# THE informed PARENT

ISSUE TWO - 2005 A QUARTERLY BULLETIN ON THE VACCINATION ISSUE & HEALTH


## MMR MUMPS EFFICACY FEARS

Pulse, 28/05/05

A 'substantial' proportion of mumps cases are occurring among children who have received a single dose of the MMR vaccine, Health Protection Agency scientists report. The HPA is warning GPs to ensure all at-risk patients receive both doses of the vaccine after its study suggested a single dose was insufficient to provide protection.

The HPA researchers, who presented their data at the European Society for Paediatric Infectious Diseases conference in Valencia last week, suggested 'the efficacy of the mumps component of MMR needs further investigation'.

The study reviewed cases of mumps in 2004, when 47 per cent occurred among people aged 15 to 19, who had received or were eligible for a single dose of MMR. Researchers used immunological modelling to estimate a 'high proportion' of them were weak positives, meaning they had received the vaccine but had low levels of antibodies.

Dr David Elliman, consultant in community child health at Great Ormond Street Hospital, said: 'As this paper suggests, perhaps the protection against mumps is not as good as we had thought.'

Dr George Kassianos, RCGP immunisation spokesperson and a GP in Bracknell, Berkshire, said the rate of seroconversion to the mumps component 'may be much lower than we have thought in the past - a second dose of the MMR vaccine is even more important'.

*Editor: Outbreaks of mumps and threats of further epidemics prompted me to respond to a recent BMJ article regarding mumps. I have reproduced some of the responses on page 4. To read all the responses, click on the noticeboard on:*

www.informedparent.co.uk

## BMA BACKS HEP B JAB FOR CHILDREN

http://news.bbc.co.uk/ 9 May, 2005.

About 180,000 people in the UK are chronically infected with hepatitis B. All UK children should be immunised against the hepatitis B virus, which can lead to potentially fatal liver diseases, doctors' leaders have said.

The British Medical Association said immunisation would save lives and be more cost effective than treating liver failure and cancer caused by the virus. Currently, only those at highest risk of infection, such as babies born to mothers with hepatitis B are immunised.

An expert committee for Dept. of Health is reviewing this policy. Dr Sam Everington, Deputy Chairman of the BMA and an East London based GP, said the current policy of immunising only those at highest risk was failing. He said hepatitis B rates were rising and that the virus was "an enormous danger" being 50 to 100 times more infectious than HIV.

Our expert committee is currently investigating whether the immunisation programme might need to be strengthened or expanded in future. A DoH spokeswoman, "It makes sense to immunise all children against hepatitis B. The vaccine is extremely safe and millions of babies around the world have been immunised," he said.

In 1997 the WHO recommended that countries immunise children against hepatitis B.

"Most of the western countries have done this already. Our country has not," said Dr Everington.

He suggested that some of it might be down to nervousness of introducing another jab for children after concerns about vaccine safety following the MMR debate.

Hepatitis B virus is transmitted by contact with blood or body fluids of an infected person in the same way as HIV. The DoH estimates that there are around 180,000 people chronically infected with hepatitis B in the UK. Most of these are among people who have entered the UK from countries with a high prevalence of hepatitis B. It acknowledges that rates of infection could rise with increases in foreign travel and the impact of migration.

A DoH spokeswoman said: "The UK has one of the lowest prevalences of chronic hepatitis B infection in the world and the incidence of acute hepatitis B remains relatively stable and low.

"Expert advice has been that we should seek to improve immunisation of groups most at risk of infection, such as babies born to mothers with hepatitis B, injecting drug users and gay and bisexual men, and this is what we have been doing.

'However, we do keep the UK's hepatitis B immunisation programme under ongoing review and a working group of our expert committee, the Joint Committee on Vaccination and Immunisation, is currently considering whether the current hepatitis B immunisation programme might need to be strengthened or expanded in future. "No conclusions have been reached yet," she added. •••

Ann Savage of the Hep A/ B Jab Victim Support Group is organising a petition against the possible introduction of the Hep B vaccine into the UK immunisation schedule. I urge all concerned subscribers to send off for a petition form, the more signatures gathered the better! Please send an SAE (A4) to: Ann Savage, Hep A/B Jab Victim Support, 11 Woodbourne Close Catisfield, Fareham, PO15 5QG. Additionally, if you would like to get more involved with this *(contd.on p3)*

# VACCINATION-INDUCED CUTANEOUS PSEUDOLYMPHOMA

NEW YORK (Reuters Health) Apr 25 - Vaccinations containing aluminum hydroxide may induce cutaneous lymphoid hyperplasia (CLH), also called cutaneous pseudolymphoma, according to a report in the April *Journal of the American Academy of Dermatology. "Long lasting cutaneous lesions occurring at the site of vaccination containing aluminum should lead to biopsy and the search for aluminum in the lymphocytic reaction," Dr. Herve Bachelez from Hopital Saint-Louis, Paris, France told Reuters Health. Dr. Bachelez and colleagues investigated 9 patients presenting with late-onset, persistent CLH at the site of hepatitis B (8 patients) or hepatitis A (1 patient) vaccination. The vaccines were all aluminum hydroxide-adsorbed and the lesions appeared a median 3 months after a recall injection of the vaccine. Histologic evaluation of skin biopsies showed a pandermal dense lymphocytic infiltrate without evidence of cytonuclear atypia, consistent with the diagnosis of CLH. Muscle biopsies years after the appearance of the skin lesions in 2 patients revealed focal lymphocytic microvasculitis in the muscle tissue in one case and lymphoid hyperplasia in perimuscular fat tissue in the second case. Electron microscopy and immunohistochemical studies identified aluminum hydroxide within the skin infiltrates in all cases, the researchers note. Four patients had their lesions excised surgically, and two patients were treated successfully with intralesional steroid injection. These findings, the researchers conclude, warrant "further prospective studies to evaluate the incidence and the clinical course of CLH in the population receiving aluminum hydroxide-containing vaccinations."

*J Am Acad Dermatol 2005; 52: 623-629. April 2005. Vol. 52 No. 4
Vaccination-induced cutaneous pseudolymphoma

ABSTRACT

Background: Although mild, early cutaneous transient reactions to vaccinations are common, late-onset chronic lesions have been scarcely reported. We report herein a series of 9 patients presenting with cutaneous and subcutaneous pseudolymphoma.

Observations: Nine patients presenting with late-onset, chronic skin lesions occurring at the site of antihepatitis B (8 cases) and antihepatitis A (one case) vaccination were reported. Histopathologic and immuno-histochemic studies, and molecular analysis of clonality of skin biopsy specimens, were performed. Furthermore, the presence of vaccine products was investigated in skin lesions by using histochemical, microanalytic, and electronic microscopy techniques.

Results: Histopathologic studies showed dermal and hypodermal lymphocytic follicular infiltrates with germinal center formation. The center of follicles was mostly composed of B cells without atypia, whereas CD4+ T cells were predominant at the periphery. Molecular analysis of clonality revealed a polyclonal pattern of B-cell and T-cell subsets. Aluminium deposits were evidenced in all cases by using histochemical staining in all cases, and by microanalysis and ultrastructural studies in one case. Associated manifestations were vitiligo (one case) and chronic fatigue with myalgia (two cases).

Conclusion: Cutaneous lymphoid hyperplasia is a potential adverse effect of vaccinations including aluminium hydroxide as an adjuvant. Further prospective studies are warranted to evaluate the incidence of this complication in the immunized population.

GLOSSARY

Cutaneous: Relating to the skin.
Pseudolymphoma: A benign infiltration of lymphoid cells or histiocytes which microscopically resembles a malignant lymphoma.
Atypia: Atypism; state of being not typical.
Hyperplasia: An increase in number of cells in a tissue or organ, excluding tumor formation, whereby the bulk of the part or organ may be increased.

# GPC REBUKES HUTTON ON MMR

Pulse, 23/04/05. Extracts.

GPC negotiators have angrily rejected health minister John Hutton's claim that they have given up the fight for informed dissent for childhood vaccines..... The Government is adamant that allowing exception reporting would undermine vaccine uptake. But GPC negotiator Dr Andrew Dearden said: 'Just because they say there's no negotiation doesn't mean we won't keep bringing it up and keep talking about it. We have done everything we can think of to tell the Government of the stupidity of this decision. We don't want to get into situations where we're coercing patients to have things done.' The contract explicitly leaves open the possibility of reviewing target payments for vaccines. At next week's Scottish LMCs conference, Forth Valley LMC will renew demands for informed dissent. Dr John Rankin, the LMC secretary, told Pulse: 'We put the motion forward each year to keep pressure on the Government.'.....

# DAY CARE PREVENTS CHILD CANCERS

http://news.bbc.co.uk/ 22/04/05
Extract.

Sending your baby to day care in the first few months of life could protect them against leukaemia, say UK experts. The Leukaemia Research Fund team believe exposure to common infections in early infancy is good and helps "prime" the immune system. Conversely, reduced exposure to bugs in the first year of life increases the risk of developing acute lymphoblastic leukaemia (ALL), they suggest....."There is abundant evidence now that the immune system requires infection in the first few months of life in order to be set up and function normally." If this does not happen, when the child is older and encounters an infection, that infection can then trigger the leukaemia, he said. "Infection early in life is good for you, it protects you - pretty much what your grandmother might have told you," he said.....

*Editor: Is it possible that disabling a baby's immune system through vaccination will lead to the suppression of early infections?*

# TOUGHER ACTION IS ORDERED OVER POOR VACCINE UPTAKE

Pulse, 02/04/05. Extracts.

Ministers are urging PCTs to consider alternative providers for immunisation, potentially including private firms, in areas where GPs' standards are 'poor'. The edict comes as new data shows MMR uptake at 24 months plunged by a further 0.5 per cent to 80.8 per cent, its lowest level for 15 months, dashing hopes of a recovery. In a blow to the immunisation programme, uptake at 12 months also fell for DTP, Hib and meningitis C, according to the latest COVER data for October to December 2004. The Department of Health is warning of 'persistent inequalities' in vaccine uptake. Its new Vaccine Services report urges PCTs to 'support local innovation' by exploring all contracting routes for immunisation, including APMS contracts for alternative providers. ...But GPs raised concerns over the effect of the plans on continuity of care, while questions remain over how the new arrangements would affect target pay and item-of-service fees. GPC negotiator Dr Andrew Dearden insisted GPs were 'best placed' to provide immunisation services. 'By commissioning other services you would duplicate work. All you're doing is rearranging the layers but it doesn't work.' Dr George Kassianos, RCGP immunisation spokesperson, said decisions on vaccination were often 'entirely about parental concern no matter how hard you work'. He added: 'We have the best system. If you tinker with it you will regret it.'

# GPs LOSE THOUSANDS IN VACCINE PAY SHOCK

Extracts taken from Pulse, 30/04/05
*By Emma Wilkinson*

GPs are set to lose thousands of pounds in vaccine pay because of a new rule change making the 90% uptake target far tougher to achieve. Pulse has learned that this year's uptake in two-year-olds will be calculated on just two vaccines the new five-in-one and MMR as opposed to four previously. Low MMR uptake is set to so distort average uptake rates that thousands of practices will miss out on the top payments by £5,700 on average. The rule change is included in the new statement of financial entitlement which came into force in England on April 1. Scotland, Wales and Northern Ireland are expected to follow suit.

The Department of Health forced through the change in negotiations with the GPC after claiming the introduction of the five-in-one vaccine had cut GP workload. The change was buried in the SFE and only emerged this week. GPC chair Dr Hamish Meldrum insisted: 'To compensate for the adverse impact of this change, the GPC will continue to push for informed dissent for childhood immunisations and MMR in particular.'

But GPs are furious. Dr David Baker, a GP in Grantham and vice-chair of Lincolnshire LMC, said the change could cost his practice £6,000. He said: 'An awful lot of GPs are going to miss out because an awful lot have had their targets hit by MMR. GPs are now going to have to hit 100 per cent for the five-in-one and 80 per cent on MMR. You only need one or two patients refusing and you won't hit the target.' Dr Lisa Silver, a GP in Nettlebed, Oxfordshire, said: 'There will be a lot of anguish.' Dr Nigel Lord, a GP in Altrincham, said: 'The GP negotiators are not up to the job.'

HOW AVERAGE PRACTICE WILL LOSE OUT

| BEFORE | |
|---|---|
| DTPolio | 93.9% |
| Pertussis | 93.5% |
| Hib | 93.7% |
| MMR | 80.8% |
| Average uptake | 90.5% |
| Annual payment | £8,488 |

| NOW | |
|---|---|
| DtaP/IPV/Hib | 93.7% |
| MMR | 80.8% |
| Average uptake | 87.3% |
| Annual payment | £2,829 |

*(contd. from p1)* particular issue contact Ann on: 01329 847588. A march to Downing Street is also being arranged should the introduction of the Hep B vaccine be announced for all children, in which case AS MUCH SUPPORT AS POSSIBLE will be required to reject the proposal!!

Regarding Hepatitis B vaccine here follows a brief extract from a Canadian book entitled 'Immunisation: History, Ethics, Law and Health' by Catherine Diodati. (p 129)

'That many 'high'risk' individuals seem to refuse vaccination does not support vaccinating all children. Immunising infants and children en masse with the hepatitis B vaccine is patently unethical, and downright dangerous, because the risks definitely outweigh the benefits. This was certainly the case for Lyla Rose Belkin, a previously healthy baby, who died at 5 weeks of age, within 15-16 hours of receiving her second hepatitis B vaccination. Lyla's mother had been screened, and tested negative, for hepatitis B so there was no sufficient reason to risk this baby's life. During the autopsy, Lyla was found to have a swollen brain and the cause of death was initially reported as SIDS. However, the coroner eventually conceded that the vaccine was involved. When the coroner attempted to report Lyla's vaccine-related death to the Vaccine Adverse Event Reporting System (VAERS), her call was never returned. One can hardly be assured that adverse events are 'rare' when it is quite evident that serious adverse events are excluded. Most infants and children are not at risk of infection and those who are genuinely at risk can be identified and treated. There simply is no justification for risking the health and lives of countless infants and children through unneccessary hepatitis B vaccination.

The National Vaccination Information Center recently reported that amongst 8 states studied, a total of 25 cases of hepatitis B occurred in children <5 years of age in 1997 *(Editor: I wonder if any of them had received the jab?)*. There were, however, 106 serious hepatitis B vaccine-related adverse events, and 10 deaths, reported for children <5 years of age amongst the same 8 states.

## SPOTLIGHT ON MUMPS

Reproduced here are a few of the Rapid Responses recently posted on the British Medical Journal website (bmj.com) in regards to mumps.

•Magda Taylor: So now the threat of measles epidemics is taking a rest, mumps is in the spotlight. It is interesting that there is now so much concern and fear being promoted about mumps, if it is so bad then why did it not become a notifiable disease until 1988? Cases of measles, whooping cough, diphtheria, for example, were reported from the mid 1800s - why not mumps? Upto the introduction of MMR the majority of parents were not too worried about a case of mumps, it was mostly viewed as a benign childhood infection. However as soon as the MMR came into use, mumps suddenly became a more dangerous illness with a list of complications. All illnesses have the potential to lead to complications, but this is rare, and due to the state of health of the individual, ie their lifestyle, diets, physical and emotional stability etc., and also the mismanagement of the disease. If the illness is left to run it's course, without suppression, a reasonably healthy child will sail through mumps, as they would with measles and rubella. Mumps was known as a CHILDHOOD illness, and this would be the normal and appropriate time to be developing such a disease. Now it is occurring in UNDER immunised young adults, which seems to be another problem caused by vaccination programmes - shifting the age of incidence to an inappropriate time. So the push to give them another dose of MMR is presented as the answer. How many doses will be necessary before they will be classed as sufficiently immunised? And how will the authorities know, when even the world health experts of the day do not even fully understand immunity, it is certainly not simply about levels of antibodies. If, as the authors state, 'People born before 1982 are not susceptible, with up to 98% seropositivity rates, owing to early natural infection in the pre-MMR era,' then it appears that the MMR has not improved the situation, but instead may have suppressed the child's ability to develop mumps leading them to become susceptible as a young adult instead. Hardly an achievement! Competing interests: None declared. 14 May 2005.

•Adrian Midgley, GP, Exeter, EX1 2QS: Although as usual, it is posed as an attack. The question of course is better phrased as:- "Why was Mumps made a notifiable disease in 1988".

Assuming it was, and not in 1989, and noting that Mumps vaccines had been around since 1948 so to present it as simply following the introduction of a vaccine would be over simplistic, it does point up something about the presentation of official information on the Web. I suspect that the answer to the question is fairly simple, that this was the time when someone considered infectious diseases, and decided that this particular one was sufficiently serious; that other notifiable diseases were now at sufficiently low rate not to create an unreasonable burden in reporting them, and for the reports to lead to something actually being done about outbreaks or cases; and that therefore it could and should be added to the list.

This is conjecture.

Since the Freedom of Information Act of course such conjectures can be answered, by asking for official documents relating to them from the Dept of Health (www.dh.gov.uk) or more prosaically but perhaps less satisfyingly to conspiracists by asking one of the still living people involved in the decision what particularly brought them to that decision. I don't know any of them, but probably some of them still read the BMJ or know people who do. Since the Web of course, documents that announce that a disease is notifiable could quite reasonably be expected to have a link to such obvious questions' answers. But in the end, the answer is going to be "because it seemed sensible". And it does. Competing interests: None declared. 17 May 2005

•Magda Taylor: My question was simply a question. And there was no assuming about when mumps was made a notifiable disease, it was published in the Dept of Health book 'Immunisation against Infectious Disease'- 'Mumps was made a notifiable disease in the UK in October 1988.' (Page 52, 1990 edition.) As regards to a mumps vaccine being around since 1948, stated in Dr Midgley's Rapid response. In 'Vaccines' by Plotkin and Mortimer 1994 edition, it states: An experimental inactivated vaccine developed in 1946 was tested in humans in 1951.' There appears to be no further discussion on that particular vaccine, and the text then leads to 1967 when a live virus mumps vaccine was introduced in the USA.

Interestingly enough it states that following the introduction of this vaccine that: 'the number of reported mumps cases in the United States decreased steadily, from 152,000 cases in 1968, to 2982 cases in 1985, a record. However, this downward trend was reversed in 1986-1987, when a relative resurgence of mumps occurred in the United States. The resurgence appears to have been the result of incomplete vaccination coverage of adolescents and young adults in the years following the introduction of the live virus vaccine. In 1991, 4264 cases of mumps were reported, a 67% decrease from 1987; this total still EXCEEDS the number of cases reported annually between 1983 and 1985.' (My emphasis.) If one looks at all these childhood infectious diseases these declines were occurring regardless of when vaccination programmes were introduced. Measles, whooping cough, diphtheria are fine examples of this. Both the morbidity and mortality were in major decline well BEFORE vaccines were introduced, and had mumps been notifiable at an earlier time no doubt the same trend would have followed.

Interestingly, another point to note is that the textbook description of mumps in the pre-vaccine era was not alarmist, unlike its present day description. For example in The MacMillan Guide to Family Health, 1982 edition, it simply runs through the general description, with lines such as 'Mumps is generally a mild disease. The usual outcome is complete recovery within about 10 days.' Even regarding orchitis, it comments that this is more common in adults and that invariably the swelling goes down after a few days leaving no after effects, and that it is excessively rare for the swelling to cause sterility. And as I remarked in my previous Rapid Response complications are more likely to occur from the general healthstyle of the individual or the mismanagement of the illness.

As regards to 'satisfying conspiracists' I always find it puzzling that when anyone starts asking simple questions or making valid points, suddenly they become conspiracists. I am not interested in conspiracies, I prefer to study a subject in depth, which in turn provokes further questions. And to broaden my knowledge I like to ask questions. Why?...because it

seems sensible, and it is!
Competing interests: None declared
19 May 2005

•Graeme Johnston,Student, MK7 6AA:

Most people know that the alleged risk of mumps causing sterility is largely an "old wives tale". However, mumps can cause meningitis -- and mumps was therefore quite a common cause of permanent deafness before the vaccine was widely used. Magda Taylor asserts that "complications are more likely to occur from the general healthstyle of the individual or the mismanagement of the illness". How does she recommend that a patient with mumps avoids the complication of deafness? And what instructions would she give his/her doctor? Incidentally, although mumps may have become less common before the vaccine was introduced, the graphs on pages 129-131 of the 1996 Green Book are impressive. Competing interests: None declared. 20 May 2005

•S Lewis,GP, Surgery, Newport, Pembs:

Magda, your responses are perfectly reasonable enquiries, and your information is impressive. Unfortunately this whole vaccine debate is now besmirched with stereotype, prejudice, conspiracy-theory and unreason, yet your contribution showed none of these.

I agree that many diseases were in decline before Vaccination was introduced. The great example we are all taught at Medical School was that of TB, which had been declining long before effective antibiotics and BCG vaccination were developed. But as the Dept of Health book 'Immunisation against Infectious Disease' shows, in it's many graphs - that is not a reason to doubt the considerable contribution of vaccination as an added value. Whooping Cough resurgence, and subsequent suppression is a good case in point.

I have always felt that the authoritarian stance on vaccines taken by the DH has been a major political mistake. Separate vaccines should have been permitted, as should parental choice. That way the conspiracists on both sides would have been marginalised. The DH now sees the upsurge in Mumps to be a vindication of it's beliefs, and presses for more MMR vaccination in adults. I'm happy with the evidence-base for this - if that's what the patient wants! But in my area I find that many of the teenagers now getting Mumps have actually had the MMR 10-15 years ago, unlike their parents who have lifelong immunity from Mumps infection in childhood. This raises the interesting questions:-

'How long does MMR immunity last ?'
'How often will it need to be repeated ? '
'Might it be better to encourage wild mumps in childhood ? '

The harms of Mumps meningitis, rather than Orchitis, would be more relevant to my mind. The fact that Mumps is now notifiable will considerably assist in coming to a reasoned response.
Yours sincerely, Dr Sam Lewis.
Competing interests: I get paid to vaccinate children as a GP. 20 May 2005

•Magda Taylor: Firstly, in response to Graeme Johnston's comments. 'Most people know that the alleged risk of mumps causing sterility is largely an "old wives tale".' Unfortunately most parents of today do not know that this is largely an "old wives tale", as this is one of the reasons given to them as to why they should have their children vaccinated. And because this sounds very worrying it has created a fear of mumps.

Graeme J. then comments: 'However, mumps can cause meningitis -- and mumps was therefore quite a common cause of permanent deafness before the vaccine was widely used.' Interestingly enough I asked Dr Mike Watson of Aventis Pasteur, about mumps meningitis as the issue was raised in a live Radio 4 discussion (2000) of which I was present. In 1992 two brands of the MMR used in the UK were withdrawn due to the mumps component causing mumps meningitis.

However in the mid 1990s one of the withdrawn brands was supplied to the Brazilian health authority to vaccinate the Brazilian children. This vaccine campaign resulted in a high number of cases of mumps meningitis occurring. When this was pointed out to Dr Watson he reacted as if it was no big concern, and said that mumps meningitis was a severe headache that would resolve itself without any treatment, and had no long term consequences. I also pointed out to Dr Watson, after the programme, that it is interesting that one minute mumps meningitis is a dangerous complication of mumps infection, but when the vaccine causes it, then it is only a bad headache.

As I have said in my last two responses complications of any nature for any of these childhood infections are due to poor health or mismanagement, ie suppressive treatments. If there are cases resulting in complications then one would need to know full details of the case to be able to understand why the complication has occurred.

Graeme then states: 'Magda Taylor asserts that "complications are more likely to occur from the general healthstyle of the individual or the mismanagement of the illness". How does she recommend that a patient with mumps avoids the complication of deafness? And what instructions would she give his/her doctor?' I do not recommend patients since I am not a health practitioner. I do however read widely on health and have a particular interest in naturopathic philosophy, and I have found using naturopathic methods in dealing with various ailments for myself and my family have been very successful. One particular book I have often referred to is from the 1930s 'The Hygienic Care of Children' by Dr Herbert Shelton. His suggestion for the care of a patient with mumps is: Rest in bed with warmth until the temperature is normal and the swelling is gone will hasten recovery. No food and no drugs should be given. There is nothing to the popular superstition that acids should not be taken during this time and if the child refuses to fast, orange or grapefruit juice may be used. As soon as the swelling has subsided fruit may be fed three times a day for the first three days, after which a gradual return to a normal diet may be made. 'Hygienic' care will prevent complications, but if these have developed before this care is instituted, the fast should continue until all swelling and pain are gone.'

I have not nursed a case of mumps myself, (I did have mumps myself in my childhood and sailed through it) but I have nursed chickenpox cases, and a severe case of tonsillitis. I used a very similar method for the tonsillitis case and it was extremely successful and the whole illness was over in 12 days. There was never any reoccurrence, and I did not go to the doctors, and I did not use any antibiotics. And in response to how do I instruct my doctor - I rarely go to the doctors, I have not been for a number of years for either myself or my children. But if I did feel the need to go then I would not be instructing anybody I would simply go for a possible diagnosis or to discuss possible ways of dealing with the situation.

The graphs in the Green Book do indeed look impressive but I find them limited. With the mumps meningitis graph - fortunately there were low numbers in the period indicated, but why were these cases occurring in the first place, what were the circumstances of those cases? How reliable are laboratory confirmed cases? Sometimes certain so-called 'disease-causing' microbes can not be isolated in a patient, and in other situations individuals can be 'infected' with microbes and yet not display any symptoms of disease. Interesting that from 1988 -1992 the age group receiving the MMR were developing more cases than the >4 year olds, you might have expected it to be the other way round. Also interesting that the mumps meningitis suddenly stops in 1992, the same year the two brands of MMR were withdrawn. Maybe all those cases from 1988 were caused by the vaccine? It is a pity that the immunisation status of the cases is not included in this data.

The other graph 'Annual incidence of mumps infections'is questionable, since mumps was not a notifiable disease until 1988, so how accurate are the figures pre-1988? As there is no reason why mumps infection would have behaved differently to other childhood infections then the number of cases would have been in decline anyway. Also absence of certain diseases after vaccination may not indicate health. Suppression of acute disease can lead to chronic conditions, so a rise may be observed elsewhere in other more chronic and long-lasting conditions. Additionally, measles, whooping cough, scarlet fever, diphtheria showed very similar trends in decline of cases and severity, from the mid-1800s to the present day, so if mumps had been notifiable then it is likely that mumps would have behaved in the same manner, regardless of vaccination. The Role of Medicine by Thomas McKeown is a useful source for looking at the morbidity and mortality of infectious diseases.

In response to Dr Lewis, I would also urge him to look at further graphs that cover much greater periods of time for the various diseases.

The outbreak in 1970s of whooping cough is often used as a fine example of the need to vaccinate. However there is a great amount of literature that highlights many aspects not included in the health department literature. For example, according to Professor Gordon Stewart during the 1978 epidemic of whooping cough the UK mortality rate was the lowest ever, and that a high proportion of cases were observed among fully-vaccinated children. I also understand that this epidemic was world-wide and not restricted to the UK. Countries with high uptake of whooping cough vaccine also experienced high number of cases, and indeed Sweden, with a reasonably high uptake withdrew this vaccination as a result of this epidemic. There is a great deal of very interesting information further to my brief comments, and I would only encourage Dr Lewis to research further.

I agree with Dr Lewis that parental choice should be permitted, but this unfortunately is not the case at present. GPs are under pressure to meet targets and many parents come under enormous pressure when either being selective or declining all vaccines for their children. A doctor on BBC radio last week stated that these target schemes were 'a good way to motivate GPs' to vaccinate. Why would GPs need any motivation, especially in the form of financial incentives, if all GPs are totally confident that vaccinations offer some benefit. Also, over the years, many parents contacting The Informed Parent have indicated to me that they were concerned by the limited knowledge on vaccination their practitioner appeared to have, and were unable to discuss the subject in any proper depth. This should not be the case.

As for Dr Lewis's questions - 'How long does MMR immunity last ?' 'How often will it need to be repeated ? ' 'Might it be better to encourage wild mumps in childhood ? ' I have been asking similar questions, especially as 'immunity' is still not understood. The WHO acknowledge that some individuals with high levels of antibody may still contract the disease, and equally an individual with no detectable antibodies may not develop the disease. In other words there is no precise relationship and therefore antibody levels do not equate immunity.

When MMR was first introduced the public was told that one jab would be lifelong protection, and then a few years later a booster jab was introduced. And how can the protection be established even if further boosters are added, if antibodies are not an indication? More should be investigated into the benefits of childhood infections, particularly the long-term benefits. I am aware of a study which indicates that women who have a history of mumps infection in childhood are less likely to contract ovarian cancer in adulthood (Epidemiological studies of malignancies of the ovaries. West R O, 1966, Cancer, July 1001-1007) This is indeed interesting and I wonder if there are any studies looking at men developing prostrate cancers and their history of mumps, maybe there will be a relationship there? Competing interests: None declared. 21 May 2005

•Mark Struthers,GP, Bedfordshire.
mark.struthers@which.net

I would like to comment on just one aspect of Magda Taylor's excellent response to Messrs Midgley, Johnston and Lewis. (21 May 2005)

She mentioned the target system for the remuneration of GPs conducting childhood immunisation. Targets for vaccination and cervical cytology were introduced in 1991 as part of Mrs Thatcherís health service reforms. They have been highly successful at raising the level of immunisation uptake. Kenneth Clarke, the then Health Secretary (and now possible Tory Party leadership hopeful) was very perceptive about what motivated doctors. The financial penalty for not reaching the higher target level is considerable. The advice a person gets about whether to have a smear or to have their children immunised has little to do with confidence in the cervical screening or child immunisation programs. It's all about practice income and maximising it - pure and simple.

The introduction of the new 'five-in-one' vaccine and the generally lower uptake of MMR will bring new financial anguish to GPs as practices struggle to reach the 90% uptake target. Just one or two conscientious objectors amongst parents will result in a loss of £5,700 in target income for the average practice (Pulse 30 April 2005, front page) It is no wonder that some GPs are tempted to remove these dissenters from their lists. Recognising the danger, the GP negotiators are now forlornly fighting the Dept of Health for 'informed dissent' for childhood immunisation, to soften the blow of these target remuneration changes. However, the bottom-line to all this is this: the GP is not a source of impartial advice on the safety or otherwise of vaccination. The parent who wants to be reliably informed should beware and look elsewhere.
Competing interests: a GP principal for 15 long years, now salaried and somewhat less conflicted by financial interest in vaccine uptake. 23 May 2005

# UNDERSTANDING INFECTION: NOT A BATTLE, BUT A HOUSECLEANING

By Philip Incao, M.D. September 2004

I once saw a young African man in my practice who impressed me with his calm dignity and his radiant good health. I asked him what his parents had done when, as a child, he had come down with a fever. He replied that they had wrapped him in blankets to get him sweating. 'Did they ever take your temperature?' I asked. He laughed and shook his head saying, 'No, it was different from what is done here.' We often hear that American medicine is the most advanced in the world. This is true in some areas of healthcare, but in other areas we could use a little of the deeply rooted wisdom that still informs some of the folk medicine in the developing world. I think this particularly applies to our modern concept and treatment of the illnesses we commonly call 'infections.'

When we come down with a cold or a flu most of us imagine that some stress or other has weakened our 'defenses' or our 'resistance' and allowed 'a bug' (a virus or bacterium) to enter our body, where it multiplies and attacks us from within. We think of this as 'an infection,' that the new bug within us is making us sick, and that we will feel better as soon as our immune system has killed it off. When we don't feel better soon enough, we might seek remedies or antibiotics to kill the bug more effectively.

This pretty much describes the way almost everyone today, physicians included, thinks about what I refer to in this article as an acute infectious/ inflammatory illness like a cold, flu or sore throat.

Yet this commonly held picture does not correspond to the facts. It is a deceptive misunderstanding that in itself is a characteristic sign of the simplistic, weakened and fear-based thinking that hinders progress in many areas of life today.

If we define infection as the presence within us of foreign micro- organisms i.e., bacteria and viruses, then all of us are continually infected from the day we are born until we die. We all harbor trillions of microbes all the time, including various disease germs, yet we only occasionally get sick.

Most of us are quite happy to never or seldom come down with an acute infectious/inflammatory fever, cold or sore throat, thinking that we therefore must have a strong immune system which guards our body from becoming 'infected.'

That too is a deception, and a dangerous one, that fools us into thinking we are healthy when the reality is otherwise.

It is a shock to learn that for over one hundred years the evidence has shown that our immune system does not prevent us from becoming infected by germs. In the early years of Pasteur's germ theory in the nineteenth century, it was first assumed that healthy people were uninfected by bacteria and only sick people were infected. This assumption was soon disproven, as science found that the great majority of those infected with disease germs were healthy, and only a small fraction of them ever got sick. The majority of people infected with the bacterium of TB, for example, never got sick from tuberculosis, but only from the same coughs and colds that we all get.

Infection alone is not enough to make us come down with a manifest illness. Something else is needed. Most of the time we are able to live in harmony with certain numbers of disease germs in our body without becoming ill. For this blessing we can thank our immune system, which is continually vigilant and active below the surface of our awareness in keeping the extremely varied and extensive germ population of our body under control. Thus it is not necessarily the entrance of new germs into our body that makes us ill, it is the sudden and excessive multiplication of certain germs that have already been in us for a longer or briefer time. In some cases the entrance of a new germ into the body is quickly followed by its rapid proliferation and in other cases the germ can remain dormant or latent in us for many years or even a lifetime while we remain healthy.

This important fact receives far too little attention and is often totally forgotten in medicine today. Most of the trillions of germs that 'infect' or inhabit our body from infancy onward are peacefully co-existing in us or even helping to maintain our inner ecological balance, like the acidophilus bacteria that live in our intestines. They are our 'normal flora.' Science has also identified a small minority of germs, called pathogens, that participate in human disease, like strep, staph, TB, diphtheria, etc., but these too have surprisingly more often been found peacefully coexisting in us rather than being involved in illnesses.

This is called latent or dormant infection, or simply the carrier state. Typhoid Mary was a famous example in the early 1900s of a cook who, though healthy herself, was a carrier of the salmonella bacterium and passed it on to others, some of whom became seriously ill and many others of whom remained healthy despite being infected. As the prominent microbiologist Rene Dubos stated in a 1950's textbook:
'the carrier state is not a rare immunologic freak. In reality, infection without disease is the rule rather than the exception'. The pathogenic [germs] characteristic of a community do commonly become established in the tissues of a very large percentage of normal persons and yet cause clinical disease only in a very small percentage of them.'

This leads us to the question which Rene Dubos, apparently alone among his colleagues, pondered for the rest of his life: if most of the time we are able to peacefully coexist with a disease germ in our body, (a fact which Pasteur did not adequately reckon with) what is it that happens when it suddenly starts multiplying rapidly and we get sick? Have our defenses weakened and allowed the germs to proliferate and go on the attack (which is the thought that frightens us so terribly) or are they merely multiplying because our body's biochemistry has been disturbed and is making available to the germs a suddenly increased supply of their preferred nourishment?

The latter is not a new thought; it was postulated by Pasteur's contemporaries. Scientists of Pasteur's time including Claude Bernard, Rudolf Virchow, Rudolf Steiner and Max Pettenkofer held the conviction that the decisive and determining factor in infectious diseases was not the microbe itself but rather the particular condition of the patient's 'host terrain' that favoured the growth of a particular microbe. In this view, microbes were not predators but were scavengers which fed on toxic substances produced by imbalance, disease and decay in the host body's terrain just as flies feed on dung and garbage. For these scientists, killing microbes without improving the host terrain imbalances

that fed the microbes was like killing flies in a messy, untidy kitchen without cleaning up the kitchen. Pettenkofer even drank a test tube of virulent cholera bacteria to prove his point that they would do no harm if the inner terrain was healthy. Pettenkofer's terrain apparently was healthy, because he suffered no ill effects at all from his bacterial brew. Nevertheless, the germ theory was an idea whose time had arrived, and for many reasons the concept of germs as vicious predators soon prevailed over the view that they were merely opportunistic scavengers.
The triumph of the germs-as-predators concept has led to a sea of change in the way people think about acute illnesses such as colds, measles, pneumonia, scarlet fever, tuberculosis, typhoid, smallpox, etc. Since ancient times these illnesses had been called inflammations, literally meaning 'a fire within.' In the first century A.D. an early Roman author, Celsus, gave the classical definition of inflammation which is still taught today to physicians: 'a fire-like process in the body which manifests in 'calor, rubor, tumor and dolor,' i.e. warmth, redness, swelling and pain. These cardinal symptoms of inflammation, even when not externally visible, were understood to characterize all inflammations from a pimple to a pneumonia. Our ancient ancestors also knew from hard experience that many acute inflammations like plague, smallpox, measles, TB etc. were 'catching' or contagious from one person to another. What they did not know was the intimate relationship of germs or microbes to these acute inflammatory and contagious illnesses.

Since Pasteur, we now erroneously consider these illnesses to be 'acute infections,' assuming that the entrance of a new microbe into the host's body (the infection) triggers the illness. As we saw earlier, it is not the initial entrance of, or the infection with, the microbe which triggers the illness, but rather the sudden proliferation of a microbe already residing in the host body for some time which initiates an acute infectious/ inflammatory illness.

Human beings become infected with a great variety of the microbes in their environment, continuing life-long as they change environments, yet this fact of life-long infection does not explain why illness happens, anymore than auto accidents are explained by the fact that the victims are life-long drivers. An infection is not itself an illness, rather it is the normal human condition and the context in which acute infectious/inflammatory illnesses occur. As we said earlier, something else must happen to cause a certain tribe of germs (like strep, with which almost everyone is infected to some degree) to suddenly proliferate and trigger what should correctly be called 'an acute strep-related inflammation' rather than 'an acute strep infection.' We need to fit our thoughts and words to the reality. The fact that a strep infection might precede a strep-related inflammation by days, months or years is essential to understanding how and why illness happens. Thus, the term 'acute strep infection' commonly used by physicians and lay people is incorrect, and it creates an incorrect picture in our mind of the illness at hand. The incorrect picture is that strep bacteria have invaded our body from the environment and are injuring us. Most importantly, this incorrect picture leads to inappropriate feelings and actions of the physician, the caregiver and the patient who must respond to an illness. Thus the grave mischief caused by a 'mere' incorrect mental picture becomes enormous - such is the power of this idea.

The consequences of the germs-as-predators idea are millions of unnecessary prescriptions written for antibiotics, and thousands of injuries and deaths from drug reactions, including 450 deaths per year from Tylenol alone. The engine driving this inappropriate and dangerous use of antibiotics and anti-inflammatory drugs is the fear generated by our common misconception that we are under attack by predatory microbes whenever we experience fever, pain, congestion and other symptoms of typical acute inflammations such as coughs, colds, flu or sore throats.

Now we will move on to consider another important and common misconception about acute infectious/ inflammatory illness. The first misconception was that infection is abnormal and causes illness, the truth being that infection is really the normal human condition because we all harbor disease germs frequently, yet become sick only occasionally.

The second misconception is that the symptoms of an acute infectious/ inflammatory illness like scarlet fever, polio, smallpox or flu are caused by the viciousness, the virulence, of the bacteria or the viruses which we imagine are attacking the cells and tissues of our body. The sicker we are, that is, the more intense our symptoms, the more vicious we assume the attacking viruses and bacteria to be. In over thirty years of practicing medicine, I've found that this assumption, shared by almost all physicians and their patients, provokes more unreasoning fear and unnecessary use of drugs than any other.

The confusion stems from the fact that in an acute infectious/ inflammatory illness we are witnessing not one happening but two polar opposite happenings which occur together. The first happening is that bacteria or viruses are proliferating in our body. If these microbes were predators, we would expect their proliferation to coincide with the worst of our symptoms, but this is not the case. Most of the germ proliferation, (which we falsely imagine as an inner attack), happens during the incubation period of the illness when we have little or no symptoms. Viruses and bacteria may enter our blood stream in large numbers, and may even start to leave our body, excreted in mucus and feces, without any awareness of illness on our part besides possible minor malaise, headache or tiredness. These symptoms might appear at the end of the incubation period during the few days of prelude or 'prodrome' just before the full-blown illness begins. When the incubation period is over and the clinical illness comes on with all its strong symptoms of fever, pain, weakness, irritation and often anxiety, it may feel as if we are being attacked but in reality the inner process causing our illness symptoms is not a battle, but an intense housecleaning.

I've said that an infectious/ inflammatory illness is a joint appearance of two separate and distinct happenings. These two happenings become related to each other in the context of the illness as a reaction is related to an action. Comparing illness to a housecleaning, the action is the gradual, mostly unnoticed accumulation of dirt and dust (along with the tiny creatures who make their home in dirt and dust) in the house, and the reaction is the sudden decision of the housekeeper to turn the house upside down in order to clean it from top to bottom. In a house, as in the human body, the housecleaning is a much bigger disturbance, though a necessary one, to the orderly routine of the household than the accumulation of dirt and dust.

Our immune system is the housekeeper of our body. Usually our inner housekeeper keeps well abreast of her work quietly, escorting dead and dying cells to the exits of our body and making sure that waste matter and poisons are cleared from the body. This

is the very important ongoing maintenance-housecleaning work of our immune system-housekeeper in maintaining the health and integrity of our human organism. From birth until death, this ongoing maintenance work never rests, and is responsible for our keeping healthy and free of illness. But occasionally our immune system-housekeeper determines that a deep cleaning is needed. That's when the dust flies and we get sick! If you are wondering where the germs are in this comparison of the human body to a household, they are the flies, ants, cockroaches, or the mice which live in the house's inner recesses unreached by the housekeeper and which feed on the crumbs and kitchen scraps that accumulate in the house.

The function of the immune system is to create inflammation. Inflammation, as the word implies, is like a fire in the body which burns up the waste and debris, along with the germs which feed on waste and debris, and cleanses the body. Thus it is our immune system which causes us to become sick, by creating inflammation to drive out infection and renew us.

The first step in an acute infectious/inflammatory illness is the accumulation of cellular waste materials and toxic by-products of our body's biochemical metabolic processes. This accumulation may go on for hours or years before the acute illness, and is unnoticed by us because the body has various ways it can store toxic substances to keep them from irritating and poisoning us. The second step is the beginning of the release of certain toxins from storage and the proliferation of bacteria which are attracted to the now accessible toxins just as flies are attracted to garbage. This release from storage may be triggered by our exposure to an ill person to whose acute infectious/ inflammatory illness we are open and unguarded. Thus we 'catch' the illness and this second step defines its incubation period, in which bacteria or viruses rapidly proliferate while causing minor or no symptoms. This second step differs according to whether the illness is bacterial or viral. In a bacterial illness specific types of bacteria are attracted to the particular types of toxins released from storage and made available to them during the incubation period. In a viral illness the viruses themselves are a special form of toxic waste product which cells release when they are provoked by stress (as in an outbreak of herpes or shingles) or by 'catching' an illness from another person.

These two steps, the gradual accumulation and storage of toxins for days or years followed by their rapid release from storage and the proliferation of microbes during the incubation period, constitute the action which provokes the third step, the reaction of the immune system to clean house. The intensity of the symptoms of our illness is a direct expression of the intensity of the reaction of our immune system. The stronger our immune system-housekeeper is, the more dust and debris she will stir up and the sicker we will feel.

If I am correct in asserting that an acute infectious/ inflammatory illness is really an intense housecleaning and not a battle against predatory invaders, then people with stronger immune systems and thus stronger housecleanings would be expected to have more intense acute inflammatory symptoms, and stronger discharges than those with weaker immune systems. By inflammatory symptoms I mean pain, redness, swelling and fever followed by a good discharge of mucus, pus, rash or diarrhea. In my medical practice I have repeatedly found that the stronger and more robust children become ill more intensely and acutely (with good outcomes nevertheless) than the weaker, pale and allergic children. I remember well one boy in my practice who, I later discovered, had a certain familial immune system defect. His mother often brought him to the office because he felt unwell and weak. Usually in children who complain of feeling sick, one can find some evidence of an inflammation in the body, a red throat, a red ear, congested lungs or sinuses, some degree of fever, swollen glands etc. In this boy I could find nothing. There were no signs of inflammation and no symptoms other than subjective fatigue and feeling unwell. Blood tests revealed a problem with his immune system.

This case brought home to me the fact that a weak immune system has difficulty reacting to a gradually accumulating infection of uncleared cellular waste and microbes in the body. Without a strong reaction of the immune system, there is no acute illness, but only a vague malaise and fatigue, which are symptoms of a low-grade poisoning or toxicity in the body - the result of our housekeeper being too weak to do her job and allowing kitchen debris to accumulate, followed inevitably by the flies and ants. When I would see this boy with the immune system defect in my office feeling unwell, it was as if he were stuck in the incubation period of an acute infectious/inflammatory illness, unable to become properly acutely ill because his immune system was too weak to react with the inflammatory healing crisis he needed to clear out his body.

Children who are able to have their normal childhood healing crisis, consisting of fevers and discharges, thereby exercise and build their cellular immune systems to be strong and resilient, which is a great benefit for their overall health. Vaccinations, antibiotics and anti-inflammatory drugs like Tylenol and ibuprofen all interfere with this inflammatory cleansing of the body and the immune system-strengthening which results.

All the experts agree that antibiotics are massively overprescribed in the U.S. - used in conditions that don't require them. Why does this overprescribing continue unabated despite large efforts to educate physicians about the proper use of antibiotics? Upon reflection, any physician can answer this question because all of us see almost daily patients who come into the office seeking antibiotics. These patients have two chief concerns: either their symptoms are too intense or they've been going on too long, or both.

If we understand the illness to be a housecleaning, then these concerns are very much minimized. 'Your immune system is doing a good job - you will soon bring this healthy, much-needed housecleaning to a successful conclusion' is what a physician of the housecleaning persuasion might say.

If we believe the illness to be an attack of hostile predatory microbes, then physician and patient are both anxious to get rid of the symptoms along with the nasty microbes we mistakenly assume are causing the symptoms. As we saw earlier, the immune system, not the microbes, causes the symptoms. The microbes however are an important stimulus which provokes the immune system to react, causing symptoms of acute inflammatory illness. Therefore, when we kill or inhibit the microbes with antibiotics, we inhibit the immune system at the same time. This inhibits the inflammatory symptoms that belong to an active working immune system, creating the illusion that we have healed the illness when in reality we have suppressed the symptoms and interfered with the immune system's work before its job was done. This is a suppression, not a healing, and it is crucial to understand the difference between the

two.

If we make our housekeeper stop her hectic cleaning in order to have some peace, we will have to put up with an untidy house. An untidy house and an inactive housekeeper are conditions which in the short run lead to a return of flies and ants, and in the long run lead to chronic disease and cancer.

This is why I've been saying for fourteen years that an important way to prevent cancer is to appreciate the great wisdom and benefit of our occasional inflammatory housecleanings and to refrain from obstructing them unnecessarily with antibiotics and anti-inflammatory drugs.

This point was recently confirmed by the publication of research showing that antibiotics increase the risk of breast cancer. Nevertheless, antibiotics are lifesaving drugs when an acute infectious/inflammatory illness becomes dangerous. This danger stems not from the intensity of the inflammation directly, but from the toxicity and the sheer volume of the metabolic wastes and poisons which are stirred up and mobilized by the inflammation. If our organism has the strength to clear out all these toxins and discharge them from our body, the illness usually resolves itself. If we lack this strength, then the discerning physician will attempt to support and promote the discharging, detoxifying process, keeping a watchful eye on the patient's strength, and will use an antibiotic if needed to prevent complications or death from the poisons that have been stirred up by our overzealous housekeeper - our immune system. This is a toxic or septic inflammation, and in such a crisis, an antibiotic is a blessing. But the likelihood of our ever having to experience such a toxic crisis will be greatly diminished if we understand how to allow all our smaller, non-threatening inflammatory crisis to do their house-cleaning work that our wise inner housekeeper knows we need.

How, therefore can one treat an acute infectious/inflammatory illness so as to work with the cleansing and discharging process of the immune system and not against it? I have discussed these practical pointers in the chapter 'How to Treat Childhood Illnesses' in the book, The Vaccination Dilemma edited by C. Murphy (www.lanternbooks.com) and also in an article published in Mothering magazine in July-August 2003 entitled, 'The Healing Crisis: Don't Worry Mom, I'm Just Growing.'

These treatment guidelines apply to adults every bit as well as they apply to children. They are designed to support and facilitate the work of the immune system, to relieve symptoms, prevent complications and to promote a successful outcome and completion of the task begun by the immune system itself. A more detailed discussion of these treatment guidelines can also be found, along with directions for use of the appropriate homeopathic/ anthroposophic remedies for specific symptoms, in my Home Remedy Kit available from the Weleda Pharmacy at 800-241-1030 (USA). Perhaps the most important points to remember in treating acute infectious/inflammatory illnesses are that fever is good, toxicity is bad, and discharge of toxicity is very good.

The danger of an acute infectious inflammatory illness is not the 105 degree fever nor the yellow thick mucus drainage from the nose, but the amount of retained toxicity that is poisoning the patient because it is unable to be discharged from the body quickly enough. It is normal for the ill patient to be weak, lethargic and oversensitive. Symptoms of excessive retained toxicity poisoning the body include increasing irritability and restlessness, an increasing look and feel of desperation or anxiety, and a decreasing ability to maintain consciousness and eye contact. If these are happening, call the doctor.

Toxicity that is stirred up within the body more quickly than it can be cleared and discharged from the body is the primary danger and cause of complications in an acute infectious/ inflammatory illness. We physicians should be advising our patients how to recognize and treat toxicity. Up to 106 degrees F, the degree of fever is not a sign of the seriousness of the illness, but is rather a sign of how strongly the immune system is working to detoxify and clear out the illness. Therefore it is best to avoid fever lowering drugs.

Here are some very effective age-old ways to support the immune system and to promote a good outcome of an acute infectious/inflammatory illness:

- Total rest and sleep, with as little distraction as possible. No T.V., radio, tapes or reading.
- Keep the patient very warmly dressed and covered. Sweating is good. Avoid chilling.
- A liquid diet of vegetable broth, herb teas, citrus juices. Add rice, millet, carrots or fruit if hungry. Absolutely no meat, fish, eggs, milk products, legumes, beans, nuts or seeds. The digestive power of the body must focus on the illness and not be burdened with food.
- Elimination through bowels, bladder and sweating is essential to treat toxicity and prevent its complications, therefore encourage drinking of lukewarm clear fluids, and use prune juice or Milk of Magnesia to promote loose BM's once or twice daily.
- Provide a sick room environment with warm, soft colors and textures and natural soft light. Include plants and flowers. The caregiver should be cheerful, peaceful, attentive, observant, encouraging, loving and respectful of the profound healing wisdom of the inner housekeeper in which she is assisting.

REFERENCES:

1 Dubos Rene J.,Bacterial and Mycotic infections of Man. Philadelphia: JB Lippinvoyy, 1958, p21-22

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Resource List: Related Reading (in chronological order based on publication date)

De Kruif, Paul Microbe Hunters. New York: Harcourt Brace, 1926, 1954.

Dubos, Rene 'Second Thoughts on Germ Theory' Scientific American 192 (May 1955): 31-35.

Dubos, Rene Bacterial and Mycotic Infections of Man. Philadelphia: J.B. Lippincott, 1958.

Dubos, Rene Mirage of Health. New York: Harper, 1959.

Rosebury, Theodor Microorganisms Indigenous to Man. New York: McGraw-Hill, 1961.

Rosebury, Theodor Life on Man. New York: Viking, 1968.

Selye, Hans, M.D. The Stress of Life. New York: McGraw-Hill, 1976.

Sonea, S. and Panisset, M. A New Bacteriology. Boston: Jones and Bartlett, 1983.

Sagan, Leonard The Health of Nations: True Causes of Sickness and Well-Being. New York: Basic Books, 1987.

Sagan, Leonard 'All in the Family.' MD Magazine (July 1988): 99-107.

Payer, Lynn Medicine and Culture. New York: Henry Holt, 1988.

Geison, Gerald The Private Science of Louis Pasteur. Princeton: Princeton U. Press, 1995.

Incao, Philip, M.D. 'Supporting Children's Health' Alternative Medicine Digest. Issue 19 (September 1997): 54-59.

Murphy, Christine, Ed. The Vaccination Dilemma. New York: Lantern Books, 2002

Bott, Victor, M.D. An Introduction to Anthroposophical Medicine. Rudolf Steiner Press ISBN 1-85584-177-0.

www.aliveandwell.org

www.lilipoh.com (Philip Incao writes a regular medical column, 'The Doctor Speaks,' for Lilipoh Magazine.)

## FIRST COMBINATION VACCINE APPROVED TO HELP PROTECT ADOLESCENTS AGAINST WHOOPING COUGH

May 3 2005. www.fda.gov (USA)

The Food and Drug Administration (FDA) today approved the first combination vaccine that provides a booster immunization against pertussis (whooping cough) in combination with tetanus and diphtheria for adolescents.

The vaccine will be marketed as Boostrix by GlaxoSmithKline (GSK) in Philadelphia, Pa. Pertussis is a highly communicable disease of the respiratory tract that can be especially serious for infants less than one year old, and may even be fatal. Pertussis can cause spells of coughing and choking that make breathing difficult.

The disease is generally less severe in adolescents, but it is thought that they might transmit the disease to susceptible infants and other family members. In the last 20 years, rates of pertussis infection have been increasing in very young infants who have not received all their immunizations and in adolescents and adults. Boostrix is a Tetanus Toxoid (T), Reduced Diphtheria Toxoid (d) and Acellular Pertussis Vaccine (ap), Adsorbed.

Although booster vaccines for adolescents containing T and d are currently licensed and marketed for use in this age group, none contain a pertussis component. Boostrix has the same components as Infanrix, a DTaP vaccine for infants and young children, but in reduced quantities. Boostrix is indicated for use as a single booster dose to adolescents 10-18 years of age. The efficacy of the vaccine was measured by looking at the immune response to the vaccine, as measured by antibody concentrations. The response to the T and d components was at least as good as the response to a licensed Td vaccine. Boostrix also induced an antibody response to the pertussis component of the vaccine. The response to the pertussis component was compared to the response induced by a three dose series of Infanrix given to infants in a previous study. The response of adolescents to Boostrix was considered adequate. It is not known how long immunity to pertussis will last. Adolescents who received Boostrix experienced pain, redness, and swelling at the injection site. The frequency of redness and swelling after Boostrix was similar to what is expected following the administration of a Td vaccine.

However, pain reactions at the injection site were more frequent with those who received Boostrix. Other side effects included headaches, fever and fatigue for a short period of time after the injection.

## INFANT DEATH RATES PUZZLE RESEARCHERS

"http://www.healthscout.com/

SIDS rates have fallen, but overall infant death rates unchanged, researchers find

*By Serena Gordon, HealthDay Reporter*

TUESDAY, May 3 (HealthDay News) - Researchers are puzzling over statistics that show the incidence of sudden infant death syndrome (SIDS) is going down while overall unexpected infant mortality remains mostly unchanged in the United States.

This paradox, seen in numbers from 1992 to 2001, may be the result of some SIDS deaths being reclassified into different categories, such as suffocation or death due to unknown causes, the researchers theorize in the May issue of Pediatrics. "We wondered, as many other researchers have, why is the SIDS rate going down, but the post-neonatal death rate is not?" said study co-author Dr. Michael Malloy, a professor in the department of pediatrics at the University of Texas Medical Branch in Galveston. "We started sorting through the various categories for infant deaths," he added, and found that apparent SIDS cases were now being reclassified.

SIDS is the sudden, unexplained death of an infant under 1 year old. It is the leading cause of death for babies between 1 and 12 months old, according to the National Institute of Child Health & Human Development.

Between 1992 and 1999, the SIDS death rate dropped by 55 percent, and the overall infant mortality rate decreased by 27 percent. Most of that decline was attributed to the national "Back to Sleep" campaign, a public education initiative begun in 1992 and designed to make sure infants were put to sleep on their back to reduce the risk of SIDS, according to the study. *(Editor: Some researchers would dispute this initiative as advantageous.)* During that time, the number of infants sleeping on their backs increased from 30% in 1992 to 80% in 1998.

Malloy said the researchers are in no way "denying the efficacy of the 'back to sleep' program. Supine positioning is a very effective way of reducing the risk for SIDS." But because the overall sudden unexpected infant death rate then levelled off while the SIDS rate still declined, Malloy said it wasn't clear if the SIDS rate really was dropping.

To answer that question, the researchers went through more than 50 years of national infant mortality data, and concentrated on the most recent data from 1999 through 2001. In 1999, there were 62 SIDS deaths per 100,000 live births; by 2001, that number was down to 51 per 100,000, they found. In 1999, the overall post-neonatal mortality was 233 deaths per 100,000; in 2001, that number had only dropped to 231. In the study, the researchers noted that "the concurrent increases in post-neonatal mortality rates for unknown and unspecified causes, and suffocation account for 90% of the decrease in the SIDS rate between 1999 and 2001." That observation, they concluded, "suggests that a change in classification may be occurring." Laura Reno, director of public affairs for First Candle/SIDS Alliance, said the most difficult part of tracking SIDS cases is that medical examiners and coroners throughout the country aren't consistently using the same types of tests, death scene investigations or death certificate coding. She added that the U.S. Centers for Disease Control and Prevention was trying to enlist local health officials to consistently use the agency's defined protocol. But, she added, one thing that is clear: "Babies are not dying on their backs in safe cribs." Along with putting your baby to bed on her back in a crib, Reno also recommended a firm mattress that fits the crib properly and no blankets, crib bumpers, pillows or stuffed toys in the crib. She said the most important thing parents can do to protect their babies from SIDS is to provide a safe sleep area. It's also important to provide a smoke-free environment, she added, because secondhand smoke exposure is also a risk factor for SIDS. In a second study in the same issue of Pediatrics, researchers from Belgium suggest that swaddling your baby may also help reduce the incidence of SIDS. The researchers said that one of the reasons some parents don't put babies to sleep on their backs is that they believe their babies sleep better on their stomachs. However, the researchers found that when babies were swaddled -- wrapped tightly in a sheet or light blanket --they tended to sleep better, thus offering parents an effective alternative to stomach sleeping. Reno added a note of caution, however. "When a baby is very young, swaddling might help, but once a baby is moving and very wiggly -- typically between 3 and 5 months -- the swaddling blanket could pose a problem," she said.

# THE VACCINATION PROBLEM

'The Vaccination Problem'
By Joseph P Swan, 1936, Published by C W Daniel Co Ltd.

Another snippet from the archives. Reproduced here is the Preface from the above book title.

PREFACE

Fifty years ago (1885) William White published a comprehensive work, extending to over six hundred pages, entitled *The Story of a Great Delusion*, in which the history of vaccination was carefully set forth and its claims refuted. Any impartial person, reading that book at the time of its publication, might well have concluded that it sounded the death-knell of the "Great Delusion." And yet, although the subsequent half-century has witnessed the concession by Parliament of a "conscience clause" (grudgingly passed in the vain hope that it might silence the irreducible demand of the anti-vaccinists for the complete repeal of the Vaccination Acts), and although more than half of the parents of England and Wales are now availing themselves of this liberty to become licensed law-breakers, the orthodox medical claims on behalf of vaccination remain almost unchanged.
Anti-vaccinists have, consequently, considerable difficulty in making avowed converts. The public at large find it hard to believe that the medical profession in general could so universally defend vaccination if it were nothing but " a grotesque superstition" *(Dr Charles Creighton)* or an "amazing empirical stunt" *(George Bernard Shaw)*.

The average man lazily concludes that this weighty body of what he calls "scientific opinion" is more entitled to respect than the views of a handful of "antis," however intelligent and honest the latter may be. Instead of attempting to form an independent judgement he credulously accepts vaccination on the truth of authority, rather than on the authority of truth, and he does not seem to object to the medical profession constituting themselves counsel, judge and jury in their own cause.

Curiously enough, there is reason to believe that not a few doctors advocate vaccination largely because so many of the public are willing to accept it, in the same way that they hand out bottles of physic for any and every ill because so many people expect them to do so. The profession and the pro-vaccinist public, as a consequence, are following one another round in a sort of charmed circle. This further statement of the case against vaccination, as confirmed by another fifty years of experience, is issued in the hope that it may show how this spell can be broken.

THE PROFESSION SPEAKS WITH 2 VOICES

An important stage in the enlightening process is the realisation that the profession speaks with two voices on the matter, and not one, as is commonly supposed. It is true that the voice of the great majority of pro-vaccinist doctors is the loudest, but majorities are not always right. Heads must be weighed as well as counted. When this is done it will be found that the voice of the minority of medical anti-vaccinists speaks a greater truth, and consequently greater authority, than that of the organised mass of pro-vaccinist doctors, who for the most part merely unite in shouting "Great is Jenner of the Jennerians."

Most anti-vaccinists (both lay and medical) were originally believers in vaccination, or thought they were. Their conversion has been the outcome of an open-minded study of both sides of the question. After their conversion they never cease to wonder how vaccination was ever able to secure the dominating position in the world's esteem which has so far marked its history, and why it has not long since been relegated to the limbo of exploded medical delusions. Here is a probable explanation of this (to them) extraordinary phenomenon:- when vaccination was introduced by Jenner the world was ready to embrace any specific which promised freedom from the terrible evil of smallpox, and its almost equally fearsome remedy - smallpox inoculation. Jenner promised this double freedom, and the peoples of the world eagerly accepted his promise with little or no investigation of its evidential basis. Kübler, the German pro-vaccinist historian of vaccination, says that the news of Jenner's teaching spread from land to land "almost like a tempest." The State establishment and endowment of the practice quickly became general, and thenceforward professional prestige and Parliamentary pride (to say nothing of vested interests) stubbornly stood in the way of an impartial investigation of the facts.

THE STRENGTH OF VACCINATION IS THE STRENGTH OF QUACKERY

Jenner never defined "vaccination" in any scientific way, and it has never been so defined by any of his followers. No reasoned explanation has been produced showing precisely what "pure calf lymph" is, or how its alleged protection is set up, or how long its effectiveness can be relied upon. As will be shown in the following pages, its history is a long record of shuffles from one untenable position to another. This will doubtless seem incredible to those unacquainted with the facts, and yet the facts remain for all to see who will.

When confronted with failures of vaccination to protect against smallpox the vaccinists have said that the operation could not have been "properly done" or that it was too old or too new, or that the "lymph" was inert, etc etc, but in advancing these excuses they have lapsed into the language of quackery because they have not previously supplied the only thing which could make such language rational, viz. a precise definition of a "properly done" vaccination.

And yet - it may well be asked - "If the strength of vaccination is but the strength of quackery, how can duly qualified and scientifically trained doctors everywhere continue to endorse it, and why are independent leaders of public opinion so backward in unmasking the make-believe?" Those who are familiar with the history of medicine will not need to be reminded that the remedies of one generation of doctors not infrequently become the laughing-stock of the next. Vaccination has, however, held its ground for a much long period than most errors of the faculty, and the reasons are not far to seek.

THE POWER OF TRAINING AND THE GRIP OF PROFESSIONALISM

The doctors are all caught young. In their student days they imbibe the dogmatic teaching of their professors in

regard to "the great discovery of the immortal Jenner," as the purest milk of medical science. Anti-vaccinist arguments are pooh-poohed as so much crankish nonsense *(see George Newman's address to medical students in The British Medical Journal, 1st September, 1923, and an article in The Lancet, 29th January, 1927, p238)* and anti-vaccinist books are excluded from their college libraries. They are led to suppose that vaccination is one of the most unquestioned and unquestionable dogmas in the world of medicine. When they become "duly qualified" they find that their professional status is bound up with the belief in vaccination. They cannot break away from it without becoming professional pariahs or "black-legs," and without prejudicing their prospects of professional advancement. Is it any wonder that only a small minority are brave enough to take this step?

Here is an example of the treatment they receive when they do take it. Dr W Scott Tebb, author of *A Century of Vaccination and What it Teaches* (an exhaustive and carefully written criticism of vaccination), had been duly appointed by the local authority as Medical Officer of Health for Penge. It was necessary for Dr Tebb's appointment to receive the approval of the Local Government Board (a duty now taken over by the Ministry of Health). At that time Mr Walter Long was President of the Local Government Board. He refused to sanction Dr Tebb's appointment. When challenged on the subject in the House of Commons on the 16th July, 1901, he said:-

"So long as I am responsible for the office which I now hold, no power on earth will induce me to sanction the appointment as a Medical Officer of Health of a gentleman who holds the views of Dr Tebb with regard to vaccination."

Many people are impressed by the opinion in favour of vaccination expressed by Medical Officers of Health, because they think that these officials must be impartial, seeing that they do not usually derive any monetary gain from vaccination fees. This incident shows, however, that they hold their appointments subject to their believing in vaccination, and hence their opinions are not entitled to be regarded as impartial and disinterested.

THE RESPONSIBILITY OF LEADERS OF PUBLIC OPINION

The indifference of leaders of public opinion is no doubt largely due to the deference which these leaders usually pay to professional opinion. The medical profession have sedulously encouraged them in this attitude by well-bespattering the "antis" with mud of all descriptions. Such deference would have been excusable had vaccination been merely a medical question, but vaccination State endowed and State enforced became something far greater than a medical question; it was transformed into a political and social question involving important principles, such as those relating to individual liberty and national health. Hence, leaders of public opinion have been, for the most part, false to their trust, in that they have allowed themselves to become blind followers of medical orthodoxy.

Anyone who makes an effort to grasp the pros and cons of the controversy will find that there is no aspect of it so medical or so scientific as to be beyond the understanding of any lay person of average intelligence - medical pretensions to the contrary notwithstanding. At least one distinguished member of the medical profession frankly admitted this when he wrote:-

"The anti-vaccinists are those who have found some motive for scrutinising the evidence, generally the very human motive of vaccinal injuries or fatalities in their own families or in those of their neighbours. Whatever their motive, they have scrutinised the evidence to some purpose; they have mastered nearly the whole case; they have knocked the bottom out of a grotesque superstition." *(Dr Charles Creighton, Jenner and Vaccination, 1889, p352-3.)*

Although this statement was made over a generation ago and supported by an abundance of incontrovertible argument, its validity is not yet generally admitted, so true is it that

"The great difficulty is always to open people's eyes; to touch their feelings and break their hearts is easy; the difficult thing is to break their heads." *(John Ruskin, Ethics of the Dust.)*

## NIGERIAN STATE TO JAIL PARENTS WHO RESIST POLIO VACCINES

www.mg.co.za/

Katisina -29/04/05. Katsina State in northern Nigeria will jail any parents who refuse to allow health workers to vaccinate their children against the crippling polio virus, a senior official said on Friday.

Northern Nigeria is home to the world's biggest remaining pocket of polio infections and resistance from Muslim families, who fear a plot to sterilise infant girls, has endangered a plan to eradicate the disease this year. Abdullahi Garba Faskari, the state's justice commissioner, said that the government would extend a law designed to enforce yellow fever jabs to cover the oral polio vaccine, which Nigerian and United Nations health workers are distributing.

The government will henceforth arrest and prosecute any parent who refuses to have his child immunised against polio. Such a parent will get between six months and one year in jail without an option of fine," Faskari said.

"In view of the baseless resistance by some parents ... and the molestation of vaccinators by parents in some areas, the government feels duty bound to take measures that will bring this madness to an end," he said.

"The refusal of some parents to immunise their children against polio is causing a serious setback in our fight to eradicate polio in our society and we will take any action necessary to change this attitude", he explained.

Nigeria has almost two-thirds of the cases of polio in the world -- 788 infants were paralysed by the crippling disease last year, more than twice as many as in 2003 -- and is the main target for a global eradication campaign.

The United Nations World Health Organisation and the UN Children's Fund Unicef are working with Nigerian officials to promote a series of massive immunisation drives designed to protect 15-million infants by the end of 2005. - Sapa-AFP

### RENEWALS

Please renew your annual subscription to The Informed Parent newsletter.

Even if you feel adequately informed, your continued support will help spread awareness to the public at large!! Many thanks! *Magda Taylor*

# VACCINATING PETS COULD DO MORE HARM THAN GOOD

http://www.nbc4.tv/news/

NBC4.TV, CA. 04/05/05

LOS ANGELES -- Many people get their pets vaccinated every year for health and protection. But is it possible those same vaccinations could be harming your pet or worse? Some veterinarians are starting to look more closely at those claims, reported NBC4's David Cruz.

Today, Molly is a playful 4-year-old Basenji, but at 2 years old, she was covered in sores and fighting for life. "She was dying," her owners told NBC4. "Laying in her bed, she wouldn't get up. She would hardly eat."

Doctors were baffled by the dog's mystery illness until they narrowed it down to a most likely cause, a severe reaction to multiple vaccines, given at the rescue shelter where her owners adopted her. "What I understand now is that that can potentially overload the immune system," said Molly's owner.

You do not need to vaccinate your pet every year and it may not be safe to do so, reported NBC4's Cruz. One veterinarian told NBC4 that millions of pets get booster shots every year, for everything from rabies and distemper to parvovirus and lyme disease, and most suffer no ill effects.

But these days, many veterinarians are taking a "less is better" approach. People often are so hysterical, they put the animals to sleep because it's an acute vaccine reaction and has to be treated rapidly to have the animal recover, but then you don't vaccinate again because the next one could kill the animal, the veterinarian said.

One Los Angeles veterinarian said vaccines can remain effective for years without booster shots. He did a survey of more than 100,000 dogs that were vaccinated once for distemper and parvovirus. In every case, those who were tested and did not get boosters have remained healthy. Overvaccination has been suspected in causing tumors in some cats and immune problems in dogs. One family said their Yorkshire Terrier, Nicky, nearly died after an annual series of booster shots. "She couldn't breathe well, she was weak, limp," a family member said. "She was going to die. They said she probably wouldn't pull through it."

After $6,000 in medical fees and a week in intensive care, Nicky pulled through. Doctors suspect an adverse vaccine reaction.

"You bring your dog in because you're trying to keep her healthy, and a week later you find out you almost killed her," the family member said. One doctor told NBC4 that if you're getting your pet vaccinated, here's a simple plan: Start with the basics, rabies, distemper and parvovirus, then consult with your vet. The doctor said German shepherds, rottweilers and poodles are at higher risk for adverse vaccine reactions, as are older pets. Concerned pet owners with questions are encouraged to consult with their veterinarian.

## TONY BLAIR'S SPEECH ON COMPENSATION CULTURE

http://politics.guardian.co.uk/ 26/05/05

The prime minister spoke to the Institute for Public Policy Research thinktank this afternoon, setting out his plans for a "common sense culture, not a compensation culture"

Here's what he says about MMR:

"one piece of research into a supposed link between autism and the MMR single jab, starts a scare that, despite the vast weight of evidence to the contrary, makes people believe a method of vaccination used the world over is unsafe. The result is an increase in risk to our children's health under the very guise of limiting that risk."

"We need calm, considered debate about technology, science and risk. government has a clear responsibility here: to be open, to provide the evidence we have, not to overclaim.

The media have a responsibility. MMR is one example. The present debate on mobile phones is another. We only narrowly avoided massive expenditure on SARS. We need to involve the media in a better dialogue about risk.

To that end, I have asked John Hutton to invite newspaper and broadcast editors to discuss with the chief medical officer and the government's chief scientist the best and most appropriate forum for ensuring that risk is communicated effectively so that the maximum information can be put into the public domain with the minimum of unnecessary alarm" *Editor: How can the media be responsible if they are brainwashed?*

# ORIGIN OF GERMS

Following on from Issue 1 2005, which featured an article by Dr Patrick Quanten on viruses, he will be giving a number of talks on many of the questionable issues surrounding vaccination. Please see overleaf for further details.

Here is an extract from an article 'Origin of Germs' (January 2003) featured on Dr Patrick Quanten's website: www.activehealthcare.co.uk

## UNIVERSAL MICROSCOPE

In February 1944 the Franklin Institute of Philadelphia (USA) published an article, "The New Microscopes", in its prestigious journal devoted to applied science. The article included a long dissertation on the "Universal Microscope", the brainchild of a San Diego autodidact, Royal Raymond Rife. This microscope, developed in the 1920's, overcame the greatest disadvantage of the electron microscope, which had just been put on the market by the Radio Corporation of America. Because in the electron microscope tiny living organisms are put in vacuum and are subjected to protoplasmic changes induced by a virtual hailstorm of electrons, it is unable to reveal specimens in their natural living state.

The Rife microscope has several arresting features, the most important of which are the crystal quartz out of which the entire optical system as well as the illuminating unit is made, and the extraordinary resolution it achieves. With a resolving power of 31,000 diameters - as opposed to 2,500 for the microscopes in use at that time and at least double the magnification available with optical solutions presently in use, Rife's device could focus on five lines of a standardized grid whereas an ordinary microscope could do no better than examine fifty lines, and that with considerable aberration.

Rife maintained that he could select a specific frequency, or frequencies, of light which co-ordinated and resonated with a specimen's own chemical constituents so that a given specimen would emit its own light of a characteristic and unique colour. Specimens could easily be identified this way.

With his invention Rife was able to look at living organisms. What he saw convinced him that germs could not be the cause, but the result of disease; that, depending on its state, the body could convert a harmless bacterium into a lethal pathogen; that such pathogen could be instantly killed, each by a specific frequency of light; and that cells, regarded as the irreducible building-blocks of living matter, are actually composed of smaller cells, themselves made up of even smaller cells, this process continuing with higher and higher magnification in a sixteen step, stage by stage journey into the micro-beyond.

Thousands of still pictures and hundreds of feet of movie films were made to reveal these facts.

Once again, as was the case with Bechamp, the use of better equipment and the acceptance of the observed, in spite of it being contradictory with the established scientific knowledge, led to a significant discovery. Rife not only described what he saw, as opposed to having a guess at what he believed to be the truth, but he documented every step of his discovery with photographs and motion pictures. His contemporaries decided that it was impossible to "see" these minute organisms as they did not have the technology and the end result is that neither you nor me had ever heard of Rife and his microscope. Furthermore, his microscope together with most of his scientific writings and evidence was taught to have been destroyed. Recently, however, some of it has been recovered but alas in a very sorry state. To this day, no one has succeeded in rebuilding the exact Rife microscope as the specific details have never been found.

The consequence of Rife's discovery is that cells are not the basic building blocks of life, as believed by the medical profession; and bacteria originate from within the diseased tissue, and not, as the profession believes, invades the system from the outside.

# VACCINATION ALONE OR IN COMBINATION WITH PYRIDOSTIGMINE PROMOTES AND PROLONGS ACTIVATION OF STRESS-ACTIVATED KINASES INDUCED BY STRESS IN THE MOUSE BRAIN

From: J Neurochem. 2005 May; 93(4):1010-20.

Wang D, Perides G, Liu YF.
Department of Pharmacology, Boston University School of Medicine, Boston, Massachusetts, USA.

ABSTRACT: Gulf war illnesses (GWI) are currently affecting thousands of veterans. To date, the molecular mechanisms underlying the pathogenesis of these illnesses remain unknown. During Gulf war I, military personnel were exposed to multiple stressors, one or more vaccines, pyridostigmine (PY), and other chemicals. In our previous studies, we found that stress induces activation of mitogen activated protein-kinase kinase 4 (MKK4) and c-Jun-N-terminal kinase (JNK) in the mouse brain (Liu et al. 2004). Our working hypothesis is that stress, vaccination, and PY may synergistically induce activation of MKK4 and JNK in the brain, leading to over-activation of these kinases and neurological injuries. To test our hypothesis, we examined the effect of keyhole limpet hemocyanin (KLH) immunization alone or in combination with PY on activation of MKK4 and JNK induced by stress. We found that KLH immunization alone had a small effect on MKK4 or JNK activity but it significantly enhanced and prolonged activation of these kinases induced by stress, from a few hours to several days.

Additionally, KLH immunization caused activation of p38MAPK. PY treatment further enhanced and prolonged activation of these kinases induced by stress in combination with KLH immunization and triggered activation of caspase-3. Our current studies suggest that stress, vaccination, and PY may synergistically act on multiple stress-activated kinases in the brain to cause neurological impairments in GWI.

GLOSSARY

Kinase: 1. an agent that can convert the inactive form of an enzyme to the active form. 2. an enzyme that catalyses the transfer of phosphate groups.
Hemocyanin: An oxygen-carrying pigment of lower sea animals, used as an experimental antigen.

# HEALTH AND IMMUNITY

Patrick Quanten had been a general practitioner since 1983. The combination of medical insight and extensive studies of Complementary Therapies have opened new perspectives on health care, all of which came to fruition when it blended with Yogic and Ayurvedic principles. Patrick gave up his medical licence in November 2001.

Dr Quanten has kindly agreed to give a number of talks where he will be challenging the germ theory of disease on which the vaccination procedure is based. He will look at the impact of vaccines on the body, and the potential effects. Dr Quanten will also present the true cause of disease, and focus on prevention by the promotion of health.

The following talks have been organised, and I would urge you to support these events by attending and/or promoting these talks to other possibly interested parties.

SEPTEMBER 2005

•19th - London *(evening)*

Contact Magda on: 01903 212969

•20th - Bournemouth *(evening)*

Contact Liz on: 01425 280678

•21st - Brighton *(evening)*

Contact Karel on: 01273 277309

•22nd - Hastings *(evening)*

Contact Lesley on: 01424 441397

•23rd - Worthing *(late morning)*

Contact Magda on: 01903 212969

# HOW TO OVERCOME ACUTE AND CHRONIC DISEASE BY NATURAL MEANS

Saturday, 25th June 2005
10.30am - 4pm
Salvation Army Hall,
Albert Street, Carter Gate,
Newark, Notts.
Fee: £20

Please bring own packed lunch.
Venue just 10 mins from Newark Northgate Station.

Organised by the naturopathic organisation 'The British Natural Hygiene Society.'

SPEAKERS: DR KEKI SIDHWA, DRS. ALEC & NEJLA BURTON, *and possibly* DR PAULINE PRICE

To book a place please contact Dr Keki Sidhwa on: 01636 682941
Alternatively send a £10 deposit to reserve a place to:
Dr Keki Sidhwa, BHNS
'Shalimar', 14 The Weavers,
Farndon Road, Newark,
Notts. NG24 4RY
(Cheques payable to: "British Natural Hygiene Society")

## PLEASE HELP PROMOTE THE INFORMED PARENT

You can send off for leaflets to pass on to friends, relatives or patients.
Just send a large sae and state quantity needed.
THANK YOU
FOR YOUR SUPPORT!

# COMPARING NATURAL IMMUNITY WITH VACCINES

*with* TREVOR GUNN, *BSc. LCH RSHom, graduate in biochemistry and author of 'Mass immunisation - A Point in Question'*

Would you like to know whether vaccines work? Would you like to know how to avoid serious illness? Would you like to live feeling safe, knowing what treatments work?

Topics covered:
Short and long term effects of childhood and travel vaccines - evidence from orthodox & complementary sources - information that the authorities don't tell you - making sense of statistics - childhood illnesses - dealing with fear- avoiding future problems- increasing health now

LONDON

Monday 14th November 2005
Friends Meeting House,
173-7 Euston Rd , London NW1
7.15 - 9.30pm
Fee: £9.00 each. Early bird fee £7.00 if booked before 30 Sept.
For bookings and further info, please contact Magda on:
01903 212969

BRIGHTON

Autumn dates to be confirmed.
For details contact Karel on:
01273 277309

*The views expressed in this newsletter are not necessarily those of The Informed Parent Co. Ltd. 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 4481, Worthing, West Sussex, BN11 2WH. Tel/Fax: 01903 212969***
**www.informedparent.co.uk**
The Informed Parent Company Limited. Reg.No. 3845731 (England)