LCH

We are running a homœopathy clinic for children at St Johns Practice on alternate Saturday mornings. The aim of this clinic is to provide low-cost treatment to all, in particular families who would otherwise not have access to homœopathy.

Children respond particularly well to homœopathy and can be used for a whole range of conditions including the many common childhood ailments such as infant colic, teething, recurrent colds/ear infections, asthma and learning and behavioural problems.

We are, also, happy to discuss the issue of vaccination with parents.

The clinic runs on alternative Saturday mornings from 10am until 2pm and is aimed at children upto 11 years old. The first appointment lasts approximately 1 hour in order to find out as much as possible about the child and his or her condition.

Follow-up appointments take place at monthly intervals and last approximately half an hour. The charge for each appointment is £10 which includes the cost of any prescription, though you may be asked to purchase any creams etc which might be helpful.

The clinic is run by Cathy, Shanagh and Kathy who are all qualified homœopaths and you will meet two of us at each appointment.

To make an appointment, please ring St Johns practice on:
0181 560 7073

If you would like to find out more about homœopathy or the children's clinic, please ring Kathy on 0181 949 5141

VACCINATION

A lecture by

VIERA SCHEIBNER PhD

Sunday 21st September
2.30 -5pm
At the International Community Centre,
Mansfield Road, Nottingham

For further details/bookings phone Andy or Jo on: 0115 946795

HOMŒOPATHY 10-WEEK FIRST-AID COURSE

Monday evenings,
7-9pm
from September 22nd 1997.
At Neals Yard Remedies
9 Elgin Crescent, London, W11
Cost: £10 per class
(£80 paid in advance)
£6 concessions
For further details
and bookings contact:
Annette Middleton RSHom
Tel: 0171 223 2522
or 0171 727 3998

Tired of being sick?
Sick of being tired? Then attend

"FIT FOR LIFE"

A British Natural Hygiene Society One Day Seminar
Saturday 6th September, 1997
10am - 5.30pm
At Conway Hall, 25 Red Lion Square, London, WC1
Tickets £50.00 including vegetarian buffet lunch

For further information and bookings, please contact: Keki Sidhwa, The British Natural Hygiene Society, 3 Harold Grove, Frinton-on-Sea, Essex, CO13 9BD. Tel: 01255 672823

Childhood Vaccinations: An Informed Choice

Tuesday 23rd September 1997 at 7.30pm
Haygarth House, Retford, Notts.
Speakers: Elke Rohn Dip Hom (York), RSHom
Paul Randall DO MCO
Cost: £3.00 Couples: £5.00
(Includes refreshments and comprehensive handouts.)
For further enquiries and bookings, please contact Paul Randall at the Retford Natural Therapy Clinic, Nelson St, Retford, Notts, DN22 6LP. Or telephone on : 01777 710811

IF YOU REQUIRE A QUANTITY OF THE INFORMED PARENT LEAFLETS, PLEASE SEND A LARGE SAE TO THE ADDRESS BELOW.

The views expressed in this newsletter are not necessarily those of the members or founder members. We are simply bringing these various viewpoints to your attention. We neither recommend nor advise against vaccination. This organisation is non-profit making.

AIMS AND OBJECTIVES OF THE GROUP

1. To promote awareness and understanding about vaccination in order to preserve the freedom of an informed choice.

2. To offer support to parents regardless of the decisions they make.

3. To inform parents of the alternatives to vaccinations.

4. To accumulate historical and current information about vaccination and to make it available to members and interested parties.

5. To arrange and facilitate local talks, discussions and seminars on vaccination and preventative medicine for childhood illnesses.

6. To establish a nationwide support network and register (subject to members permission).

7. To publish a newsletter for members.

8. To obtain, collect and receive money and funds by way of contributions, donations, subscriptions, legacies, grants or any other lawful methods; to accept and receive any gift of property and to devote the income, assets or property of the group in or towards fulfilment of the objectives of the group.

The Informed Parent, P O Box 870, Harrow, Middlesex HA3 7UW. Tel./Fax: 0181 861 1022