THE *informed* PARENT

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

SHAKE-UP PLANNED FOR IMMUNISATION PROGRAMME

Pulse, Issue: 23 July 2005

Government immunisation advisers have proposed a raft of changes to the UK vaccine programme, writes Emma Wilkinson.

Included in the measures is an agreement that Hib and meningitis C booster doses will be added into the childhood vaccine schedule. Influenza vaccine advisers have also asked the Department of Health 'to set in train' plans for expanding the annual immunisation campaign to include adults aged 50 to 64.

The Joint Committee on Vaccination and Immunisation has also asked the Committee on Safety of Medicines to look at the evidence for giving influenza vaccine during pregnancy with a view to making 'wider recommendations'.

The National Vaccine Evaluation Consortium is currently conducting studies to work out the best schedule for the Hib and men C boosters and the recommendations will not be implemented until they report.

The JCVI said it was currently considering a range of options for the men C booster. They include adding it at 13 months, priming at two and four months and then a booster, and priming at three months plus a booster.

GPC negotiators stressed any new vaccine work would have to be paid for under a directed enhanced service because a shift to immunise the over-50s against flu would have workload implications.

GPC negotiator Dr Andrew Dearden said: 'It needs to be clear what has to be done, who's doing it and how it's going to be paid.'

He added: 'I hope the department has learnt from past mistakes.'

Planned changes

·Hib and men C childhood boosters

·Flu vaccine for all 50- to 64-year-olds

HOME VIDEOS HIGHLIGHT AUTISM REGRESSION

http://www.medwirenews.md/news/article.aspx?k=51&id=37660
02 August 2005

Analysis of home videos has provided evidence to back up parents' claims that some autistic children initially develop normally, before regressing as toddlers.

Some parents of children with autism maintain that their infant had normal or near-normal development until 15 to 24 months old, before experiencing a regression in communication or social skills.

Researchers from the University of Washington in Seattle, USA, who looked at video footage of autistic children when they were aged between eight and 12 months, say: "Whilst we cannot be certain from these data that children with autistic regression were developing normally before the regression occurred, the results of the present study suggest that at least some children with autism do not display prototypical impairments in joint attention... nor do they display obvious delays in their use of language."

Home video footage of 56 children as babies was assessed by the investigators. Thirty-six of the children had since been diagnosed with autistic spectrum disorders, although in 15 of these cases the parents *(contd on p3)*

DR QUANTEN'S LECTURE DATES

Just a reminder about the forthcoming talks by Dr Quanten entitled 'Health & Immunity'.

Patrick Quanten had been a general practitioner since 1983. The combination of medical insight and extensive studies of Complementary Therapies opened new perspectives on health care, all of which came to fruition when 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!! We would like to see full audiences, so please make that possible!!

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

See page 3 for details of Trevor Gunn's forthcoming talks

AUTISM: THE MERCURY TRAIL

By Margaret Cook, 8/08/05
The writer is a retired consultant haematologist, formerly at St John's Hospital, Livingston This article first appeared in the New Statesman.
www.newstatesman.com

Powerful evidence points to a preservative in vaccines as the likely culprit, writes Margaret Cook

The classic juvenile tactic to get out of a scrape is to deny it vehemently, even if that means claiming black is white. Curiously, governments adopt the same technique, reinforcing their indignant denials with name-calling.

This has been the response from both US and British establishments to parental fears that autism is causally related to vaccines. Andrew Wakefield was sent packing after he suggested MMR vaccines were suspect. His failure to declare an interest in connection with his research was used to destroy his career, even though his lapse pales into insignificance beside the conflicting incentives present in the entire chain of vaccine-policy command from Cabinet Office to consulting room.

But it is more difficult to bully away the question of mercury in vaccines and its putative link with autism. A book published in the US this year, Evidence of Harm by David Kirby, makes a compelling case. Any unbiased doctor who reads it, following the golden rules of listening to the parents' stories and assessing the evidence the book quotes, cannot fail to be persuaded. Yet the response in the British Medical Journal, in a review by Dr Michael Fitzpatrick, is to rubbish it in a hectoring tirade, the theme of which is that parents are not reliable witnesses and the experts know best. How dare the parents side with "credulous journalists" and defy the "authoritative US Institute of Medicine"?

Since 1939 a preservative called thiomersal (thimerosal in the US) has been used in some vaccines, and it contains nearly 50 per cent mercury. Mercury is a nerve-cell poison, but the amounts in vaccines were said to be "traces" only. It was used in, among others, the diphtheria/tetanus/ pertussis vaccine given in three doses early in infancy. It is not present in MMR or other vaccines containing live viruses. In the US, pre-school vaccinations are compulsory and, under this blanket, jabs upon jabs were added to make a worryingly crowded programme. It was nearly a decade before the Food and Drug Administration added up the mercury being injected into infants in the first few months of life, and then it found that it was well in excess of federal legal limits even for adults. In 1999 regulators in the US and Europe advised phasing out mercury in childhood vaccines in the shortest possible time - while continuing to deny it was harmful. Believe that if you will.

Autism and related disorders were unknown before 1939. The exponential increase in recent years seems to parallel the rising number of mercury-containing vaccines given at an ever earlier age. The infant blood-brain barrier is not developed until six months of age, and it is to be expected that even minuscule amounts of this cumulative toxin can do harm. A causal association between the metal and autistic disorders is wholly biologically plausible. Epidemiological studies have come up with conflicting results, depending on the mindset of the researcher.

There is evidence that autistic children have a (probably genetic) problem in excreting mercury. It now seems likely that these predisposed children, burdened and immuno-suppressed with toxic metal, then given a dose of MMR live vaccine, suffered a triple whammy causing full-blown autism. The history obtained from parents of children with autism is consistent and should not be dismissed so contemptuously as the reviewer Fitzpatrick did. The story that a child progressed normally until an adverse reaction to a vaccine seemed to tip him or her into a slide into autism is heard again and again.

The extraordinary increase in autism among children - one child in 166 now suffers from an autism spectrum disorder - cannot be explained away by better recognition and diagnosis, as claimed by psychiatrists. If it were so, where are all the adults with covert autism?

So worried was the US government about the mercury question that a rider barring thiomersal litigation was tacked on at the 11th hour to the (unconnected) Homeland Security Bill 2002 - a sign of the US health, federal and industrial establishments ganging up to evade a mercury fallout.

Mercury was removed from UK infant vaccines in 2004. Parents of autistic children in the UK struggle to engage the support of public services, and many find that physical symptoms are ignored. Autism is compartmentalised as a mental illness and doctors tend to leave it to psychiatrists. Gastro-intestinal aspects of autism were Wakefield's speciality, and look what happened to him.

Yet this disease needs to be wrested back into mainstream medicine and that will happen only when the establishment seriously addresses the theory of mercury as a contributory cause.

INFANRIX HEPB WITHDRAWAL

Public Statement on Infanrix HepB Withdrawal of the Marketing Authorisation in the European Union
European Medicines Agency
http://www.emea.eu.int

LONDON, Aug. 4, 2005 - On 25 April 2005 the European Commission adopted the decision withdrawing the Marketing Authorisation for the medicinal product for human use "INFANRIX HepB". It followed the notification by the Marketing Authorisation Holder (GlaxoSmithKline Biologicals) to voluntarily withdraw the Marketing Authorisation for INFANRIX HepB for marketing reasons. The MAH confirmed that this decision was based on commercial reasons and not due to any safety related concerns.

INFANRIX HepB [diphtheria toxoid, tetanus toxoid, acellular pertussis components (pertussis toxoid, filamentous haemagglutinin and pertactin), recombinant hepatitis B surface antigen (r-HBsAg)], was indicated for active immunization of all infants from the age of 2 months against diphtheria, tetanus, pertussis and hepatitis B.

It should be noted that there are other Community Marketing Authorisation valid throughout the European Union which contain the same antigens, i.e. diphtheria toxoid, tetanus toxoid, acellular pertussis, recombinant hepatitis B surface antigen (r-HBsAg). As a consequence to this decision the European Public Assessment Report for INFANRIX HepB has been removed from the EMEA website. *Noël Wathion, Head of Unit for the Post-Authorisation Evaluation of Medicinal Products for Human use*

UNEXPLAINED CASES OF SUDDEN INFANT DEATH SHORTLY AFTER HEXAVALENT VACCINATION

Published in Vaccine, 18 May 2005
Letter to the Editor - Extracts

Polyvalent vaccines like Hexavac® and Infanrix Hexa® were developed to increase acceptance of vaccinations by decreasing the number of necessary injections. Compared to their pentavalent predecessors, these hexavalent vaccines additionally contain hepatitis B serum. They are used for immunisation against diphtheria, pertussis, tetanus, influenza, poliomyelitis and hepatitis B. Hexavac® and Infanrix Hexa® are available in European markets since October 2000. Until April 2003, approximately 3 million children have been vaccinated in this way and about 9 million doses were sold in the European union during this time. Children are to be vaccinated with these vaccines at the age of 2, 4, 6 and 12-14 months.

We report six cases of sudden infant death after hexavalent vaccination that were autopsied and examined at the Munich Institute of Legal Medicine from 2001 to 2004.

Among those investigated children, three were male and three female, ageing between 4 and 17 months. Five children had been vaccinated with Hexavac®, one with Infanrix Hexa® during the past 48 hrs before death. Shortly after the vaccination, three of the children developed symptoms like tiredness, loss of appetite, fever up to 39 .C and insomnia. All children were found dead without explanation 1-2 days after the vaccination. They were assumed to be typical cases of SID (sudden infant death) because there was no history of a serious illness, and since all children died suddenly and unexpectedly.....

Autopsy and all further investigations did not reveal other serious abnormalities that could have lead to the deaths of the children. The neuropathological findings in the investigated cases are unlikely to explain the deaths, since early post-vaccinal encephalopathy is mostly associated with a congestive and edematous brain without relevant inflammatory infiltration.

Post-vaccinal encephalopathies are mentioned especially in relation with vaccinations against pertussis. Such cases, however, typically show clinical symptoms like somnolence,convulsion, headache or paresis . Such or similar symptoms could not be found in any of the examined cases.

However, between 2001 and 2004 five of such cases were identified in our institution among 74 children with SID. This would indicate a 13-fold increase.....

We reported these six cases to direct attention to a possibly serious vaccination side effect. So far, there is no way to prove that these infant deaths are caused by vaccination.

Therefore, the relation between the vaccinations and the death of the children must remain uncertain.

Nevertheless, we feel that it is important to inform vaccinating physicians and pediatricians as well as parents about such possibly fatal complications after application of hexavalent vaccines. Especially, physicians and pediatricians should be also informed about the possibility of using pentavalent vaccines, which seem to be associated with lesser complications.

Finally, if broad use of hexavalent vaccines continues, extensive studies are most likely required to assess or exclude a relation between vaccination and death in infants.*B. Zinka, E. Rauch, A. Buettner, R. Penning*

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(Contd from front page) maintained that signs of autism were not apparent until the second year of life. The remaining 20 children showed ordinary patterns of development.

Focusing on the frequency and duration of behaviours such as language, gaze, repetition, emotion and play, the researchers were able to compare early development between the three groups. They also interviewed the parent or guardian who provided most care for the child in the early years about social responsiveness, language skills and temperament.

Children who experienced regression were comparable to normally-developing children in terms of how frequently they communicated with babble or words and engaged with joint attention, such as pointing. However, these activities were found less frequently in the footage of the 21 children with early-onset autism, it is reported in the latest issue of the Archives of General Psychiatry. Speaking to MedWire, Professor Geraldine Dawson, co-author of the study, said the research highlights the importance of continuing to check for autism during the toddler years.

"The more we understand about the early course of autism and possible subtypes of autism, the more likely we will be able to identify the different causes of autism," she commented. "I was not surprised by the findings," added Professor Dawson. "Historically, research has shown that parents are generally reliable reporters on their children's development. "This is another case in which parents' observations turned out to be correct." *Our emphasis.*

COMPARING NATURAL IMMUNITY WITH VACCINES

with TREVOR GUNN, *BSc. LCH RSHom, graduate in biochemistry*

Topics covered include: 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, London NW1
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

2005 - 9 November
2006 - 15 March & 14 June
Two 'Follow-up' talks have been organised on 1 Feb & 19 July 2006 for those who have attended a Trevor Gunn presentation and would like to hear more.
For details contact Karel on:
01273 277309

NO TO SECOND DOSE OF CHICKENPOX VACCINE - USA

Although chickenpox vaccine has not been added to the immunisation schedule in the UK, it is certainly very much in the pipeline. Reproduced here is an article reporting on a recent meeting of the Advisory Committee on Immunisation Practices, in the USA, regarding future changes with their chickenpox vaccine policy.

ACIP: No to routine second dose of varicella (chickenpox) vaccine
By Judith Rusk, August 2005

ATLANTA - Members of the Advisory Committee on Immunization Practices (ACIP) did not recommend a second dose of varicella vaccine (Varivax, Merck). Some members said the issue should be deferred because of the possible licensure of a combined measles-mumps-rubella-varicella vaccine (MMRV; ProQuad, Merck).

Merck filed an application for approval with the FDA for the combination vaccine last August, and a decision could come this fall, according to some ACIP members.

THE RECOMMENDATIONS

Although members voted down a routine second dose, the committee did make recommendations expanding the use of the Varivax vaccine, including a second dose for out-break control. ACIP members recommended varicella vaccine as an entry requirement for middle school, high school and college students. Current recommendations specify that only children who attend day care or elementary school must receive the vaccine. All school entry laws are state laws, however, not federal laws.

All people ages 13 and older born in the United States since 1965 should be assessed for varicella immunity. Physicians should vaccinate those who lack immunity against varicella if there are no contraindications.

Physicians should conduct routine screening of pregnant women for varicella immunity and should vaccinate those who lack immunity against varicella after giving birth or terminating pregnancy. A second dose is recommended in this case four to eight weeks later. *(Editor: Meaning that new mothers will be targeted at a time when they may be breastfeeding.)*

Vaccination with varicella vaccine is safe for children who are HIV positive with age-specific CD4+ T-lymphocyte percentage of 15% or greater.

The recommendations made by the ACIP do not become policy until they are accepted by the director of the CDC and secretary of the Department of Health and Human Services as well as published in Morbidity & Mortality Weekly Report.

WHY A NO-GO

During the first day of the two-day ACIP meeting, committee member Gus Birkhead, MD, MPH, director of the center for community health and the AIDS Institute in the New York State Department of Health, asked for a 'straw poll' of individuals who might have voted for the second dose had the MMRV vaccine been an FDA-approved option.

'I am very concerned that we will set the price if we do that,' said Jon S. Abramson, MD, Weston M. Kelsey Professor and chair of the department of pediatrics at Wake Forest University School of Medicine and new chair of the ACIP.

In response to Abramson's comment, Birkhead said he would have backed the second dose if MMRV were available.

Stephen L. Cochi, MD, MPH, acting director of the National Immunization Program at the CDC questioned why, in light of evidence that a second dose might provide a public health gain, the ACIP members would delay initiating a second dose until MMRV. The new vaccine might have cost implications, he added. 'What added benefit or advantage do we gain by waiting on the decision?' he asked. Abramson said earlier in the discussion that the incremental benefit of the second dose is modest since most hospitalizations and deaths have been eliminated with the current single dose schedule. The only clear benefit of the second dose is that it will decrease by about two-thirds breakthrough disease *(Editor: Breakthrough disease simply means chickenpox in the vaccinated).* Thus the cost of the new vaccine would matter most. However, 'I would certainly reconsider a second dose of MMRV if reasonably priced.'

The second day of the meeting, ACIP member and chair of the MMRV working group, Judith Campbell, MD, associate professor of pediatrics at Baylor College of Medicine in Houston, said the MMRV working group was pleased with the recommendations, which the ACIP passed. However, the working group would like for the ACIP to consider a permissive recommendation for two doses of varicella zoster virus, which would allow individual practitioners to give two doses if they are seeing many children with breakthrough disease in their practice. In addition, a permissive recommendation should be considered given the proposed AAP recommendation for a two-dose regimen.

This time it was phrased with more permissive language, but it did not pass, although the vote was close. In addition to speculation over MMRV, cost-effectiveness studies showed that the second dose might not save money. That was a concern to ACIP members voting for a routine second dose.

The committee was in favor of administration of two doses of the vaccine for children between 12 months and 12 years, but the recommendation has not been presented to the AAP board, according to H. Cody Meissner, MD, chief of the department of pediatric infectious diseases at the Tufts-New England Medical Center in Boston, speaking on behalf of the committee on infectious diseases of the AAP.

Based on surveillance data, the present burden of disease due to varicella will not be reduced without a second dose. Despite the success of the one dose vaccination program in reducing varicella morbidity and mortality, the number of reported cases has not changed much in the last three to four years, according to Meissner. The breakthrough rate even in highly vaccinated populations are sufficient to sustain transmission of the virus. Children with breakthrough disease generally are excluded from school for three to five days and parents may miss work while caring for their sick

child.

Other concerns ranged from whether the burden of varicella disease warranted a second dose of vaccine to whether a second dose would be more appropriate later in life than at ages 4 to 6.

An estimated 4 million cases of varicella were reported annually prior to licensure of the vaccine in 1995. Since then, cases of varicella have steadily declined more than 80% in surveillance sites. From 1995 to 2001, varicella hospitalizations declined by 72%, and deaths among those younger than 50 decreased by 92%.

VARICELLA VACCINE

This year marks the 10 year anniversary of the vaccine. The first dose of varicella vaccine is recommended for children between 12 months and 18 months of age and in 2003, an estimated 85% of children between 19 months and 35 months were vaccinated against the disease, according to the CDC.

The vaccine is 80% to 85% effective against varicella and 95% against severe disease. However, outbreaks of the disease continue to occur among vaccinated schoolchildren. In recent outbreaks, 11% and 17% of vaccinated children developed varicella.

Although disease in vaccinated children is typically mild, children are contagious and can transmit the virus to others. Data from the NIP's Chickenpox Report Card shows varicella vaccine coverage varies between 67% and 12.2%.

SHINGLES VACCINE NOW A REALITY

An article in the San Francisco Chronicle, 2/6/05, reported that an experimental vaccine made by Merck was tested in a 5-year clinical trial, and that the vaccine's hope could provide a badly needed boost to Merck (due to the arthritis drug Vioxx being pulled from the market because of side-effects).

It remains uncertain whether children vaccinated against chickenpox will suffer from shingles as they get older. 'That's a story that has yet to be written,' said Dr Mark Holodniy, an associate professor at Stanford University, 'They don't have the natural infection. We don't know whether their protection wanes with time.'

TESTIMONY ON CHICKENPOX VACCINE

From: www.aapsonline.org

1601 N. Tucson Blvd. Suite 9
Tucson, AZ 85716-3450
Phone: (800) 635-1196
Hotline: (800) 419-4777
Association of American Physicians and Surgeons, Inc.
A Voice for Private Physicians Since 1943
Omnia pro aegroto

Andrew Schlafly
Far Hills, NJ
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Testifying as General Counsel for the Association of American Physicians & Surgeons (AAPS), and as a New Jersey father of two school-age children.
May 12, 2003

Re: Proposed New Rule N.J.A.C. 8:57-4.17 (Varicella Vaccine)

To the Department of Health and Senior Services, Division of Epidemiology, Environmental and Occupational Health:

The Association of American Physicians & Surgeons, Inc. ("AAPS"), founded in 1943, is a nationwide group of thousands of physicians. We oppose the proposed mandate for vaccination against chickenpox.

Prior to the development of the varicella (chickenpox) vaccine, the disease was widely recognized to be one of the most benign illnesses. For example, Encyclopedia of Medicine of the American Medical Association stated in 1989 that chickenpox is a "common and mild infectious disease of childhood" and that "all healthy children should be exposed to chickenpox ... at an age at which it is no more than an inconvenience." Likewise, the American Academy of Pediatrics declared in a 1996 brochure that "[m]ost children who are otherwise healthy and get chickenpox won't have any complications from the disease."

Indeed, the chickenpox fatality rate is among the lowest of all known diseases, with only about 100 dying out of millions who contract chickenpox each year. Moreover, most of those fatalities are in adults rather than children. For example, a study published in the British Medical Journal on July 27, 2002, confirmed that 81% of the deaths attributable to chickenpox over a recent 12-year period in Britain were adults, not children.

The risk of contracting and dying from chickenpox is little more than the risk of being struck and killed by lightning, which is about 89 per year in the U.S. Nevertheless, those adults who are concerned about such a low health risk may obtain the varicella vaccine voluntarily. The vaccine manufacturer can advertise, and consumers can make their own decisions. Over time, the free market would force improvements in the cost and efficacy of the vaccine, and the consumer will be better off for it.

But what we object to here is the forcing of children to take this vaccine at public expense. Children have nothing to fear from the disease, and should not be forced by law to undergo unnecessary medical treatment. The varicella vaccine is still relatively new and unproven, both in safety and efficacy. Forcing millions to receive this vaccine, at substantial expense, would constitute an experiment on the public. Given the scarcity of money for medical care, our dollars are much better spent where people actually want the services.

The FDA Summary for Basis of Approval (SBA) is posted online at www.fda.gov/cber/sba/varmer031795sba.pdf. It conceals key data comparing the vaccine to the placebo. Nevertheless, the limited posted data about vaccine side effects are themselves alarming. For example, the data disclose that post-vaccine fatigue was reported in 27.4% of recipients in healthy children and 29% of healthy adolescents and adults; post-vaccine chills were reported in 4.8% of children and 8.7% of adolescents and adults; abdominal pain was reported in 8.2% of children and 7.7% of adolescents and adults; disturbed sleep in 24.1% of children and 15.6% of adolescents and adults; eye complaints in 6.2% of children and 8.5% of adults; and so on. These side effects are alone worthy of concern, and also suggest the likelihood of more serious injury.

This report ignores side effects occurring beyond 42 days of receipt of

the vaccine, such as exacerbated asthma, diabetes or autism. Shingles is also a serious problem connected with the vaccine.

Against these significant adverse effects, what are a child's chances of being injured by the disease? Less than 1 in one million die from chickenpox annually, and it is unlikely most children today will ever contract the disease. A study of 3000 children in 11 daycare centers between 1995 and 1997 was published in "Conference Coverage (ICAAC) Unvaccinated Children Protected, But May Pay Later," Immunotherapy Weekly, Oct 12, 1998. Despite being in group care, chickenpox among the children studied was zero among children age 1 to 2 years, 5 percent in children age 2 to 3 years, and 13 percent in children age 3 to 4 years.

In a survey of pediatricians published in August 1998 in the Archives of Pediatrics & Adolescent Medicine (vol. 152, no. 8, p.792(5)), it was found that only 42% adhered to a report by the American Academy of Pediatrics recommending universal varicella vaccination of children. Why would New Jersey require a universal treatment that most pediatricians feel is unjustified?

The reason is profit for the companies selling the mandated products. Children need vaccines only 1/100th as much as adults, yet childhood vaccinations account for 65% of the multibillion dollar annual U.S. vaccine market. Vaccine manufacturers force their goods on kids, who do not need them, while failing to persuade adults to buy them in a free market. As with other vaccine mandates, disease data based on adults are used to force vaccines on children. There is no evidence that the vaccines will even remain effective into adulthood for those children. In the SBA for the varicella vaccine (cited above), Merck admits that "[t]he duration of protection of VARIVAX is unknown at present and the need for booster doses is not defined."

In addition, New Jersey does not have a philosophical exemption to these vaccine mandates and the varicella vaccine is a highly objectionable one on moral grounds. The vaccine was developed based on having been "serially passaged through primary human embryonic lung culture" (quoting the SBA cited above). The published SBA, however, has deleted and drawn a huge "X" through its explanation of the details of how human embryos were used in developing this vaccine. All indications are that the varicella vaccine was developed through use of abortion. Parents in New Jersey have a right to know the details, and there should not be mandatory vaccination of a morally offensive vaccine. A majority of New Jerseyans adhere to religions that reject abortion; why should they be forced to receive a vaccine based on it?

It is worth noting that the Physicians Desk Reference contains this warning: "Vaccine recipients should attempt to avoid, whenever possible, close association with susceptible high-risk individuals for up to six weeks. ... Susceptible high-risk individuals include immunocompromised individuals; pregnant women without documented history of chickenpox or laboratory evidence of prior infection; newborn infants of mothers without documented history of chickenpox or laboratory evidence of prior infection." (Emphasis added.) Thus this Department is proposing a mandate that creates a serious risk of harm, without legal remedy for the injured victims. AAPS strongly opposes this proposal.

Three months into the federally mandated smallpox inoculation, the federal government has recently permitted states to terminate the program if they choose. Only 35,000 of the half-million targeted workers had received the smallpox vaccine before it became necessary to reverse the mandate. In that relatively short period of time the smallpox mandate caused eleven cases of unusual heart inflammation, three civilian deaths, plus the unexplained death of NBC correspondent David Bloom within weeks of receiving the smallpox vaccine. Earlier, the federal government also had to reverse its mandate for the rotavirus vaccine after infants tragically and unnecessarily died from it. New Jerseyans should not be forced down the same road with a mandatory chickenpox vaccine.

GLAXO PLANS FIVE VACCINES OVER 5 YEARS

www.latimes.com/business 1/7/05

The company will target markets that could reach $18 billion by 2010 and will double its flu shot production to supply the U.S.

GlaxoSmithKline aims to launch five major vaccines over the next five years targeting markets that could reach $18 billion by 2010, Europe's biggest drug maker said Thursday. The company also plans to double manufacturing capacity in Dresden, Germany, for its flu shot Fluarix to 80 million doses a year by 2008 in order to supply the U.S. market.

Vaccines have long been viewed as a low-growth, low-price business, but Glaxo says this is changing with the arrival of new technologies. Some of its new vaccines will become pharmaceutical blockbusters with sales above $1 billion a year, the company says.

"The global vaccines market is now poised for accelerated growth," David Stout, Glaxo president of pharmaceutical operations, told reporters during a vaccines seminar in London.
Most attention is focused on Cervarix, Glaxo's big new hope for preventing cervical cancer. It will compete with Merck & Co.'s experimental product Gardasil, which is further along in the process of getting to market. Cervarix has been touted by industry analysts as a potential $4-billion-a-year seller. Many analysts now expect Glaxo to seek approval from the Food and Drug Administration in 2007, although it might be able to apply in 2006 if clinical trials progress rapidly. Like Gardasil, the vaccine targets a sexually transmitted infection called human papillomavirus, which causes cervical cancer, the second-biggest cancer killer in women.

Although Cervarix alone has the potential to transform Glaxo's vaccine business, the company also has high hopes for four other major new vaccines that are scheduled for launch by 2010. They include Rotarix, for preventing a common cause of severe diarrhea in children called rotavirus. Glaxo also is pursuing a vaccine for pneumococcal disease known as Streptorix as well as new vaccine combinations against meningitis and an improved flu vaccine.

AN INTRODUCTION FOR PARENTS ON THE CLASSICAL OSTEOPATHIC APPROACH AND UNDERSTANDING OF ILL HEALTH

.By Jamie Archer, B(Ost), MICO

Classical Osteopathy adheres to and never strays from the principles laid down by its founder Andrew T. Still over one hundred years ago and developed by the genius of John Martin Littlejohn in the early part of the last century. Our aim is to 'adjust' the body and as Littlejohn used to say 'give it back to itself'.

Our treatment or body adjustment consists of a series of slow, quiet, gentle, rhythmic movements of the arms, legs, and spine integrating all parts of the body anatomically, mechanically and physiologically. This begins to unlock lesions/disturbances and allow the free flow of fresh clean blood and nerve forces, assisting and giving a helping hand to the healing powers of nature. Make no mistake this is not massage, bone-setting or just aimless waving around of limbs but scientific mechanical principles and treatment employed to gain a physiological response.

Classical Osteopathy believes that the body has its own medicine chest and contains within it all that is necessary for the recovery from illness. We regard health as perfect structural, functional and, environmental adjustment. Any disturbance, absence or change in all or some of these factors will set the wheels of illness and eventually disease in motion. Ill health presents as symptoms, we regard these as the body's cry for help and insist that they must not be suppressed by external drugs or medicines.

These symptoms are an expression of the internal environment and are usually the end results of a long line of disturbances within the physiology of the body. Classical Osteopathy does not treat these end results, as is the trend of modern medicine, but asks the question why they have occurred and then proceeds to seek out and find the cause or causes that have lead to these disturbances. This is what the great John Martin Littlejohn the founder of Osteopathy in Britain constantly reminded his students to do. He would say you must get 'way behind' the problem.

Classical Osteopathy is successful in the treatment of patients of all ages and babies and children are no exception. The birth process although joyous can also be a traumatic time for both mother and baby. The tremendous pressures involved in giving birth, frequently result in osteopathic lesions/disturbances of the infants pelvis, spine and skull. During childhood, bumps, knocks and falls lead to further lesioning that disturbs the physiology of the body obstructing nerves, blood vessels and lymph channels blocking the vital healing powers of nature. These lesions if left untreated and unresolved contribute to many childhood ailments and conditions such as disturbed sleep, eczema, ear, nose and throat problems, baby colic, learning difficulties and developmental problems. They also lead to the weakening of the body, along with the obstruction and congestion of vital fluids. This results in the accumulation of waste and toxic products within the tissues that then provide the ideal playground for micro-organisms or germs.

Classical Osteopathy does not deny the existence of germs. But our philosophy teaches us that germs are the result of ill health and disease and not the cause. The environment in which the germs are grown determine their type. We interpret this as meaning that there is some specific poison at the foundation of each particular type of illness and disease. This poison affects and intoxicates the white blood cells of the immune system which then go on to become pathological poison carrying micro-organisms. Killing them chemically with drugs will provide little more than symptom suppression, failing to remove the morbid matter that they thrive on and has no benefit to the body or patient.

Littlejohn used to say that germs 'die in their own excretions' (1) and that this should be brought about physiologically to be of any benefit rather than chemically with dangerous drugs and poisons. He went on to say that:

'Pharmacology takes the human body and analyses it from the chemical side but we take the human body and make it our pharmacology. That is to say, the human body is inherently its own master chemist, producing all the chemicals necessary for energy and the stimulation of vitality. It is the connecting link between the different parts of the body and a laboratory, which keeps everything in proper order, so that all the vital currents may go to each part through a network of tissues, tubes, nerves and blood vessels. It only remains to supply the system with the right crude materials and to make sure that the different parts of the body are free to prepare and distribute the needs of the body'. (2)

But alas the germ theory is such a convenient idea of ill health and disease because it takes the responsibility of health away from the individual and places the blame on 'invasions' from tiny creatures. Does the medical profession really believe that when the earth began germs or pathogenic bacteria were specifically created to float around the world waiting to spot a suitable human being to attack?

Jocelyn Proby, another great osteopathic pioneer in his introduction to the book '*Bechamp - an Appreciation*' states that Pasteur did the world a great evil when he concentrated

people's attention on micro-organisms as the cause of disease. He says that: 'he made people seek for the cause of their physical ills outside themselves instead of within'(3)

He continues:

'It is easier and in the short term, more profitable to set people to hunting germs and destroying them with drugs or disinfectants, internally or externally applied, than it is to discover and apply natural laws which govern health and disease and to teach people that they are personally responsible for their own physical health and that of posterity'. (3)

Classical Osteopathy is beneficial in dealing with many types of problems. An example of this is in the constitutional conditions such as eczema. Here the toxic body is attempting to dispose of waste that is building up in the tissues and organs, through the skin. This is due mainly to the disturbed functioning of the organs of elimination (namely the bowels, kidneys, lungs etc) and underdevelopment of the spinal curves. The body is no fool and is only too happy to sacrifice the skin in place of more vital organs. The body adjustment sets in motion the release of these toxins and waste from the tissues and adjusts lesions disturbing spinal development and the eliminatory organs. This release may produce what Henry Lindlahr called the 'healing crisis' (4) or in other words the body's attempt to clean itself. This can appear as a bad case of flu or diarrhoea as the eliminatory system is stirred up and begins to release these toxins. It is important that this is not suppressed by drugs or medicines but nursed and allowed to run its course.

As the lesions are adjusted and proper channels are used, the skin is no longer needed as the main organ of elimination and begins to heal. Eczema then can be viewed not as a skin disease but a disturbance within the body, as is the case of most ill health and disease.

In concluding this brief introduction, Classical Osteopathy can be seen as a system of health care that has its own principles, practice and philosophy. Many patients arrive for treatment having lost confidence in medical methods and seek a safe natural alternative. It is important to note that you do not have to have just back pain to visit a Classical Osteopath or even be in any type of pain. Indeed, many people are patients for years and view their osteopathic treatments as they would their regular dental check ups and by doing so lead a more natural healthy life.

I will leave you with a quote from our president and principal here at the Institute of Classical Osteopathy, John Wernham now in his ninety-ninth year and himself a former pupil of the late John Martin Littlejohn:

'It is important to remember that no recovery can be complete in the presence of the osteopathic lesion, while the lesion persists, the patient is potentially ill'. *August 2005*

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DISEASES ARE NOT DUE TO GERMS ALONE

Letters,The Independent
2 July 2005

Sir: Acquiring an infection equals infective agent plus level of immunity ("Superbug hits 15 hospitals", 30 June). Louis Pasteur favoured the germ theory whereby the infective agent was the direct cause of disease. Claude Bernard, on the other hand, believed that the internal "terrain", or health of the immune system, was more important.

It is well established that our immune systems are compromised by poor diet, stress, pollution and inappropriate use of antibiotics. Antibiotics can cause microbial resistance and therefore more virulent microbes: they also kill off beneficial bacteria leaving the intestines open to invasion by pathogens which can become harmful to the host, causing diarrhoea and septicaemia. The diarrhoea causes loss of vital nutrients, further compromising the immune system. Therefore doctors should be prescribing probiotics, nutritional supplements and improving diets for vulnerable patients and not oversubscribing antibiotics.

On his deathbed Pasteur said: "Bernard was right, the pathogen is nothing, the terrain is everything." Unfortunately Pasteur's legacy is the obsession with the pathogen. Modern medicine has largely forgotten the importance of the terrain.

HELEN MURRAY
Cardiac physiologist, Brighton.

RENEWALS

Renewal reminders are sent out monthly, so please renew your annual subscription to The Informed Parent newsletter. Even if you feel adequately informed, your continued support is very much needed for the continuation of the organisation!!! as well as increasing the public's awareness of this issue!!

Many thanks!

Magda Taylor

DR INCAO'S HEP B TESTIMONY

The following letter was written by Dr Incao in March 1999 in relation to the USA hep b vaccine programme for babies.
It read:

Representative Dale Van Vyven
Chairman, Health Committee
Ohio House of Representatives
77 South High Street
Columbus, Ohio 43266

March 1, 1999

Dear Representative Van Vyven:

I have been asked by Kristine M. Severyn for testimony regarding hepatitis B vaccination. Dr. Severyn is doing excellent work on behalf of the children of Ohio and of our nation and I am honored to add my voice to hers in a plea for reason and objectivity regarding vaccination policy in the U.S.

I am a physician in private general practice, having received my M.D. degree in 1966 from Albert Einstein College of Medicine in New York City. For 29 years I have privately and independently pursued a study of vaccinations and vaccine policy. I have served as an expert witness in court trials concerning vaccinations and have submitted medical opinions in cases of vaccine-damaged children adjudicated under the National Vaccine Injury Compensation Program. I was an invited speaker at the First International Public Conference on Vaccinations sponsored by the National Vaccine Information Center in Alexandria, Virginia in September 1997.

I am one of the two physician-signers of the cover letter to the 16-page special report "Hepatitis B Vaccine: The Untold Story" which the National Vaccine Information Center sent out recently to 55,000 U.S. pediatricians. The report was also sent to 8,000 state and federal legislators and to 1500 media outlets in the United States.

In October 1998 I was invited to speak at a special workshop on vaccinations in Manchester, New Hampshire where a citizens initiative to roll back the hepatitis B vaccine mandate is under way. As a private physician with no ties to any academic or government institution, I am free to give voice to my conscience without the usual onstraints that group affiliation confers. In what follows I am motivated simply to express the truth as I see it, by a deep concern for the long term health of our nation's children.

The present growing distrust of vaccinations by concerned parents nationwide is a grassroots movement that will not go away because it springs from a very real source: from a frequency of acute and chronic adverse effects of vaccinations far greater than is being officially acknowledged. This grassroots movement is only bound to increase until its concerns are acknowledged and dealt with in a scientifically objective and forthright manner.

In 1979 the Centers for Disease Control stated: "Vaccinations are recommended and administered to millions of children and other individuals each year on the presumption (emphasis mine) that the benefits far outweigh the risks. The benefit side of the equation is straightforward: vaccinations can prevent serious disease. The risk side is not as straightforward since it includes factors that are known and others that may exist but have not yet been discovered. It is necessary, therefore, to maintain surveillance of potential risks of vaccination to continually reevaluate whether individual vaccinations are, on balance, good for people."

The above clear statement of purpose to monitor vaccine safety has unfortunately been totally eclipsed by our nations' enormous intellectual, bureaucratic and economic commitment to vaccination as the method to eradicate illness. This commitment has made it virtually impossible to achieve an open, fair and unbiased risk-benefit evaluation of any vaccination in use today. With a conflict of interest of this magnitude, the pressures that exist to maintain the momentum of our national vaccine initiative and to avoid "alarming the public" overshadow by far those voices who might question the wisdom of such a one-sided and politicized health agenda.

In addition, severe constraints are placed on the media in the name of "responsible journalism" with the result that the American public very seldom hears both sides of the vaccination story, and comes to have an unquestioning faith in vaccinations as our greatest hope against future imagined disease plagues. In this fear-based scenario, the questioning voice of reason is drowned out amid the hysteria surrounding the emerging "killer infections" which are such a favorite media topic.

This propagation of fear by the media and by its sources in the public health industry has resulted in a growth of power of this industry far beyond the usual checks and balances of our democracy. One aspect of this power is the ability of many state health departments to legally mandate a new vaccination for all children completely bypassing any discussion or deliberation in that state's legislature. In a democracy this cannot and must not be.

Practicing physicians and the general public rely on the monitoring capacity and the scientific objectivity of the C.D.C., the F.D.A. and the health departments of our 50 states to alert us to the very real risks of vaccinations in use today, and to provide us with as accurate an assessment of that risk, both acute and chronic, as is scientifically possible.

In fact, the C.D.C. has retreated utterly from its 1979 statement quoted above emphasizing the importance of vaccine safety monitoring. It is extremely regrettable, but no exaggeration to say that with regard to informing physicians and the public on vaccine safety, the responsible agencies have failed the American people. In support of this assertion, I cite the following facts:

1. In 1994 a special committee of the Institute of Medicine of the National Academy of Sciences published a comprehensive review of vaccine safety which had been commissioned by federal law. Of five possible and plausible adverse effects of the hepatitis B vaccination which the committee investigated, they were unable to come to any conclusion for four of them because they found to their dismay that the relevant research had not been done!

Why aren't the agencies responsible for vaccine safety commissioning such research? For the fifth adverse effect, anaphylactic shock, the committee concluded that the evidence positively established a causal relation to the hepatitis B vaccination.

2. In contrast to the lack of research on the adverse effects of hepatitis B vaccination found by the Institute of

Medicine, the National Vaccine Information Center in its recent special report on hepatitis B vaccination sites 38 reports in the international medical literature, some dating back to 1987, that hepatitis B vaccination is causing chronic autoimmune and neurological disease in children and adults.

3. In July 1998, 15,000 French citizens filed a class action lawsuit against the French government accusing it of understating the risks of hepatitis B vaccine and of exaggerating its benefits for the average person. In October 1998 the French government declared a moratorium on hepatitis B vaccination in public schools while it evaluates more carefully the true risk-benefit profile of the vaccine.

4. Since July 1990, 17,497 cases of hospitalizations, injuries and deaths in America following hepatitis B vaccination have been reported to the Vaccine Adverse Event Reporting System (VAERS) of the U.S. government. This figure includes 146 deaths in individuals after receiving only hepatitis B vaccine without any other vaccines, including 73 deaths in children under 14 years old.

In 1996 alone there were 872 serious adverse events in children under 14 years old reported to VAERS. 658 of those injuries were following hepatitis B vaccination in combination with other vaccinations and 214 of these injuries were after hepatitis B vaccination alone. In these children under 14 years old, there were 35 deaths after hepatitis B vaccination in combination and 13 deaths after hepatitis B vaccination alone, for a total of 48 deaths.

Compare these statistics with the total number of hepatitis B cases nationwide reported that same year (1996) in children under 14, just 279, and the conclusion is obvious that the risks of hepatitis B vaccination far outweigh its benefits. In those infants who died under one month of age, most of the deaths are classified as Sudden Infant Death Syndrome (SIDS). However, in the past this syndrome has never struck infants so young, and SIDS is officially defined as beginning only after one month of age.

With 6,000 children dying of SIDS every year, we have no idea how many of these deaths are actually caused by hepatitis B vaccination. Though the Vaccine Adverse Event Reporting system was created by federal law to permit a more accurate assessment of the risks of vaccination, and although the raw data it generates is analyzed, the individual reports of injury or death are rarely, if ever, investigated. If one factors in that fewer than 10% of physicians report adverse reactions to vaccines because we are taught to regard them as merely "temporally related", as only a coincidence, it would be quite plausible to say that the risks of hepatitis B vaccination clearly outweigh its benefits for 99% of the children who receive it.

5. The best way to determine the risk-benefit profile of any vaccination is well known and in theory is quite simple: Take a group of vaccinated children and compare them with a matched group of unvaccinated children. If the groups are well-matched and large enough and the length of time the children are observed following vaccination long enough, then such a study is deemed the "gold standard" of vaccine research because its data is as accurate a reflection as medical research is capable of achieving of how vaccinations are actually affecting our nation's children.

Incredible as it sounds, such a common-sense controlled study comparing vaccinated to unvaccinated children has never been done in America for any vaccination. This means that mass vaccination is essentially a large-scale experiment on our nation's children.

6. A critical point which is never mentioned by those advocating mandatory vaccination of children is that children's health has declined significantly since 1960 when vaccines began to be widely used. According to the National Health Interview Survey conducted annually by the National Center for Health Statistics since 1957, a shocking 31% of U.S. children today have a chronic health problem , 18% of children require special health care or related services and 6.7% of children have a significant disability due to a chronic physical or mental condition. Respiratory allergies, asthma and learning disabilities are the most common of these.

Three controlled studies comparing vaccinated to unvaccinated children in England and New Zealand have shown that the vaccinated children have significantly more asthma, ear infections, hospitalizations and inflammatory bowel disease than their unvaccinated cohorts. Since vaccinations have a lasting effect on the immune system, and since it is known that many vaccines shift the balance of the immune system away from its acutely-reacting "Th1" side and toward its chronically - reacting "Th2" side , it is a very plausible scenario that vaccines are contributing greatly to the large-scale and unprecedented increase in chronic conditions such as allergies, asthma, diabetes and a wide range of neurological dysfunctions including learning disabilities, attention deficit disorder, seizures and autism in U.S. children today.

The shocking facts that 31% of U.S. children today suffer from a chronic condition and that the rate of disability from such chronic conditions in children has seen nearly a fourfold increase since 1960 ought to seriously challenge our medical research establishment. But, far from taking a proactive approach toward these disturbing facts, our medical establishment remains curiously uninterested in children's chronic diseases and instead continues to pursue its narrow focus of using vaccines to eradicate every possible acute childhood illness, even those like hepatitis B and chicken pox which pose no threat to 99% of children.

The idea that illnesses exist in an ecological balance like everything else in nature and that eradicating acute diseases could very likely upset the balance and cause chronic disease to increase is not seriously considered or pursued in medical science today. Whenever any evidence pointing in this direction is published, usually in the international medical literature, it is usually dismissed out of hand by American physicians or angrily repudiated with the implication that such research is "irresponsible" because it might cause the American public to lose trust in our vaccination program.

With such a total commitment of our medical community to a policy of universal vaccination, is it any wonder that new and potentially upsetting discoveries relating to the role of vaccinations in the alarming prevalence of chronic illness in our children are never seriously considered much less pursued? When the Institute of Medicine published its Federally mandated reports on vaccine safety in

1991 and 1994, their disturbing conclusion was that there is very little data on vaccine safety because the necessary research is simply not being done.

7. Eugene Robin, M.D., Emeritus Professor of Medicine from Stanford Medical School is one of the world's leading experts on risk/benefit analysis in medicine. He authored the definitive book on the subject, Matters of Life and Death: Risks vs. Benefits of Medical Care. In a statement at the First International Public Conference on Vaccination in September, 1997, Dr. Robin said the following:

"The scientists who develop vaccines should be given great credit and respect for their pioneering work. But it must be recognized that once a promising vaccine is available, that should be the beginning and not the end of the process.

Accurate assessment of the risk/benefit ratio of the vaccine by means of a controlled clinical trial should be obligatory. An educational process involving the public should be mandatory in which the risks and uncertainties are described as well as the potential benefits.

So, what can we 'teach' the public if we ourselves, the medical scientific community, have not done the proper and required studies?

A true process of informed choice would, for example, raise grave questions about the vaccination of young children for hepatitis B.

We must be honest and admit that we do not know the impact of administering multiple, different vaccines on very young children or, indeed, on anyone."

8. My final comments are drawn from my 27 years of experience as a general practitioner of medicine. Twenty-three of those years were in a rural farming community in upstate New York where as many as 50% of my pediatric patients were unvaccinated due to their parents' conscientious personal choice. When I started my practice I believed, as I had been taught in medical school, that the benefits of vaccinations outweighed the risks. I also believed that the right of parental choice in vaccinations ought to be respected.

For 23 years I had the opportunity to observe my young patients grow from infancy to young adulthood and to appraise their overall health and vitality. It was out of this experience that my present views took shape. I observed that my unvaccinated children were healthier, hardier and more robust than their vaccinated peers. Allergies, asthma and pallor and behavioral and attentional disturbances were clearly more common in my young patients who were vaccinated.

My unvaccinated patients, on the other hand, did not suffer from infectious diseases with any greater frequency or severity than their vaccinated peers: their immune systems generally handled these challenges very well.

CONCLUSION

Like all science, medicine has radically changed many of its views over time. What seems wise and prudent today may be totally repudiated a decade or two later. Vaccinations are powerful medical tools which impact human immune systems to achieve the desired effect of preventing certain infectious disease manifestations. In the early 1900's when diphtheria and whooping cough were life-threatening, the uncritical acceptance and implementation of vaccination was understandable and perhaps unavoidable. Today, when far more children suffer from allergies and other chronic immune system disorders than from life-threatening infectious diseases, it is neither reasonable nor prudent to persist in presuming that the benefit of any vaccination outweighs its risk.

When the medical scientific community makes a total and one-sided commitment to any public policy, no matter how noble its intentions, then vigorous debate and fact-finding tend to be neglected. The facts on hepatitis B brought out by Dr. Severyn and by the special 16-page report of the National Vaccine Information Center deserve our very careful consideration. They indicate that the risk of hepatitis B vaccination outweighs its benefit for the vast majority of American children today.

When these facts are ignored, and when vital medical research on the safety and adverse effects of hepatitis B vaccine is left undone, then the truth suffers, our children suffer and we all suffer.

Yours Truly,
Philip Incao, MD.

BUTEYKO: A BETTER WAY TO BREATHE

Professor Konstantin Buteyko's discovery is to say that most of our ideas about breathing - the most fundamental function and life-giving reflex we have - are wrong. Most of us do not breathe correctly; if we did, many of the ailments that plague us, such as diseases of the heart, lung and immune system, would clear up within weeks. For the past ten years, Buteyko's disciples have been using his techniques in the UK to treat a few thousand of the 5m asthmatics, with remarkable results.

Buteyko Practitioner Alexander Stalmatski proposed to a top asthma consultant on the TV programme QED that he could dramatically improve the condition of any three of his worst patients within a week. After five days one patient had stopped taking drugs altogether, another described his improvement as "phenomenal" and the third exalted: "I can get up in the morning able to breathe." They joined thousands of asthmatics in the UK and Australia who say that by learning to breathe less, their lives have been transformed.

Despite such convincing evidence, the results have failed to sway the medical establishment and are dismissed as "anecdotal". So are there any plans to conduct funded clinical trials? Not at the moment. Even the consultant involved in QED, who had seen his patients transformed, said it wasn't worth it.

Such indifference does not surprise Buteyko. "I was taken secretly to treat top KGB and military officers when my method was officially banned. Academics of the chest are jealous and hopeless."

So why should breathing less, as Buteyko advocates, be of such benefit for our health? There's nothing magical about it. The mechanism involved is textbook physiology. We all know that you breathe in oxygen (O) and breathe out the so called (waste gas), carbon dioxide (CO2). It is not so well known that we need CO2 in the lungs and blood for oxygen to pass efficiently from the blood to oxygenate the cells. In fact, the lungs need a concentration of about 6% CO2; *(contd on back page)*

ESSAY ON VACCINATION

Here follows the Preface from a 120-page essay by Dr Charles T Pearce, Member of the Royal College of Surgeons of England, Fellow of the Anthropological Society of London. 1868

PREFACE

The author of the following essay became deeply impressed with the importance of the subject fourteen years ago, by an accident alluded to in the essay, which accident made him sceptical of the value of vaccination. As medical referee to one of the largest and most prosperous life assurance corporations, he was led to observe the apparent large mortality in vaccinated persons from what is commonly called "consumption," a great number being cut off in the flower of their age, while those, belonging to the same families, having had smallpox arrived at maturity. The very rare occurrence of phthisis in those who had had small-pox strengthened the idea which the author had conceived, that vaccination, while it prevented smallpox, increased the danger to life when the subject was overtaken by other diseases. The conclusions to which he came, from the data he collected, was, that vaccination generally was inefficiently performed; further inquiry, however, convinced him that vaccination is a crime against nature, and ought not to be enforced.

The Lancet, when the first Compulsory Vaccination Bill was before Parliament, on the 21st May, 1853, thus expressed itself on vaccination: "In the public mind, extensively, and in the profession itself, doubts are known to exist as to the efficacy and eligibility of vaccination - the failures of the operation have been numerous and discouraging."

In the London Medico-Chirurgical Review for 1825, vol. ii., page 554, Dr. Gregory, then physician to the small-pox and vaccination hospital (no mean authority), thus wrote on vaccination: "The hope entertained by its illustrious and amiable discoverer that it might ultimately exterminate smallpox from off the face of the earth, appears vain and unfounded. The decree of Providence seems to be that smallpox shall never cease out of the land. In His mercy He has keen pleased greatly to lessen the sphere of its virulence, and to mitigate the intensity of its horrors, but it still exists, and, as far as the human eye can penetrate, will for ever continue to exist - one of the many diseases by which man is chastised."

So far from viewing small-pox as a Divine chastisement, Dr. Bateman, in his work on fever, says, "The propagation as well as the character of those diseases is chiefly influenced by causes of a moral nature, or at least by such circumstances as the habits and institutions of man create, and which are, therefore, much within his own control; the character of an epidemic is in some measure a test or index of the situation and circumstances of the population among which it occurs."

In 1856, the author petitioned Parliament against compulsory vaccination. Still further research into the origin, extent, condition, and effects of vaccination, led him to abandon the advocacy of vaccination in his medical practice, and in the year 1860 he publicly discussed the question, and lectured against the practice, which public lecture had an extensive circulation. The author does not stand alone in his opposition to compulsory vaccination. Many of his professional brethren have expressed their misgivings on the utility of vaccination.

To Mr. John Gibbs, England is especially indebted for his little book on the evils of Vaccination; ("Compulsory Vaccination briefly examined: being a letter to Sir Benjamin Hall, President of the Board of Health. 1856.") that gentleman has devoted much attention to the subject, and has brought together much valuable information from all quarters of Europe and America.

Dr. Nittinger of Stuttgard, and Dr. Bayard, of France, have also diligently laboured in the same good cause of opposing and exposing the practice of vaccination.

No subject in social science can be of deeper importance, or wider interest, than that to which the study of vaccination necessarily leads, viz., the mortality of the United Kingdom. Notwithstanding the attention which has been given in the last ten years to sanitary questions, it is discouraging to find that the annual rate of mortality in England is increasing - the boasted saving of life claimed for vaccination is not apparent, though Dr. Simpson, of Edinburgh, recently stated that "Jenner's discovery had been the means of saving a number of lives, equal to the whole population of the United Kingdom, every twenty-five years." In page ii. of the last report, issued by the Registrar-General, a table is given of the annual rate of mortality in England from 1838 to 1865 (See Appendix to the following Essay). The mean death average in those twenty-eight years was 2.238 for every 100 living. If we take the first eight years in the table, viz., from 1838 to 1845, inclusive, the average will be found to be 2.176, and in the last eight years, viz., from 1858 to 1865, the average had increased to 2.251, a heavier death rate than the mean of the whole twenty-eight years, although in 1849 (the cholera year) the death-rate reached 2.512.

This increase in the death rate is coeval with the extension of vaccination under compulsory laws, whether to be viewed in the relation of cause and effect, may be determined by a perusal of the following essay. There is no evidence that "Eighty thousand lives are annually saved by vaccination," as stated by Dr Simpson (See further observations in Appendix).

The most serious aspect of this great question, however, is presented in the following extract from the last Report of the Registrar General, lately issued, page 178.

" The 53,734 deaths by Phthisis of persons, the greater part of them adults, prove the great importance of a careful study of the causes of this disease. At the age of 20 and under 25, the deaths of young women, from all specified causes, were 8,477; and of these 4,290 (being more than one-half) died of Phthisis."

Appalling, indeed, is this fact, that half the young women of England who die are cut off by consumption. That there must be some cause for this state of things, everyone will admit - the climate of England is not so materially changed, nor the habits of the people, as to account for this state of things. Food and creature comforts are less costly to the masses than in the earlier years of smaller mortality. Notwithstanding that drainage of certain districts has materially diminished the local mortality, yet the death rate of England advances in a greater ratio than the increase of

population. [The fifteen principal towns in which the death rate has been been materially lessened by draining, and thus drying the soil, are - Salisbury, Worthing, Ely, Rugby, Banbury, Macclesfield, Leicester, Newport, Cheltenham, Bristol, Dover, Warwick, Croydon, Cardiff, Merthyr]

How comes it that half the present inmates of our orphan asylums have been made orphans by the death of one or both parents from consumption? There is too much reason to fear that the cause is to be found in vaccination; if such be the results of having vaccinated one-half of the people of England, what may we expect if the bill passed in the last Session of Parliament, to enforce vaccination under penalties, be carried out?

Full and impartial investigation of the subject in all its bearings and relations, not only in the United Kingdom, but in the principal Continental States, has fully confirmed the Author in his view, that Vaccination is a mistake - that it is one of the numerous theories which will be tenaciously held by the Profession for a time, until it ultimately gives way and falls before the inexorable teachings of experience.

The Author is in the possession of data which would enable him to extend the following Essay into a complete treatise, and it would be interesting to do so, though tedious to the general reader; but he prefers presenting the subject in a comparatively brief essay, in the hope that his professional brethren, now wedded to the Jennerian theory, will, fairly and without prejudice, examine the question. Should his humble efforts excite the attention of the Philanthropist, the Statistician, and the Medical Philosopher, above all, should the Author's efforts to elucidate the subject, lead to the suspension or repeal of all Acts of Parliament on Vaccination, that the people may exercise their inherent right of choice in medical matters, and no longer be submitted to the indignity of being fined in a Magisterial Court for refusing, at the bidding of the State, to contaminate their offspring, he will have the satisfaction and happiness of knowing that his labour has not been in vain.

28 Maddox St, London, W. Feb 1868.

BACTERIA SNIFF OUT HOST'S HELP

Published online: news@nature.com - 22 July 2005. *By Tom Simonite*

Nosy neighbours call on the immune system to wipe up competitors. Bugs battle it out for supremacy inside your nose.

Many different species of bacteria live in our noses and throats. These 'opportunistic pathogens' are usually no trouble, but can cause infection if a person's immune system is weakened owing to stress or poor health. Still, they need to fight for space and resources with other bacteria living in the same place.

To work out the strategies that common bacteria use in this competition, scientists from the University of Pennsylvania School of Medicine, Philadelphia, pitted Haemophilus influenzae against Streptococcus pneumoniae. Both are leading causes of ear, nose and throat infections, and the latter is a common cause of pneumonia.

They found that S. pneumoniae always came out on top when the two fought it out in a lab dish. But, surprisingly, the results were reversed when the competition took place in mice. They report their results in the journal PLoS Pathology1.

NOSE JOB

The outcome implied that living in the host gave H. influenzae an advantage. "People tend to study their bacteria as if they exist naturally alone in pure culture," says team member Jeff Weiser. "But they don't, and when you put them together there are often complex interactions."

When they looked closer, the researchers found that the presence of H. influenzae prompts white blood cells called neutrophils to mobilize and move to the area where the bacteria are. The colonizer is resistant to the immune response it stimulates, so can take over more space when its rival is killed off.

This work could have consequences for the way that doctors use antibiotics, the team says. If a treatment removes bacteria that were serving to keep others in check, it could have effects beyond those intended.

BIG SHOTS

Weiser suggests their results may explain some side-effects of a pneumonia vaccine given to US children and at-risk patients in Britain.

"The pneumococcal conjugate vaccine has been given to children and has reduced infection, but there has been an increase in ear infections caused by another bacterium," he explains. "There may be secondary effects to be understood."

The overall message that vaccines and antibiotics can interfere with complex interactions between organisms that live in our bodies isn't in itself a surprise.

"People involved in vaccination programmes fully appreciate they are grossly disturbing the balance of organisms resident in the body," notes Mike Barer, a microbiologist at the University of Leicester, UK.

But the interaction of bacteria with the host's immune system is a new twist on this story. Weiser says that more work into the interactions between us and our bacterial flora could lead to greater understanding and perhaps a better way of designing treatments. "Maybe we'll get smarter about using these things in the future."

1. Lysenko E. S., et al. PLoS Pathogens, http://www.plospathogens.org/10.1371_journal.ppat.0010001.pdf (2005).

LETTER FROM THE EDITOR

I would like to thank you, the subscribers, for helping The Informed Parent continue to exist. Many of you have been long-term subscribers and that has been an enormous benefit, so I do hope you will continue with your support!

Although I continue to receive letters of support and encouragement there has been a slight fall in the number of subscribers - which I believe is mostly to do with the amount of information that is now available on the internet. Whilst this increase of information is certainly a good thing -- for the continued existence of The Informed Parent there must be an increase in subscribers to keep the organisation afloat. So if you can help promote the newsletter in anyway I would be most grateful. If you need a stock of leaflets to pass on to friends, relatives, or patients, then just send a SAE, stating the quantity required, to The Informed Parent. Thanking you in advance. Best wishes and good health!

Magda Taylor

COURT TO REVIEW "SHAKEN BABY" CASES

Court to review Judges are to consider a joint appeal by four defendants convicted of shaking their babies to death, known as shaken baby syndrome. If the convictions are overturned, more than 90 other convictions could be challenged if the judges doubt the medical evidence used to establish guilt in the four test cases.

The appeal come from a review ordered by Attorney General Lord Goldsmith following the overturned conviction of Angela Cannings who was accused of murdering her two baby sons. Mrs Cannings was cleared after judges ruled that no one should be prosecuted solely on the basis of medical opinion. The review involved 300 infant death convictions, including more than 90 which raised the issue of shaken baby syndrome.

Over the past 15 years courts have accepted evidence from pediatricians that shaken baby cases involve three classic signs: swelling of the brain; bleeding between the brain and the skull, and bleeding behind the eyes. But recent research suggests that such injuries can be caused by falls from a low height or vaccinations and medication causing lack of oxygen to the brain.

Defence lawyers will argue that it is wrong to accept the shaken baby theory when there is no evidence of previous injury or abuse.

Story filed: 09:39:38 16/06/05
http://www.tesco.net/news/

GPs SHUN UNLICENSED MMR VACCINE

Extracts from Pulse, 13/08/05

GPs are boycotting use of unlicensed German and US MMR vaccines in protest at the failure of the Department of Health or PCTs to provide indemnity.

One LMC reported that GPs in the area had dumped unlicensed vaccines back at their PCT and demanded licensed vaccines in return. The chaos came as an estimated 120,000 new students were expected to come forward for vaccination before the start of the university year.

The department insisted new stocks of licensed vaccine were now available and that there should be no need to give the unlicensed supplies. But it reiterated that any GPs who gave the unlicensed vaccines would do so at their own risk. LMCs contacted by Pulse were unaware of the new supplies with some reporting that supplies of licensed vaccines had run out.

'Some GPs have been stuck with no other supplies at all because they have completely run out of the UK version,' said Kent LMC clerk David Barr. He said some GPs faced losing income *(our emphasis)* because they were unable to hit vaccination targets.

Dr Ryan, a GP in Loughborough, Leicestershire, said the continued inaction by the Government had left GPs feeling bullied into taking a risk the Government itself refused to take. 'The vast majority of practices in our PCT are unwilling to administer the unlicensed vaccine,' Dr Ryan said.... .....But GPs said some practices had decided the public health implications of not giving MMR were sufficiently severe to outweigh the legal problems.

They strongly criticised the Government for endangering public health and said the vaccine supply system in general was in chaos.

MINISTER MISLEADS KIM HILL AND PUBLIC

New Zealand-MeNZB: Minister Annette King Misleads Kim Hill and Public. *Extracts from a Press Release by Barbara Sumner Burstyn and Ron Law.* 16/06/05

"The Minister of Health has mislead the public by claiming on Kim Hill's TV programme last night that making the MeNZB(tm) vaccine was akin to making the flu vaccine; the claim is another example of junk science used toundergird a mass medical experiment," say risk & policy analyst Ron Law and researcher/writer Barbara Sumner Burstyn.

If vaccines were as simple to make as that then we would simply substitute the bird flu virus, or the common cold virus, and we have new and effective vaccines. Science does not work like that; junk science does.

The Minister said that other countries such as Australia had done the same thing and introduced similar meningococcal vaccines there.....

Ministry of Health officials and advisors know that vaccines against the meningococcal B strain can not be made the same way as vaccines against other meningococcal strains such as A, C, W, Y and so a new type of vaccine has been attempted.

The Minister has mislead the public into believing that many other similar countries are using similar vaccines to the MeNZB(tm) vaccine. Not a single country outside of Cuba and a couple of Latin American countries have used meningococcal B vaccines in mass vaccination programmes, and not a single one has licensed such vaccines... not even Norway where the MeNZB(tm) originated and where they rejected their own vaccine for mass public health use after thoroughly testing it.

"Something is terribly wrong with the Ministry of Health's case supporting the experimental MeNZB(tm) vaccine when they knowingly resort to feeding the Minister of Health false information who in turn feeds it to the public in the name of science;" says Ron Law, "terribly wrong!"

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In July 2005 Maureen Hickman (author of Vaccination-The Right Choice?) received the following letter from New Zealand-based chiropractor Dr Kelly.

Hi Maureen,

There has been a huge flu here. Many high schools have had 20 - 25 percent absences. E.g 500 students absent in schools of 2,400 students (Auckland Grammar).

This is unprecedented numbers.

The Health Department has come under fire for the timing of the Meningococcal vaccine as having a potential negative immune response and then kids being more susceptible to the flu'.

It has been quite a disaster, but parents are getting a feel as their kids have been VERY sick, and then deciding not to have the third menb shot.

Dr Brian Kelly,
President of the New Zealand Chiropractic College

AVOID LOSING INCOME IN VACCINE RULES CHANGE

Pulse, Issue: 4 June 2005

A recent rule change in immunisation payments has threatened GPs' earnings – Dr Stephen Gardiner and Rachel Stark explain what has changed, who will be affected and what GPs should do about the situation

Income for childhood immunisations is at risk this year as the formula for the uptake targets has altered to reflect the impact of the new five-in-one vaccine. This change has been included in the new statement of fees and allowances that came into effect in April 2005. Although the targets themselves haven't changed, the new formula makes achievement more difficult.

The targets for children having had their full course of immunisation following their second birthday remain at 90% for the higher level and 70% coverage for the lower level of payments. But instead of being calculated on previously administered four vaccinations (DT and polio, pertussis, Hib and MMR) the target will be based on just two vaccinations (MMR and the new five-in-one vaccination). The Dept of Health argues that this reflects the lower workload generated from the 5-in-one vaccination. Before this year, as the target for childhood immunisations at two years was based on all four vaccinations, each vaccination contributed 25% of full coverage.

If a child did not have one vaccination – eg MMR – the practice would only achieve 75 per cent of the target for coverage for that child. From April, however, the target for childhood immunisations at two years is based on just two vaccinations, each counting as 50 % of the target. Therefore if a child does not have one of the vaccinations the practice only achieves 50% of the target for that child.

The impact of this change is highlighted when you look at vaccination trends. Following the MMR debacle, uptake has not yet recovered and as it now contributes to 50% of the target many practices may struggle to achieve income at the higher level.

For an average practice of 5,000 patients it will only take 12 parents to decide their child does not have MMR to knock out the 90% target. This will mean a drop in income this year of £5,657 (from £8,486 to £2,829). If the practice has 36 children (of their 59.25 children) who don't receive MMR, the practice will fall below the 70% achievement level for the year and will not receive any income.

WHAT CAN PRACTICES DO?

Ensure your immunisation data is accurate and complete. Patients who have just joined may have had their immunisations elsewhere, so notes should be reviewed and all information coded to ensure income is received.

Where it seems vaccinations have not been given, it may be useful to ask the parents whether they have. Omissions can be added to the child's record.

Also do not forget that a significant number of parents arranged for their children to be immunised privately with the single vaccinations for measles, mumps and rubella and these are eligible to be included in your target data.

Practices should proactively educate and encourage parents to ensure their children receive appropriate immunisations.

A system to do this can be easily set up to identify children who are eligible for the target in each quarter. You should identify children approaching their second birthday every month and you should send out leaflets about the immunisations with a letter from the child's GP encouraging the parent to ensure the child has their injections.

This could also include a questionnaire for the parent to confirm whether they plan to have their child immunised or whether they actively object. Many parents have become confused about the benefits and risks and often just need the opportunity to discuss this with their doctor or health visitor. Those who actively object should be recorded for practice information and in the hope that informed dissent may be applied to the targets in the future.

For the cohort of children who should have had their immunisations but haven't, the practice should assess why the child hasn't been vaccinated. Some parents intend to have their child vaccinated but simply forget or are unable to make clinics. Flexibility can often result in vaccinating this group of children.

For children of parents who actively object to the vaccination, the patient's GP is probably best placed to judge how to proceed – perhaps with further information and support in decision-making. Such a campaign should not wait until the child is approaching the time in which they are eligible for the target. The whole practice team should be involved in educating parents – even prior to the child's birth – about the importance of immunisaton. This may include:

- information promoting the immunisation programme in all maternity packs and postnatal packs
- ensuring all health professionals promote the importance of immunisation at all appropriate times
- promotional material in the waiting room and in the practice newsletter and leaflets
- promotional press coverage – for example a discussion on the local radio promoting the vaccination programme or press releases to the local papers.

The GPC is also said to be pressing the Dept of Health to allow informed dissent to apply to immunisation targets. It is an unacceptable anomaly that informed dissent is not allowed for immunisation income whereas it is allowed for QOF and smears. If it was, it would prevent practices from being unfairly penalised if parents assert their right to refuse vaccination of their children.

In some countries I understand that governments take the prevention of these important diseases so seriously that, for example, they refuse to pay child benefit unless a child is fully immunised or even refuse to allow unimmunised children to attend school (with appropriate penalties).

Here, however, the responsibility is left to us. Let us hope for change, therefore, but in the meantime practices must maximise their achievement by a combination of good data capture, provision of information and flexibility. Although this may generate some extra work for practices, it should guard against a potential loss of income of up to £8,486 for an average practice.

Stephen Gardiner is a GP in Bridgwater, Somerset, Rachel Stark the practice manager.

(Contd from page 11) the amount present in the air is only about 0.03 per cent. So our body's solution has been for the alveoli - the tiny air sacs in the lungs - to act as CO2 accumulators. But because CO2 is a light gas, heavy breathing has the effect of diluting the portion stored in the air sacs. Less CO2, paradoxically, means less oxygen being released from the blood to cells meaning that the more you breathe the less oxygen your cells receive. This phenomena has been known for over a hundred years as the Bohr Effect.

"In 1960, I had an expensive lab in Siberia," said Buteyko. "A party boss was my supporter. There we ran all sorts of tests to prove my theories. It is all written up in the literature. We measured the breathing of thousands of asthmatics and other sick people and found that all of them were over-breathing." But the government suddenly closed the lab and, said Buteyko, falsified the results. Since then he has been unemployed, teaching his technique, which involves learning how to breathe less and is supported by an army of admirers who say they owe him their lives.

Textbook teaching is that we should all breathe about 5 litres a minute, but Buteyko finds that asthmatics are breathing two, three or even four times that amount. The consequence, he explains, is that the CO2 levels go down and the body responds by constricting the airways, increasing inflammation and mucus production. The Buteyko method treats asthma by reducing the amount of air breathed in, which raises the CO2 levels and results in the airways opening.

Although it is counter-intuitive, at least treating asthma by changing breathing has a certain logic. But the Buteyko method also has an effect on other diseases. Over-breathing causes a loss of CO2 in the body which creates a condition called respiratory alkalosis i.e your blood becomes more alkaline, of which the early signs are dizziness, breathlessness and pins and needles. Later, as the body tries to reduce the alkalinity, it starts producing more lactic acid, which in turn leads to feelings of tiredness and depression. It is even more dramatic when the low CO2 levels start making smooth muscles such as the heart and arteries constrict.

The medical profession recognises the danger of short-term over-breathing or hyperventilation. "You hyperventilate when you have a panic attack," said Anne Pitman, chartered physiotherapist at the London Clinic. "You breathe faster and faster and you feel like you are suffocating. The standard cure is to breathe into a paper bag to raise your CO2 levels."

Where Buteyko and the medical establishment differ is whether there is such a thing as chronic hyperventilation and if it is responsible for a range of apparently unconnected diseases, from ME and asthma to irritable bowel syndrome.

Pitman, independently of Buteyko, is one practitioner who estimates that 25 per cent of us don't breathe properly. "Because doctors don't recognise it," she said, "people who hyperventilate often get written off as hypochondriacs or neurotic. But when I teach them to breathe properly their symptoms frequently disappear."

Claude Lum has been studying hyperventilation for 30 years. "When I was in charge of the respiratory department at Papworth (Hospital, Cambridge), I routinely measured carbon dioxide in the blood of asthmatics and found it 10 to 15 per cent lower than normal. In other words, evidence of hyperventilation."

But such a sympathetic hearing is rare. Much more common is the response of the consultant in the QED documentary. At the beginning he declares there is no known method by which the Buteyko technique can work - that hyperventilation is not a cause.

At the end, when he is trying to brazen it out, he concedes that "perhaps we are underestimating the number of asthmatics who are over-breathing". He then adds: "I'm still sceptical that it adds anything to the techniques we have for handling over-breathing." Most asthmatics would be amazed to learn there were any.

If you are interested in organising an Introductory Buteyko talk in your area or would like more information about Buteyko events (including a dedicated children's program) in Brighton please contact Buteyko Practitioner, Kim Upton on 0845 2268073
email: kim@buteykohealth.com,
www.buteykohealth.com
www.buteykohealth.com/
Kim Upton is a member of the Buteyko Institute of Breathing and Health (BIBH) www.buteyko.info

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.

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