CLERK OF THE BOARD OF SUPERVISORS

EXHIBIT/DOCUMENT LOG

MEETING DATE & AGENDA NO. 11/15/2022 #29

STAFF DOCUMENTS (Numerical)

No.	Presented by:	Description:
1	Staff	18 Page Powerpoint
2		
3		
4		

PUBLIC DOCUMENTS (Alphabetical)

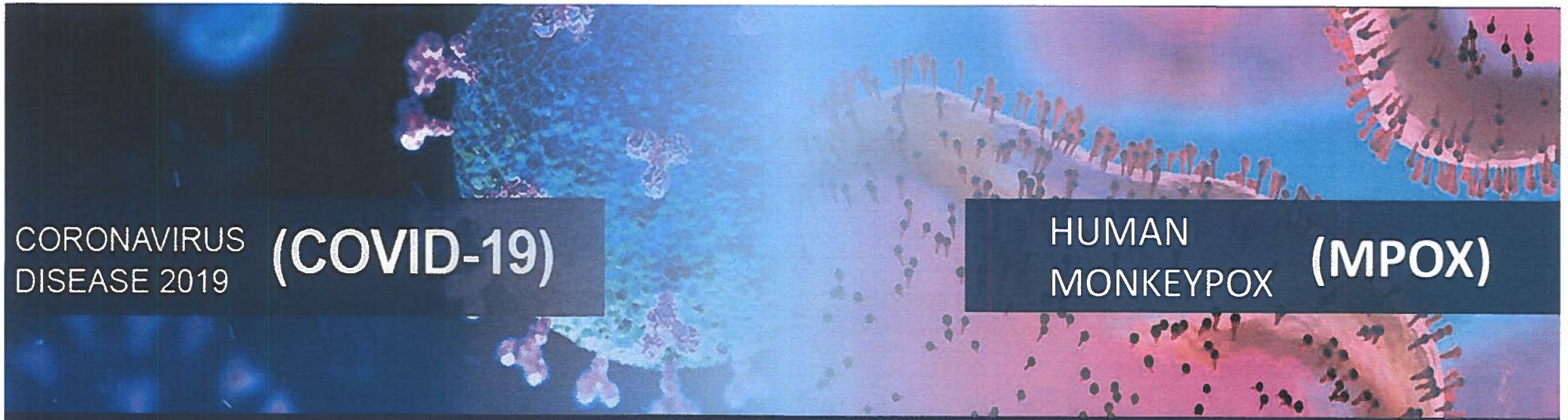
No.	Presented by:	Description:
A	Vira Brooks	1 page of pictures
B	Mike Borello	318 page document
C		
D		
E		
F		
G		

OFFICIAL RECORD
Clerk of the Board of Supervisors
County of San Diego

Exhibit No. 1

Meeting Date: 11/15/2022 **Agenda No.** 29

Presented by: Staff

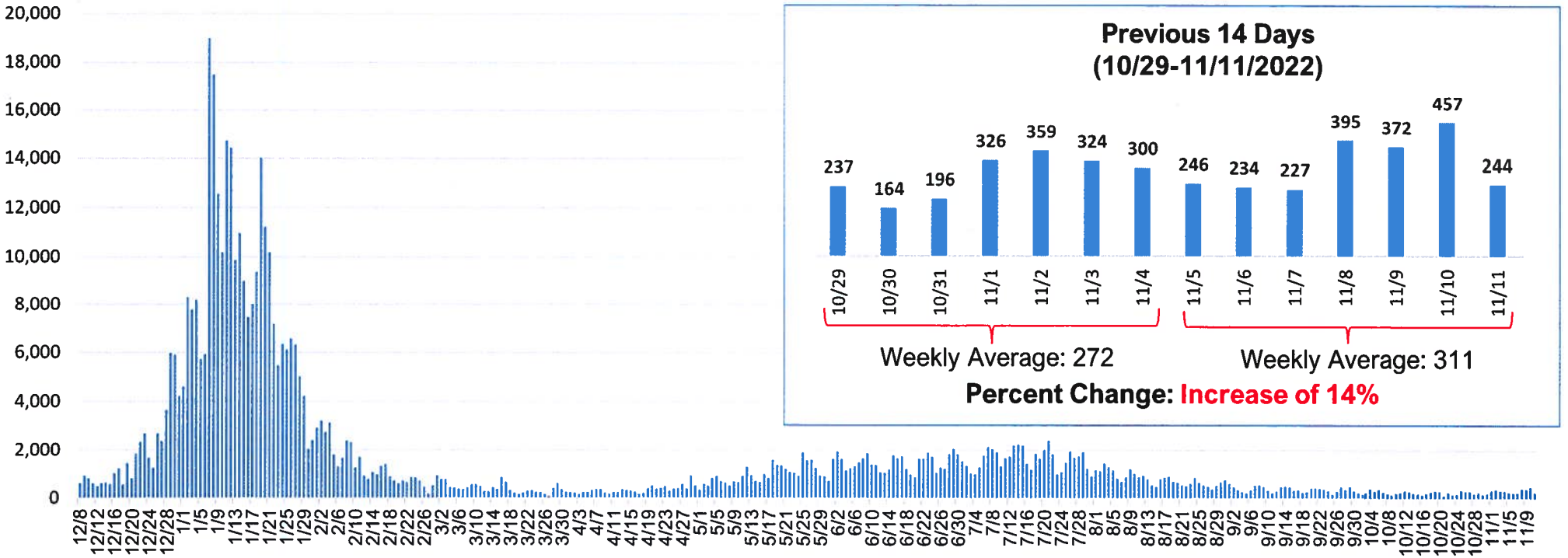


Item #29:
County of San Diego COVID-19 and MPOX Update

November 15, 2022

COVID-19 Cases

COVID-19 Confirmed Cases Among San Diego County Residents
New Cases by Date Reported Since December 15, 2021



Previous 14 Days
(10/29-11/11/2022)

Percent Change: Increase of 14%

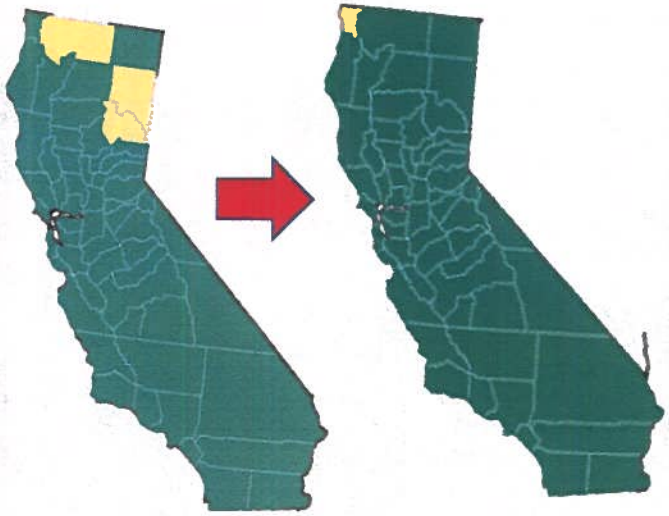
Data through 11/11/2022
Updated 11/14/2022

CDC COVID-19 Community Levels

As of November 14, San Diego County = LOW

October 11, 2022
Last BOS Meeting

November 14, 2022
Updated



COVID-19 Community Levels

Assignment Based on Highest Metric Among: 1) Case Rate, 2) New COVID-19 Hospital Admissions, and 3) Percent of Staffed Inpatient Beds Occupied by COVID-19 Patients

Community-level prevention strategies
(as recommended by state or local authorities)

Low	Medium	High
Limited impact on healthcare system, low levels of severe disease	Some impact on healthcare system, more people with severe disease	High potential for healthcare system strain; high level of severe disease
• Administer vaccines with equity • Ensure access to testing • Community outreach and education	• Enhanced prevention measures in high-risk congregate settings • Protect people at high risk for severe illness or death by ensuring equitable access to vaccination, testing, treatment	• Consider setting-specific recommendations for prevention strategies based on local factors (indoor masking)

Data as of 11/14/2022. Data are preliminary and subject to change.
Source: CDC COVID-19 by County, https://www.cdc.gov/coronavirus/2019-ncov/your-health/covid-by-county.html, accessed 11/1/2022.

Vaccinations in San Diego County

Vaccination Status of San Diego County Residents

Doses Received	Doses Administered†
9,909,780	8,197,504

Primary Vaccine Series* (Previously known as Fully Vaccinated)	Primary Vaccine Series and All Boosters^	Bivalent Booster Only‡
Eligible Population (6 months of age or older): 3,343,827 San Diegans	Booster Eligible Population^^: 2,490,511 San Diegans	Booster Eligible Population‡: 2,487,623 San Diegans
2,684,917	1,490,046	343,812
80.3%	59.8%	13.8%

†May not include all administered doses and individuals vaccinated due to reporting delays. Total doses administered includes extra doses (booster doses and additional doses). Data sources include vaccines that have been recorded in California Immunization Registry (CAIR2), and data provided by Veterans Affairs and Department of Defense. This includes doses from Federal Pharmacy Program and Federally Qualified Health Centers. Doses administered by some tribal providers, some prisons and federal detention facilities do not report to CAIR2. Includes all doses administered in San Diego County, as well as, doses administered to San Diego County residents vaccinated outside of San Diego County.

*Primary vaccine series completion is defined as receipt of 2 vaccine doses for persons over the age of 5 who received Pfizer-BioNTech, Moderna, NovaVax, Astrazeneca, or recipient of 2 doses for persons who received unspecified U.S.-authorized or approved COVID-19 vaccine, or receipt of 1 dose for persons who received Janssen. For those 6 months to 4 years of age, primary vaccine series completion is defined a receipt of 3 vaccine doses for persons who received Pfizer-BioNTech, or receipt of 2 doses for persons who received Moderna. Immunocompromised status cannot be determined, therefore, the recommended primary vaccine series schedule is not listed for immunocompromised individuals ages 6 months to 4 years.

^Booster doses include only doses recorded in CAIR2 (excludes Veterans Affairs and Department of Defense).

^^Booster eligibility is updated each week as the number of San Diego County residents who have completed their primary vaccine series are eligible to receive a booster dose. Individuals are eligible for a monovalent booster dose if 1) they are 5 years of age and older AND 2) the appropriate time period has passed since completing their primary vaccine series. Additionally, residents may receive a bivalent booster dose if 1) they are 5 years of age and older AND 2) at least 2 months have passed after completing their primary vaccine series.

‡Bivalent booster eligibility is updated each week as the number of San Diego County residents are eligible to receive a bivalent booster dose. Individuals are eligible for a bivalent booster dose if 1) they are 5 years of age and older (for a Pfizer bivalent booster) or 6 years of age and older (for a Moderna bivalent booster) AND 2) at least 2 months have passed after completing their primary vaccine series or at least 2 months have passed after their most recent monovalent booster dose.

The Estimated eligible Population in San Diego County is 3,343,827 individuals, which is the total estimated San Diego County population as estimates are calculated by years.

Data source: California Immunization Registry (CAIR2), California Department of Finance 2021 Population Estimates, July 2021 release.

Updated 11/14/2022, data through 11/9/2022

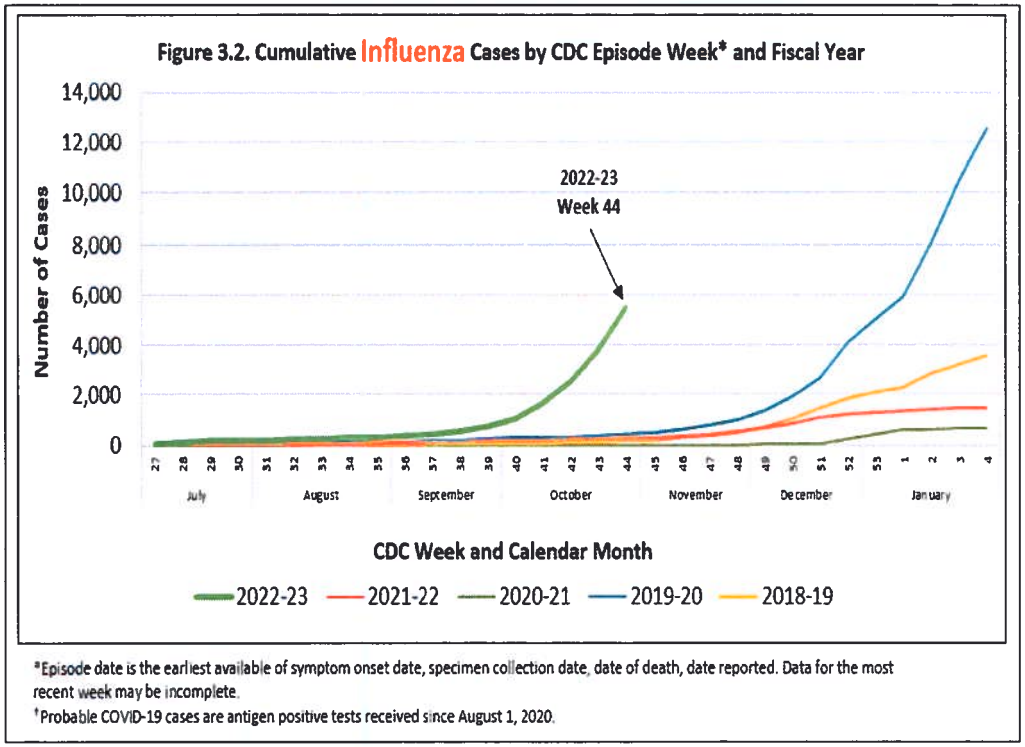
Monoclonal Antibody (mAb) Treatment Updates

- **As of 10/31/2022, available Monoclonal Antibody Regional Centers (MARC) sites:**
  - MARC at Vista Community Clinic and Family Health Centers of San Diego (FHCSD) at Hillcrest
- **MARC model was developed due to no oral medications to treat COVID-19.**
  - Options for persons at high-risk:
    - Antiviral pills
    - Test to treat and telehealth clinics
    - Oral medications
    - IV Monoclonal Antibody treatment

- **Service Outcome**
  - 15,066 mAb infusions performed across 10 sites since 2/9/2021

Respiratory Syncytial Virus (RSV) and Influenza Trends

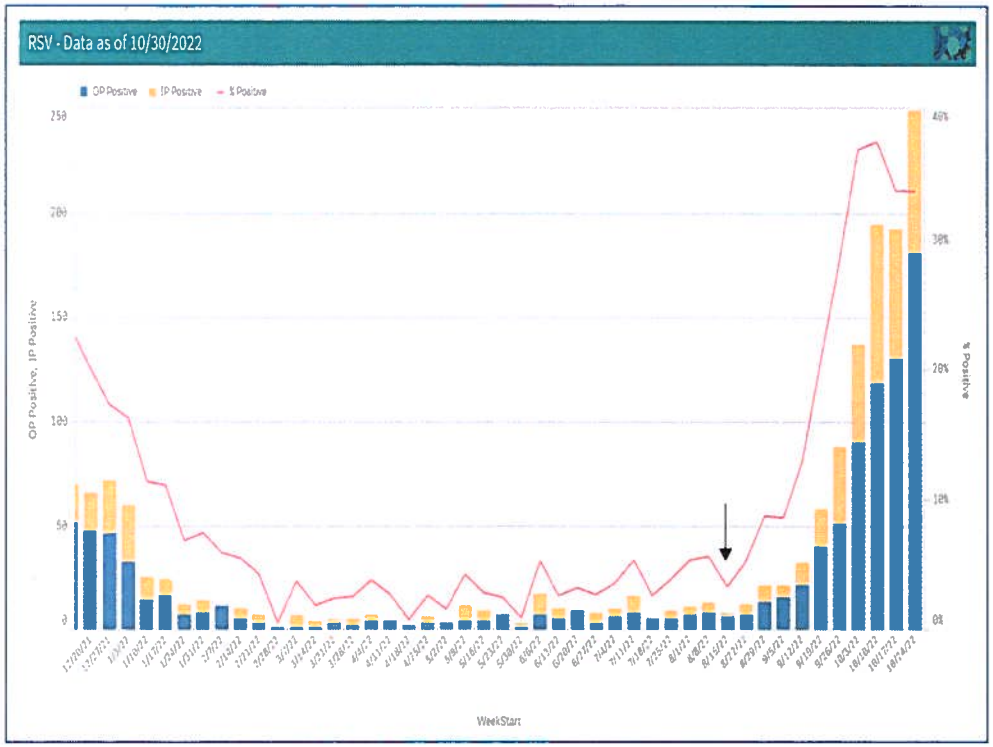
County Influenza Trends (2018-2022)



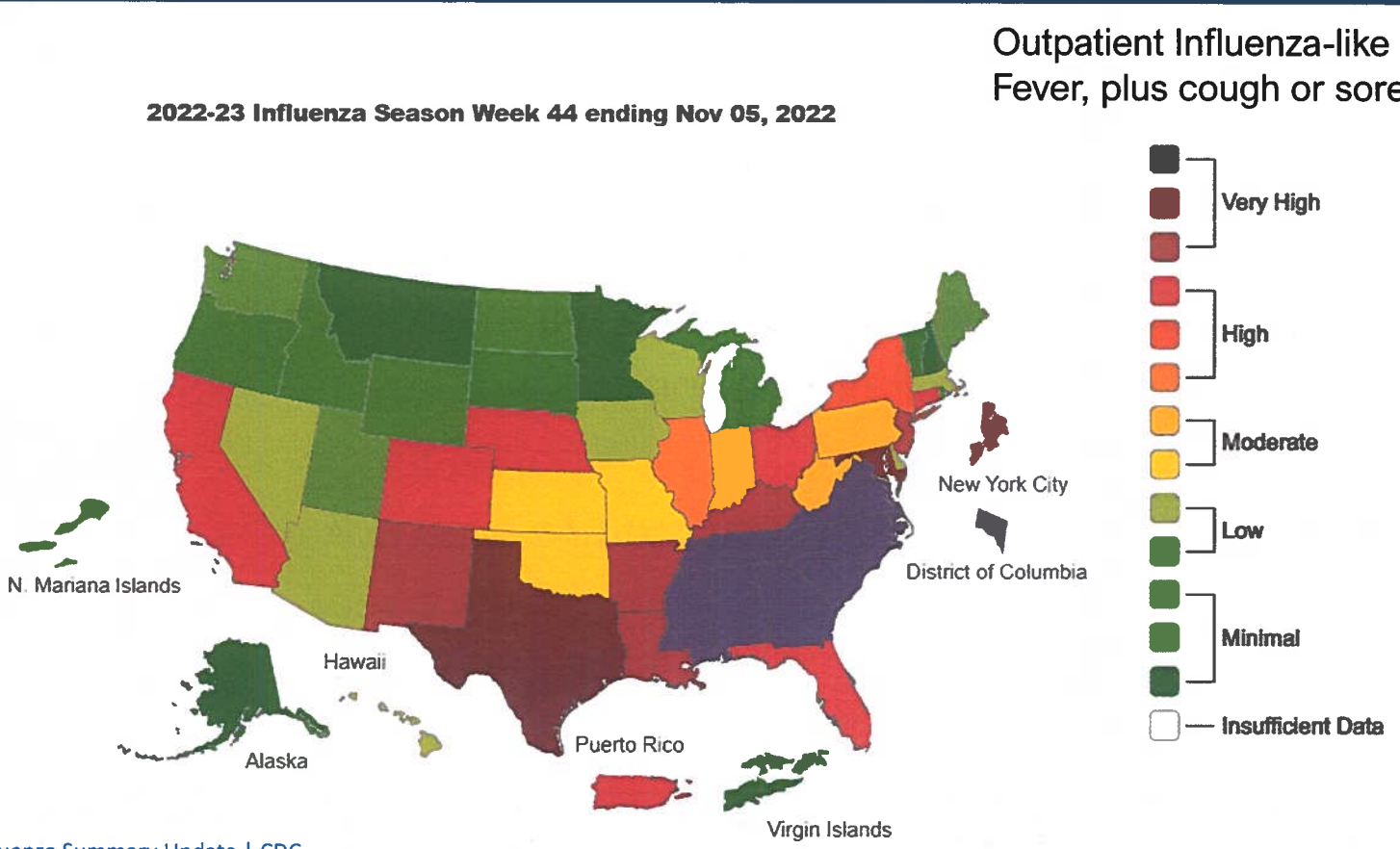
*Episode date is the earliest available of symptom onset date, specimen collection date, date of death, date reported. Data for the most recent week may be incomplete.

†Probable COVID-19 cases are antigen positive tests received since August 1, 2020.

Rady Children's Hospital RSV Trends (2021-2022)



CDC Outpatient Influenza-like Illness Activity Map



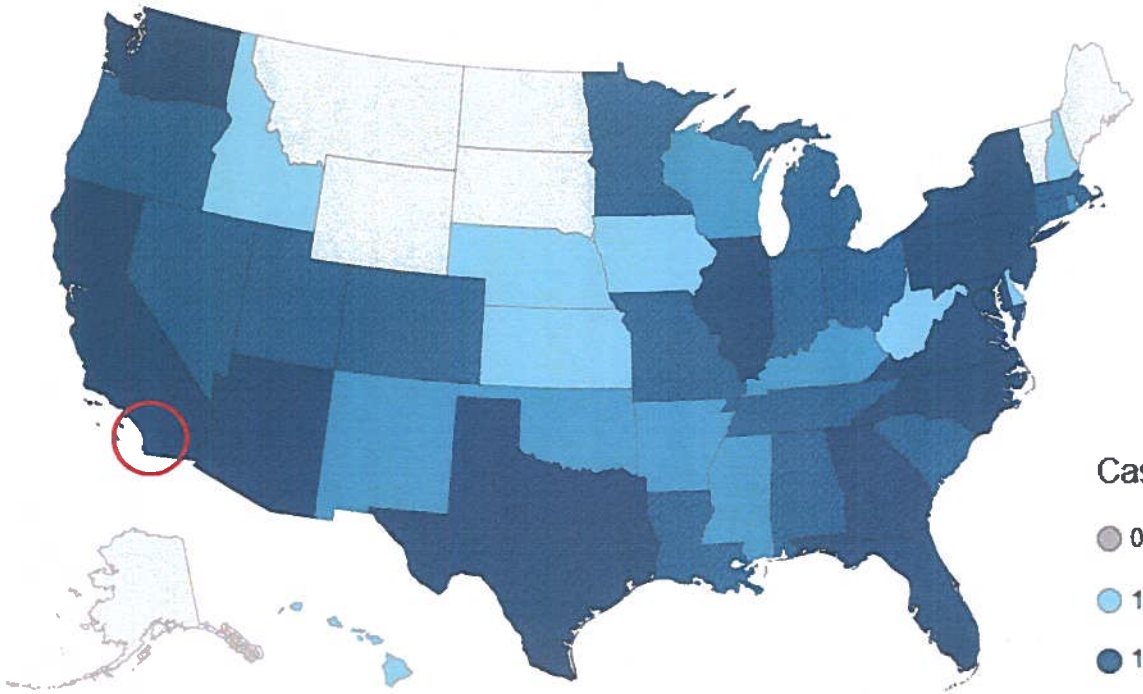
Source: Weekly US Map: Influenza Summary Update | CDC
Data through: 11/5/2022
Data Accessed: 11/14/2022

BE SAFE

- Wash your hands
- Wear a mask
- If you have symptoms:
  - Get tested
  - Ask your provider if you are a candidate for treatment
- Don't go to the emergency department for COVID-19 testing
- Get all recommended doses of the COVID-19 vaccine
- Get the influenza vaccine

www.coronavirus-sd.com

MPOX - 2022 U.S. & California Cases



Territories PR

U.S. Cases
28,881
California Cases
5,547
San Diego County Cases
448

Case Range

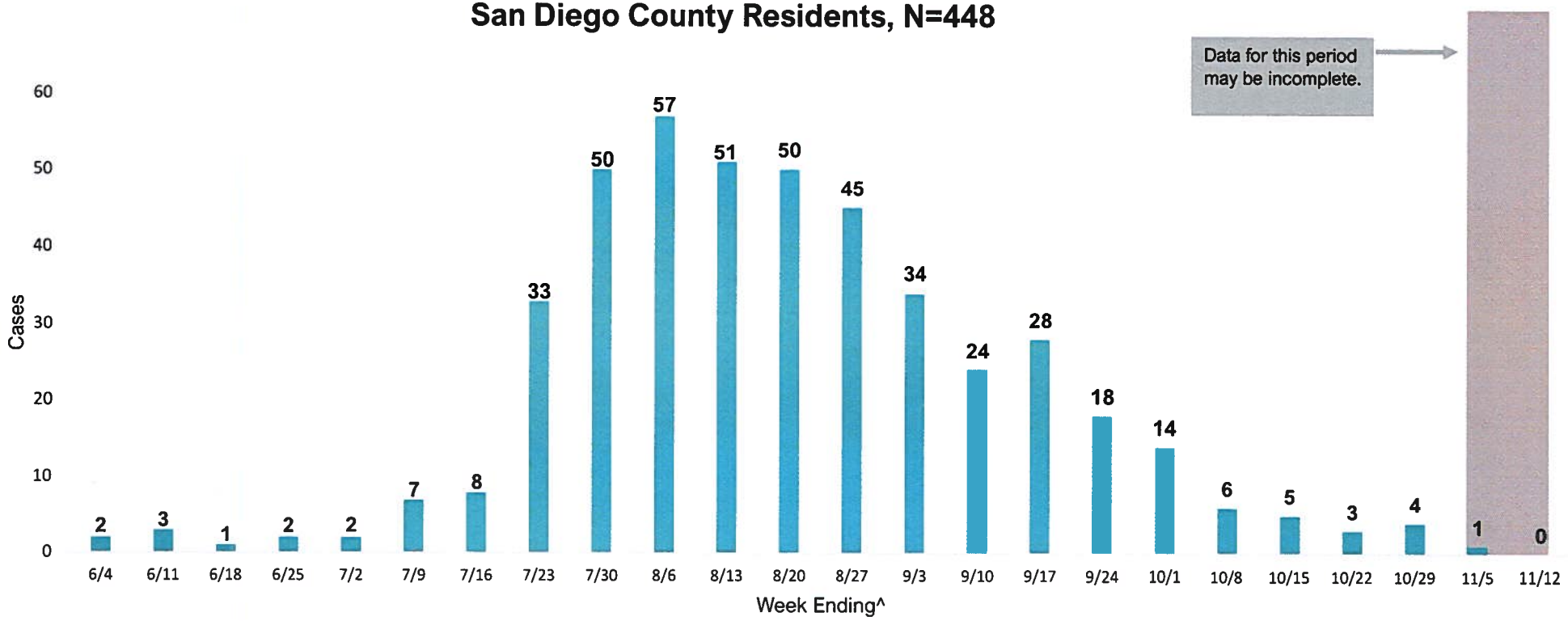
- 0
- 1 to 10
- 11 to 50
- 51 to 100
- 101 to 500
- >500

CDC

CDC: Data as of November 11, 2022
CDPH: Data as of November 10, 2022
San Diego County: Data as of November 12, 2022
All Data Accessed on November 14, 2022
2022 U.S. Map & Case Count | Monkeypox | Poxvirus | CDC
Monkeypox Data (ca.gov)

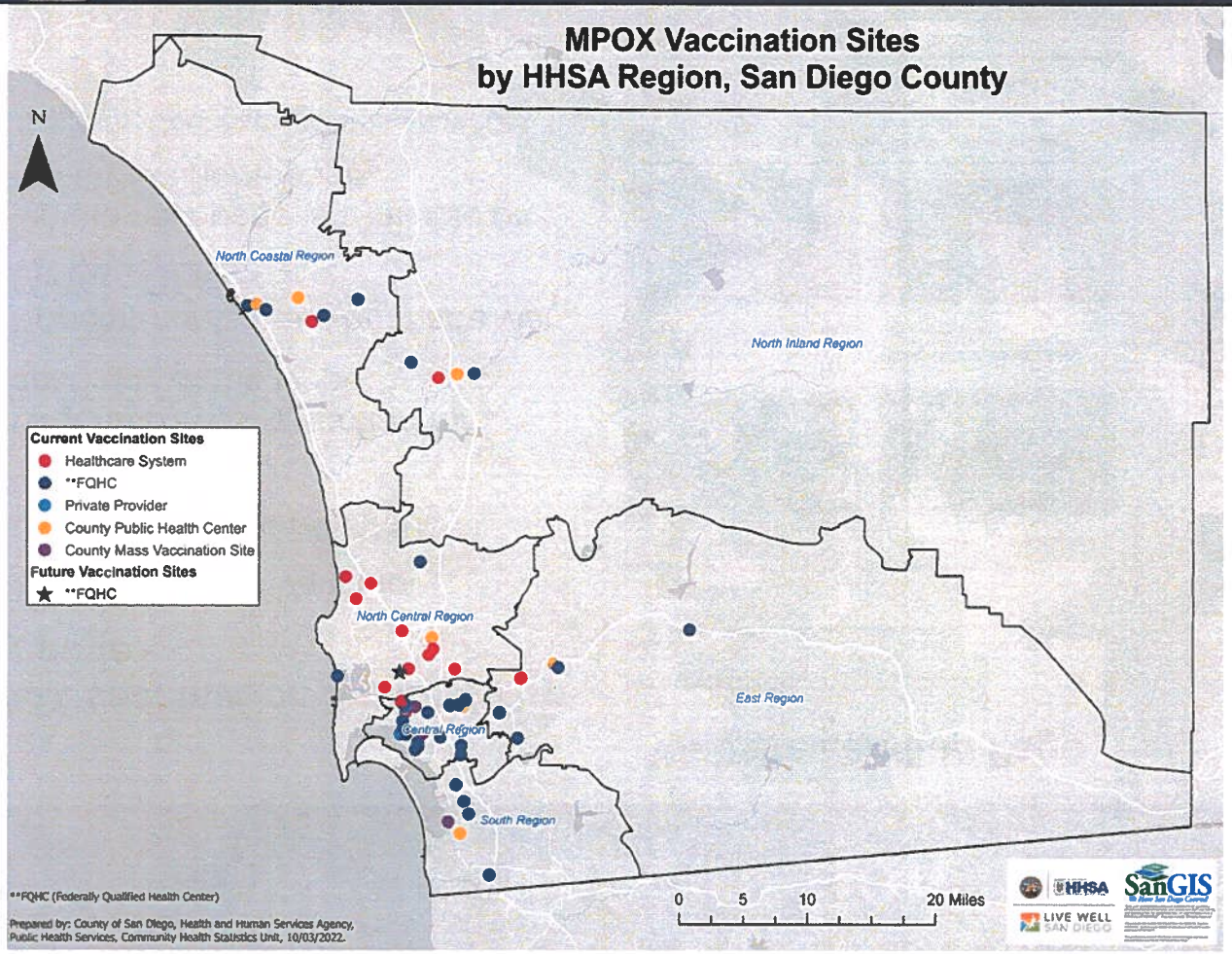
MPOX Cases by Episode Date

Confirmed and Probable MPOX Cases* by Episode Date†
San Diego County Residents, N=448



Data are provisional and subject to change as more information becomes available.
*A confirmed case has tested positive specifically for monkeypox virus. A probable case has tested positive for orthopoxvirus with no suspicion of other recent orthopoxvirus exposure and is pending confirmatory testing.
† Episode date is defined as the earliest of the following dates: onset, specimen collection, diagnosis, death, and report received.
^Data for the most recent weeks may be incomplete as cases that may have occurred during this time period might not yet be reported.
Data through 11/12/2022, Updated 11/14/2022

MPOX Vaccine Ecosystem



Hospital System Sites

FQHC Sites

Private Providers

County Clinics

MPOX Vaccination Schedule

MPOX Vaccination Schedule by Day page

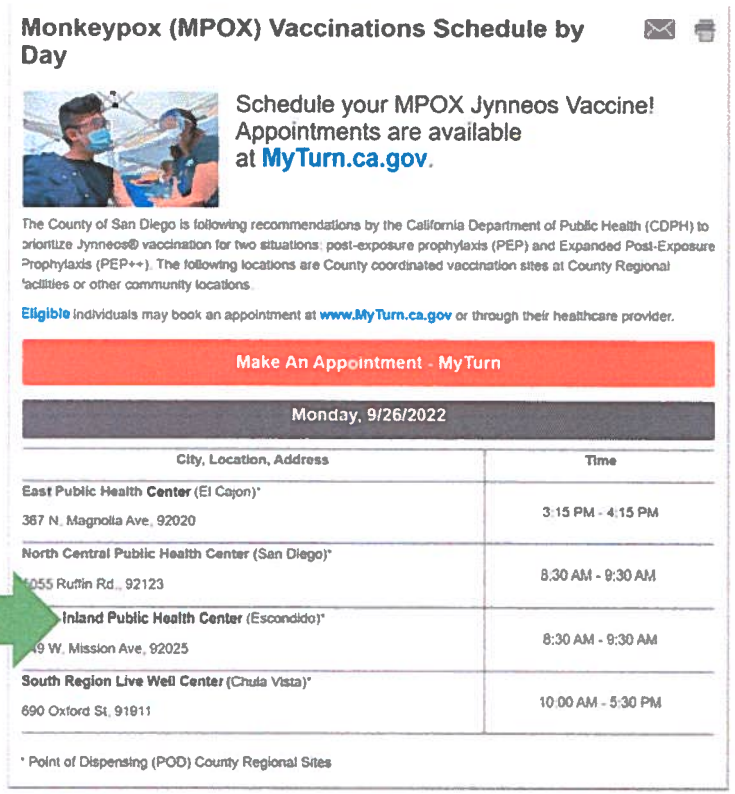
- MPOX Jynneos Vaccine
- Lists County coordinated vaccination sites
- Organized with a section for each day of the week
- Appointments must be made via MyTurn.CA.gov
- Link to new page is available on the MPOX homepage:

  SanDiegoCounty.org/MonkeypoxSD

NEW

Website Landing Page

Vaccination Clinic Schedule



Social Media Efforts

8,537

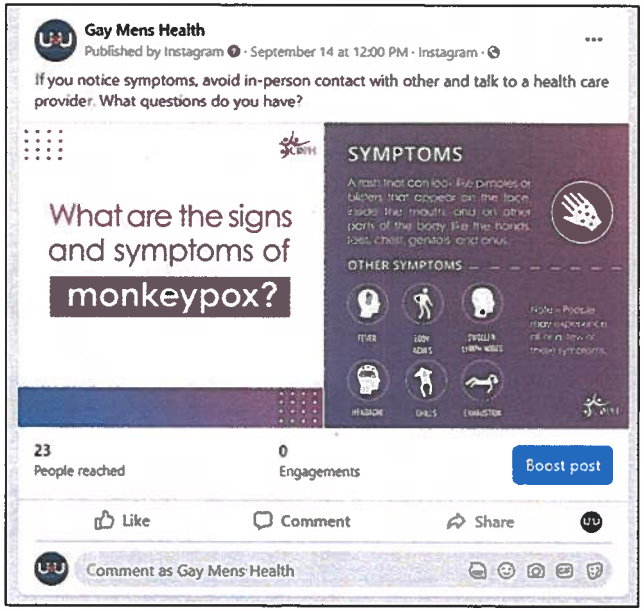
- Outreach to the population of focus through online social media and networking site posts

6,732,272

- Impressions via digital posts

117,081

- MPOX website page views



Data range: 8/1/22 – 10/31/22

High Impact Prevention Contractors

5,466 Individual outreach with members of the focused population

4,001 Educational materials distributed

Data range: 8/1/22 – 10/31/22

Outreach to Vulnerable Communities

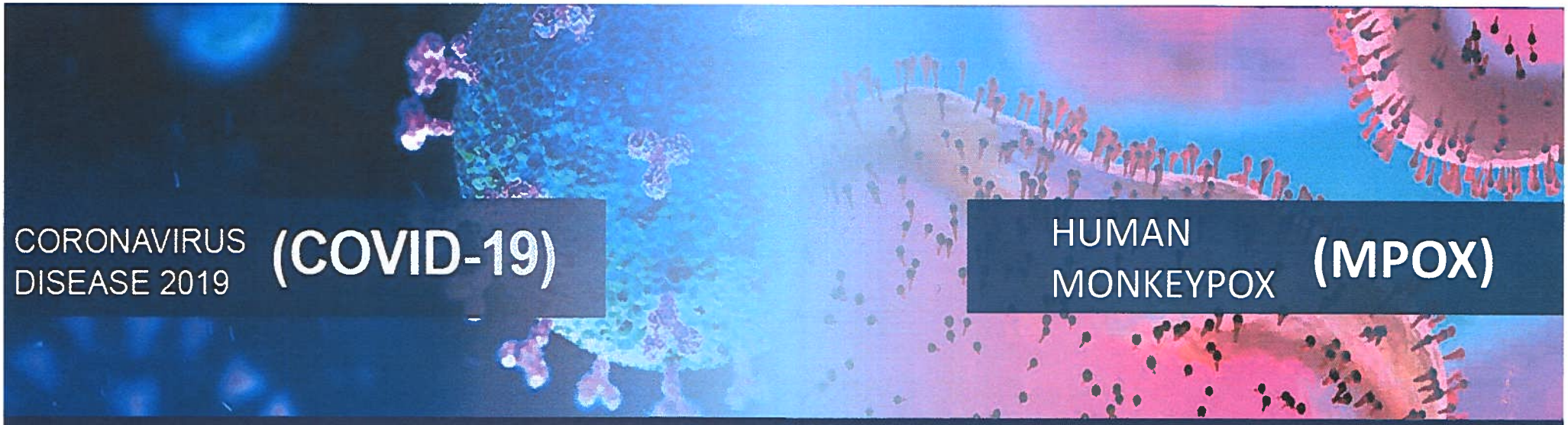
- Tri Vaccination Events
  - MPOX, Flu, and COVID-19,
- Health Fairs throughout the Region
- Homeless Resource Fairs & Outreach
- Foot Teams

Recommendations

1. **Receive an update** on the COVID-19 pandemic response.
2. **In accordance with Section 401**, authorize a Competitive Solicitation for specimen collection, testing, and resulting services for COVID-19 and other infectious diseases.
3. **Receive an update** on the MPOX outbreak response.
4. **Authorize the acceptance** of $1,233,869 in funding from the California Department of Public Health to aid in the distribution of MPOX vaccines, tests, outreach and education, and treatments.

Recommendations

5. **Ratify actions** taken by the Director, Department of Purchasing and Contracting in response to the MPOX local health emergency to execute Contract #567618 for testing, treatment, and vaccination administration services for MPOX with Family Health Centers of San Diego.
6. **Adopt a resolution entitled** *Resolution Authorizing Continuance of Teleconferenced Public Meetings Pursuant to Government Code Section 54953.*



Item #29:

County of San Diego COVID-19 and MPOX Update

November 15, 2022

OFFICIAL RECORD
Clerk of the Board of Supervisors
County of San Diego

Exhibit No. A.

Meeting Date: 11/15/22 **Agenda No.** 29

Presented by: Vira Brooks

Hospital Protocols (Remdesevir + Ventilators) = DEATH!!

What is misinformation??

OFFICIAL RECORD
Clerk of the Board of Supervisors
County of San Diego

Exhibit No. B

Meeting Date: 11/15/2022 **Agenda No.** 29

Presented by: Mika Borello

COVID-19 Vaccine Injury; a Compendium of Authoritative Resources

Prepared by: Mike Borrello[1]

15 November, 2022

The information in this report is neither misinformation nor disinformation, nor is it intended to disparage beliefs or opinions of others. This report simply consolidates facts and information gathered from authoritative sources on the COVID-19 vaccines to provide a more complete and balanced perspective of COVID-19 vaccine harms.

[1] Email contact: maborrello@roadrunner.com

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5.5.5 Cases of visual impairment: 13,285; 55% within two days after injection 105
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5.5.7 Cases of fetal death or disorders: 1,072; 33% within two days after injection. 114
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5.5.9 Cases of myocarditis, pericarditis or myopericarditis: 25,127; 35% within two days after injection. 116
5.5.10 Cases of cardiomyopathies: 37,303; 55% within two days after injection 145
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injection. 185
5.5.20 Cases of myasthenia gravis: 506; 23% within 2 days after injection 188
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5.5.32 Cases of aphasia: 3,744; 50% within two days of injection 220
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1. Introduction

This report was originally intended to supplement information reported by San Diego County Health and Human Services (SD HHS) regarding local COVID-19 response, particularly current information county health authorities were neglecting to address in their monthly 'COVID-19 updates' and more particularly: **injuries and deaths associated with or caused by the COVID-19 vaccines**. The culmination of immense amounts of data and concerning publications presently serve as a body of compelling evidence of the harm and injury COVID-19 vaccines and policies have caused. This report is also a testimony to the lack of response by county officials when it evevntually became evident agencies had failed in their duty to provide safe and effective 'vaccination'. This report might not 'prove' causation, but it does present sufficient evidence to warrant a cessation of vaccination and reason to pursue thorough and complete investigations. The county persists in ignoring or suppressing this evidence.

SD HHS typically reports at the first monthly regular meeting of the County Board of Supervisors. County COVID-19 updates, since the start of the COVID-19 pandemic, have largely focused on: (1) "The number of COVID-19 cases" in San Diego County and (2) the percentage of population that has complied with vaccination programs (i.e. percent of San Diego County residents fully vaccinated). To date, and since the declaration of the county's COVID-19 'emergency' order, SD HHS has neglected to provide any data or metrics addressing the safety, risks and efficiency of the COVID-19 vaccines within their jurisdiction, nor any reports of injury or death caused by the vaccines – even if these numbers were legitimately determined to be zero. Neither did SD HHS ever respond to the contents of these series of reports, rebut the information herein, or include in their agenda any efforts to address vaccine injury and death.

As a resident of the county of San Diego, and one who has become actively involved in the pursuit of truth, I've encountered individuals that have been injured or others that reported deaths of friends or family members and who were likely killed by COVID-19 vaccines. I myself have experienced the death of family members that may have been caused by the vaccines. This experience, along with extensive research has convinced me that COVID-19 vaccines do cause significant harms that are not acknowledged by SD HHS, the FDA, CDC or corporate media. On the contrary, it seems to be within their protocol to suppress any information that compromises their campaign to promote vaccination. This report is one voice for many of the injured, and for those unfortunate few in San Diego, unknown names that have either died from vaccine side effects or have been injured, and for family and friends that continue to grieve their losses or share their pain.

COVID-19 vaccination programs launched in December of 2020. After hundreds of millions of doses in the US, there is solid evidence continuing to accumulate from published, peer reviewed studies in well-respected scientific and medical journals: the COVID-19 vaccines have indeed caused injury and death, and in significant and unprecedented numbers. These numbers far exceed any numbers that, from prior FDA policies, would have normally evoked immediate hold on vaccinations, black labeling, and recall followed by a full blown in-depth investigation, not to mention making the 6 o'clock news. But the federal government, public health, and their iron grip on the media continues on a misguided, if not ethically and morally corrupt mission to perpetuate a universal state of emergency when there is no emergency, and to continue vaccinating the entire American populace come hell or high water.

Vaccination with the present COVID-19 vaccines, boosters, or bivalent COVID-19 vaccines clearly 'wane' over several months' time, and target now extinct variants of the virus. The data reveals negative efficacy and confirmed long term adverse effects[2] [3]. The FDA has now 'approved' COVID-19 EUA vaccines for infants – as young as 6 months since June of this year and these are already reporting thousands of adverse events and hundreds of deaths. Mainstream media has failed its citizens, siding with corporate narrative over the health and welfare of fellow Americans. Other countries,

---

[2] Dar-Odeh N et al, **Long-term adverse events of three COVID-19 vaccines as reported by vaccinated physicians and dentists, a study from Jordan and Saudi Arabia**. Hum Vaccin Immunother. 2022 Dec 31;18(1):2039017. doi: 10.1080/21645515.2022.2039017. Epub 2022 Mar 3. PMID: 35240939; PMCID: PMC9009903.

[3] https://dailysceptic.org/2022/03/20/vaccine-effectiveness-hits-as-low-as-minus-300-as-ukhsa-announces-it-will-no-longer-publish-the-data/

like the UK and Germany are finally publishing, indicating vast injuries[4] have occurred. The COVID-19 pandemic, and in particular the response by Public Health Officials in the US will turn out to be the largest widespread health disaster in world history.

2. Summary of changes in the vaccine injury report for November

This report is now organized into numbered sections to improve organization and readability. Section 3 now serves to present more current news surrounding covid-19 vaccines. The last month has seen significant developments that collectively indict a preponderance of malfeasance, fraud, corruption and junk science. This section contains cited facts, but also my personal opinions. Section 4 is a compilation of online resources for vaccine research. These have been expanded from previous reports to include other databases of vaccine adverse events and websites that support search for scientific and medical journal publications. The core of the vaccine injury report starts in section 5. This is the part that has been regularly updated each month regarding adverse event data mainly sourced from VAERS and PubMed; numbers, statistics and associated publication citations. All categorical and specific adverse events noted in the report have continued to increase in number each month as covid-19 vaccine doses increase, now exceeding 641 million in the USA with the most significant increase of events being inflammatory, thrombogenic or neurogenic in nature. Deaths associated with the COVID-19 vaccines are now nearly 32,000.

Many new categories have been added to the report. All of the specific adverse event queries have been update/modified and documented as text. Distribution of the onset of adverse events have been added to each category. And some categories involving multiple symptoms include a table on the prevalence of the symptoms under the category. It was realized the search function could be used across the entire database of events and that some codes, relevant to the category were not being utilized. So some of the report numbers have substantially increased, but at least one, intracranial brain hemorrhage/brain bleed decreased in reports since it was discovered some of the codes were not actually applicable. The reader is encouraged read through the entire report. Many publication citations have been added to support the VAERS numbers.

Sections beyond section 5 include other special topics from prior vaccine injury reports that supplement the material in section 5. For the most part those sections are fixed, but some, like 'Revisiting Effectiveness of the COVID-19 vaccines have had additional material added. Finally there's now conclusions and recommendations in section 10.

3. Current News on COVID-19 Vaccines

This 'newsletter' provides current, significant research findings and events surrounding COVID-19 vaccine injury and death. The 'report' with current adverse event numbers and publication citations starts in section 5.

3.1. A Preponderance of Malfeasance, Fraud, Corruption, Junk Science and Conspiracy

October has yielded a significant number of reports in scientific research further exposing concerning problems with the safety and efficacy of the COVID-19 vaccines, the policies, and methods of testing for SARS-Cov-2. More scientific researchers and doctors are finally finding the courage to publish convincing evidence and opinions on vaccine injury. These individuals on their own accord to expose truth are organizing and forming groups to get the information out and influence better policy. And it appears the peer review boards might be finally buckling under the pressure of an awakened public demanding truth. People grow weary of the censorship and new publishers are organizing to compete.

Scandalous cover-ups by government agencies and pharma are being been exposed as this report is being written. Withheld, incriminating data, presumably to facilitate vaccine approvals and distribution, has clearly put people's health and lives at risk. The reported facts in the following subsections collectively serve as an indictment on the COVID-19

[4] https://www.christianitydaily.com/articles/14539/20220108/uk-newspaper-publishes-data-on-covid-vaccine-deaths-injuries-and-more-via-full-page-spread.htm

vaccines and those that continue to promote their use. These reports broadly paint a picture of malfeasance, fraud, corruption and junk science; overwhelming evidence that all public officials at every level need to acknowledge and respond to, regardless of the chain of command demands. What was the saying? "If you see something, say something". But one has to look to see. The mainstream media is no longer our friend, they are paid by corporate interests. Leadership fails when leaders fail to honor their oath or violate ethical practice. It's clear, for many reasons, **the COVID-19 vaccines should be immediately suspended worldwide**. The papers and events that follow support this conclusion.

3.1.1 Was the Coronavirus Pandemic Even Real?

Apolone G, Montomoli E, Manenti A, Boeri M, Sabia F, Hyseni I, Mazzini L, Martinuzzi D, Cantone L, Milanese G, Sestini S, Suatoni P, Marchianò A, Bollati V, Sozzi G, Pastorino U. **Unexpected detection of SARS-CoV-2 antibodies in the prepandemic period in Italy**. Tumori. 2021 Oct;107(5):446-451. doi: 10.1177/0300891620974755. Epub 2020 Nov 11. PMID: 33176598; PMCID: PMC8529295. https://pubmed.ncbi.nlm.nih.gov/33176598/

This prospective cancer study in Italy examined blood samples from 959 *asymptomatic* individuals between September 2019 and March 2020 detecting the presence of SARS-CoV-2 in circulation in early September, 2019.

What?

Consider the incidence of an extraordinary spike in EXCESS death did not occur until March to April of 2020 coinciding rather with 'official measures' in response to the 'pandemic'. Measures like lockdowns, masking, social distancing, etc. And the incidence of excess deaths was a SUDDEN event, synchronized globally and HUGE in magnitude, not a planetary wave, slowly rising as would be expected as an infectious virus gradually spread throughout populations of the world. It was sudden and triggered by policy[5].

Dr. Campbell reviewed Apolone et al in a recent episode of his YouTube channel[6], but of course couldn't come out and directly say what I wrote above. YouTube does not allow negative reporting about covid policy. But the result is obvious. This paper gives reputable credence and consideration to the question:

Was the coronavirus pandemic even real?

I'm not saying SARS-CoV-2 isn't real or that it led to infection and death. I'm asking was it really a pandemic and whether it necessitated the response officials mandated. Reading further, some key remarks from the paper:

> *"Two phenomena need to be highlighted and discussed. The first concerns the underestimation of the prevalence of cases. Regional and national health authorities, after an attempt to identify cases and suspects early and trace all the potential contacts, soon abandoned this strategy as unsustainable and concentrated on the identification strategy, with swabs and serology, on symptomatic cases only. As a consequence, an underestimation of overall COVID- 19 cases was created, and a selection bias was introduced, with an overestimation of the mortality rate. ... As a consequence, the true number of Italians who had been in contact with the virus would be approximately 1.5 million, many of whom were asymptomatic, an estimate almost 5 times higher than the official figures reported."*

5 https://denisrancourt.ca/entries.php?id=116&name=2022_08_02_covid_period_mass_vaccination_campaign_and_public_health_disaster_in_the_usa

6 https://youtu.be/XzPophi-9MY

"The second concern regards the onset of the epidemic, which is likely to have preceded the identification of the first case, probably in the last part of 2019"

"Evidence from environmental monitoring showed that SARS-CoV-2 was already circulating in northern Italy at the end of 2019."

"Molecular analysis with reverse transcription polymerase chain reaction assays of 40 composite influent wastewater samples ... also indicates that SARS-CoV-2 was circulating in different geographic regions simultaneously, which agrees with our serologic findings."

"[other] findings suggest that the virus may have already been circulating at the time of the outbreak in several countries."

The puzzle pieces are coming together and may possibly reveal a sham of epic proportion. The pandemic is far from 'over'. It's not over until the ENTIRE puzzle is solved and TRUTH is revealed. Truth tends to find a way as long as there are people willing to speak it even in the face of adversity.

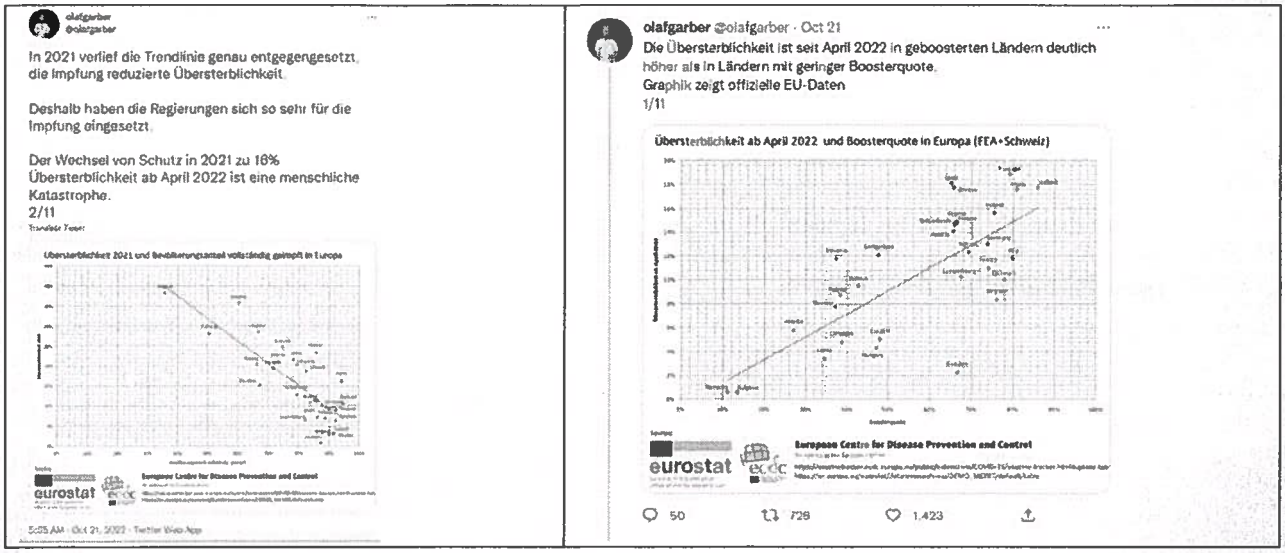
3.1.2 Excess Deaths Correlate with COVID-19 Vaccine Uptake – Analysis by HART

A group of highly qualified doctors, scientists, economists, psychologists and other academic experts in the UK organized a team to address the concerns about policy and guidance recommendations relating to the COVID-19 pandemic: HART, or Health Advisory & Recovery Team. The 36 members of HART recognize the lack of open scientific debate in the mainstream media and the worrying trend of censorship and harassment directed towards anyone who questions the mainstream narrative.

The HART Website link:

https://www.hartgroup.org/

The most concerning result HART has helped reveal recently is the correlation between vaccine uptake and excess deaths. HART and another independent researcher, Igor Chudov, have replicated results originally discovered by a German economist, Olaf Garber using data from UE vaccine uptake and excess deaths



Translation from German:

> In 2021 the trend line was exactly the opposite, vaccination reduced excess mortality.
>
> That's why governments have pushed so hard for vaccination.
>
> The shift from protection in 2021 to 16% excess mortality from April 2022 is a human catastrophe.

HART published their work here:

Comparison of European deaths[7]

Concluding: More vaccinated countries have had more recent death.

Yet the EU, much like many American jurisdictions continue to encourage and promote COVID-19 vaccines and boosters.

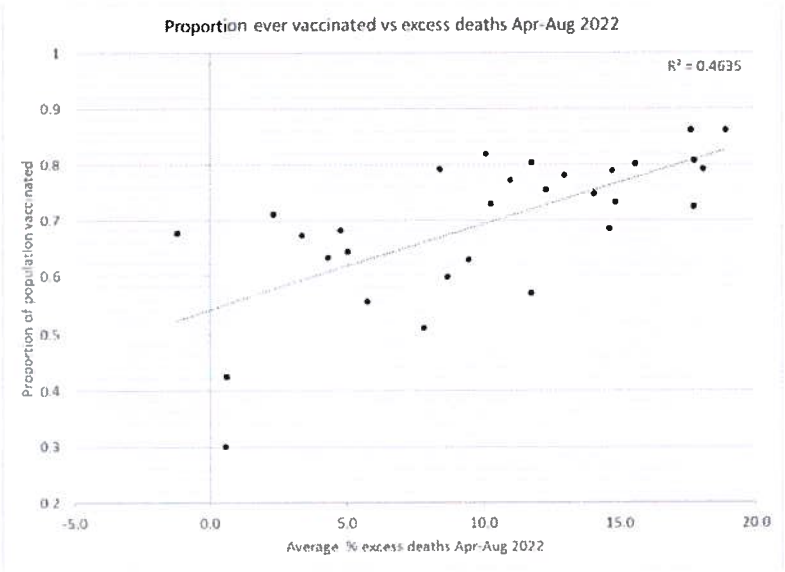


Figure 2: Eurostat excess mortality data for April to August 2022 plotted against proportion of each country vaccinated

The full analysis by HART can be accessed here:

https://www.hartgroup.org/country-comparison-of-deaths/

It seems the governmental machine, is too inefficient, too absorbed in its own version of science, and too slow to recognize and act. But many have died. And many lives remain threatened. Where are the analyses by American health agencies to either confirm or deny?

[7] https://www.hartgroup.org/country-comparison-of-deaths/

3.1.3 Large Population Study Reveals Unvaccinated NOT at greater risk of Myocarditis or Pericarditis from COVID-19 infection

How often have we heard that COVID-19 infected patients are at greater risk of contracting myocarditis or pericarditis compared to getting myocarditis or pericarditis from COVID-19 vaccination? Here are some examples:

American Heart Association:
COVID-19 infection poses higher risk for myocarditis than vaccines
August 22, 2022; no reference studies given

CNBC News:
Myocarditis risk higher after Covid infection than Pfizer or Moderna vaccination, CDC finds
April 1, 2022; References CDC

Journal Circulation
Risk of Myocarditis After Sequential Doses of COVID-19 Vaccine and SARS-CoV-2 Infection by Age and Sex
August 22, 2022 – peer reviewed
In this study they concluded the overall risk of myocarditis is greater after SARS-CoV-2 infection than after COVID-19 vaccination but conceded the risk of myocarditis after vaccination is higher in younger men, particularly after a second dose of the mRNA-1273 vaccine.

The study published in Circulation involved a large cohort, but it compared cases of myocarditis between unvaccinated cases of covid infection and vaccinated cases due to vaccine. There was no control group of people that never were vaccinated OR had covid (pre-covid control). There was a study, earlier this year and involving a large population that did have such a control; Tuvali et al:

> Tuvali O, Tshori S, Derazne E, Hannuna RR, Afek A, Haberman D, Sella G, George J. **The Incidence of Myocarditis and Pericarditis in Post COVID-19 Unvaccinated Patients-A Large Population-Based Study**. J Clin Med. 2022 Apr 15;11(8):2219. doi: 10.3390/jcm11082219. PMID: 35456309; PMCID: PMC9025013. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9025013/

The Tuvali study involved 196,992 adults after COVID-19 infection between March 2020 and January 2021. The control group, 590,976 adults with at least one negative PCR and no positive PCR, age and sex matched with the test group. Conclusion:

> *"Our data suggest that there is no increase in the incidence of myocarditis and pericarditis in COVID-19 recovered patients compared to uninfected matched controls. Further longer-term studies will be needed to estimate the incidence of pericarditis and myocarditis in patients diagnosed with COVID-19."*

However it's a known fact now by that COVID-19 vaccines do indeed increase risk of myocarditis by a factor of about 4 – all age groups … read on.

3.1.4 COVID-19 Vaccines Are Pharmaceutical Drugs, NOT Vaccines

For over a year we have heard arguments from COVID-19 vaccine opponents that the vaccines cannot be properly classified as vaccines. But many of these allegations were either off the cuff or not fully justified until now. Finally a landmark opinion paper appeared in the International Journal of Molecular Sciences written by two researchers in Varese Italy. They thoroughly and systematically provide convincing arguments the mRNA vaccines indeed are NOT vaccines. The paper has seen almost 17,000 full text views since its publication in September:

> Cosentino M, Marino F. **Understanding the Pharmacology of COVID-19 mRNA Vaccines: Playing Dice with the Spike?** International Journal of Molecular Sciences. 2022; 23(18):10881. https://doi.org/10.3390/ijms231810881

The main point: while injections were intended to be a localized intramuscular treatment, there's clear evidence now in the post-market surveillance data indicating systemic distribution of the S-Protein throughout the body of injected subjects. The mRNA vaccines exhibit a *complex pharmacology* more characteristic of a pharmaceutical drug rather than the static, localized behavior characteristic of vaccines. The mRNA vaccines have been called *leaky* since they tend not to remain near the site of injection as intended. They are rather *systemic* drugs. The mis-classification of these injections are putting patient safety at grave risk. The authors note that mounting reports of injury and death indeed justifies immediate action. The FDA approved the vaccines, and irresponsibly continues to allow them to be used.

> **EVIDENCE** in one study vaccine-induced S protein circulated in the blood of 11 out of 13 subjects as early as one day after injection and for about two weeks after injection. That's a clear characteristic pharmacodynamics of *drugs*, not vaccines.
>
> **EVIDENCE**: Long term residence times of vaccine mRNA and S-Protein in lymph glands at least 60 days after injection. Another characteristic of *drugs,* not vaccines. Vaccines are rather intended to stimulate immune response, then rapidly be eliminated by the body.

Cosentino & Marino's paper makes a critical point that should not be ignored. It reads like expert testimony for legal deposition. It could certainly be used for such a purpose. These results clearly call for indictments on pharma and the government agencies that have apparently **colluded and allowed them to distribute drugs as vaccines**.

3.1.5 COVID-19 mRNA Vaccines Produce Spike Protein in the Same Amounts as COVID-19 infection ... In Some Cases, Perhaps More

In a letter to the October issue of Trends in Molecular Medicine, the same two Italian authors further discuss the question of improper vaccine 'leakage' into the circulatory system:

> Cosentino M, Marino F. **The spike hypothesis in vaccine-induced adverse effects: questions and answers.** Trends Mol Med. 2022 Oct;28 (10):797-799. doi:10.1016/j.molmed.2022.07.009. Epub 2022 Sep 12. PMID: 36114089; PMCID: PMC9494717. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9494717/pdf/main.pdf

But another provocative issue has come to light. Until now no one has properly addressed the question regarding relative cytotoxicity of the S protein between covid infection and covid vaccination.

The authors present the question:

> *How does production of Spike protein compare between COVID-19 mRNA vaccines and SARS-CoV-2 infection?*

And their conclusion:

> *"Such considerations as a whole support the possibility that COVID-19 mRNA vaccines*

under some circumstances induce high and possibly toxic amounts of S protein in organs and tissues, in turn leaking into the circulation."

As many suspected, but as Cosentino & Marino provide in simple 'back of the envelope' calculations, the COVID-19 Vaccines may be as dangerous as, or possibly more dangerous than the SARS-Cov-2 infection itself. The root cause: the S protein. For further details on the cytotoxicity of the spike protein, see section 7 of this report - Spikopathy.

Another paper written at the end of 2021 further condemns the vaccines questioning whether they are indeed causing some of the same disease the infection itself causes. What is more concerning is the spike protein has indeed been shown to cross the blood brain barrier:

Oldfield PR, Hibberd J, Bridle BW. **How Does Severe Acute Respiratory Syndrome-Coronavirus-2 Affect the Brain and Its Implications for the Vaccines Currently in Use**. Vaccines (Basel). 2021 Dec 21;10(1):1. doi: 10.3390/vaccines10010001. PMID: 35062662; PMCID: PMC8780773. https://pubmed.ncbi.nlm.nih.gov/35062662/

Oldfield et al reinforce Cosentino and Marino's concerns but further add another concern about delayed effects:

"... the occurrence of acute neurological symptoms (i.e., fatigue and/or headaches), although not considered to be serious, were high, especially in the younger age group (16 through to 55 years of age). Such neurological symptoms, especially if prolonged, could well be indicative of inflammation, which can act as the trigger giving rise to synucleinopathies such as Parkinson's disease up to two to three decades post-immunization"

About the same time frame, a private practitioner and two gastroenterologists also Italian published a scorching editorial regarding their concerns over spike protein toxicity:

Actis GC, Ribaldone DG, Pellicano R. **COVID vaccine's hot problems: erratic serious blood clotting, ill-defined prion-like reactogenicity of the spike, unclear roles of other factors**. Minerva Med. 2021 Dec;112(6):695-697. doi: 10.23736/S0026-4806.21.07769-7. PMID: 35168305. https://pubmed.ncbi.nlm.nih.gov/35168305/

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Minerva Medica 2021 December;112(6):695-7
DOI: 10.23736/S0026-4806.21.07769-7

EDITORIAL

COVID vaccine's hot problems: erratic serious blood clotting, ill-defined prion-like reactogenicity of the spike, unclear roles of other factors

Giovanni C. ACTIS [1] *, Davide G. RIBALDONE [2], Rinaldo PELLICANO [3]

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The authors address the same issue as Cosentino & Marino regarding vaccine escape (leakage), but also the

thrombogenic nature of the spike protein warning:

> *"... these uncontrolled accidents are posing a growing toll of (young) lives. This ability of the virus and/or an ill-effective therapy to exert a "disease mimicry" is again an appalling feature of this agent."*
>
> *"In in-vitro models, sub-units of the spike were shown to readily turn a lab-made blood surrogate into disfigured fibrin, with formation of a suggestive amyloid deposit reminiscent of the brain precipitates in Alzheimer's disease. Again, we wish to pose the emphasis on the process, vital to the vaccine, of the on-site spike synthesis. It is not difficult to figure out that a highly thrombogenic fragment may bud from the nascent protein and trigger the characteristic amyloid-like clotting when the still defective sequence lacks the inhibitors (still speculative at the moment)."*

The mounting evidence of cytotoxicity of the S-protein tends to cast major doubt on the designers made sound decisions. The principle was clear, it was actually genius. But the complex nature of the acting and interacting mechanisms between vaccine and humans required significantly more due diligence than what was exercised. Experimenting and learning should not come at the expense of so many lives.

3.1.6 Proper Risk-Benefit Analysis Conclude Students Should not be forced to vaccinate.. More importantly, Ethics say so

Any global response involving dispensing medications or vaccinations should require proper benefit risk assessment. 'Proper' meaning whatever methodology used should utilize systematic methods providing a sufficient level of confidence by validation. Benefit risk assessment should also agree on ethically sound criteria. Who takes the risk, what types of risk and what level of risk is acceptable to societal norms. Such benefit risk analyses appear not to exist for decisions on the use of COVID-19 vaccines. After viewing at least several live ACIP meetings with the CDC I can attest that much of the benefit risk assessment involved 'hand waving' and rhetoric. I challenge anyone to show me a document that provides proper risk assessment. The phrase "... but the benefits outweigh the risks" is meaningless and used far too often in meetings, publications and the media. It makes me sick.

A paper from Bardosh et al in August includes a group of accomplished authors from leading academic institutions. Their collaboration focused on a cohort of young students and they offer convincing arguments why students should not be forced to vaccinate as a condition to attend school. As of November 4, over 84,000 downloads and 374,000 abstract views:

> Bardosh, Kevin and Krug, Allison and Jamrozik, Euzebiusz and Lemmens, Trudo and Keshavjee, Salmaan and Prasad, Vinay and Makary, Martin A. and Baral, Stefan and Høeg, Tracy Beth, **COVID-19 Vaccine Boosters for Young Adults: A Risk-Benefit Assessment and Five Ethical Arguments against Mandates at Universities** (August 31, 2022). http://dx.doi.org/10.2139/ssrn.4206070

Sound ethics should be at the foundation of medical practice: 'first, do no harm'. But vaccine campaign juggernauts steam rolled over any ethical considerations with the sophomoric slogan: "a *jab in every arm*" - without latitude or consideration of *personal risk-benefit for individuals*. The state's brute force attitude and dogmatic belief trickled through society - that injury or death as an outcome of vaccination was an impossibility. But so many have been permanently disabled or killed.

Bardosh et. al. features authors across a number of well-known and trusted universities and institutions: University of Edinburgh, Edinburgh Medical School, University of Oxford, University of Toronto - Faculty of Law, Harvard University - Harvard Medical School, University of California, San Francisco (UCSF), Johns Hopkins University - Department of Surgery, and the Florida Department of Health.

3.1.7 Deceptive Risk Reduction Metrics used by Pharma

Gaming risk reduction metrics is not new. Details on the metrics of risk reduction were detailed in some of the earliest vaccine reports I presented to SDC HHS, but it's essential to briefly remind readers of the issue since the subject of proper benefit risk was addressed in the last section. How can benefit-risk assessment be proper without *meaningful* risk reduction? Risk reduction in this case connects with the benefit side of the comparison and is critical for proper assessment. The topic of risk reduction also recently came up in a peer reviewed paper by Dr. Aseem Malhotra's that's gone viral in social media posts[8] [9]. Doctor's careers are at stake now for speaking out. But the death of his father by vaccine prompted him to speak out. Malhotra in his paper is calling for an immediate and "complete suspension" of COVID-19 vaccines. That's doctor's orders.

One can conceive a number of different ways to mathematically calculate a metric expressing the 'efficacy' of a vaccine, but the more typical metrics used by pharma are known as the relative risk reduction (RRR) and absolute risk reduction (ARR). I will not go into the details here, but a paper by Brown, published early in the year the COVID-19 vaccines were deployed, offers excellent and approachable details of the calculations involve. Brown further calculates risk reduction metrics from actual data from Pfizer's and Moderna's phase 3 trial to illustrate the disparaging difference.

> Brown RB. **Outcome Reporting Bias in COVID-19 mRNA Vaccine Clinical Trials**. Medicina (Kaunas). 2021 Feb 26;57(3):199. doi: 10.3390/medicina57030199. PMID: 33652582; PMCID: PMC7996517 https://pubmed.ncbi.nlm.nih.gov/33652582/

Briefly an in summary, only the ARR – absolute risk reduction provides a more intuitive and practical metric since the number is inversely proportional to the **number needed to vaccinate** (NNV). In other words, how many persons would we need to vaccinate to prevent one covid infection? Brown showed, using Pfizer and Moderna data that they have been using RRR with figures above 94% as efficacy. The RRR metric is useful if the intent is to successfully market the drug. However some would call that deception. A naïve reader might believe that 94% means that of the vaccinated, 94% would be protected from infection, but that's far from true. Brown calculated the ARR from the same data which turned out to be an efficacy of no better than 1.1% for either vaccine! Brown showed that from their clinical trial the number needed to vaccinate for Moderna was 88, and for Pfizer, 142. That's not very effective. But it well illustrates that ARR is a useful metric for the drug recipient.

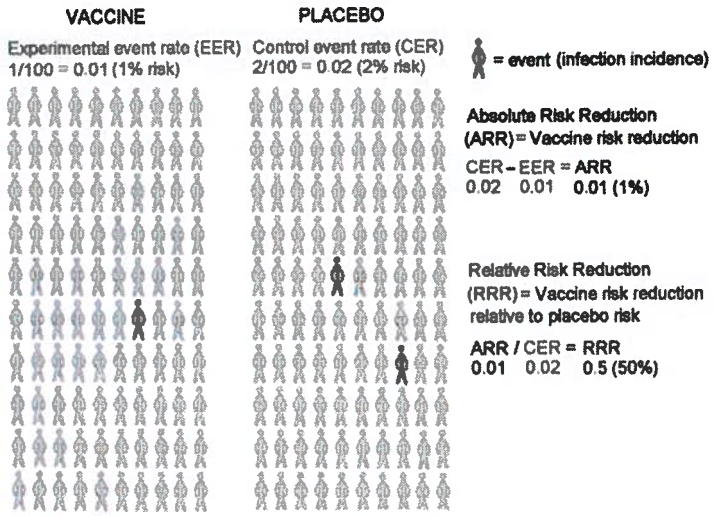
Are the details of proper choice risk reduction being considered when the CDC, FDA or pharma chant 'the benefits outweigh the risks"? Maybe they mean risks of losing profits.

Brown's exposure of the fraud also mentioned the FDA has admonished drug companies in the past for their use of RRR demanding they report efficacy in terms of absolute risk reduction. So then why has the FDA ignored this critical detail for the COVID-19 vaccines?

---

[8] Malhotra, Aseem. "Curing the pandemic of misinformation on COVID-19 mRNA vaccines through real evidence-based medicine - Part 1." Journal of Insulin Resistance [Online], 5.1 (2022): 8 pages. Web. 3 Nov. 2022 https://insulinresistance.org/index.php/jir/article/view/71

[9] Malhotra, Aseem. "Curing the pandemic of misinformation on COVID-19 mRNA vaccines through real evidence-based medicine - Part 2." Journal of Insulin Resistance [Online], 5.1 (2022): 10 pages. Web. 3 Nov. 2022 https://insulinresistance.org/index.php/jir/article/view/72



3.1.8 Japanese study of cohort near 1 billion conclude that the risk of myocarditis increased by a factor of four in all age groups

Two Japanese doctors in Kure, Japan studied outcomes of a large cohort vaccinated with mRNA vaccines, Moderna & Pfizer, based on a control of pre-covid population. They confirmed what other studies have concluded but further discovered a disturbing result – all age groups are significantly affected:

Sintaroo Watanabe, Rokuro Hama, **SARS-CoV-2 vaccine and increased myocarditis mortality risk: A population based comparative study in Japan**, medRxiv 2022.10.13.22281036; doi: https://doi.org/10.1101/2022.10.13.22281036
https://www.medrxiv.org/content/10.1101/2022.10.13.22281036v1

Watanabe & Hama conclude:

> *SARS-CoV-2 vaccination was associated with higher risk of myocarditis death, not only in young adults but also in all age groups including the elderly. Considering healthy vaccinee effect, the risk may be 4 times or higher than the apparent risk of myocarditis death. Underreporting should also be considered. Based on this study, risk of myocarditis following SARS-CoV-2 vaccination may be more serious than that reported previously.*

3.1.9 Pfizer Executive Reveals COVID-19 Vaccines NOT Tested for Transmission

To the shock and horror of the entire world, and during a live committee meeting of the European Parliament, Pfizer Executive Janine Small admitted that the Pfizer COVID-19 vaccines were never tested for their ability to prevent transmission of covid disease. Well … were we, really shocked?

The Dailywire provides a summary and video link of the scandalous encounter: 'Scandalous': Pfizer Exec Tells EU Lawmaker COVID Jab Was Never Tested To Show It Blocked Transmission [10]

[10] https://www.dailywire.com/news/scandalous-pfizer-exec-tells-eu-lawmaker-covid-jab-was-never-tested-to-show-it-blocked-transmission

When pressed on the high incidence of 'breakthrough' infections, Dr. Fauchi recently recanted:

"Nobody said you wouldn't get COVID if you're vaccinated"

But media records don't lie:

"When people are vaccinated they're not going to get infected"
Dr. Anthony Fauchi (NIAID Director)

"You're not going to get COVID if you have these vaccinations"
Joe Biden (the so-called POTUS)

"Vaccinated people do not carry the virus and don't get sick"
Rocelle Walensky. MD (CDC Director)

"Now we know the vaccines work well enough that the virus stops"
Rachel Maddow (MSNBC News)

"Everyone who takes the vaccine is reducing their transmission"
Bill Gates (alien entity?)

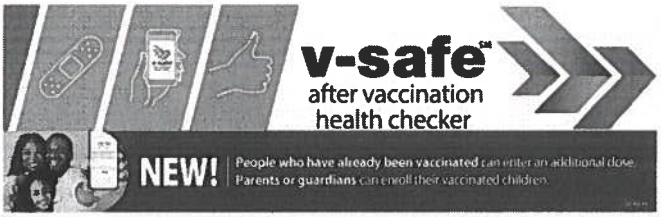
"There is no variant that escapes the protection of our vaccines"
Albert Bourla (CEO Pfizer)

Researching COVID-19 vaccine adverse events in PubMed reveals a large number of publications addressing the concern of COVID-19 vaccine *hesitancy* or *vaccine uptake*. These authors are seriously scratching their heads wondering why people aren't rushing out to get boosters or have their kids vaccinated. Most of these papers blame *misinformation*. But none consider the hypocrisy that's on public display and the loss of trust in their officials and the product they are pushing.

3.1.10 V-safe Data Reveals Substantial COVID-19 Vaccine Adverse Events Causing Nearly 800,000 to seek Immediate Medical Attention

V-safe After Vaccination Health Checker

Updated July 18, 2022 Español | Other Languages Print



Get vaccinated. Get your smartphone. Get started with v-safe.

Yet another Earth shattering development on vaccine safety or lack thereof. The Informed Consent Action Network (ICAN) released data from the CDC's V-safe database after court actions decided the CDC should have honored the original FOIA request. The data is publicly available either for download or dashboard display:

V-safe Covid Vaccine Adverse Health Impacts [11].

The magnitude of harm recorded by V-safe is jaw dropping, immediately begging the question why didn't the CDC or other responsible agencies with access to this data put a stop to the vaccinations? Almost 800,000 vaccine recipients had to seek immediate medical attention, many involving multiple visits after receiving COVID-19 vaccines. Over a million reports cite that people missed significant time at work or school.

The V-safe data obtained from the CDC may be distressing, but there's more to come. What's been disclosed so far does not include any symptoms that don't fit into the 'checkbox' categories. Symptoms that involve more egregious harms, life threatening conditions or permanent disabilities. V-safe reports should reflect the same types of injuries VAERS reports. But what about reports of death? There we have a problem. V-safe, by its inherent design, is not capable of reporting vaccine related deaths. No one has yet recognized the fact that since V-safe reporting is done through a cell phone app only accessible by the vaccine recipient, if the patient dies, reporting the event is most likely impossible. So I posed the question to the CDC through their website Q&A:

Required Information

Subject:

V-safe System

From:

General Public

Email Address

maborrello@roadrunner.com

Re-enter your Email Address (for validation):

maborrello@roadrunner.com

Please do not provide an email address that blocks or restricts CDC-INFO from responding.

Question:

My understanding of how the V-safe system works is that adverse events experienced by the vaccine recipient can only be entered by an enrolled recipient, and only through the cellphone app. The exception might be a parent submitting an event for their child. My question is: If the vaccine recipient were to die from the vaccine, how can that event be recorded in V-safe since the enrolled recipient is only allowed to enter the event?

1565 characters left

The following is an email response I received back just days later:

[11] https://www.icandecide.org/v-safe-data/

Reply Reply All Forward

Fri 10/21/2022 8:14 AM

CDC IMS 2019 NCOV Response VCU v-safe <eocevent523@cdc.gov>

Fw: RESPONSE REQUIRED, Priority Medium; Mode WebForm; Topic, V-safe System; [CDC-2685042-Q1D0T7] CRM:09170449

To [redacted]

Follow up. Start by Friday, October 21, 2022. Due by Friday, October 21, 2022.

Dear Mike,

The v-safe after vaccination health checker was created to supplement existing vaccine safety surveillance systems during the rollout of COVID-19 vaccines in the United States. The main purposes of v-safe are to capture local and systemic reactogenicity following the receipt of any dose of COVID-19 vaccine and to provide active surveillance for medically attended events. Regarding the latter, the v-safe call center conducts call follow-up to participants who have reported a medically attended adverse event after vaccination to facilitate submission of a report to the Vaccine Adverse Event Reporting System (VAERS). Due to the self-reported nature of data collected in v-safe, it is not suitable for assessing reports of death following vaccination.

For serious adverse events where a participant may not be able to respond, a VAERS report can be directly submitted to the VAERS website (VAERS - Report an Adverse Event (hhs.gov)). Healthcare providers are required by law to submit a report to VAERS for certain adverse events, including death; you can find a list of adverse events following COVID-19 vaccine for which a VAERS report is required here.

Kind regards,
v-safe team
www.cdc.gov/vsafe

---------- Original Message----------

Sent: 10/18/2022
From: General Public
Subject: V-safe System
Email Address: [redacted]
Question: My understanding of how the V-safe system works is that adverse events experienced by the vaccine recipient can only be entered by an enrolled recipient, and only through the cellphone app. The exception might be a parent submitting an event for their child. My question is: If the vaccine recipient were to die from the vaccine, how can that event be recorded in V-safe since the enrolled recipient is only allowed to enter the event?

Optional Information

Name: Mike A Borrello
Title:
Organization:
Phone: [redacted]

This confirms it. The CDC freely admits: **V-safe is "not suitable" for assessing reports of DEATH following vaccination.**

The CDC, from their email seems to suggest this is perfectly OK. But there's still a big PROBLEM. The media and other 'official' sources have relentlessly and ceremoniously HYPED up the narrative that VAERS is not a reliable source for tracking adverse events. That VAERS is a *passive* system, and that's 'bad'. They insinuate that many intentional false reports are entered into VAERS. But that's not true. Regardless, many medical and public health officials stuck to using V-safe as the primary and perhaps sole system for monitoring adverse events. But since V-safe will indicate ZERO deaths, they'll all believe - no problem here with the vaccines. They are under an illusion.

3.1.11 VAERS Myths Busted

Dovetailing on the topic of V-safe and VAERS, Steve Kirsch wrote in his October 22 newsletter analysis and results that refutes much of the narratives being circulated in the media, and even among health care officials, that VAERS is a *passive* reporting system and therefore 'unreliable' in providing suitable adverse event data on COVID-19 vaccine adverse events. If this were true, AND considering the CDC admits V-safe is not suitable for reporting vaccine induced deaths, then there is NO system for tracking vaccine induced death. Kirsch argues in favor that VAERS indeed is reliable and if anything the deaths and injury are significantly underreported.

Kirsch's substack article is linked from here:

https://stevekirsch.substack.com/p/vaers-myths-busted?

To corroborate Kirsch's claims of underreporting, I can personally testify I know at least two nurses that work at UCSD medical center and Radys Children's; one in cardiology. They tell me reports to VAERS regarding potential vaccine adverse events are **NEVER** made. The staff either does not believe the events are vaccine induced or they simply do not want to take the time. Indeed to enter a report takes considerable time and it does not pay the reporter or institution for their effort. Profit motives kill information and they kill people.

3.1.12 PCR test for SARS-CoV-2 flawed; at least 42% false positives in nasopharyngeal swab samples collected in January 2022

A shocking study just published revealing that a standard diagnostic test for COVID-19 is fundamentally flawed. Lee

> Sin Hang Lee, **Evidence-Based Evaluation of PCR Diagnostics for SARS-CoV-2 and the Omicron Variants by Gold Standard Sanger Sequencing**, Science, Public Health Policy,and the Law, Volume 4:144–189, November, 2022, Clinical and Translational Research, https://www.publichealthpolicyjournal.com/_files/ugd/adf864_01b8d2e159014d53a342e807a540c143.pdf

writes:

> *"SARS-CoV-2 has generated a COVID-19 pandemic causing more than 6 million human deaths worldwide, while the SARS outbreak quickly ended in six months with a global total of 774 reported deaths. One of the factors contributing to this stunning difference in the outcome between these two outbreaks is the inaccuracy of the RT-qPCR tests for SARS-CoV-2, which generated a large number of false-negative and false-positive test results that have misled patient management and public health policymakers. "*

and:

> *PCR was invented to replicate, or to amplify, a target segment of DNA for DNA sequencing without going through a laborious bacterial cloning [35]. PCR needs a pair of primers, single-stranded DNAs of about 20 bases long, to define the segment of target DNA to be replicated. But PCR primer/template hybridization is not fully sequence specific because PCR primers may attach to non-target DNAs and amplify unwanted DNAs if these DNAs are present and partially match the primers in nucleotide sequence. As a result, relying on PCR, especially the qPCR technology using Ct numbers as the surrogate for actual PCR product analysis, for disease diagnosis is bound to generate false positives. The experimental results of this work emphasize that while RT-qPCR is generating a significant number of false-positive test results at the current stage of the COVID-19 pandemic, the very nature of PCR lacking specificity can be exploited for designing useful diagnostics for all SARS-related coronaviruses in general if the PCR products are routinely monitored by DNA sequencing.*

The key points of discussion in the paper are outlined as follows:

- The COVID-19 pandemic could have been avoided or curtailed by using the SARSCoV-1 specific RT-PCR primers in early 2020
- PCR needs DNA sequencing to verify the authenticity of its products in molecular diagnosis
- The N gene is a more reliable target for RTPCR detection while partial S gene sequencing is needed for variant determination
- Multi-allelic SNPs found in Omicron variants
- A 42% false discovery rate of RT-qPCR assays for SARS-CoV-2 RNA detection
- Limitations of diagnostic testing for SARSCoV-2 Omicron subvariants

On top of the evidence revealed by Apolone et all casting substantial uncertainty on the true death rate due to covid infection, we have here considerable additional uncertainty on the specificity and accuracy of diagnostic testing for SARS-CoV-2, and worse a bias that further skews towards higher incidence of infection. Consider the billions of dollars leveraged by health agencies to 'attack' what is beginning to appear a quixotic threat.

Although Lee provides a means to remedy the high positive rate by process modification, his paper misses an important point. Perhaps including that point would lead to rejecting the publication. In any event, the recommended modification is too late. The damage is already done. They cannot mitigate tests already ran and subsequent improper decisions made by health authorities. If anything, the value this paper offers is a lesson. Science, no matter the urgency, should never be rushed. Completeness, skepticism and repetition of results are what keep science healthy and useful. We have to ask the question: would the excess deaths, we are even experiencing to present day and suffered across the world, been any different if the testing was required to meet high standards of specificity and accuracy that traditional diagnostics have required[12]?

3.1.13 Genuine Science Emerges from the Ashes of Banished Discourse

Too often there's protests that research, views and opinions opposing mainstream covid vaccination policy are not being given a fair shake when it comes to communicating with the public. But these protests are quickly and systematically squashed without proper review as misinformation, and would-be publications are hammered down by clique peer reviews, never to see the light of day.

It's no wonder when tens of billions of dollars in profits are at stake. No one can deny money ordains power and influence. That consideration alone for fair minded people should affirm the benefit of a doubt. Rarely do any of these opposing views manage to make it into the established journals unless they are tailored to meet the narrative; unless conclusions are candy coated with rhetoric like:

"Well yes we had some concerning cases of myocarditis, but hell, they are mild cases, and the benefits still outweigh the risks- believe me".

Fortunately good science, which truly depends on full discourse and debate, seems to find a way thanks to courageous individuals willing to speak up in face of the fray and dedicate their precious time and personal resources without the benefit of billions let alone any compensation to right the injustice that's taken hold of society.

We now see new journals and publishers emerging in these dark times. Individuals and groups with a sense of justice and entrepreneur seizing the opportunity. One such open-access journal is Surgical Neurology International[13] who in October permitted the following bold title to publish:

> Fabien Deruelle. **The pharmaceutical industry is dangerous to health. Further proof with COVID-19.** 21-Oct-2022;13:475 https://surgicalneurologyint.com/surgicalint-articles/the-pharmaceutical-industry-is-dangerous-to-health-further-proof-with-covid-19/

The article, preceded with a note from the Editor-in-Chief, James I. Ausman, MD, PhD, Emeritus:

> *"SNI is devoted to publishing the truth. SNI has no characteristics by which it judges papers except by fact supported information. The COVID-19 pandemic is one that is marked by conflicting and confusing information for the public. The only solution to this problem scientifically is to hear all sides of the issue, so that a reasonable decision*

[12] https://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA
[13] https://surgicalneurologyint.com/

can be made. Instead, we find and learn that practice was not and is not being done. Is the virus a[s] lethal as is described with high death rates? Should everyone be vaccinated and receive booster including small children and babies? Should people wear masks and socially isolate? Are the vaccines safe to use or do they have complications, notable of which are their respiratory, blood clotting, and neurological effects? Why is the public not being told about them? Are their deeper self-serving interests among the pharmaceutical companies, the Media, and governments to limit what the public knows? What is the truth? Fabien Deruelle, a French scientist, who is an independent thinker, saw some disturbing factors involved in the COVID -19 reporting. After spending 8 months researching and writing on his own to learn that the controversies surrounding COVID-19, he concluded that there was a huge amount of misinformation being told and spread, intentionally. The science was being corrupted by bureaucratic, governmental, pharmaceutical company, Media, and political forces so that the truth was not being told. The following is his review of the literature on the COVID-19 controversies. Hence, this independent scientist has discovered known facts which have been suppressed and are emerging in SNI pages and now, elsewhere around the world. His independent observations are what makes his report special."

But of course the misinformation Deruelle cites is not of the same orthodoxy that the Nathan Fletcher and the San Diego Board of Supervisors would have people believe. It's in the public record and the YouTube productions he arranged with Chief Medical Officer Eric McDonald to *promote* vaccination. The drug company commercials couldn't have done any better.

Indeed the questions raised by Ausman, everyone would like to hear the answer to since they are questions that could decide life or death, health or a lifetime of pain and suffering, or a lifetime of regret and sorrow by those that unnecessarily lost a loved one. These are not just good questions, they are *essential* questions for any society claiming ethical and moral ground. Deruelle spent considerable time and effort crafting this professionally written indictment on the pharmaceutical industry. His paper, like this report call for a reckoning. It's time to hold these elected officials accountable. They claim to champion the health and welfare of their electors but rather act with ill intent.

Deruelle's work supplements the details of injury and death in this report by providing more general comments on side effects, cytotoxicity of the spike protein and inaccuracy of testing. But it provides information at a layer above what I address here; results from the corruption, fraud and malfeasance by the pharmaceutical industry.

3.1.14 Website for the Vaccine Injured takes root: JIG

Actual victims of vaccine injury are rarely if ever invited to give their stories in the mainstream media. They are new cast in America, like the untouchables of India. But worse than that, they are the *unseeable*. Up until now any reports of injury or death have mainly appeared on scattered social media platforms that have not (yet) aggressively policed and censored the posts. They are the true poster children of pharma outcomes. The uncensored cites are limited to only a few like the Telegram channel https://t.me/covidvaccineinjuries which presently has a following of over 75,000 subscribers and another, https://t.me/died_suddenly that appeared more recently with almost 8000 followers. But there's good news. A new website is now in the making that plans to become a centralized global resource for the vaccine injured: Jab Injuries Global.

JIG's mission is to serve as a platform strictly to give the vaccine injured a collective voice and by that mechanism spread awareness of injury without serving as an advocate, offering opinions or judgements. Consider many of these people became injured because they were coerced by their company. The mandates threatened actual job loss, and indeed carried through when many refused. Most of those that didn't and accepted vaccination were indeed unaffected. But MANY lost their jobs anyway because they are now permanently disabled. And the vaccine act of 1986 gives the vaccine manufacturer indemnity. How is any of that fair?

3.1.15 Robert Malone Spills the Beans

On October 28, 2022 Robert Malone posted a video of a talk he gave that casts a different light on what the actual intent of the covid vaccines are and why they happened. Many remain skeptical of what Malone says, but look back just three years ago. Could you have anticipated the world the way it is now? I'll give him the benefit of a doubt. Here is a link:

mRNA Vaccines: The CIA and National Defense[14]

If mass formation psychosis is a reality, then many may not have enough of an open mind to see this. With their jobs and salaries at stake they'll not even consider it. But make no mistake, we are at war. And as Malone says, an information war. Someone, if not the CIA, has weaponized health care in the same manner that CIA has weaponized other opportunities in the past. Initially I was going to just summarize or post key points from his talk here, but the content is so compelling I decided to include the entire transcript. If you are an employee of the health care megaopoly just skip over to the next section.

mRNA Vaccines: Fact versus Fiction.

Robert Malone, full transcript from October 28

This isn't going to end well.

My purpose is not to overwhelm you with all of the various clips, newspaper clippings, scientific journal articles, et cetera, et cetera, but rather to help you to comprehend the technology and why it's being pushed and how it's being pushed. I'm going to present this as being focused on comprehension, not politics.

Now that may elicit some, "Oh, you're just controlled opposition." That seems to be a favorite theme that's hitting me and Jordan Peterson and Peter McCullough and a number of others, which is extremely divisive right now and isn't helping any of us. But just to set the record straight, two months ago in the Global COVID Summit Declaration IV we made unequivocal statements about the need to prosecute, that the need for accountability is there, that the vaccine should be stopped. They're neither saved nor effective, et cetera. I just want to make it clear that I put out, and my colleagues in Global COVID Summit and the International Alliance of Physicians and Medical Scientists have been very clear about our position regarding these products. I won't call them vaccines. I think that's really not an appropriate term given their activity, but that's not my purpose here. I'm hoping that by, if I can make the slides work, there we go,

[14] https://rwmalonemd.substack.com/p/mrna-vaccines-the-cia-and-national?utm_source=post-email-title&publication_id=583200&post_id=80797095&isFreemail=true&utm_medium=email

that by the time we're through with this, you'll kind of understand these core things. What are the drivers of COVID crisis response and the multiple truths behind them?

Looking at understanding the RNA technology as a way to start to make sense out of what we've all experienced. Paul has just given you another lens that through which you can view what has occurred. There are many others. He, for instance, just barely touched on the World Economic Forum and the World Health Organization, the collusion with the UN, et cetera. He hasn't really talked about the Bill & Melinda Gates Foundation initiatives. There is so many different ways that we can understand and begin to process what we've experienced over the last two and a half years. I speak about those various ways in different forums. But this one, I'm just going to focus on the RNA tech. It's enough to handle that in the time we have here.

What was the unmet medical need that was being addressed? I think it's important for us to understand at least those points of view of the other side that are comprehensible. There are clearly aspects that are nefarious, but I want you to understand at least some of the underlying rationale. Understand genetic vaccine technology, including mRNA. What is really the tech? It has been presented to a lot of people as a black box. It has this acronym that seems very intimidating to many people. I hope that when you leave here, you'll feel that you have a good grasp of what the technology is, what its fundamentals are so that you can process information and read the papers and make your own decisions about what you think things mean.

I want you to understand the difference between the payload and the platform. We're talking about the fundamentals of the pharmacology of this product category. I want you to understand how and why it's being pushed. This is more about me trying to give you insight and understanding about what is going on here as seen through this one lens of the mRNA technology and the falsehoods and truths that are behind it. It is only one of many lenses. I've spoken about mass formation. I've spoken about the World Economic Forum. I've spoken about the administrative state. There's so many variables going on here that we could talk for eight hours, but I'm just going to focus on the RNA.

Why mRNA vaccines? Why is this being pushed? There is this universal global, and understand what you've experienced here in Virginia is mirrored by the people that I was just speaking to at a conference in Padua, Italy about an hour and a half ago. The same things have been experienced in Brazil, all over the Western world. Why has this been pushed? What is the unmet need that's being addressed? Now, I'm not placing a value on whether they're right or wrong. I just want you to understand the underlying logic, at least at the surface of this.

The problem we have is that the technology to enable individuals to engineer bio-weapons has become so trivial that a college senior working out of their, or somebody of similar education level, they can self-train, working out of their garage with stuff they can get off of eBay, can easily recreate the most lethal pathogen combinations that our government came up with in the bio-warfare program that we ran for years. I'm not saying we're not still running it. We do it under a different moniker. We call it defensive bio-weapons research, not offensive bio-weapons research. I'm not sure what the difference is, but that's the language that's imposed from the bio-warfare treaty that was signed. It leaks like a sieve.

But I want you to understand, and if you don't mind keeping the slides up on the monitor because I need those because I'm of a certain age that I need these visual connections. Just to frame it, with traditional vaccine technology, we anticipate having vaccines, if everything goes well, for all of the bio-warfare agents deployed up until the end of World War II, that's tularemia and smallpox and all those things. Vaccines for all of the warfare agents deployed up until the end of World War II, and we'll have all those by the year 2050 if everything goes well.

Clearly, now we're in an environment in which a young adult or a bad actor in any part of the world can create very potent bio-weapons. Clearly, we don't have the capability to respond to that efficiently. That is the underlying unmet medical need. That's the problem set. We need to be all clear about that. We get all wound up. I'm not defending in any way the way this has been deployed. I'm not saying that this solution is the best solution. I'm just saying there is an unmet medical need, which is there is a very significant threat. It is not trivial. It's not a figment of Cheney's imagination that bio-warfare agents can be engineered.

I'm convinced we have been doing most of the engineering up until this point, and the stuff that is going to come out in Bobby's (Robert F. Kennedy, Jr.) next book is going to blow your circuits in terms of what we have done in

Georgia and Ukraine. We'll park that. These things are being done. The problem is that once they're let loose, which we've all experienced over the last three years, it's almost three years now really. It's the end of September, the data shows that the beginning of the outbreak was at least September of 2019, if not earlier. We've got three years of experience now in what this means.

Once those things are let loose, they can sweep the world. The technology is now advanced to the point where pathogens can be engineered so they're relatively specific for different ethnic groups based on their genetics. Pathogens can be engineered. I can tell you my friends, or what used to be my buddies at DTRA, Defense Threat Reduction Agency Chem Bio Division, are extremely acutely aware that agents can be engineered to target ethnic groups. That's the battlefield. That's the real environment we're in. We have to have some technology to enable rapid response.

We have to have some technology to enable rapid response for special forces teams that are going to go in to wherever the bad guys are when we detect them and address that problem and take them out. Those special forces need to be protected. We need to have capabilities that can be deployed at the battalion level. We need to have capabilities that can be deployed at the population level. This RNA tech was one of the ones, together with monoclonal antibodies, that the government has long believed had huge potential to enable that type of rapid response.

They actually like monoclonal antibodies better. The idea behind monoclonal antibodies that they really like is you can administer these products to a special forces group. They go in theater, do their business, come back out, go see their wife, monoclonal antibody is gone. It's cleared. Yay. The problem is that the technology just has not performed. The monoclonal antibody technology is too kludgy. It's too cumbersome. What we've learned over the last three years is that viruses and pathogens can evolve to escape that fairly rapidly because they're fairly specific. We've all seen the viral evolution in real time. We experienced it.

That's the unmet medical need and the justification underlying this. That there is an unmet need for some technology, that will now allow rapid response to both emerging pathogens and engineered pathogens such as bio-warfare or terrorism-based pathogens. I think we can all agree that we would like such a technology to exist.

The truth is that DARPA, which is the operational development arm, basically the CIA, fell in love with the RNA technology over a decade ago. They decided to capitalize it and force it into the market space. For instance, they're the ones that have capitalized through In-Q-Tel, their investment arm, the new RNA manufacturing facilities up in Canada. This is a CIA program. There's no ambiguity here. I'm not telling state secrets.

The technology was basically pulled out of the trash can, because it had been suppressed by Merck after I developed it over 30 years ago. Then it was advanced very aggressively by DARPA. DARPA funded and basically built Moderna. They're continuing to push all this. They're pushing it through the government. What you're seeing is the power of the intelligence community and the new bio-defense industrial complex that's developed since the anthrax attacks and it really goes beyond that in being able to push their agenda through the government.

When you see all these circumventing of normal procedures and rules, that's happening because largely our intelligence community is pushing that through the administrative state structure. Why are they doing it? I think if we just back up for a minute and say, "Okay, let's try to give them the benefit of the doubt for a moment." What I think they are believing is that they have to push this, they have to get acceptance for this technology because there are no alternatives. The threat is so severe, in their opinion, in their spooky world, the threat is so severe that something has ...

spooky world. The threat is so severe that something has to exist, and this is something they've latched onto. Now, I'm saying this not to defend them. I'm saying this to try to help you to understand what you've been subjected to. DNA versus RNA vaccines. I had come up with both ideas back at the Salk in '89. DNA can also be used for vaccine purposes. This is the core idea, the little brilliant insight that I had. I don't think I'm being arrogant in saying that. This little thing that popped into my brain when I was at this gene therapy lab at the Salk, and I realized that we had a problem. The gene therapy wasn't going to work because the new genes that are the good genes are seen by the immune system as just different. They're producing different proteins, and your immune system doesn't know whether it's a good protein or a bad protein. It just knows that it's a different protein. It will attack it.

And that turned out to be the logic flaw in gene therapy. And they still haven't solved that. The only way to solve it is to put the genes into an immunocompromised compartment like the back of your eye or to immunosuppressed people. And I basically was there as a student passionately wanting to develop gene therapy, realized that the whole field that I'd committed my life to was never going to work. And came up with the idea, oh, well, it could be used to elicit a vaccine response. Gene therapy could be used for vaccines. Which is why I've said all the way through, these are not really vaccines. These are gene therapy technologies applied to vaccination. That includes the adenovirus vectors. It's explicit.

And the first embodiment, I filed these patents, and they included use of mRNA in particular. I thought it had advantages, but also, DNA. And the world picked up on the DNA part because it worked in mice. Merck bought the rights, and they spent well over a billion dollars that could never make it work. And they just abandoned it until, like I said, the CIA basically picked up the RNA part out of the trash can and pushed it forward and made it work. So, that's what's happening here. It's about the idea that we can use gene therapy technology, deliver genes into your body and cause your cells to become little manufacturing factories, to produce a part of a virus, a foreign protein, and generate an immune response, both a T-cell and a B-cell. So, cellular and humoral immunity against that foreign protein in a way that would be very similar as if you got infected by the virus. But there's no virus. That was the logic.

The problem is like everything, it all sounds great on paper, and then, you got to make it work, and you got to deal with the consequences when things don't go right. I just wanted you to understand that. The logic for why mRNA was because mRNA typically only lasts for a few hours or maybe half a day after it's manufactured in your body. The idea that I had way back then was that this RNA could be used like a drug, administered, and that if somebody has a toxicity, a toxic reaction, it'll be degraded and gone. Just like you clear most drugs. And then, a physician can decide, let's not do that again. That was the idea behind RNA as opposed to DNA, which sticks around for a long, long time in your body once it's in a cell. That's where this started from.

Now, let's talk about, remember, my goal is that you walk out of this understanding. This is not a focus on passing judgment. This is a focus on empowering you to comprehend what's going on. And the starting point is you have to understand that DNA makes RNA, and RNA makes protein. Not everybody has been through modern biology and understands the central dogma, but that's where this is going. mRNA is one of many different types of RNA. It's an acronym. It sounds scary to some people. It means messenger RNA. There's other kinds of RNA. Ribosomal RNA, transfer RNA. They do different things. RNA is just a molecule, a polymer that your body uses for many different things.

And one of them is to transfer information from DNA to the protein manufacturing machinery. And so, the idea of using mRNA as a drug is basically like hijacking the normal apparatus. If you think of RNA like a ticker tape to tell the little machine that makes protein what to make, you're taking and sticking in a foreign molecule, a foreign RNA that's not made from a copy of your DNA, and that's going to make the protein manufacturing machinery make a different protein, protein from a virus. I just wanted you to understand that. And this is just a diagram of those different types of RNAs and the machinery. We don't need to go into the molecular biology of it.

And we all know this virus now. Everybody's become a virologist and an epidemiologist over the last three years. And the spike protein on the right, as you can see, has kind of two parts. One is a part that sticks into the cell. And by the way, it exists as a trimer. I like to think of it as a treble hook, anybody go fishing. It's a trimer. And the little hook's on the end, so the barbs or the receptor binding domain, and the part that you tie the string to is the S1 subunit that sticks itself into the cell when it's being manufactured. That's the basic structure of the virus and the protein. Now, these are images, and they're hard to see from where you are. I'm going to talk to you about the tech, the formulation platform.

These are not liposomes. These are positively-charged fats, and RNA is negative. And you take these fats and you mix them with the RNA, and it all collapses into a glob. The problem with that is that when it collapses into a glob like this, it can stick to other globs. It produces very large aggregates. That's why the people that are administering these vaccines have very strict guidelines. Once they open the bottle and they hydrate it, they need to use it within a short period of time because otherwise, it forms big aggregates. And those big aggregates can be toxic to people. And there is a technology used to keep this aggregation from happening. And it's one of those different little parts that are in that upper panel that shows examples schematically of the chemicals that are used, these positively charged fats, and some of the other things that are added into the formulation, which includes cholesterol, among other things.

And one of those is polyethylene glycol. And polyethylene glycol is probably responsible for a lot of the short-term anaphylaxis. These are people that die within an hour or two after administration. Some people have hypersensitivity to polyethylene glycol. Polyethylene glycol is in there to keep these things from aggregating, and it's specifically engineered in this case so that it falls off of the particle soon afterwards because otherwise, it would keep the particle from binding to cells and delivering the RNA. That's kind of all I want to talk about, about the core idea. And as you can see from that little spiral, all of this aggregates and forms around a synthetic RNA that's made in the test tube. It's not really RNA. The stuff that's being administered is not natural RNA. That's another... Paul has his list of lies.

Another one of the lies is that the stuff that's being injected with these vaccines is not truly RNA. It's modified. One of the four parts, AUGC, that forms the bead, the string of pearls. Think of string of pearls with four different colors. That's RNA. But one of those colors, the U, is actually a modified U. It's pseudouridine. And it's put in there because the RNA has two problems as a mechanism for vaccination, as a delivery mechanism.

One is that these formulations are incredibly inflammatory. They provoke... If you want to generate pus, take these formulations without all the bells and whistles they've had to put on them, and inject them into an animal. They are highly inflammatory, and they're still inflammatory now. We know that now. We've experienced over the last three years. That's always been the problem with the tech. And they tried to solve it by incorporating this modified U called pseudouridine, which depresses the immune response to the RNA and a lot of other things. And it makes the RNA last a much longer time so it can keep making protein.

Pseudouridine is what's put all the way through this RNA rather than regular uridine. And because it has, it confers these activities, but it is not a natural RNA. It's not what the ideas that I originally came up with. The stuff would only stick around for a few hours. Now, this is too small for me to read and probably is too small for you to read, but the bottom line, as I said, is that pseudouridine greatly modifies this whole equation in so many different ways. And when it was developed and patented at UPenn as a modification to the core patents and technology, it wasn't really understood what it does.

The biology of pseudouridine is still not understood. And that's part of the story of all of this is that folks have kind of gotten ahead of their skis all the way through. They've pushed the technology because they want it so badly because the unmet medical need is so profound. They're so afraid of the risk, in part because we're creating that risk. But that's another story. And they wanted to have something that would be universal that they could apply for any new pathogen and that could go straight from gene to vaccine. That's the idea.

And what they did is they kind of rushed things without understanding it. Now, you'll recall that we're administering, we're all receiving... Those that have received the vaccine, receive it in their deltoid. And what the FDA has told all the docs and Pfizer has told all the docs, is that that RNA, those complexes go to draining lymph nodes, and they do. The axillary lymph nodes that drain from that deltoid take that complex, it's piped into there through the lymphatics, and a lot of it does go there. Unfortunately, the data show that it also goes all over the body. But back in the day when this was just getting started, three years ago, well, we could argue about that, but as these particular products were being developed, they were being sold, the technology was being sold that the formulations used would only go to those lymph nodes. Now, we know that that's not true, but that's how it was pitched.

Now, what happens when that's done? The big story here underlying all this fraud and everything that Paul is talking about is the FDA did not do its job. FDA did not do its job, I think, because it was being pushed into a position of having to go along with what the intelligence community wanted and all of the push from the White House and everywhere else that we needed to have this technology, we needed to have this technology deployed globally. And so, we're going to just allow a lot of corners to be cut.

Finally, at the beginning of this year, with this paper published in January, a group from Stanford University asked the questions. How long is the RNA there? How long is the protein, spike protein being made? How much spike protein is being made? Fundamental questions that should have been known at the very beginning. But the FDA did not force the pharmaceutical companies to do those tests because they justified it. They did a little hand waving.

... because they justified it, they did a little hand waving. They said, "These are not gene therapy products. These are vaccine products." Now that's a lie, a convenient lie, but that's what they did and that allowed them to justify only applying the vaccine safety checklist at the FDA rather than also applying the gene therapy checklist. This is why when I first started talking about this and I said, "This is gene therapy." I got so much blow back from all the fact checkers in the press, et cetera, is because they could not allow the narrative to come out that this is actually a gene therapy product applied for vaccine purposes. But we know that the manufacturers knew that to be the case because they had said so in their SEC filings before all this happened years ago, okay? So this is another one of the little slights of hand that was used.

But this group at Stanford went and finally did the work that should have been done before this was administered to all of us, and what did they find? Well, among other things they documented, this is one of the first key papers that immune imprinting is happening, which is why when you get multiply jabbed, and I think these boosters are going to make it even worse, you actually become more susceptible to the viral infection because your immune system is tuned to only responding to the historic strain, not the current strain.

But they found some other things in here, and I'm sorry this is too much text, so I'll just tell you. What they found was that the levels of protein, these are actual patients, this isn't animal models or anything else, this is patients that have received vaccine, the levels of spike protein in the blood of these patients were much higher than the levels of spike protein found after infection. With infection, the virus is slowly starting to replicate in your nose and your oral pharynx and your mouth and your upper respiratory tract and your immune system is kicking in and starting to neutralize that, and they're having a fight as a gradual balance and it results in a slow growth in the amount of antigen.

With the RNA, when that young gentleman there that's going to sleep gets his vaccine, which hopefully he didn't take, what happens is his body gets a truckload of spike antigen that's basically dumped into his bloodstream on a very short time course, very different from natural infection. And so when people say, "Well, why would you see toxicity with the spike protein from the vaccines and not see the same... Why would it be worse with the vaccines than with the infection?" Well, because of dosing, there's so much more protein being produced, and by the way, it's being produced for a long time, about 60 days or longer. They didn't test beyond 60 days. Furthermore, the RNA doesn't just go away after a few hours like real RNA, this RNA that has pseudouridine in it lasts for up to 60 days as long as they test it. Again, this is not theoretical, this is putting needles into patients axillary lymph nodes, taking a sample and asking is the RNA there and taking blood samples and asking how much protein is in those blood samples. So that explains a lot of what we've experienced.

Then there's this issue, and this is part of the lies that Paul was talking about that we've all experienced, that natural immunity is not as good as vaccine-induced immunity. There are many, many papers out now that show that that's not true. And from first principles it's easy to understand why it's not true. When they built these vaccines they chose to basically start with what had been done before and failed with MERS and SARS 1 vaccine development and only use a single protein, only used the spike protein and used the whole spike protein because they were in denial that the whole spike protein was a toxin and they still are, but they're kind of starting to have to concede that point.

But they only used one antigen. When you get infected by the virus, you mount an antibody and a cellular immune response against a whole bunch of antigens, and so if the virus starts to evolve to evade immune surveillance on the spike protein, which is what's happened in the face of all these jabs that everybody's got all over the world, if it starts with a natural immunity, if it starts to evolve to escape that immune suppression, immune pressure on the spike, it can't do that at the same time that it's evolving to escape all the other forms of immune pressure that are there because of all the other proteins that it makes. This is fundamental. Everybody knows this in my field, but they've been in denial about this and this is this insistence that their approach is the best and is accurate and it won't drive the immune escape, et cetera, et cetera. But the data are in now, natural immunity is more robust, longer lasting, more protective, and likely, results in much less [inaudible 00:33:50] development.

What are the risks? Let's see if I can read them here. This is actually the Cumulative Analysis of Post-Authorization Adverse Event Report from Pfizer, this is from the data that was forced to be released by Pfizer by court order instead of being delayed for 7 years, like Paul was talking about. Central general disorders, nervous system disorders, musculoskeletal disorders, gastrointestinal disorders, respiratory disorders, skin disorders, infections, cardiac,

vascular, psychiatric, blood and lymphatic, eye, immune, it goes on and on. In the Pfizer disclosure, it's 11 pages, okay? They've known all this stuff. This isn't what they thought might happen, this is coming from pharmaco vigilance at Pfizer with their licensed vaccines, because the stuff that's here in the United States is not the licensed product, by the way. This is data coming from all over the world accumulated by Pfizer by the pharmaco vigilance team, and this is what they're reporting to the FDA, which the FDA of course then denied was actually happening.

The list of adverse events is huge, it's like nothing any of us have ever really seen with a product like this. I've certainly never seen anything like with this vaccine, let alone the mortality. And why our government and our regulatory agencies, both in the US and globally, aren't willing to address that is another whole discussion about the politics and the corruption that's gone on, and Paul kind of touched on that a little bit, but we could go on for hours.

Now, the last key thing I kind of want you to understand as we talk about this, we talk about these genetic vaccine technologies, and I guarantee they're going to be deployed on you for years now, but you need to understand some of these fundamentals, platform versus payload, and everybody gets mixed up in this. There's the platform technology, which has the potential to enable a whole new class of pharmaceuticals, therapeutics, customized treatments for individuals for their cancer, all kinds of good stuff, this is why these companies have their market cap, potentially to enable a new class of pharmaceuticals based on delivery of genetic information.

The idea, as I mentioned with the platform, is that you can go direct from genetic sequence to product and shorten the development time because the manufacturing is the same no matter what the sequence is. You just key it into the computer. That's why they love it. They think that once they get one standard manufacturing process with all the characterization associated with it, they don't have to do it again. They can just go to the computer, key it in, sequence whatever the thing is, make customized medicines for your wife because she's got cancer or any new pathogen that's come out of Central Africa or whatever the thing is. That's their belief system.

The mRNA platform includes all of the things that are required to manufacture and deliver the RNA, that's separate from the thing that's made, the protein that's made, that's called the payload. It's kind of important for you to understand going forward to make sense out of all this stuff. Okay, so you understand platform versus payload, the spike protein and the RNA coating the spike protein is the payload. The way that it's packaged, assembled, manufactured, tested, et cetera, is the platform. The platform consists of these fats, the polyethylene glycol, other RNAs, the synthetic mRNA, other components.

Is there graphene oxide? The problem I have with that question, which has been coming at me for almost two years now, is there's no way for me to know whether there's graphene oxide or not. There's a lot of graphene oxide in the general environment, and the only way that this can ever be demonstrated to either true or false is either if, number one, the pharmaceutical companies come clean with the components that are in these products, and they will not release that, okay? They will not release a full component list. Or, a regulatory agency or someone else empowered will test the lots coming off of the line rigorously in a controlled way with a clear chain of custody as they have always done in the past, and which they are forbidden from doing by contract from these manufacturers.

So the problem I have with the graphene oxide and the other contaminants is that in most cases there is no good way to answer that question because we are forbidden from answering that question because, through contract, the regulatory agencies aren't able to do their job all over the world and assess what's actually in those vials. Are they truly pure? Is the identity what's defined? Is the potency what's defined? The pharmaceutical companies have executed contracts that prevents that from being known.

There's no question that we have contaminants of small glass fragments and small metal fragments in many lots, not necessarily all lots, and those are known types of contaminants that come from existing pharmaceutical manufacturing processes like fill/finish, and they're absolutely toxic. And again, that's evidence that the regulatory agencies have not been doing their job. That's their job is to ensure purity, potency, and identity.

The payload also includes the manufacturing, purification and testing processes, which I've just talked about, have been co-opted. It includes the regulatory package, including the nonclinical testing. So this is the notorious animal testing that was done not with the spike encoding RNA, but with the firefly protein called luciferase, using the least sensitive method for detecting where the product goes, which is whole body imaging as opposed to dissecting the tissues

and analyzing them. Somehow the FDA allowed the wool to be pulled over their eyes by the pharmaceutical companies and they allowed them to use the least sensitive method for determining where this stuff goes and where it's making protein. That's another huge failure.

But the platform includes all of that data, fill, finish, distribution and storage, all of that goes into the platform tech. And the payload is, as I mentioned, the RNA, which causes your cells to become the manufacturing facilities. And that RNA itself can have biologic activity, so I've talked about the pseudouridine immunosuppression, increased half-life. Another major problem with these products is that during the manufacturer of the RNA itself or the pseudouridine RNA, what happens is that the polymerase, the thing that's making it in this biologic reaction stops periodically and when it does that it releases a fragment of RNA that's incomplete. Those RNA fragments...

RNA that's incomplete. Those RNA fragments are biologically active. They can interfere, they can elicit immune responses, all kinds of things. And they don't have a good way to purify those. So the material that's being injected, it's not just a false RNA, a pseudo uridine, including RNA, but it's a whole mixture of stuff of which they hope the majority is the thing they want. But they haven't created any purification guidelines for all these other contaminants. If it was a normal drug or a normal biologic, the FDA would be rigorously scrutinizing and ensuring that it is only the biologic that it's claimed to be and doesn't have any other contaminants or so, if they're contaminants there's strict guidelines about how much. That doesn't exist here.

The payload also includes the protein. And the primary protein in this case is spike. In other cases is the influenza hemagglutinin for the new flu vaccines. But that protein we now know can have other things embedded in it. And I mentioned the snake venom story. I don't think that the sequence analysis supports that thesis of Dr. Artis. I'm absolutely not convinced. But the possibility that these proteins can be engineered to include other antigens, or do include other antigens is absolutely feasible, is absolutely viable. So the payload and the sequence of the payload and what it causes your cells to manufacture are crucial.

Now, how and why is this being pushed? Obviously, we've all experienced the propaganda and censorship, and Paul's talked about that. I've experienced it personally. This is uncontrolled information warfare, unrestricted information warfare at a level the world has never seen before. We have a situation in which all of the major media is controlled by large financial entities that happen to be the same ones that control the pharmaceutical industry. And functionally, control our government. What we've seen is that the propaganda information warfare blocking of anybody disclosing adverse events, like all of you that got up and said you've known of people directly that have either died or been damaged. I've been vaccine damaged. That's not allowed to be discussed.

It's not allowed to be discussed because of the potential impact on the deployment of this product, which they believe that the ends justify the means. That it is absolutely essential that they get the world to be able to accept this new technology because if they don't... And there's all the other agendas about the vaccine card, and the personal ID and central bank digital currency, et cetera. But, at the fundamental level, there's a belief that this technology is so important that we have to push it through the entire population. And we have to get people to accept it. And so, that's so important that they believe that they were justified in deploying the largest propaganda effort the world has ever seen.

Paul underestimated. It was over a billion dollars spent by the CDC, okay? And it's still ongoing. What that results in is that people cannot have informed consent. So I have a colleague who blames me, says that because I talk about mass formation psychosis, I'm saying that everybody is responsible and the global predators are not responsible. In no way is that true. That's a false narrative. And I'm in no way saying that individuals are responsible if they, like I, took the vaccine. We were not able to obtain informed consent.

In my case, I had a teleconference because of who I am and my background. I had a teleconference specifically with Peter Marks at the FDA early on where I said, "Peter, I'm concerned about these things that are in this non-clinical package. You guys have been hoodwinked." And he told me, basically, "Robert, give me some time to get this out. I have the new data package from Pfizer. I have no concerns now. Please don't make a big issue out of this." And I stayed silent for a few months based on that, and I took the jab. And I got the toxicity. My point is I was fooled. We were all fooled. And we were all prevented from having informed consent. So forgive each other, please. Forgive me.

Now, this is new information that was just published. In April of 2021 there was a World Health Organization consultation. Now, that's fancy bureaucratic talk for we all get together and figure out what we're gonna do. It was chaired by Margaret Liu of Merck, who was the person that was at the forefront of the team trying to get DNA vaccines developed back in the '90s and failed. But she was the chairperson, very much an industrial scientist. In this meeting that brought together all the regulatory agencies from all over the world, it was decided to circumvent normal preclinical and clinical testing based on this shared core platform concept. That's why I wanted you to understand what the platform was as opposed to the payload.

So there was a conference at WHO in which all the Western regulatory agencies got together and China, and they all agreed that we're gonna treat this as a platform technology, and we're going to push it through with very limited testing. And then once we've done that, new products can be rapidly developed by grandfathering in that old inadequate data package. Now, I'm not saying this as a conspiracy theory. It's published. And we are now seeing that being deployed. The only new data that will be required for these new vaccine and mRNA based therapeutic products is going to be that associated with the payload. So they're gonna assume that the platform is safe now because it's been deployed in billions of people. That's another reason why they have to deny all the adverse events 'cause the whole logic collapses otherwise.

The FDA position, and we've now seen this deployed, thank you for five minutes... We've now seen this deployed with the new boosters. The FDA position is that changes in the mRNA sequence for similar payloads do not require substantial non-clinical or clinical data. What that means is what we've seen. They went to manufacturing, sales, and deployment of these new vaccines with virtually no real testing. To the extent that they did any testing in mice what they found was that it didn't in any way interfere with infection of those mice by the pathogen. It didn't work in the mice. It doesn't matter. They've all agreed that this is the new rules.

So now, we have over 100 clinical trials for mRNA vaccines, 51 of which are currently enrolling, the rest are about to start enrolling in the United States, and they're all grandfathered based on what they assert is the clear evidence that there is no safety risks associated with this technology because it's been deployed in billions of people in the United States and worldwide.

In addition, there's over 200 clinical trials for mRNA based drugs based on this same logic. This all grandfathers in a technology platform, ignores that what's being delivered is not natural RNA. And what it creates is a situation. This is how things work in regulatory space. There's only two companies right now that have those approved data packages. And what that means is that these two companies now have a monopoly on any new drugs, or vaccines developed and deployed with this technology. Because anybody else that's gonna try to come in with their own version of it is gonna have to go through all of that other testing and demonstrate that their stuff is at least as safe and effective as the stuff that's been deployed on all of us. So what the FDA has done is granted a monopoly in perpetuity to Pfizer, BioNTech and Moderna.

So I hope that instead of talking about this toxicity or that toxicity, the event rate for the cardio toxicity, or whether or not we're all going to die in five years that have taken the vaccines, what I've tried to do is to help you to comprehend what's really going on underneath all of this. And remember my statement at the start, that's not to say that this outbreak and the situation was not exploited for economic and power reasons by a bunch of other bad actors. It's not to say that there wasn't planning aforehand. It's not to say that Bill and Melinda Gates Foundation and Bill Gates has not made book on this. It's not to say that in any way I'm denying that the corruption in the FDA, and the CDC and academia, as Paul was talking about, is profound and deep and systemic. I'm only giving you this little lens of looking through the RNA technology environment so that you can comprehend at least that part as you try to make sense out of everything else.

I thank you for your time. I hope it was helpful.

3.1.16 How new technology can supersede better judgement; the Therac-25 incident

We all know how technology can capture our minds, hearts and souls. As a technology creator there's the enticement of financial opportunity, but there's also the sheer excitement of pioneering new capability and invention. Far too often excitement blinds many to the risks new technologies *always* incur.

Consider the global pandemic. Whether real or fabricated, the 'emergency' provided opportunity to launch, on a grand scale, the mRNA and nucleoside technologies that had been on the back burners for years. Yes astronomical profits and yes way cool, but the risks … we are only now beginning to learn.

Rewind 40 years…A history lesson.

Computer technology was expanding and permeating all types of applications to 'improve' life. One of those application areas were medical devices. And one of those devices was the Therac-25[15] , a linear particle accelerator adapted as a radiological tool for treating cancer. Whereas prior models of Therac used electrical circuits or mechanical devices to address safety issues, the Therac 25 used *software* to manage safety. The designers had faith, without proper due diligence, the software was more *reliable* than mechanical or electrical systems. A technological illusion. They allowed limited testing and risk analysis based on *beliefs* of the way software functioned. Nowhere did they include *computer failure* or *user variation* in their analysis.

Then came the 'accidents' after the product was released. Patients reported being burned. Some feeling a tremendous source of heat. Some screamed under intense pain during treatment with technicians insisting there was nothing wrong with the machine. But in the end the outcomes were horrible – devastating. One women had to have her breast, burned by the radiation surgically removed. Others later died from excessive radiation burns.

It turned out there were 'bugs' in the software that were not anticipated in the design stages, and the test protocols were not comprehensive enough to screen for the mode of failure. I encourage the reader to review the full report provided by the link above to appreciate the complexity of the issue. Patients were receiving radiation doses in some cases that were 5 orders of magnitude greater than the set dose.

The Therac-25 incident turned out to be the turning point for regulators regarding software quality in medical devices. The FDA, which also regulates devices calls for special software validation measures, risk analysis and design controls to assure proper safety.

As I recently recalled the Therac-25 incident and pondered on mRNA technology and the hasty release of COVID-19 vaccines, it occurred to me that we still havn't learned our lesson. The COVID-19 vaccine technology in many ways parallels what happened when computer technology was introduced to the Therac design. It may very well be history is repeating itself. In the present situation it's the new genetic technology being forced into the application of a vaccine. But the designers underestimated how truly complex the problem is. For the vaccines we may incur many more casualties than what the Therac caused. For the Therac it took two full years to realize they were causing death and injury. How long will it take for the vaccines?

[15] https://escholarship.org/uc/item/5dr206s3

3.2.Cancer: An Inconvenient Outcome of Extended Mask Use?

The harms that COVID-19 policies cause extend outside vaccine injury or death. So called 'collateral' damage. Mask use may very well be contributing to the excess deaths now recognized by almost every country on the planet. Thousands of deaths might be expected to peak during a bad flu season, but since lockdowns were announced in the spring of 2020, many countries have experienced persistent levels of excess death in the thousands to this day. There's been an ongoing debate over mask use regarding effectiveness (or lack thereof) in preventing transmission of viral infection, and also harmful side effects they might lead to.

So far most scientists and doctors are reluctant to blame vaccines as a contributing factor in the excess deaths. OK, so then what else? Vaccines weren't the only thing that changed the landscape of human habitation starting in 2020. Some institutions, like healthcare for example, still require the ritual wearing of masks to receive service, but even today many persist on their own recognizance wearing masks in public spaces, and some even alone while driving in their cars. At home? I would not doubt it. The 'pandemic' seems to have permanently disabled some people psychologically - mysophobia.

Dr. Christina Parks recently claimed that extended mask use can lead to acidosis, a shift in the blood and other fluids of the body towards an acidic pH level. Acidosis is documented in the literature as favorable conditions in the growth and propagation of cancerous tumors. Could this, on a longer time frame of many months, be contributing to the excess death? Is what Parks claims even plausible?

First the mechanism. Physically, what happens with a face covering to raise fractional inspired carbon dioxide ($FiCO_2$)? Any device attached to the face that complicates normal gas flow into the noise and mouth can potentially disturb proper flushing (clearance) of exhaled gas from the airway, and that can lead to *rebreathing* of the end tidal gas. End tidal gas contains the highest concentration of carbon dioxide in exhaled gas ranging between 4% to 6%, compared to atmospheric concentration of only about 0.04% or 400 parts per million. Clearance of exhaled gas could also be affected by disease states of the upper or lower airways, such as chronic obstructive pulmonary dysplasia (COPD). COPD is a respiratory disease that tends to 'trap' exhaled gas in the lung and airways.

Any device, including face coverings, artificially extend the physical breathing dead space beyond what the natural anatomy imposes. During exhalation, end tidal gases can be physically trapped in this dead space and rebreathed in the subsequent inhalation. Engineers that design PPE for safeguarding against respiratory hazards address this issue by (1) minimizing the dead space volume of the device, (2) using directional valves to maintain a unidirectional flow of gases, or most effectively, (3) positive pressure breathing systems that actively flush end tidal gas throughout exhalation.

The adoption of cloth and paper masks as PPE during the covid pandemic rapidly proceeded without careful and thorough consideration of either their effectiveness or safety. These masks indeed create an extension of the effective dead space in the airway. The mask, even though porous, acts as a barrier blocking surrounding air currents that would normally tend to clear exhaled gas near the uncovered airway. Masks effectively trap end tidal static gas between the mask and face long enough to be rebreathed on subsequent inhalation. There are a number of studies that that provide data supporting this hypothesis indicating increase of carbon dioxide:

[1] Rhee MSM, Lindquist CD, Silvestrini MT, Chan AC, Ong JJY, Sharma VK. **Carbon dioxide increases with face masks but remains below short-term NIOSH limits**. BMC Infect Dis. 2021 Apr 16;21(1):354. doi: 10.1186/s12879-021-06056-0. PMID: 33858372; PMCID: PMC8049746. https://pubmed.ncbi.nlm.nih.gov/33858372/

[2] Epstein D, Korytny A, Isenberg Y, Marcusohn E, Zukermann R, Bishop B, Minha S, Raz A, Miller A. **Return to training in the COVID-19 era: The physiological effects of face masks during exercise**. Scand J Med Sci Sports. 2021 Jan;31(1):70-75. doi: 10.1111/sms.13832. Epub 2020 Sep 30. PMID: 32969531; PMCID: PMC7646657. https://pubmed.ncbi.nlm.nih.gov/32969531/

[3] Geiss, O. (2021). **Effect of Wearing Face Masks on the Carbon Dioxide Concentration in the Breathing Zone**. Aerosol Air Qual. Res. 21, 200403. https://doi.org/10.4209/aaqr.2020.07.0403 https://aaqr.org/articles/aaqr-20-07-covid-0403

[4] Chandrasekaran B, Fernandes S. **"Exercise with facemask; Are we handling a devil's sword?" - A physiological hypothesis**. Med Hypotheses. 2020 Nov;144:110002. doi: 10.1016/j.mehy.2020.110002. Epub 2020 Jun 22. PMID: 32590322; PMCID: PMC7306735. https://pubmed.ncbi.nlm.nih.gov/32590322/

Chandrasekaran et al, written at the height of mask use before vaccines were deployed, actually compares the mask user to a person suffering from COPD. Persons exercising with a mask reduces the arterial partial pressure of oxygen (PaO_2) and increases the partial pressure of carbon dioxide ($PaCO_2$). The unbalance can lead to peripheral vasodilation, and a vast range of metabolic upsets on various organ systems causing headache, lethargy, fatigue, an increase in anxiety and depression, and a higher susceptibility to infection.

[5] Shein SL, Whitticar S, Mascho KK, Pace E, Speicher R, Deakins K. **The effects of wearing facemasks on oxygenation and ventilation at rest and during physical activity**. PLoS One. 2021 Feb 24;16(2):e0247414. doi: 10.1371/journal.pone.0247414. PMID: 33626065; PMCID: PMC7904135. https://pubmed.ncbi.nlm.nih.gov/33626065/

[6] Walach H, Weikl R, Prentice J, et al. **Experimental Assessment of Carbon Dioxide Content in Inhaled Air With or Without Face Masks in Healthy Children: A Randomized Clinical Trial**. JAMA Pediatr. Published online June 30, 2021. doi:10.1001/jamapediatrics.2021.2659 https://jamanetwork.com/journals/jamapediatrics/fullarticle/2781743 RETRACTED with over a million views. https://jamanetwork.com/journals/jamapediatrics/fullarticle/2782288

[7] Sanri E, Karacabey S, Unal E, Kudu E, Cetin M, Ozpolat C, Denizbasi A. **The Cardiopulmonary Effects of Medical Masks and Filtering Facepiece Respirators on Healthy Health Care Workers in the Emergency Department: A Prospective Cohort** Study. J Emerg Med. 2022 May;62(5):600-606. doi: 10.1016/j.jemermed.2021.11.021. Epub 2022 Jan 19. PMID: 35058098; PMCID: PMC8767914. https://pubmed.ncbi.nlm.nih.gov/35058098/

[8] Matuschek C, Moll F, Fangerau H, Fischer JC, Zänker K, van Griensven M, Schneider M, Kindgen-Milles D, Knoefel WT, Lichtenberg A, Tamaskovics B, Djiepmo-Njanang FJ, Budach W, Corradini S, Häussinger D, Feldt T, Jensen B, Pelka R, Orth K, Peiper M, Grebe O, Maas K, Gerber PA, Pedoto A, Bölke E, Haussmann J. **Face masks: benefits and risks during the COVID-19 crisis**. Eur J Med Res. 2020 Aug 12;25(1):32. doi: 10.1186/s40001-020-

00430-5. PMID: 32787926; PMCID: PMC7422455. https://pubmed.ncbi.nlm.nih.gov/32787926/

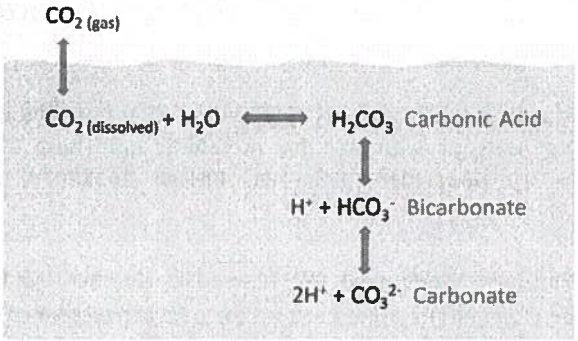
> *"Depending on the design, masks can increase the lung's dead space. In extreme cases, carbon dioxide retention (hypercapnia) can occur with side effects. Only few investigations are available and addressing this medical problem. The available literature examined different types of N95 masks in the industrial setting in detail [14–16], and found relevant effects on the wearer. In this context, Kim et al. [17] studied the role of N95 masks on lung function and heart rate during low-to-moderate exercise/physical work load. Only healthy subjects seem to tolerate wearing such a mask."*
>
> *"N95/FFP2 masks. Test results demonstrated the potential risks of wearing this type of mask in the presence of advanced COPD [19]. Their use should be recommended with caution in this patient population, a questionably relevant recommendation, since the use of these masks is limited to health care workers"*

[9] Sinkule EJ, Powell JB, Goss FL. **Evaluation of N95 respirator use with a surgical mask cover: effects on breathing resistance and inhaled carbon dioxide**. Ann Occup Hyg. 2013 Apr;57(3):384-98. doi: 10.1093/annhyg/mes068. Epub 2012 Oct 29. PMID: 23108786. https://pubmed.ncbi.nlm.nih.gov/23108786/

[10] Roberge RJ, Coca A, Williams WJ, Palmiero AJ, Powell JB. **Surgical mask placement over N95 filtering facepiece respirators: physiological effects on healthcare workers.** Respirology. 2010 Apr;15(3):516-21. doi: 10.1111/j.1440-1843.2010.01713.x. Epub 2010 Mar 11. PMID: 20337987. https://pubmed.ncbi.nlm.nih.gov/20337987/

So we can accept as a fact that mask wearing can lead to an increase in rebreathed carbon dioxide.

It's also general knowledge among respiratory therapists and engineers that develop various types of breathing apparatus that a high $FiCO_2$ (fractional inspired carbon dioxide) over extended periods of time can lead to acidosis; an increase in $PaCO_2$ and a lowering of blood pH. A pH less than 7.35 is considered acidotic since normal healthy blood is slightly alkaline (pH = 7.0 is neutral). The chemical process is relatively simple. Carbon dioxide, compared to other respired gases, is highly soluble in water, and once dissolved undergoes chemical bonding to create carbonic acid. Carbonic acid spontaneously dissociates into bicarbonate and carbonate ions, liberating 'hydrions'; hydrogen ions. The concentration of hydrions determine the level of pH. By this chemical process in a human, an equilibrium is reached in pH depending on the tension (partial pressure) of carbon dioxide in the inspired gas. This is illustrated in the simple diagram below.



Therefore extended mask use will lead to an increase in inspired carbon dioxide, which will lead to hypercarbia, and hypercarbia will lead to acidosis.

Does acidosis cause or promote the growth of tumors?

For that we need to dig into the literature.

[11] Anne Riemann, Sarah Reime, Oliver Thews, **Tumor Acidosis and Hypoxia Differently Modulate the Inflammatory Program: Measurements In Vitro and In Vivo**, Neoplasia, Volume 19, Issue 12, 2017, Pages 1033-1042, ISSN 1476-5586, https://doi.org/10.1016/j.neo.2017.09.005 , https://www.sciencedirect.com/science/article/pii/S1476558617302919

[12] Jonathan W. Wojtkowiak, Jennifer M. Rothberg, Virendra Kumar, Karla J. Schramm, Edward Haller, Joshua B. Proemsey, Mark C. Lloyd, Bonnie F. Sloane, Robert J. Gillies; Chronic **Autophagy Is a Cellular Adaptation to Tumor Acidic pH Microenvironments**. Cancer Res 15 August 2012; 72 (16): 3938–3947. https://doi.org/10.1158/0008-5472.CAN-11-3881 https://aacrjournals.org/cancerres/article/72/16/3938/576339/Chronic-Autophagy-Is-a-Cellular-Adaptation-to

[13] Gutt CN, Kim ZG, Hollander D, Bruttel T, Lorenz M. **CO2 environment influences the growth of cultured human cancer cells dependent on insufflation pressure**. Surg Endosc. 2001 Mar;15(3):314-8. doi: 10.1007/s004640000321. Epub 2000 Oct 20. PMID: 11344436. https://pubmed.ncbi.nlm.nih.gov/11344436/

[14] Merryman JI, Park PG, Schuller HM. **Carbon dioxide, an important messenger molecule for small cell lung cancer**. Chest. 1997 Sep;112(3):779-84. doi: 10.1378/chest.112.3.779. PMID: 9315815. https://pubmed.ncbi.nlm.nih.gov/9315815/

[15] Nevler A, Brown SZ, Nauheim D, Portocarrero C, Rodeck U, Bassig J, Schultz CW, McCarthy GA, Lavu H, Yeo TP, Yeo CJ, Brody JR. **Effect of Hypercapnia, an Element of Obstructive Respiratory Disorder, on Pancreatic Cancer Chemoresistance and Progression**. J Am Coll Surg. 2020 Apr;230(4):659-667. doi: 10.1016/j.jamcollsurg.2019.12.033. Epub 2020 Feb 11. PMID: 32058016; PMCID: PMC7498306. https://pubmed.ncbi.nlm.nih.gov/32058016/

[16] Pillai SR, Damaghi M, Marunaka Y, Spugnini EP, Fais S, Gillies RJ. **Causes, consequences, and therapy of tumors acidosis**. Cancer Metastasis Rev. 2019 Jun;38(1-2):205-222. doi: 10.1007/s10555-019-09792-7. PMID: 30911978; PMCID: PMC6625890. https://pubmed.ncbi.nlm.nih.gov/30911978/

[17] Ibrahim-Hashim A, Estrella V. **Acidosis and cancer: from mechanism to neutralization**. Cancer Metastasis Rev. 2019 Jun;38(1-2):149-155. doi: 10.1007/s10555-019-09787-4. PMID: 30806853; PMCID: PMC6625834.

[18] Corbet C, Pinto A, Martherus R, Santiago de Jesus JP, Polet F, Feron O. **Acidosis Drives the Reprogramming of Fatty Acid Metabolism in Cancer Cells through Changes in Mitochondrial and Histone Acetylation**. Cell Metab. 2016 Aug 9;24(2):311-23. doi: 10.1016/j.cmet.2016.07.003. PMID: 27508876.

[19] Pishbin E, Ahmadi GD, Sharifi MD, Deloei MT, Shamloo AS, Reihani H. **The correlation between end-tidal carbon dioxide and arterial blood gas parameters in patients evaluated for metabolic acid-base disorders**. Electron Physician. 2015 Jul 20;7(3):1095-101. doi: 10.14661/2015.1095-1101. PMID: 26388974; PMCID: PMC4574694.

[20] Damaghi M, Tafreshi NK, Lloyd MC, Sprung R, Estrella V, Wojtkowiak JW, Morse DL, Koomen JM, Bui MM, Gatenby RA, Gillies RJ. **Chronic acidosis in the tumour microenvironment selects for overexpression of LAMP2 in the plasma membrane**. Nat Commun. 2015 Dec 10;6:8752. doi: 10.1038/ncomms9752. PMID: 26658462; PMCID: PMC4682176. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4682176/

[21] Wm. H. Woglom; **Acidosis, Alkalosis and Tumor Growth**. The Journal of Cancer Research 1 April 1922; 7

(2): 149–150. https://doi.org/10.1158/jcr.1922.149
https://aacrjournals.org/jcancerres/article/7/2/149/449988/Acidosis-Alkalosis-and-Tumor-Growth

[22] Gabi Drochioiu, **Chronic metabolic acidosis may be the cause of cachexia: Body fluid pH correction may be an effective therapy**, Medical Hypotheses, Volume 70, Issue 6, 2008, Pages 1167-1173, ISSN 0306-9877, https://doi.org/10.1016/j.mehy.2007.11.007 .
https://www.sciencedirect.com/science/article/pii/S0306987707006457

Even this rudimentary search of the literature suggests a connection or even a cause. So we can at least establish a chain of *plausibility*; not necessarily causality. It gives foundation to the hypothesis Dr. Parks claimed. With every hypothesis we must require an experiment for validation. But the experiment started three years ago. Many were forced to wear masks and many have chosen to continue wearing masks. The keyword here is *choice*. It is an experiment, so far with unknown results and conclusions. And so no one should be forced to be a lab rat. That goes against the Nuremberg Code, and guess what, the principles of the Nuremberg Code were codified into California Law – look it up! All you need to say is: "I DO NOT CONSENT". And if you feel you need to explain further you can say you don't want to take the risk of getting cancer, and present this research as evidence of concern.

Perhaps anyone still insisting on wearing a mask but after reading this might choose differently. But real phobias are hard to shake on your own and usually require psychological counseling. In any event since plausible harm is established – **no one, and especially children should be mandated, forced or shamed to wear a mask if they choose not to**. And in the case of children, that's up to the parent's choice. Just be aware of the potential harm. The grand experiment will eventually determine if they are truly causing cancers. But we should be free to NOT be a subject of that experiment.

3.3.COVID-19 Travel Restriction Update. Hey where's the USA?

To appreciate the state of our nation with regards to liberty, consider the following list

Source:
https://www.traveloffpath.com/countries-without-any-travel-restrictions-or-entry-requirements/
As of November 8, 2022, 129 countries –

- No tests before arrival
- No tests upon or after arrival
- No countries banned due to covid-19
- No quarantine periods
- No vaccine requirements

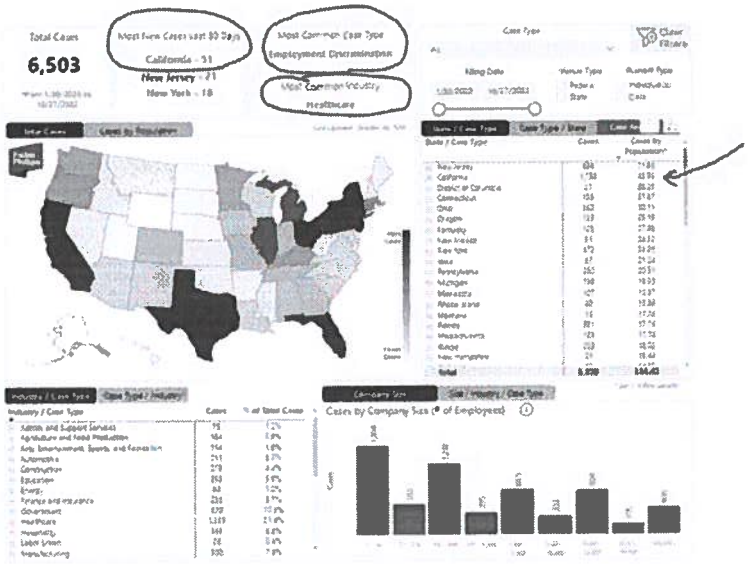
Afghanistan	Cambodia	Gibraltar	Madeira	Romania	Uzbekistan
Albania	Canada	Greece	Malaysia	Russia	Vanuatu
Algeria	Cape Verde	Grenada	Maldives	Rwanda	Vietnam
Andorra	Cayman Islands	Guadeloupe	Malta	Samoa	Yemen
Anguilla	Congo	Guatemala	Martinique	Saudi Arabia	
Antigua & Barbuda	Cook Islands	Guatemala	Mauritius	Serbia	
Argentina	Costa Rica	Guyana	Mexico	Slovakia	
Armenia	Croatia	Hungary	Moldova	Slovenia	
Aruba	Curaçao	Iceland	Mongolia	Somalia	
Australia	Cyprus	Ireland	Montenegro	South Africa	
Austria	Czechia	Israel	Montserrat	South Korea	
Bahamas	Denmark	Italy	Morocco	Spain (including Canary Islands)	
Bahrain	Dominica	Jamaica	Namibia	St Kitts & Nevis	
Barbados	Dominican Republic	Jordan	Netherlands	St. Lucia	
Belarus	Ecuador	Kazakhstan	New Zealand	St. Maarten	
Belgium	Egypt	Kosovo	North Macedonia	St. Vincent and Grenadines	
Belize	El Salvador	Kuwait	Norway	Sudan	
Benin	Estonia	Kyrgyzstan	Oman	Sweden	
Bermuda	Ethiopia	Latvia	Panama	Switzerland	

Bhutan Bonaire Bosnia and Herzegovina Botswana Brunei Bulgaria	Finland France French Guiana Gabon Georgia Germany	Lebanon Lesotho Liechtenstein Lithuania Luxembourg Madagascar	Papua New Guinea Paraguay Peru Poland Portugal Qatar	Tahiti Thailand Trinidad and Tobago Turkey United Arab Emirates United Kingdom	

Note that countries noted to once have the *harshest* restrictions like Canada, Australia and New Zealand are ON this list. They have freely opened travel into and out of their countries. But the United States of America is NOT on this list. We no longer lead the world in terms of freedom to travel; a right specifically afforded by the constitution of the United States.

3.4.Employment Litigations over COVID-19 Vaccination Mandates in California

California presently leads the nation in the highest number of cases of employment litigation over COVID-19 issues according to Fisher Phillips[16]. The statistics illustrated below do not include the very recent, high profile lawsuit where California Doctors are suing Gavin Newsom and the California Medical Board over the law censoring medical advice – AB 2098. California has the most new cases in the last 30 days, mostly employment discrimination in the healthcare



industry. Many nurses have publicly spoken out in protests or before local governments that have endorsed the firing of nurses because they chose not to receive a COVID-19 vaccine; all of which are still experimental, and only approved under the auspices of the EUA.

A 13 year veteran pediatric nurse from Radys Children's Cardiothoracic Intensive Care Unit spoke speech at the San Diego Board of Supervisors on September 13, 2022 during an agenda item presented by SD HHS; an update on COVID-19. After having to take an extended leave for non-compliance, Tawny Buettner was fired. She shared with the board on the record, her firsthand experience of injuries caused by the COVID-19 vaccines on children; children that had little risk of injury from the infection itself.

[16] https://www.fisherphillips.com/innovations-center/covid-19-employment-litigation-tracker-and-insights/index.html

Tawny: "I Am The Face Of Your 'Misinformation' Campaign Nathan."

Here is a transcript of her talk that day:

> *My name is Tawny Buettner. I came before you guys a year ago. I'm a nurse, or at least so was, at Radys Children's in the Cardiovascular Intensive Care Unit until Nathan and his misinformation pandemic caused me to lose my job.*
>
> *I took care of those children who came in with myocarditis and after the vaccine. And I talked to doctors cause I was a charge nurse and I said:*
>
> *"Why aren't we reporting these to VAERS?"*
>
> *"Who is going to report these to VAERS?"*
>
> *It was an unspoken thing that that we were not allowed to talk openly on the unit.*
>
> *I've worked for 13 years in this community taking care of some of the sickest patients. The day before I was taken away from my position I was actively giving compressions to a child, pushing epi, pushing calcium into his veins to keep him alive. And we did. And he went home. And yet I was ridiculed by those who were supposed to be my colleagues and my friends.*
>
> ***I am the face of your misinformation campaign Nathan.***
>
> *I'm the one who lost my career in pediatric cardiovascular ICU care. I took care of my children who had covid. I never got covid in the hospital. I tested twice a week. I wore my PPE because I loved my job and I love this community.*

As she spoke, Nathan Fletcher and the other supervisors sat silent without emotion. All except Terra Lawson Remer who actually got out of her chair and left chambers in the middle of Tawny's address. Tawny knew better from her firsthand experience on the front lines that the vaccines are not safe. And yet her employer, Radys Children's insisted she risk her own health under misinformed consent to remain employed.

Regardless of Tawny's heartbreaking testimony the board that day voted 3 to 2 to continue the emergency order for COVID-19, although it was clear from Wilma Wooten's data, and it had been that way for many months, there was no longer an emergency; there is still no emergency. It's all a sham so the county can continue to rake in ARPA funds.

After what happened at the Board of Supervisors Steve Kirsch interviewed Tawny, learning more details that led her to her decision not to vaccinate and to speak out[17]. Tawny told Kirsch that before the COVID-19 vaccine rollout, their unit saw roughly 4 to 5 cases of myocarditis per year. In the last half of 2021 she counted 33 cases, so over a 10X increase. That's significant. That's not a coincidence.

It's not only healthcare workers that have lost their jobs. Many corporations also instituted strict COVID-19 vaccine policies and many employees at the end of 2021 or the start of 2022 who chose not to be vaccinated unfairly lost their jobs as corporate leadership, uninformed by health officials and mainstream media of the risk of injury or death from the vaccines, just followed the narrative.

NYC fired roughly 1,700 city employees for being unvaccinated earlier this year after the city adopted a vaccine mandate under former Mayor Bill de Blasio. But on October 24, 2022, New York State Supreme Court ordered all New York City employees who were fired for not being vaccinated to be reinstated with back pay. The court ruled that "being vaccinated does not prevent an individual from contracting or transmitting COVID-19."

It's uncertain where decisions like this will lead in the corporate world where some companies are still insisting on vaccination as a condition for employment. The hypocrisy is unnerving since these same corporations are the ones promoting the Diversity, Equity and Inclusion policies. How do these conditions for employment serve diversity, equity and inclusion?

https://ycharts.com/indicators/california_unemployment_rate

4. Online tools and resources in researching vaccine injury outside of CDC WONDER

This section contains a list of web based tools for anyone interested and willing to do their own research into vaccine injury and death. WONDER is the tool that the CDC offers to query, parse and present VAERS data, but there are other tools. One option, for anyone able to write database scripts, is to access the CDC VAERS raw data and just write their own tool. But most neither have the time or inclination to do that. There are other resources of vaccine injury data that is outside the VAERS database, and those are also mentioned here.

4.1.OpenVAERS

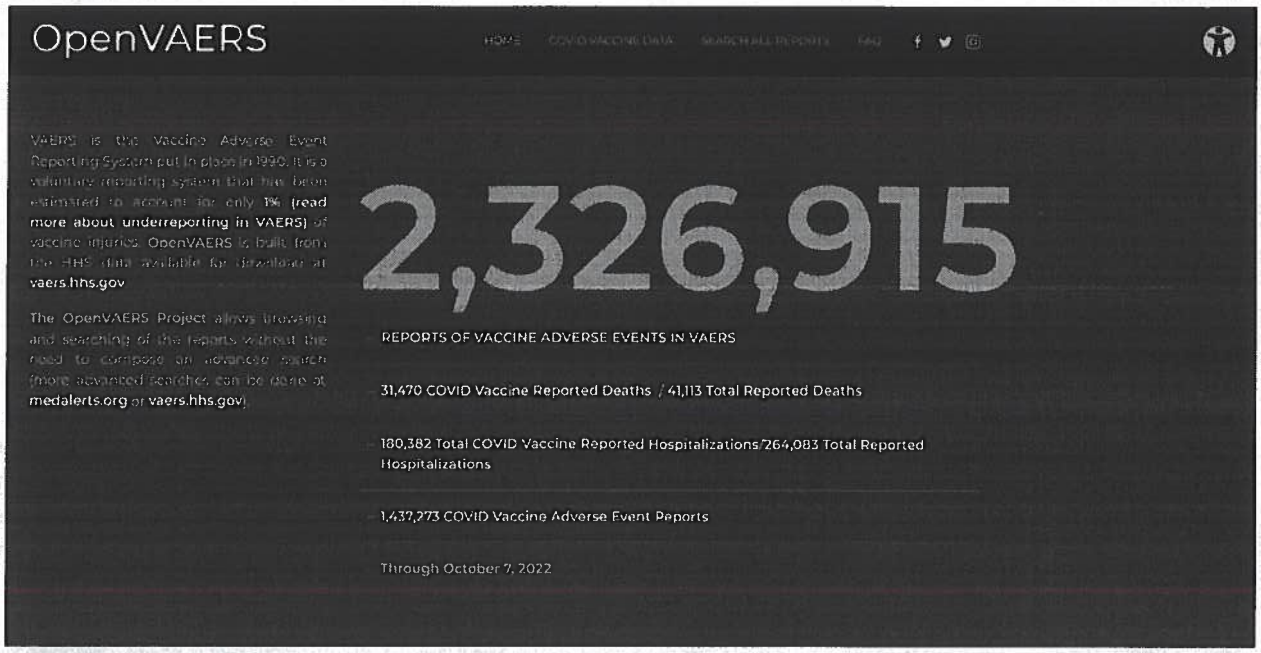
OpenVAERS, unlike the other two online tools that access CDC VAERS data: CDC WONDER and Medalerts, is not a query tool but rather a prepackaged analysis of CDC VAERS data. With all due respect OpenVAERS is a "*VAERS for dummies*" tool ☺. Nevertheless it serves a very useful purpose having informed the multitudes that either don't have the will, aptitude or time to navigate the more extensible web based tools.

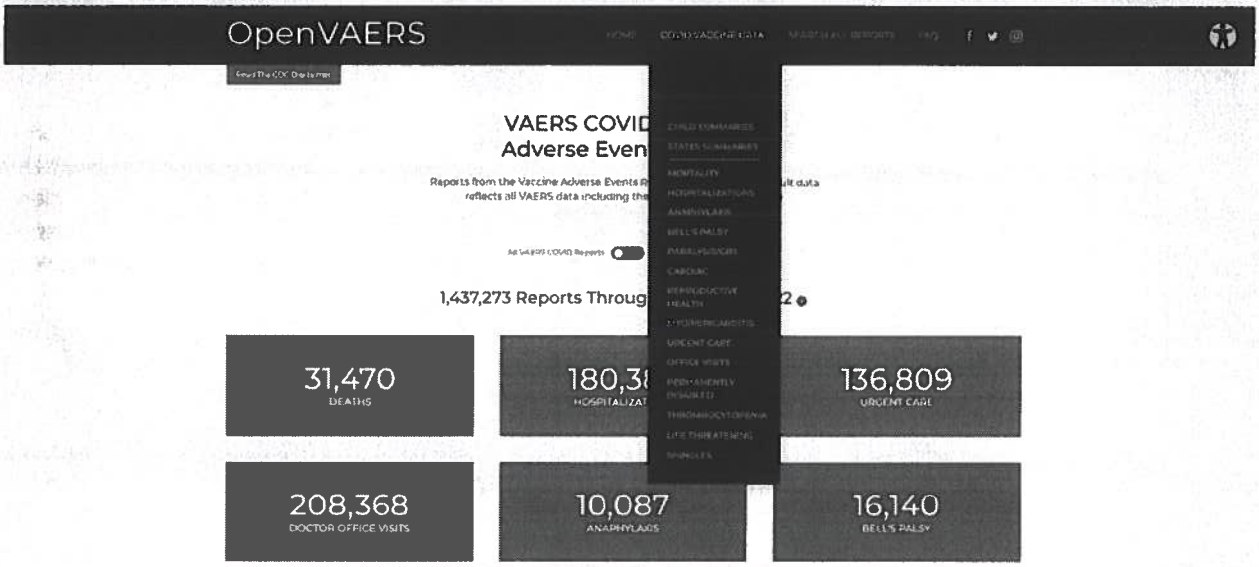
OpenVAERS is created by a private organization that describes their mission briefly as:

> *OpenVAERS is a project developed by a small team of people with vaccine injuries or who have children with vaccine injuries. We do not accept donations or solicit fees. There is zero monetization of this site. It is purely created in order to help others browse the VAERS records and to identify the reported signals that may otherwise get missed.*

While OpenVAERS allows immediate access to what they call 'Red Box Data' – such as overall deaths from COVID-19 vaccines, it's very limited in being able to parse information from lesser researched symptoms, as for example, syncope. Some pages do allow parsing of data according to categories, but that is also limited.

[17] https://stevekirsch.substack.com/p/tawny-buettner-rn-observed-a-10x





OpenVAERS can be accessed at https://www.openvaers.com/

4.2.MedAlerts

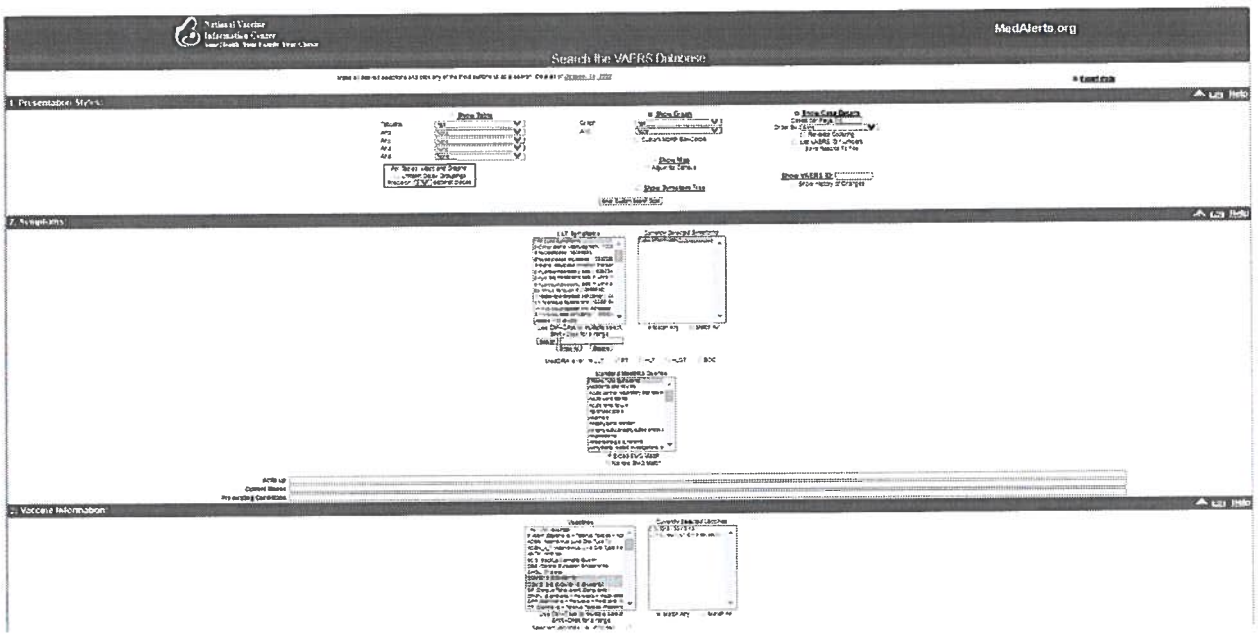
To search the VAERS database, the CDC provides its own data base tool, WONDER at https://wonder.cdc.gov/vaers.html . But the National Vaccine Center, an independent non-profit has developed an alternative, their own tool, to access CDC VAERS data. Here are statements from NVIC's latest financial statement that describes who they are and what their mission is:

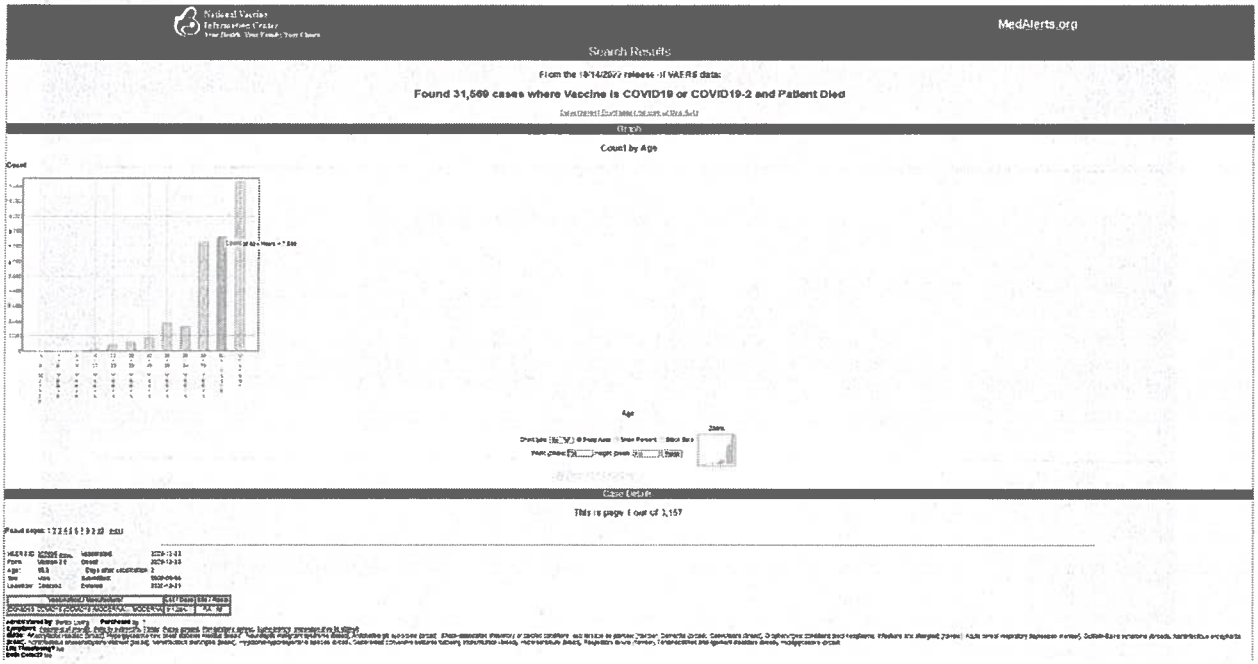
> *The National Vaccine Information Center (NVIC) was originally incorporated as Dissatisfied Parents Together (DPT) in Washington, DC, on June 11, 1982, and was*

recognized as a 501(c)(3) exempt organization on August 14, 1982. The organization was reincorporated in the Commonwealth of Virginia as the National Vaccine Information Center on January 6, 1995, and was again recognized as a 501(c)(3) exempt organization on that date and headquartered in the Commonwealth of Virginia.

The purpose of NVIC is to promote and protect the health and welfare of children and adults by preventing vaccine injuries and deaths through public education and to assist individuals who have been injured by vaccination and their families. NVIC does not make vaccine use recommendations. NVIC defends the ethical principle of informed consent to medical risk taking and civil liberties that protect freedom of thought, speech and conscience to support educated, voluntary healthcare decision making.

Upon first inspection, Medalerts has a similar look and feel as CDC WONDER, but its capabilities are much more versatile and extensible. Medalerts provides different modes of operation to create, execute queries and produce reports. There is standard or expert mode. In expert mode there's many more options in how to parse and present the data. Many more capabilities and features than what is offered by CDC WONDER. For example, well organized case outputs can be included as an output. WONDER tends to choke if the number of cases is too large and doesn't provide easy formatting for review like Medalerts does.

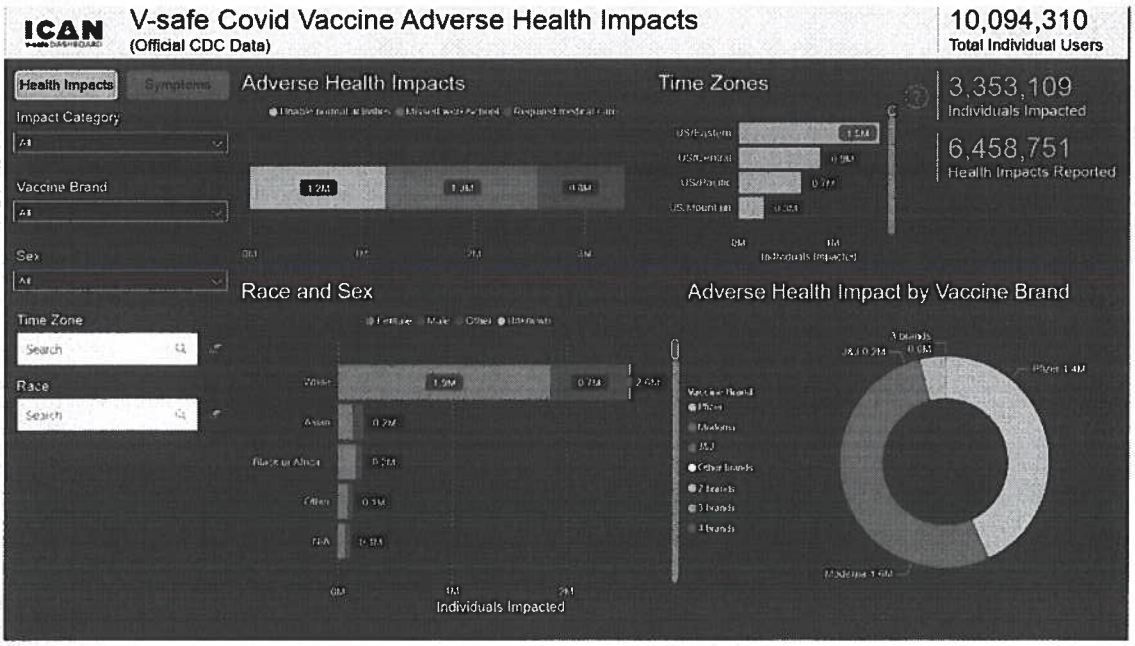


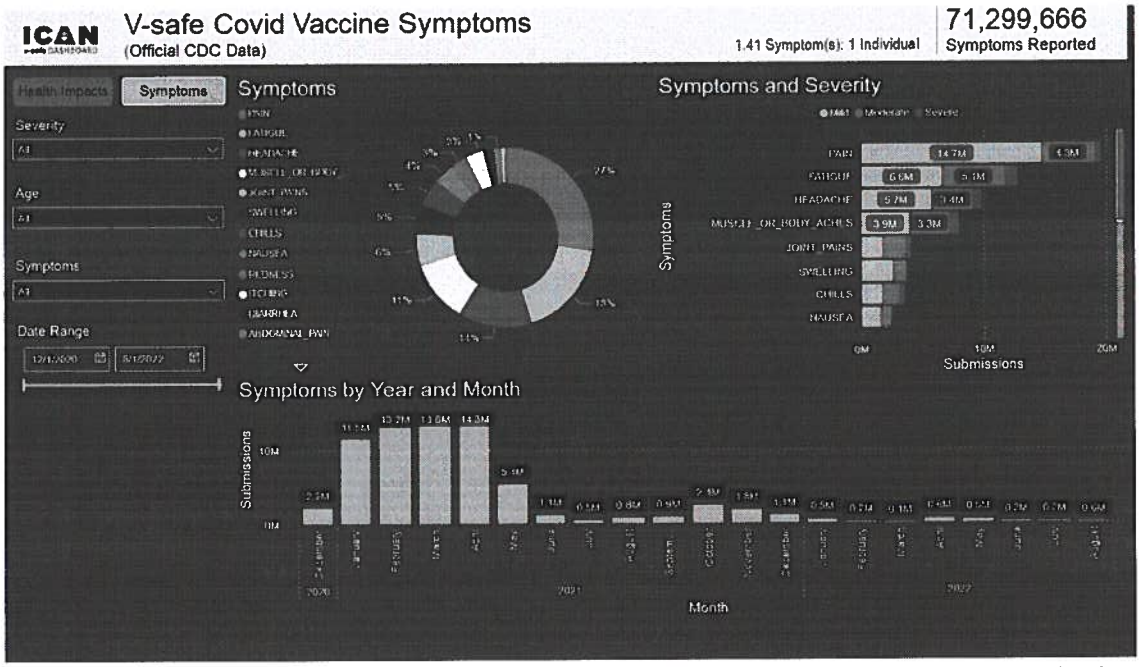


The main page to access Medalerts is https://medalerts.org/index.php

4.3.V-safe

Before October 2022, V-safe data was not publicly accessible. A nonprofit organization, Informed Consent Action Network (ICAN) was able to finally obtain this data only after suing the CDC. The data can now be publicly accessed at: https://www.icandecide.org/v-safe-data/ . The raw data can be downloaded for analysis in 5 .csv files or viewed on dashboards provided by ICAN. The following screenshots illustrate these dashboards.





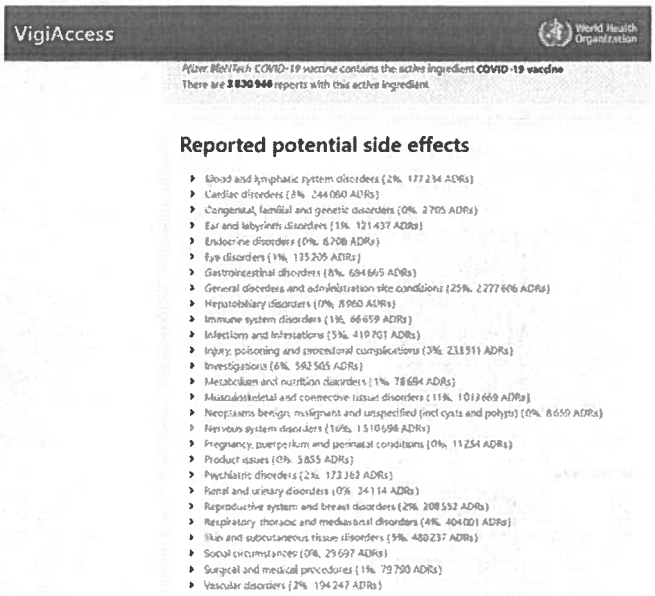
According to FAQ from the CDC website, people without cell phones are excluded from participating in V-safe:

> *"If I don't have a smartphone, but I got a COVID-19 vaccine, can I still participate in v-safe?"*
>
> *"No. Currently, v-safe is designed to be accessed using a smartphone with a touchscreen, text messaging service, and internet access."*

The question not asked, but obviously a flaw of the V-safe system is "How are deaths recorded in V-safe?" The answer I believe is – they can't be recorded since input is restricted to enrolled participants through their personal cellphones.

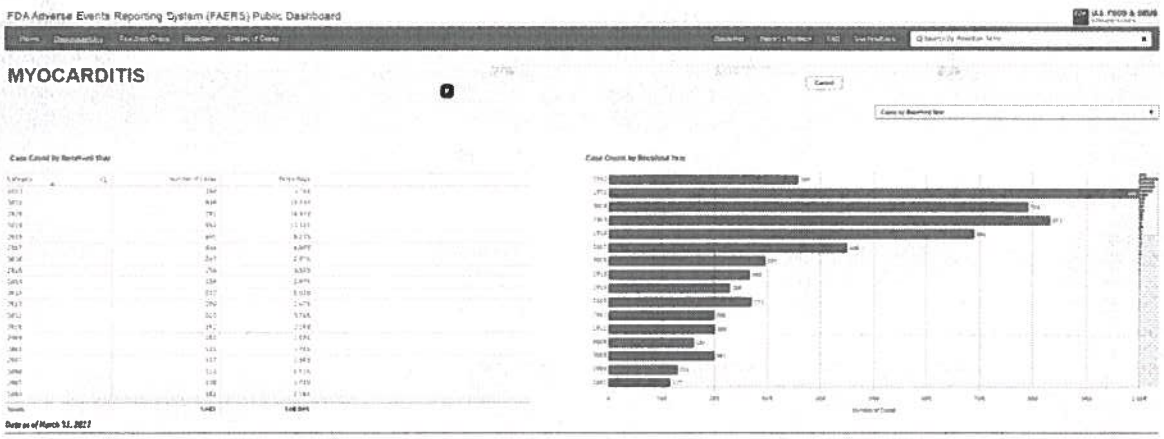
4.4.VigiAccess

Public access site: VigiAccess https://vigiaccess.org/
VigiAccess is maintained by the World Health Organization and providing global scale access to adverse event reports for all medications including specific COVID-19 vaccines. It is very limited regarding detailed case information demographics, etc. only the numbers of events, at least on the public site. Only numbers and percentages are given in drop down categorized adverse events that are sorted according to highest incidence. An example of the search: covid-19 vaccines Pfizer is shown below.



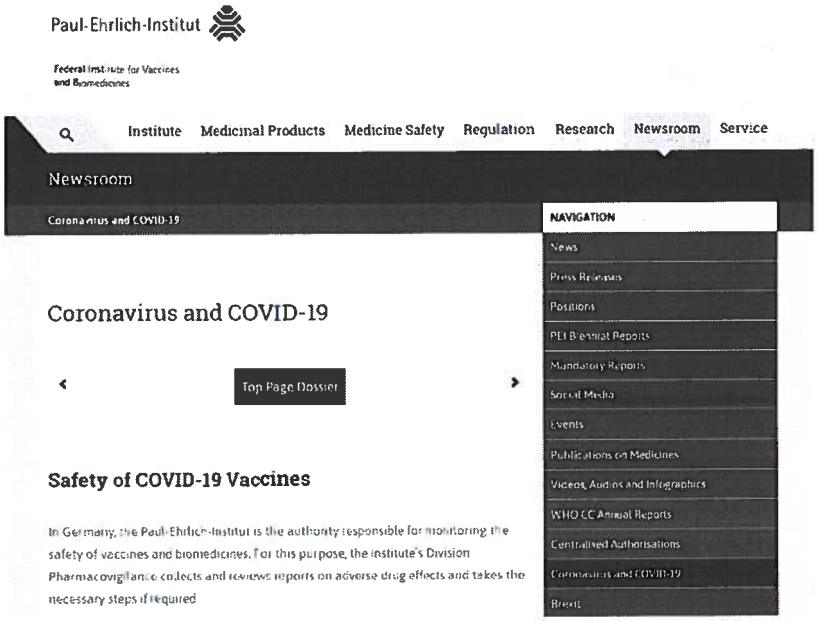
4.5.FAERS

FDA Adverse Event Reporting System (FAERS) https://www.fda.gov/drugs/questions-and-answers-fdas-adverse-event-reporting-system-faers/fda-adverse-event-reporting-system-faers-public-dashboard is NOT a vaccine reporting system, but rather a tool, a public dashboard for accessing adverse events related to pharmaceutical drugs. It is mentioned in this report since there have been a large number of concerned people reporting that hospital deaths have been occurring from improper treatment of patients hospitalized with covid. These treatments, allegedly the cause or a leading factor in cause of death. This includes drugs like Remdesivir (Veklury) and Vancomycin that presumably have led to kidney failure and death. The FDA, not the CDC maintains FAERS. FAERS allows search by drug reaction, or if you wanted to know for example the number of deaths or serious injuries by year for specific medications. FAERS does not provide detailed case reports.



4.6.Paul- Ehrlich-Institute

Germany's surveillance webpage for covid-19 vaccines. Reports only; no raw data:
https://www.pei.de/EN/newsroom/dossier/coronavirus/coronavirus-content.html?nn=164146&cms_pos=6

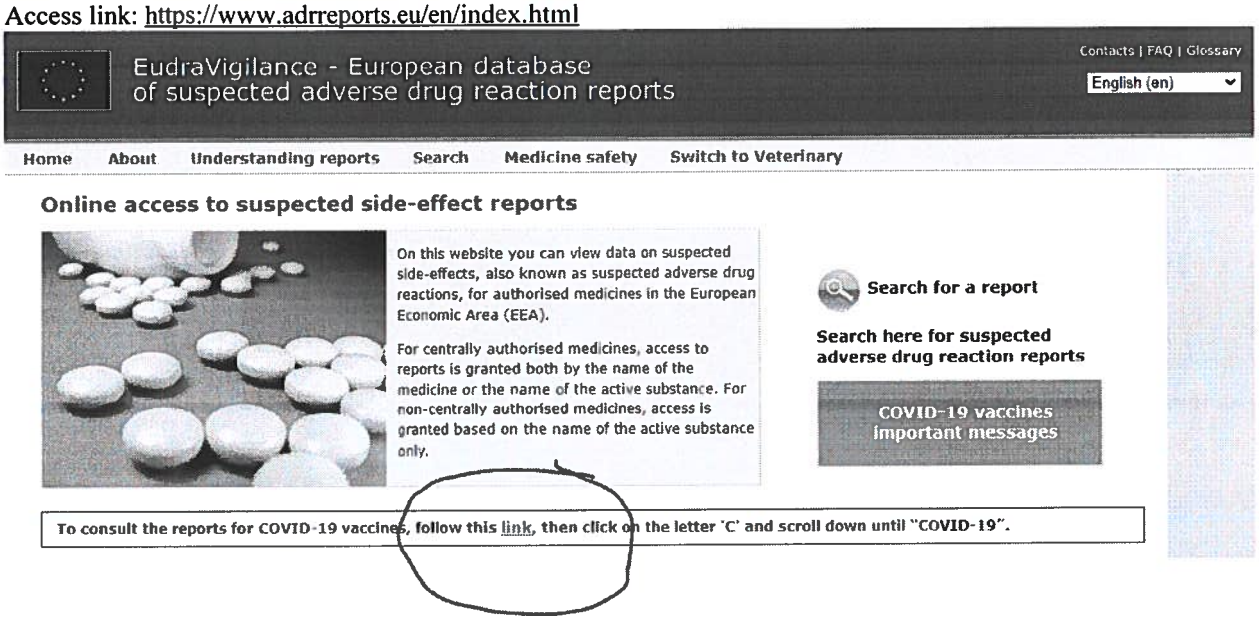


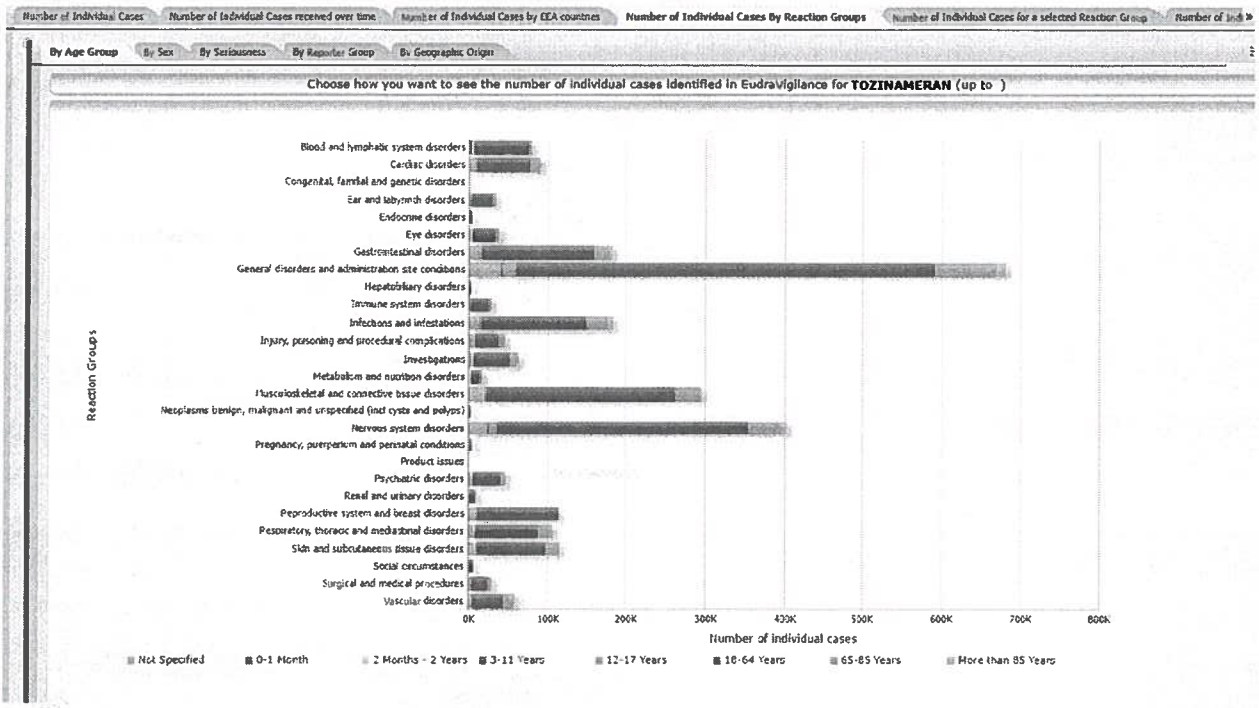
4.7.EudraVigilince

EudraVigilance allows the public to view data on suspected side-effects, also known as suspected adverse drug reactions, for authorized medicines in the European Economic Area (EEA).

For centrally authorized medicines, access to reports is granted both by the name of the medicine or the name of the active substance. For non-centrally authorized medicines, access is granted based on the name of the active substance only.

Access link: https://www.adrreports.eu/en/index.html




Number of Individual Cases
Number of Individual Cases received over time
Number of Individual Cases by EEA countries
Number of Individual Cases By Reaction Groups
Number of Individual Cases for a selected Reaction Group
By Age Group
By Sex
By Seriousness
By Reporter Group
By Geographic Origin
Choose how you want to see the number of individual cases identified in EudraVigilance for TOZINAMERAN (up to)
Reaction Groups
Blood and lymphatic system disorders
Cardiac disorders
Congenital, familial and genetic disorders
Ear and labyrinth disorders
Endocrine disorders
Eye disorders
Gastrointestinal disorders
General disorders and administration site conditions
Hepatobiliary disorders
Immune system disorders
Infections and infestations
Injury, poisoning and procedural complications
Investigations
Metabolism and nutrition disorders
Musculoskeletal and connective tissue disorders
Neoplasms benign, malignant and unspecified (incl cysts and polyps)
Nervous system disorders
Pregnancy, puerperium and perinatal conditions
Product issues
Psychiatric disorders
Renal and urinary disorders
Reproductive system and breast disorders
Respiratory, thoracic and mediastinal disorders
Skin and subcutaneous tissue disorders
Social circumstances
Surgical and medical procedures
Vascular disorders
0K
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300K
400K
500K
600K
700K
800K
Number of individual cases
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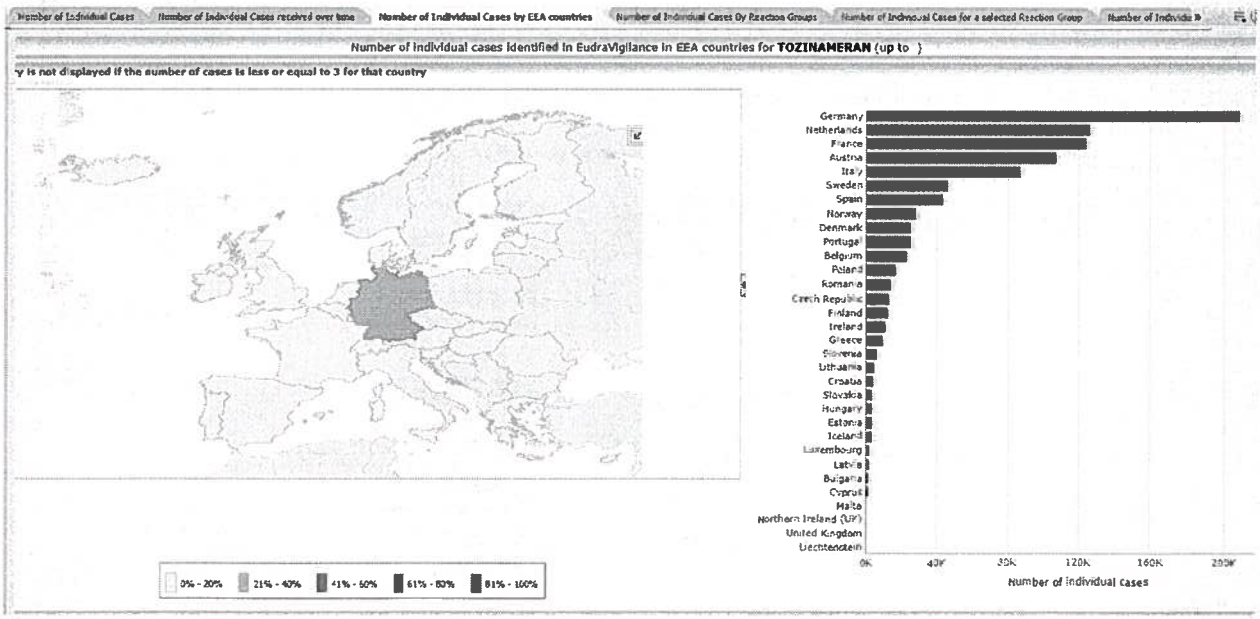
0-1 Month
2 Months - 2 Years
3-11 Years
12-17 Years
18-64 Years
65-85 Years
More than 85 Years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Number of Individual Cases by EEA countries
Number of Individual Cases By Reaction Groups
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Number of individual cases identified in EudraVigilance in EEA countries for TOZINAMERAN (up to)
y is not displayed if the number of cases is less or equal to 3 for that country
Germany
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Sweden
Spain
Norway
Denmark
Portugal
Belgium
Poland
Romania
Czech Republic
Finland
Ireland
Greece
Slovenia
Lithuania
Croatia
Slovakia
Hungary
Estonia
Iceland
Luxembourg
Latvia
Bulgaria
Cyprus
Malta
Northern Ireland (UK)
United Kingdom
Liechtenstein
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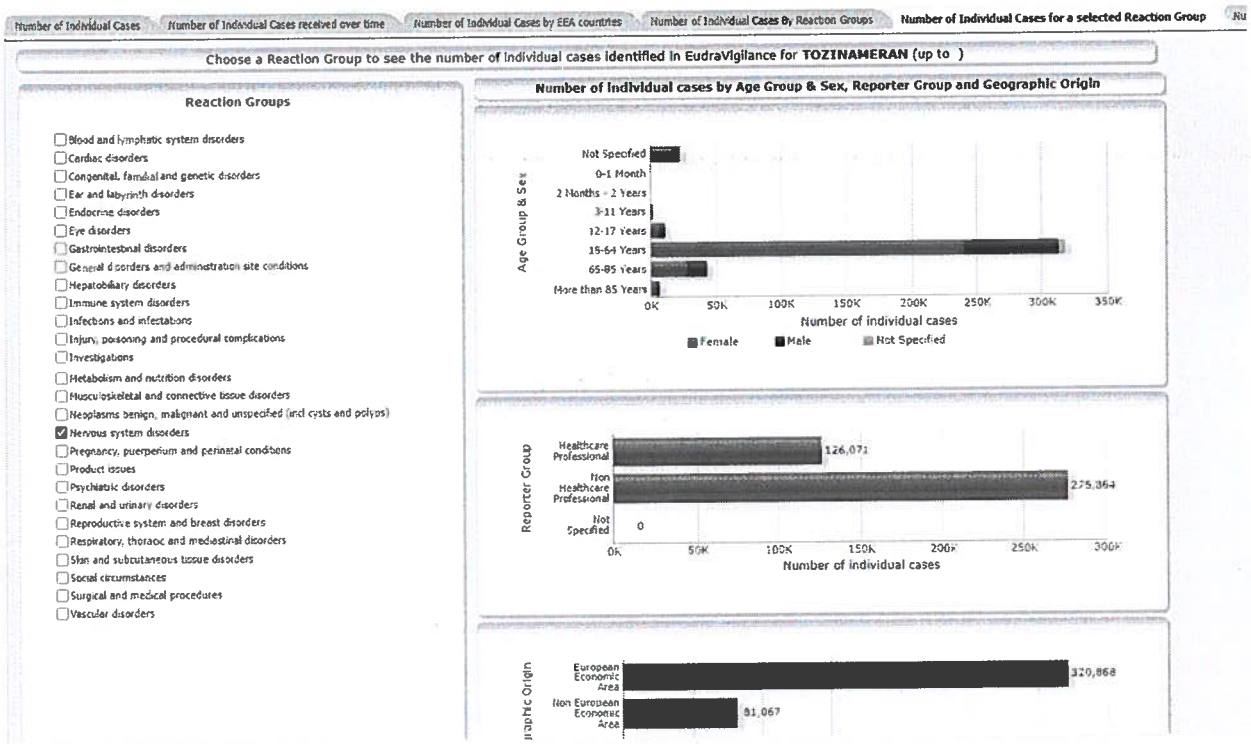
120K
160K
200K
Number of individual cases
0% - 20%
21% - 40%
41% - 60%
61% - 80%
81% - 100%



The last tab in the tool allows to run custom "Line Listing Reports" which are reports of individual cases on selected topics and groups

Line Listing Report
Time run: 08/11/2022 20:57:11

EU Local Number	EV Gateway Receipt Date	Report Type	Primary Source Qualification	Primary Source Country for Regulatory Purposes	Literature Reference	Patient Age Group	Patient Age Group (as per reporter)	Patient Sex	Parent Child Report	Reaction List PT (Duration – Outcome - Seriousness Criteria)	Suspect/interacting Drug List (Drug Char - Indication PT - Action taken - [Duration - Dose - Route])	Concomitant/Not Administered Drug List (Drug Char - Indication PT - Action taken - [Duration - Dose - Route])	ICSR Form
EU-EC-10011131290	31/12/2021	Spontaneous	Healthcare Professional	European Economic Area	Not available	18-64 Years	Adult	Male	No	Myocarditis (n/a - Recovering/Resolving - Caused/Prolonged Hospitalisation)	COMIRNATY [TOZINAMERAN] (5 - n/a - n/a - [1d - n/a - n/a])	Not reported	ICSR
EU-EC-10011132003	31/12/2021	Spontaneous	Healthcare Professional	European Economic Area	Not available	18-64 Years	Not Specified	Female	No	Myocarditis (n/a - Unknown - Other Medically Important Condition), Troponin increased (n/a - Unknown - Other Medically Important Condition)	COMIRNATY [TOZINAMERAN] (5 - n/a - n/a - [n/a - n/a - Intramuscular])	Not reported	ICSR
EU-EC-10011133165	31/12/2021	Spontaneous	Healthcare Professional	European Economic Area	Not available	18-64 Years	Adult	Male	No	Insomnia (n/a - Unknown - Other Medically Important Condition), Myocarditis (n/a - Unknown - Other Medically Important Condition), Nausea (n/a - Unknown - Other Medically Important Condition)	COMIRNATY [TOZINAMERAN] (5 - n/a - n/a - [1d - n/a - Intramuscular])	Not reported	ICSR
EU-EC-10011135552	31/12/2021	Spontaneous	Healthcare Professional	European Economic Area	Not available	18-64 Years	Not Specified	Male	No	Myocarditis (n/a - Not Recovered/Not Resolved - Caused/Prolonged Hospitalisation)	COMIRNATY [TOZINAMERAN] (5 - COVID-19 immunisation - Not applicable - [1d - 1(DF) - Intramuscular])	Not reported	ICSR
EU-EC-10011135610	31/12/2021	Spontaneous	Healthcare Professional	European Economic Area	Not available	18-64 Years	Adult	Male	No	Chest discomfort (n/a - Recovered/Resolved -), Myocarditis (n/a - Recovered/Resolved - Caused/Prolonged Hospitalisation), Presyncope (n/a - Recovered/Resolved -)	COMIRNATY [TOZINAMERAN] (5 - COVID-19 immunisation - Not applicable - [1d - n/a - Intramuscular])	Not reported	ICSR
EU-EC-10011137065	31/12/2021	Spontaneous	Healthcare Professional	European Economic Area	Not available	18-64 Years	Adult	Male	No	Arrhythmia (8wk - Recovered/Resolved - Other Medically Important Condition), Atrial fibrillation (8wk - Recovered/Resolved - Other Medically Important Condition), Myocarditis (8wk - Recovered/Resolved - Other Medically Important Condition), Palpitations (8wk - Recovered/Resolved - Other Medically Important Condition)	COMIRNATY [TOZINAMERAN] (5 - COVID-19 immunisation - Not applicable - [n/a - 1(DF) - Intramuscular])	Not reported	ICSR
EU-EC-10011139058	30/12/2021	Spontaneous	Healthcare Professional	European Economic Area	Not available	18-64 Years	Not Specified	Male	No	Myocarditis (n/a - Not Recovered/Not Resolved - Other Medically Important Condition)	COMIRNATY [TOZINAMERAN] (5 - Immunisation - n/a - [n/a - n/a - n/a])	Not reported	ICSR
EU-EC-10011139466	30/12/2021	Spontaneous	Healthcare Professional	European Economic Area	Not available	18-64 Years	Adult	Male	No	Myocarditis (n/a - Recovering/Resolving - Caused/Prolonged Hospitalisation)	COMIRNATY [TOZINAMERAN] (5 - n/a - n/a - [1d - n/a - Intramuscular])	Not reported	ICSR
EU-EC-10011120425	30/12/2021	Spontaneous	Healthcare Professional	European Economic Area	Not available	18-64 Years	Not Specified	Female	No	Myocarditis (n/a - Not Recovered/Not Resolved - Caused/Prolonged Hospitalisation)	COMIRNATY [TOZINAMERAN] (5 - Immunisation - n/a - [n/a - n/a - n/a])	Not reported	ICSR
EU-EC-10011122928	30/12/2021	Spontaneous	Healthcare Professional	European Economic Area	Not available	18-64 Years	Not Specified	Male	No	Myocarditis (9dd - Recovering/Resolving - Caused/Prolonged Hospitalisation)	COMIRNATY [TOZINAMERAN] (5 - COVID-19 immunisation - Not applicable - [1d - n/a - Intramuscular])	Not reported	ICSR
EU-EC-	29/12/2021	Spontaneous	Healthcare Professional	European Economic Area	Not available	18-64 Years	Not Specified	Male	No	Extrasystoles (n/a -	COMIRNATY [TOZINAMERAN] (5 - COVID-	Not reported	ICSR

4.8.REACT19

During the research for recent publications involving COVID-19 vaccine injuries, I came across a group that also consolidates peer reviewed publications involving categorical vaccine injuries called REACT19[18]. The website is a wealth of resources focusing mainly on the wellness and treatment of people either suffering from long term effects of COVID-19 or COVID-19 vaccine induced illness. The specific link to the publications list is https://react19.org/1250-covid-vaccine-reports/ . This link will be included as a permanent fixture in any future covid vaccine injury reports.

This vaccine injury update and attached report delivered to the San Diego Board of Supervisors and San Diego Health and Human Services on October 11, 2022, by

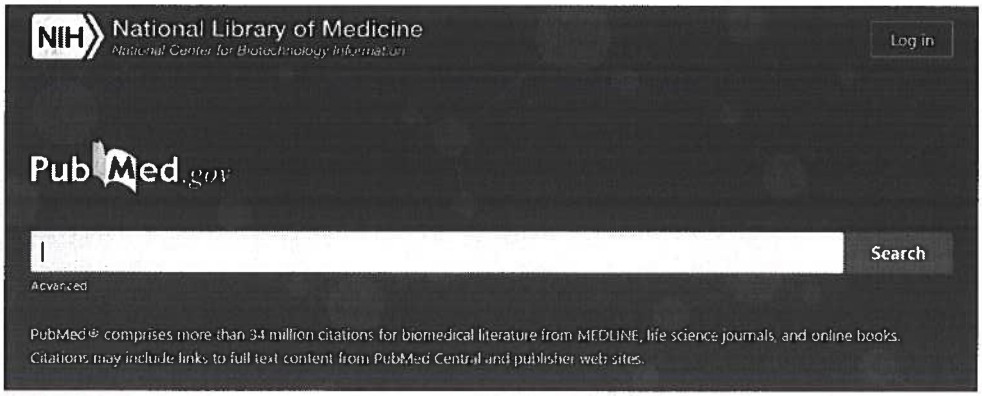
4.9.PubMed; National Center for Biotechnology Information

According to the website:

"PubMed® comprises more than 34 million citations for biomedical literature from MEDLINE, life science journals, and online books. Citations may include links to full text content from PubMed Central and publisher web sites"

The link: https://pubmed.ncbi.nlm.nih.gov/

Many of the citations in this report were discovered on PubMed using targeted search queries. Most of the citations in this report are unique (no duplicates) unless it was necessary to duplicate in different research topics because of the *gravity* of the publication. Note that citations are not ordered by either date or any other attribute however new citations are added at the tops of lists as they appear in searches. One of the advantages the pandemic brought is an agreement by most if not all journals that they will allow full text open access even with papers having a remote connection with COVID-19. That's true with most if not all outlets that connect with PubMed, but others as well.

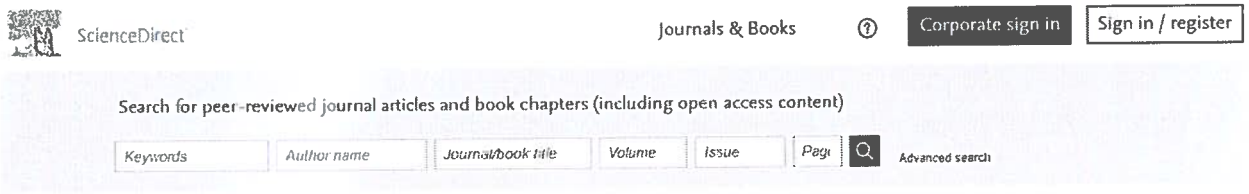


[18] https://react19.org/

4.10. Science Direct

Scientific journals including health and life sciences provide a good companion resource to PubMed. Owned and operated by Elsevier publishing, they tend to oblige to the same policy of full text open access for COVID-19 research. Many citations in this report were discovered in Science Direct.

Link: https://www.sciencedirect.com/



4.11. Google Scholar

On occasion when a new publication or preprint is announced without links, it may not be found on either PubMed or science direct, but sometimes on Google Scholar

Link: https://scholar.google.com/

Mike Borrello

"You may choose to look the other way, but you can never say again that you did not know."

— William Wilberforce

5. COVID 19 VACCINES INJURY REPORT

Mike Borrello November 5, 2022

Unless otherwise specified, the data contained in this report was sourced from:

United States Department of Health and Human Services (DHHS), Public Health Service (PHS), Centers for Disease Control (CDC) / Food and Drug Administration (FDA), Vaccine Adverse Event Reporting System (VAERS) 1990 - 10/28/2022, CDC WONDER On-line Database. Accessed at http://wonder.cdc.gov/vaers.html on Nov 5, 2022 6:41:13 AM

Common to all VAERS queries cited herein unless otherwise specified:

(1) **Vaccine products** considered include the following COVID-19 vaccines:

(a.) Janssen
(b.) Moderna
(c.) Novavax
(d.) Pfizer-BioNtech
(e.) Moderna bivalent
(f.) Pfizer-BioNtech bivalent
(e.) unknown

(2) **All locations** under jurisdiction of VAERS reporting

(3) **Onset interval** of adverse event relative to vaccine administration, unless otherwise noted in the following reported data, is recorded as percentage occurring within the interval of 2 days as a basis for inferring temporal correlation.

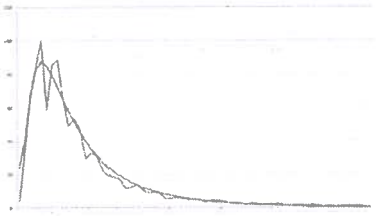
Temporal correlation, if present, usually has *structure*. The expected structure in a pharmacodynamic system involves the occurrence of a discrete event (in this case vaccine reaction) and is typically exponential in nature. Hickey and Rancourt explain in a paper[19]; briefly:

> *The other important discovery is what the researchers refer to as "decay time." That is the time in which the risk of an adverse event "decays," or decreases. While there was a very high peak for adverse reactions found within the first five days post injection, that risk then persists before decreasing by about half approximately every two weeks (Figure S5). However, this phenomenon was still measurable up to 60 days post injection. "The fact that this is tied to the time since the injection, and not time alone, proves that this is due to the injection – it proves a causal relationship. If it were just accidental, if people just happened to die within those 60 days, then you would not get that decay of probability, it would be uniform," says Dr. Rancourt.*
>
> *Dr. Rancourt notes that he and Dr. Hickey are the first to show this exponential decay. "It's robust in that it happens to every adverse event [in the VAERS*

[19] Nature of the toxicity of the COVID-19 vaccines in the USA

dataset] and it's consistent across all three manufacturers so it's a common feature seen across the data."

I believe by 'uniform' Rancourt means that the number of adverse events over time, on the average would be flat. Flatness would indicate independence of the event from vaccine injection, so definitely not causation. But that's not what is seen in VAERS data. Rancourt and Hickey suggest a suitable model as 'exponential', but considering that events cannot realistically happen 'instantaneously' a more realistic model might rather be a temporal Weibull model as illustrated in the following graph.



Weibull model fit to pharmacodynamic response

An opinion paper by Cosentino and Marino [20] claims the COVID-19 mRNA vaccines cannot be rightly called vaccines. According to their pharmacodynamics, pharmacokinetics and influence of S-Protein molecular interactions on multiple targets in multiple organ systems they should rather be considered pharmaceutical drugs. In other words they behave more like a systemic drug, interacting with more than just immune system response. The authors further mention these [unintended] responses are causing harm, adverse effects and they give examples such as Vaccine Induced Thrombocytopenia that's been a proven VAERS signal and treated in many papers and case studies.

Typically the causality between drugs and observed adverse reactions has depended on the Bradford Hill criteria; a nine point checklist[21]. But there are debates in the epidemiology community saying these criteria are outdated, possibly too strict. Cosentino and Marino point out that the World Health Organization (WHO) considers accepts a less strict assessment stressing only two points:

> *"...On the contrary, the WHO guidelines for causality assessment of an adverse event following immunization (AEFI) state that "two critical questions in the revised WHO causality algorithm, namely: "Is there evidence in published peer reviewed literature that this vaccine may cause such an event if administered correctly?" and "In this patient, did the event occur within a plausible time window after vaccine administration?". It is important to consider the background rates for the occurrence of an event of interest and then after a population has received vaccine, determine if the observed rate of that event is in excess of the background rates"*

Note this report, and prior reports submitted to San Diego County Public Record and HHS present evidence supporting causal relationship between vaccination and specific injuries, and across a broad range of injuries plausible by the given facts Cosentino & Marino suggested regarding vaccine escape.

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[20] Cosentino, M.; Marino, F. Understanding the Pharmacology of COVID-19 mRNA Vaccines: Playing Dice with the Spike? Int. J. Mol. Sci. 2022, 23, 10881. https://doi.org/10.3390/ijms231810881

[21] https://en.wikipedia.org/wiki/Bradford_Hill_criteria

VAERS presently does not provide query of adverse events at the county level; the finest granularity possible in the database is at state level.

On September 5, 2022 a local journalist Marco Cáceres published an opinion article[22] in an online publication The Vaccine Reaction, sponsored by the National Vaccine Information Center. Cáceres focused on San Diego County suggesting HHS is ignoring the many cases of vaccinated and 'fully boosted' in the county that are becoming ill, presumably from vaccine side effects. Citing KUSI news reports, Cáceres noted "41 percent of people in San Diego County who recently died of COVID were fully vaccinated and boosted. Cáceres concluded:

> *"The point is that out of the total 104,288 COVID cases, more than 68,000 San Diegans who dutifully got their shots became infected with SARS-CoV-2 (about 65 percent) and out of 2,417 COVID hospitalizations, approximately 1,600 of them (about 66 percent) involved fully vaccinated or fully vaccinated and boosted people. And between 41 and 67 percent of the 88 COVID deaths occurred in people who were either fully vaccinated or fully vaccinated and boosted."*

The information KUSI reported and that Cáceres further researched is regularly omitted by Wilma Wooten during her monthly COVID-19 updates. Regardless of a dearth of cases, Wooten's report and recommendations are slanted to perpetuate the false state of emergency in San Diego County so that ARPA spending can be continued. I've suggested this opinion before the board and HHS in person without receiving either confirmation or denial.

The figures in this report, as noted above, and unless otherwise specified address all locations in VAERS queries to provide a suitable comparison with the number of doses of vaccine across the nation as updated above.

5.1.Reported Deaths

The COVID-19 vaccines collectively account for nearly 84% of ALL deaths reported in VAERS for ALL the vaccines combined over the 30 year period VAERS has been in existence. But covid-19 vaccines haven't been in existence for quite 2 years. Neither the FDA, CDC, NIH nor any Public Health Agency, nationally or local has bothered to explain or comment on this fact. This is just one of MANY issues surrounding the COVID-19 vaccines.

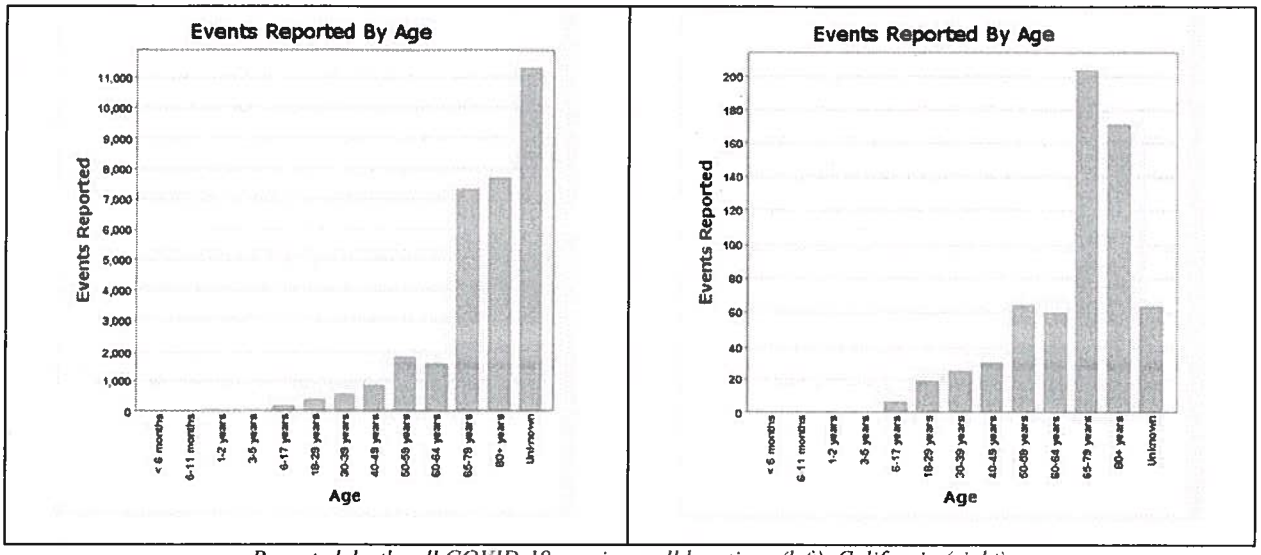
[22] https://thevaccinereaction.org/2022/09/lots-of-vaccinated-boosted-san-diegans-die-from-covid/#comment-133978

Vaccine	Events Reported	Percent (of 41,479)
COVID19 (COVID19 (PFIZER-BIONTECH)) (1200)	22,029	53.11%
COVID19 (COVID19 (MODERNA)) (1201)	9,909	23.89%
COVID19 (COVID19 (JANSSEN)) (1203)	2,774	6.69%
PNEUMO (PREVNAR13) (1141)	994	2.40%
PNEUMO (PREVNAR) (1001)	980	2.36%
POLIO VIRUS, ORAL (ORIMUNE) (17)	790	1.90%
INFLUENZA (SEASONAL) (NO BRAND NAME) (44)	786	1.89%
VACCINE NOT SPECIFIED (NO BRAND NAME) (999)	700	1.69%
HIB (ACTHIB) (256)	611	1.47%
HIB (HIBTITER) (35)	591	1.42%
DTP (NO BRAND NAME) (2)	567	1.37%
HEP B (ENGERIX-B) (38)	542	1.31%
ROTAVIRUS (ROTATEQ) (1096)	514	1.24%
HEP B (RECOMBIVAX HB) (25)	470	1.13%
PNEUMO (PNEUMOVAX) (30)	443	1.07%
DTAP + HEPB + IPV (PEDIARIX) (1082)	418	1.01%
HPV (GARDASIL) (1098)	389	0.94%
DTAP (INFANRIX) (286)	359	0.87%
MEASLES + MUMPS + RUBELLA (MMR II) (26)	353	0.85%
INFLUENZA (SEASONAL) (FLUZONE) (7)	350	0.84%
POLIO VIRUS, INACT. (POLIOVAX) (9)	329	0.79%
DTP (TRI-IMMUNOL) (22)	313	0.75%
HEP B (NO BRAND NAME) (110)	313	0.75%
ROTAVIRUS (ROTARIX) (1124)	312	0.75%
HIB (PEDVAXHIB) (129)	298	0.72%
POLIO VIRUS, INACT. (IPOL) (1030)	269	0.65%
POLIO VIRUS, INACT. (NO BRAND NAME) (232)	269	0.65%
POLIO VIRUS, ORAL (NO BRAND NAME) (118)	255	0.61%
DTAP + IPV + HIB (PENTACEL) (1125)	234	0.56%
DTP + HIB (TETRAMUNE) (250)	220	0.53%
COVID19 (COVID19 (UNKNOWN)) (1202)	211	0.51%
DTAP (TRIPEDIA) (242)	205	0.49%
HIB + HEP B (COMVAX) (287)	196	0.47%
ZOSTER LIVE (ZOSTAVAX) (1097)	189	0.46%
VARICELLA (VARIVAX) (269)	179	0.43%
DTAP+IPV+HEPB+HIB (INFANRIX HEXA) (1139)	178	0.43%
HPV (NO BRAND NAME) (1102)	172	0.41%
HIB (NO BRAND NAME) (111)	161	0.39%
DENGUE TETRAVALENT (DENGVAXIA) (1195)	152	0.37%
PNEUMO (NO BRAND NAME) (120)	140	0.34%
DTAP (DAPTACEL) (1064)	137	0.33%
ZOSTER (SHINGRIX) (1192)	123	0.30%
INFLUENZA (SEASONAL) (TIV DRESDEN) (1186)	118	0.28%
INFLUENZA (SEASONAL) (FLUVIRIN) (262)	115	0.28%
DTAP (NO BRAND NAME) (258)	110	0.27%
RABIES (NO BRAND NAME) (57)	105	0.25%
MENINGOCOCCAL (NO BRAND NAME) (113)	91	0.22%

Many of the VAERS queries reported herein are further substantiated by separate research cited in peer reviewed medical and scientific journals freely available for download by the public. These studies provide further observations, analysis and evidence of the presence and significance of these adverse events from clinical and scientific experts.

Number of deaths associated with the three COVID-19 vaccines: 31,818; 26% of these deaths occurred within 2 days after injection. Of these reported deaths, **643** have been reported having occurred in California. Given that San Diego is the 2nd largest populated county among 58 counties in California, the likelihood is that some of those deaths were reported within San Diego County. But SD County HHS does not report this number in their monthly presentations.

From VAERS, the number of deaths according to age group are plotted below.



Reported deaths all COVID-19 vaccines: all locations (left), California (right)

According to the CDC (https://covid.cdc.gov/covid-data-tracker/#vaccinations_vacc-total-admin-rate-total) as of November 5, 2022 about 641 million doses of the COVID -19 vaccines have been administered over a period of about 23 months. This includes 1st, 2nd doses, & boosters.

For the 14 seasonal influenza vaccines, there have been about 3.7 billion doses administered over 42 years[23]. For these vaccines, the reported deaths number much lower than the deaths from influenza vaccines: reporting a much lower death count: 2,211 deaths.

Contrasting the numbers: covid vs the 14 flu vaccines:

COVID-19	vs	FLU	
31,818	vs	2,226	deaths
0.641	vs	3.47	billion doses
1.9	vs	42	years
50	vs	< 1	deaths/million doses

So the COVID-19 vaccines are more than 50 times deadlier than the influenza vaccines.

It's believed by at least several researchers that adverse events reported in VAERS are severely under-reported. This position is well justified because of the dearth of information that would otherwise provide evidence of reporting compliance. While the CDC mandates reporting of vaccine associated deaths, there's no apparent system for enforcing or monitoring compliance. Other researchers have suggested that reported numbers could only represent 1% of actual adverse events whether the reporter, for some reason, fails to report the event believing there is a connection between the vaccine and the event or else failing to make any connection.

[23] https://www.cdc.gov/flu/prevent/vaccine-supply-historical.htm

Healthcare providers and manufacturers, are required to report deaths and life threatening events. But I can produce testimony by at least one first hand witness that this is not being done, at least at one local institution if not two. Regardless other researchers estimated that a realistic under-reporting factor (URF) is somewhere between 10 and 41[24]. **Keep in mind; that some (unknown) URF applies to all the numbers provided in this report**. In other words the numbers reported herein are a lower bound of actual events. But in this report, the **numbers** are only what VAERS provides. So we might expect that the death toll for covid-19 vaccines is actually between 318,100 and 1,304,538 deaths. So perhaps over a million have died due to COVID-19 vaccination.

According to VAERS data, most reported deaths are largely split between the first and second doses of the vaccine

Messages:
- VAERS data in CDC WONDER are updated every Friday. Hence, results for the same query can change from week to week.
- These results are for 31,818 total events.

Vaccine Dose	Events Reported	Percent (of 31,818)
1 Dose	11,778	37.02%
2 Doses	11,855	37.26%
3 Doses	3,366	10.58%
4 Doses	398	1.25%
5 Doses	26	0.08%
6 Doses	1	0.00%
7 or more Doses	8	0.03%
Unknown	7,512	23.61%
Not Applicable	29	0.09%

And there's a concerning disparity between the number of deaths across various vaccine lot numbers as shown by the graphs that follow. But it's not clear if

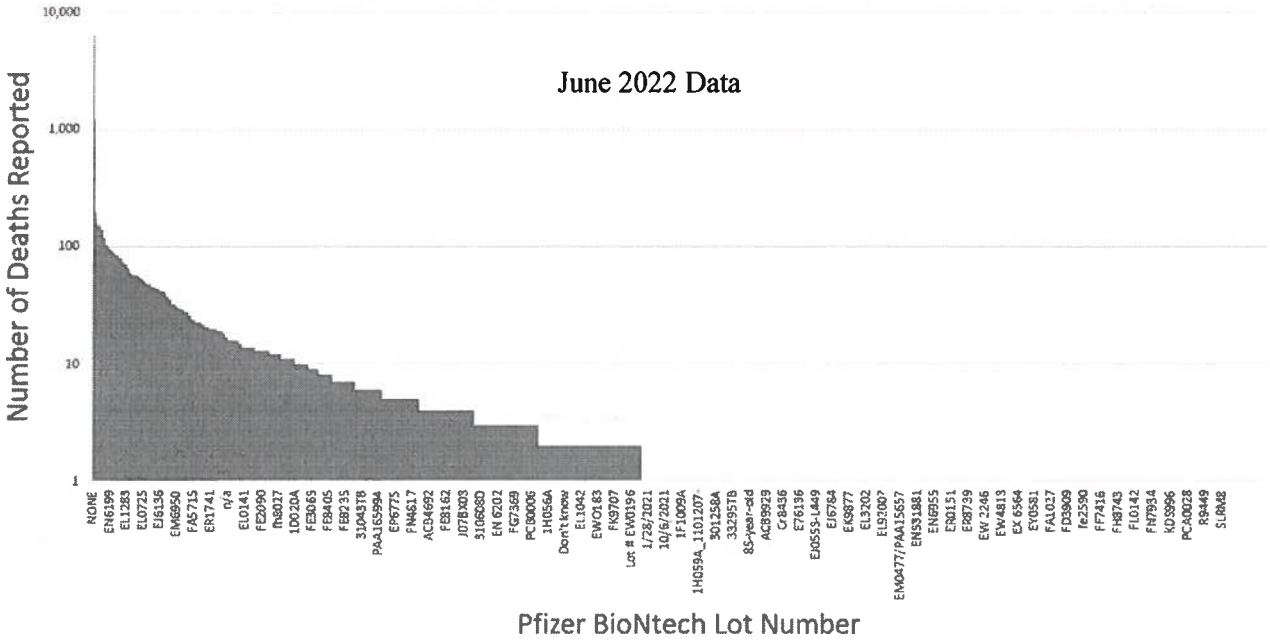
(1) the number of vaccine vials per lot is the same or

(2) that the number of administered doses per lot is somewhat uniform.

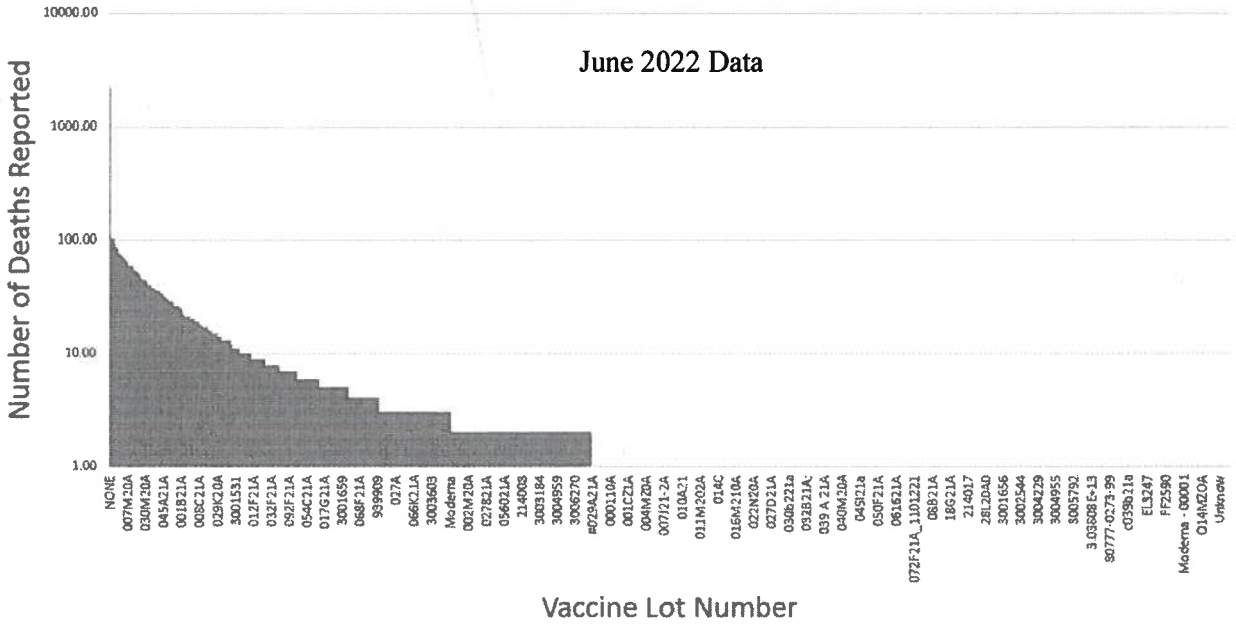
If the lot size and administration of vaccines are somewhat consistent, the data shown below as the frequency of deaths attributed to lot numbers might suggest at least part of the problem is a serious quality issue: that something in the manufacturing process is yielding specific lots that are causing most of the harm[25]. Or it might be variability in the way end point customers are storing, handling or dispatching vaccines. In any event there is no publicly available evidence that officials have any concern to investigate the matter.

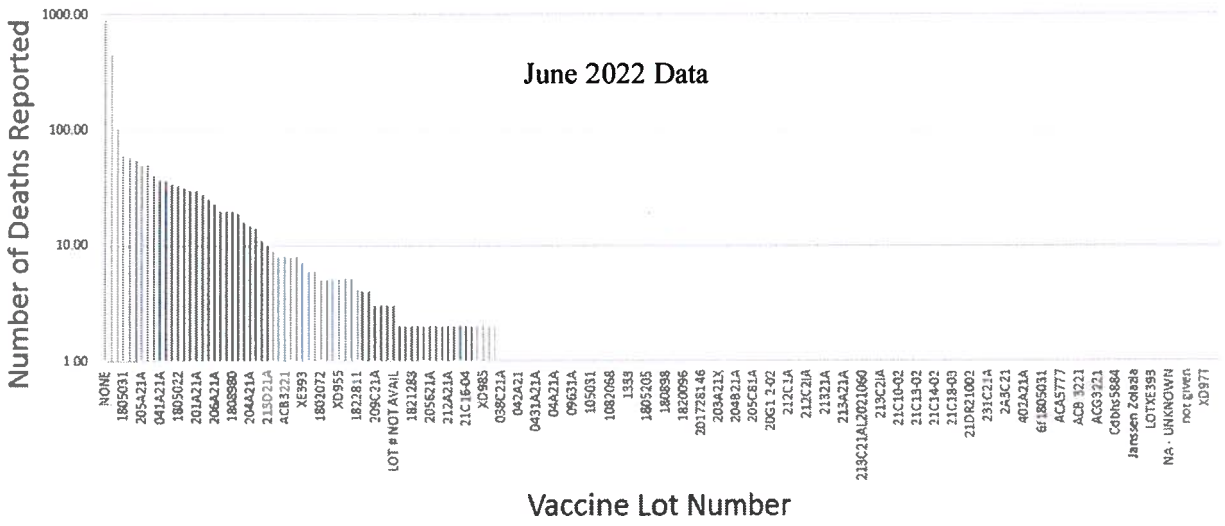
[24] Steve Kirsch Latest VAERS estimate: 388,000 Americans killed by the COVID vaccines
[25] https://www.nutritruth.org/single-post/covid-truths-hot-lots-deadly-batches-of-vaccines

Deaths By Lot Number, Pfizer BioNtech



Deaths by Lot Number, Moderna





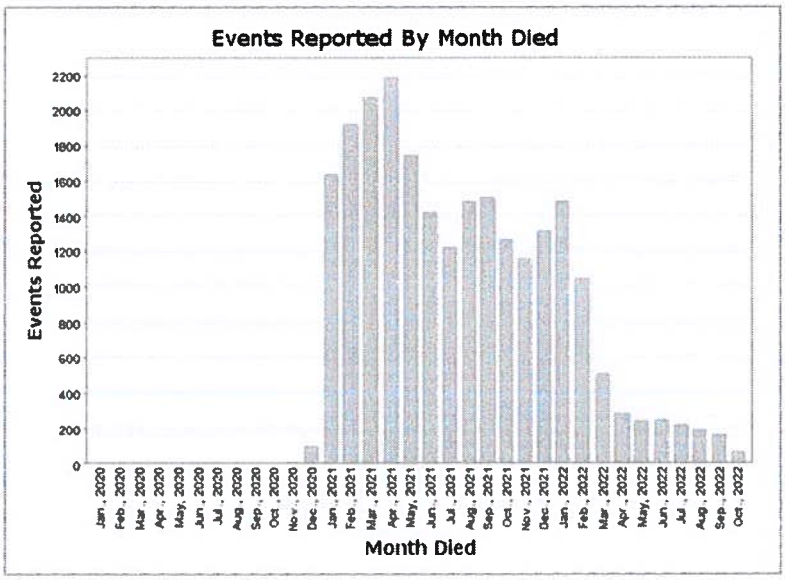
According to sex, the reported deaths associated with COVID-19 vaccines show that males are about 27% more likely to be killed by COVID-19 vaccination.

Messages:

- VAERS data in CDC WONDER are updated every Friday. Hence, results for the same query can change from week to week.
- These results are for 31,818 total events.

Sex	Events Reported	Percent (of 31,818)
Female	13,280	41.74%
Male	16,880	53.05%
Unknown	1,658	5.21%

Many of the deaths reported in VAERS from COVID-19 are associated with cardio pulmonary events or stroke, and a hypothesis offered in the June 2022 report posits that young males are more able and tend to push the envelope of physical exertion as an explanation of higher percentage of male deaths.



Citations regarding COVID-19 vaccination deaths:

Spiro P. Pantazatos, Hervé Seligmann, **COVID vaccination and age-stratified all-cause mortality risk**, ResearchGate, October 2021 https://www.researchgate.net/publication/355581860_COVID_vaccination_and_age-stratified_all-cause_mortality_risk

Mörz M. A **Case Report: Multifocal Necrotizing Encephalitis and Myocarditis after BNT162b2 mRNA Vaccination against COVID-19**. Vaccines (Basel). 2022 Oct 1;10(10):1651. doi: 10.3390/vaccines10101651. PMID: 36298516; PMCID: PMC9611676. https://pubmed.ncbi.nlm.nih.gov/36298516/

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5.2. Ethics; Vaccine Mandates, Coercion & Force

Before presenting other adverse events, it's important to realize a fundamental issue with the ethics of vaccine policy having the outcome of death. Consider from the reported deaths, what are the chances that even 1 report of association is indeed caused by the vaccine. Then ask the question, knowing that the vaccine has the potential to kill at random, how is it ethical to vaccinate a population *en masse* when conceivably some people may die that never would have died from the infection, let alone be infected? The obvious answer: **it is NOT ethical**.

Somehow Public Health Officials and the government that installed them have managed to convince the society that it is ethical; to kill one group of people in order to save another group. This policy is maliciously labeled by the media as "the greater good" and it condones the twisted premise that some benefit risk analysis mitigates this fact. That there is some 'acceptable' number of vaccine induced deaths.

So far no one has addressed this grievous fault in the policy, or perhaps recognized its existence. The policy is one of indiscriminant sacrifice; no different than throwing the virgin into the volcano to appease the gods. In the case of COVID-19 vaccines it's only investment and profits that are being appeased. The medical and scientific literature only touch lightly on the subject of vaccine ethics, and NONE has addressed the question posed above.

Bardosh, Kevin and Krug, Allison and Jamrozik, Euzebiusz and Lemmens, Trudo and Keshavjee, Salmaan and Prasad, Vinay and Makary, Martin A. and Baral, Stefan and Høeg, Tracy Beth, **Covid-19 vaccine boosters for young adults: A risk-benefit assessment and five ethical arguments against mandates at universities** (August 31, 2022). Available at SSRN: https://ssrn.com/abstract=4206070

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Kowalick concludes:

> *... there is neither a moral obligation to vaccinate nor a sound ethical basis to mandate vaccination under any circumstances, even for hypothetical vaccines that are medically risk-free.*
>
> *Agent autonomy with respect to self-constitution has absolute normative priority over reduction or elimination of the associated risks to life. In*

practical terms, mandatory vaccination amounts to discrimination against healthy, innate biological characteristics, which goes against the established ethical norms and is also defeasible a priori.

Other references on the ethics of vaccination ...

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Note that a review of the article by Mello et al in Lancet was completed by David Bell for the Brownstone Institute[27]. Bell pointed out their conclusion for best managing vaccine compliance:

"... the best way to implement such mandates is for employers and educational institutions to threaten job security and the right to education."

Incredible.

Pomara C, Sessa F, Ciaccio M, Dieli F, Esposito M, Giammanco GM, Garozzo SF, Giarratano A, Prati D, Rappa F, Salerno M, Tripodo C, Mannucci PM, Zamboni P. **COVID-19 Vaccine and Death: Causality Algorithm According to the WHO Eligibility Diagnosis**. Diagnostics. 2021; 11(6):955. https://doi.org/10.3390/diagnostics1106095 https://www.mdpi.com/2075-4418/11/6/955

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[26] Yes – that Chelsea Clinton
[27] https://brownstone.org/articles/the-experts-still-pushing-coerced-jabs/

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> Conclusion from Lv et al: *The benefits of COVID-19 vaccines outweigh the potential risks in older frail populations, and our findings do not support actions to exclude older adults from being vaccinated. However, continued monitoring of COVID-19 vaccination is still warranted.*

One more time, an underwhelming candy coated conclusion.

5.3.Categorized Adverse Events

Besides the category of death, thefollowing categories, defined in CDC VAERS, do not define the specific illness or injury, but rather the disposition or final outcome from the injury or illness.

The numbers of the noted categorical adverse events are cumulative events recorded in VAERS since the roll out of the COVID-19 vaccines, but summarized in the following table:

Messages:
- VAERS data in CDC WONDER are updated every Friday. Hence, results for the same query can change from week to week.
- These results are for 1,453,323 total events.

Event Category	Events Reported	Percent (of 1,453,323)
Death	31,818	2.19%
Life Threatening	34,731	2.39%
Permanent Disability	59,614	4.10%
Congenital Anomaly / Birth Defect *	1,177	0.08%
Hospitalized	182,296	12.54%
Existing Hospitalization Prolonged	2,166	0.15%
Emergency Room / Office Visit **	124	0.01%
Emergency Room *	137,950	9.49%
Office Visit *	210,970	14.52%
None of the above	951,984	65.50%

5.3.1 Life threatening events: 34,731; 39% within two days after injection.

5.3.2 Permanent disabilities: 59,614; 50% within two days after injection.

5.3.3 Hospitalized: 182,296; 31% within two days after injection.

5.3.4 Emergency room visits: 137,950; 52% within two days after injection.

5.3.5 Office visits: 210,970; 47% within two days after injection.

Considering children only (under age 18) we see there have been **58,402** adverse events reported, with **168** deaths.

Messages:

- VAERS data in CDC WONDER are updated every Friday. Hence, results for the same query can change from week to week.
- These results are for 58,402 total events.

Event Category	Events Reported	Percent (of 58,402)
Death	168	0.29%
Life Threatening	689	1.18%
Permanent Disability	547	0.94%
Congenital Anomaly / Birth Defect *	18	0.03%
Hospitalized	4,532	7.76%
Existing Hospitalization Prolonged	126	0.22%
Emergency Room / Office Visit **	15	0.03%
Emergency Room *	5,302	9.08%
Office Visit *	7,776	13.31%
None of the above	43,476	74.44%
Total	62,649	107.27%

Of the **168** deaths, **6** were reported in California. The following 4 reports attempt to align some these cases with news reports identified by web search. One case positively confirmed by VAERS ID in news report.

1. 9-Year-Old Dies Two Weeks After Taking COVID-19 Vaccine: VAERS

Details for VAERS ID: 2377304-1

Event Information			
Patient Age	9.00	Sex	Female
State / Territory	California	Date Report Completed	2022-07-21
Date Vaccinated	2021-12-13	Date Report Received	2022-07-21
Date of Onset	2021-12-27	Date Died	2021-12-27
Days to onset	14		
Vaccine Administered By	Other	Vaccine Purchased By	Not Applicable *
Mfr/Imm Project Number	NONE	Report Form Version	2
Recovered	No	Serious	Yes

* VAERS 2.0 Report Form Only
** VAERS-1 Report Form Only
"Not Applicable" will appear when information is not available on this report form version.

Event Categories	
Death	Yes
Life Threatening	No
Permanent Disability	No
Congenital Anomaly / Birth Defect *	No
Hospitalized	No
Days in Hospital	None
Existing Hospitalization Prolonged	No
Emergency Room / Office Visit **	N/A
Emergency Room *	No
Office Visit *	No

* VAERS 2.0 Report Form Only
** VAERS-1 Report Form Only
"N/A" will appear when information is not available on this report form version.

Vaccine Type	Vaccine	Manufacturer	Lot	Dose	Route	Site
COVID19 VACCINE	COVID19 (COVID19 (PFIZER-BIONTECH))	PFIZER\BIONTECH	NONE	1	SYR	UN

Symptom
ABDOMINAL PAIN UPPER
CHEST PAIN
DEATH
OROPHARYNGEAL PAIN

Adverse Event Description
Death after 2-3 days of stomach ache, sore throat and chest pain; two weeks after receiving the vaccination

Lab Data	Current Illness	Adverse Events After Prior Vaccinations

Medications At Time Of Vaccination	History/Allergies

2. 15-Year-Old Boy Died Suddenly Just 2 Days After Second Dose of Pfizer Covid-19 Vaccine

Details for VAERS ID: 1382906-1

Event Information			
Patient Age	15.00	Sex	Male
State / Territory	California	Date Report Completed	2021-06-08
Date Vaccinated	2021-05-15	Date Report Received	2021-06-08
Date of Onset	2021-06-07	Date Died	2021-06-07
Days to onset	23		
Vaccine Administered By	Other	Vaccine Purchased By	Not Applicable *
Mfr/Imm Project Number	NONE	Report Form Version	2
Recovered	No	Serious	Yes

* VAERS 2.0 Report Form Only
** VAERS-1 Report Form Only
"Not Applicable" will appear when information is not available on this report form version.

Event Categories	
Death	Yes
Life Threatening	No
Permanent Disability	No
Congenital Anomaly / Birth Defect *	No
Hospitalized	No
Days in Hospital	None
Existing Hospitalization Prolonged	No
Emergency Room / Office Visit **	N/A
Emergency Room *	No
Office Visit *	No

* VAERS 2.0 Report Form Only
** VAERS-1 Report Form Only
"N/A" will appear when information is not available on this report form version.

Vaccine Type	Vaccine	Manufacturer	Lot	Dose	Route	Site
COVID19 VACCINE	COVID19 (COVID19 (PFIZER-BIONTECH))	PFIZER\BIONTECH	EW0187	2	IM	LA

Symptom
DEATH

Adverse Event Description
Unexplained death within 48 hours

Lab Data	Current Illness	Adverse Events After Prior Vaccinations
	none noted	

Medications At Time Of Vaccination	History/Allergies
None known	Acne, no other conditions noted,None noted

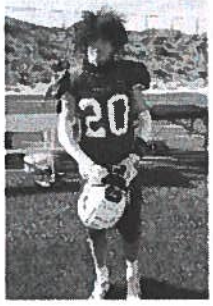
3. <u>3 more teenagers suddenly collapse and die of cardiac arrest</u>

Nathan Esparza, aged 16 Cardiac arrest, collapsed and died

OBITUARY

Nathan Emanuel Esparza

MARCH 18, 2005 - JULY 13, 2021



IN THE CARE OF

Eternal Valley Memorial Park & Mortuary

Nathan Emanuel Esparza, age 16, of Valencia, California passed away on Tuesday, July 13, 2021. Nathan was born March 18, 2005.

Presumed reports of Esparza's death:

Details for VAERS ID: 2459533-1

Event Information			
Patient Age	16.00	Sex	Unknown
State / Territory	California	Date Report Completed	2022-09-23
Date Vaccinated		Date Report Received	2022-09-24
Date of Onset		Date Died	
Days to onset			
Vaccine Administered By	Unknown	Vaccine Purchased By	Not Applicable *
Mfr/Imm Project Number	USMODERNATX, INC.MOD20226	Report Form Version	2
Recovered	No	Serious	Yes

* VAERS 2.0 Report Form Only
** VAERS-1 Report Form Only
"Not Applicable" will appear when information is not available on this report form version.

Event Categories	
Death	Yes
Life Threatening	No
Permanent Disability	No
Congenital Anomaly / Birth Defect *	No
Hospitalized	No
Days in Hospital	None
Existing Hospitalization Prolonged	No
Emergency Room / Office Visit **	N/A
Emergency Room *	No
Office Visit *	No

* VAERS 2.0 Report Form Only
** VAERS-1 Report Form Only
"N/A" will appear when information is not available on this report form version.

Vaccine Type	Vaccine	Manufacturer	Lot	Dose	Route	Site
COVID19 VACCINE	COVID19 (COVID19 (MODERNA))	MODERNA	NONE	UNK	OT	

Symptom
MYOCARDITIS

Adverse Event Description

Inflammation of the heart: This spontaneous case was reported by a consumer and describes the occurrence of MYOCARDITIS (inflammation of the heart) in a 16-year-old patient of an unknown gender who received mRNA-1273 (Moderna COVID-19 Vaccine) for COVID-19 prophylaxis. No Medical History information was reported. On an unknown date, the patient received dose of mRNA-1273 (Moderna COVID-19 Vaccine) (unknown route) 1 dosage form. On an unknown date, the patient experienced MYOCARDITIS (inflammation of the heart) (seriousness criterion death). The reported cause of death was inflammation of the heart. It is unknown if an autopsy was performed. Concomitant medication list was not provided. Treatment information was not provided. Company comment: This spontaneous case concerns a 16 year old patient of unknown gender, with no reported medical history, who met with the fatal, unexpected AESI of Myocarditis, unknown days after receiving the dose of mRNA-1272 vaccine. The reporter mentioned that a cardiologist testified that mRNA vaccines cause inflammation of the heart and as a result two 16 yearolds died. They were discovered dead in bed by their parents. The reporter wanted to know the likelihood of his children having myocarditis decrease with each additional dose received. No information on patient specific risk factors, detailed clinical course, management of the event, dose number and manufacturer details was available in the report. The benefit-risk relationship of mRNA-1273 is not affected by this report. The case was linked to US-MODERNATX, INC.-MOD-2022-648153 (E2B Linked Report).: Sender's Comments: This spontaneous case concerns a 16 year old patient of unknown gender, with no reported medical history, who met with the fatal, unexpected AESI of Myocarditis, unknown days after receiving the dose of mRNA-1272 vaccine. The reporter mentioned that a cardiologist testified to a Pennsylvania senate that mRNA vaccines cause inflammation of the heart and as a result two 16 yearolds died. They were discovered dead in bed by their parents. The reporter wanted to know the likelihood of his children having myocarditis decrease with each additional dose received. No information on patient specific risk factors, detailed clinical course, management of the event, dose number and manufacturer details was available in the report. The benefit-risk relationship of mRNA-1273 is not affected by this report. US-MODERNATX, INC.-MOD-2022-648153:Reporter's case: Reported Cause(s) of Death: Inflammation of the heart.

Lab Data	Current Illness	Adverse Events After Prior Vaccinations

Medications At Time Of Vaccination	History/Allergies
	,

Details for VAERS ID: 2459534-1

Event Information			
Patient Age	16.00	Sex	Unknown
State / Territory	California	Date Report Completed	2022-09-23
Date Vaccinated		Date Report Received	2022-09-24
Date of Onset		Date Died	
Days to onset			
Vaccine Administered By	Unknown	Vaccine Purchased By	Not Applicable *
Mfr/Imm Project Number	USMODERNATX, INC.MOD20226	Report Form Version	2
Recovered	No	Serious	Yes

* VAERS 2.0 Report Form Only
** VAERS-1 Report Form Only
"Not Applicable" will appear when information is not available on this report form version.

Event Categories	
Death	Yes
Life Threatening	No
Permanent Disability	No
Congenital Anomaly / Birth Defect *	No
Hospitalized	No
Days in Hospital	None
Existing Hospitalization Prolonged	No
Emergency Room / Office Visit **	N/A
Emergency Room *	No
Office Visit *	No

* VAERS 2.0 Report Form Only
** VAERS-1 Report Form Only
"N/A" will appear when information is not available on this report form version.

Vaccine Type	Vaccine	Manufacturer	Lot	Dose	Route	Site
COVID19 VACCINE	COVID19 (COVID19 (MODERNA))	MODERNA	NONE	UNK	OT	

Symptom
MYOCARDITIS

Adverse Event Description

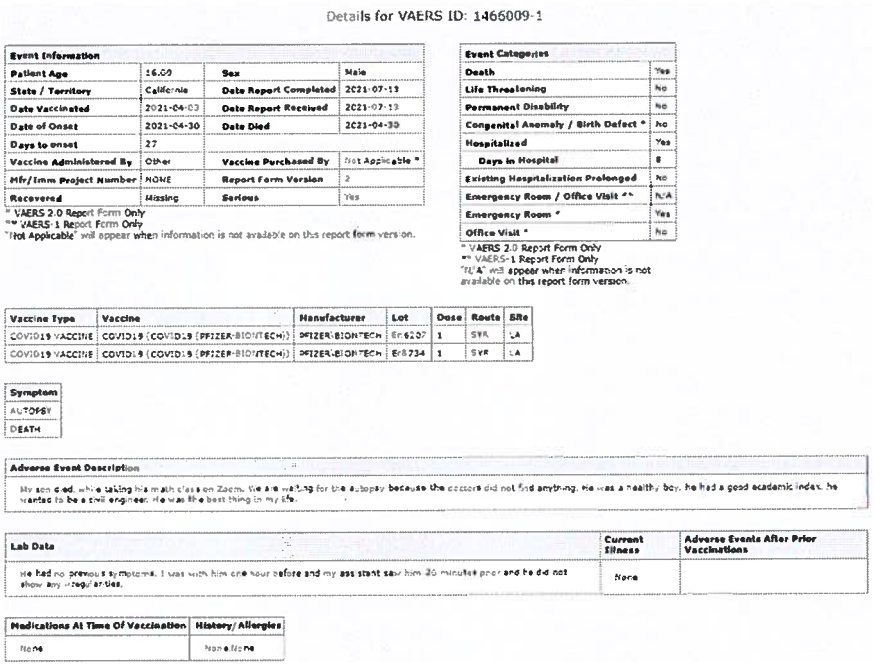
This spontaneous case was reported by a consumer and describes the occurrence of MYOCARDITIS (inflammation of the heart) in a 16-year-old patient of an unknown gender who received mRNA-1273 (Moderna COVID-19 Vaccine) for COVID-19 prophylaxis. No Medical History information was reported. On an unknown date, the patient received dose of mRNA-1273 (Moderna COVID-19 Vaccine) (unknown route) 1 dosage form. On an unknown date, the patient experienced MYOCARDITIS (inflammation of the heart) (seriousness criteria death and medically significant). The reported cause of death was inflammation of the heart. It is unknown if an autopsy was performed. No concomitant medication was reported. It was reported that mRNA vaccines causes inflammation of the heart and as a result patient was died. No treatment medication was reported. Company comment: This spontaneous case reported by a consumer, concerns a 16-year-old patient of unknown gender, with no reported medical history, experienced the serious (fatal and medically significant) unexpected AESI of Myocarditis which occurred unknown days after administration of a dose of mRNA-1273 vaccine. There is limited information regarding latency, clinical course, investigations, treatment received for the event, time and date of death, in the report. It was unknown whether an autopsy was performed. The benefit-risk relationship of mRNA-1273 Vaccine, is not affected by this report. This case was linked to US-MODERNATX, INC.-MOD-2022-648153 (E2B Linked Report). Sender's Comments: The spontaneous case reported by a consumer concerns a 16-year-old patient of unknown gender, with no reported medical history, experienced the serious (fatal and medically significant) unexpected AESI of Myocarditis which occurred unknown days after administration of a dose of mRNA-1273 vaccine. There is limited information regarding latency, clinical course, investigations, treatment received for the event, time and date of death, in the report. It was unknown whether an autopsy was performed. The benefit-risk relationship of mRNA-1273 Vaccine, is not affected by this report. US-MODERNATX, INC.-MOD-2022-648153: reporter's case: Reported Cause(s) of Death: Inflammation of the heart

Lab Data	Current Illness	Adverse Events After Prior Vaccinations

Medications At Time Of Vaccination	History/Allergies
	,

One year ago: Sweden, Denmark pause Moderna COVID-19 vaccine for younger age groups

4. Healthy 16-year-old boy in California DIES after receiving second dose of Pfizer's coronavirus vaccine – VAERS ID 1466009 noted in news report:



Details for VAERS ID: 1466009-1

Event Information			
Patient Age	16.00	Sex	Male
State / Territory	California	Date Report Completed	2021-07-13
Date Vaccinated	2021-04-03	Date Report Received	2021-07-13
Date of Onset	2021-04-30	Date Died	2021-04-30
Days to onset	27		
Vaccine Administered By	Other	Vaccine Purchased By	Not Applicable *
Mfr/Imm Project Number	NONE	Report Form Version	2
Recovered	Missing	Serious	Yes

* VAERS 2.0 Report Form Only
** VAERS-1 Report Form Only
"Not Applicable" will appear when information is not available on this report form version.

Event Categories	
Death	Yes
Life Threatening	No
Permanent Disability	No
Congenital Anomaly / Birth Defect *	No
Hospitalized	Yes
Days in Hospital	8
Existing Hospitalization Prolonged	No
Emergency Room / Office Visit **	N/A
Emergency Room *	Yes
Office Visit *	No

* VAERS 2.0 Report Form Only
** VAERS-1 Report Form Only
"N/A" will appear when information is not available on this report form version.

Vaccine Type	Vaccine	Manufacturer	Lot	Dose	Route	Site
COVID19 VACCINE	COVID19 (COVID19 (PFIZER-BIONTECH))	PFIZER-BIONTECH	En6207	1	SYR	LA
COVID19 VACCINE	COVID19 (COVID19 (PFIZER-BIONTECH))	PFIZER-BIONTECH	En8734	1	SYR	LA

Symptom
AUTOPSY
DEATH

Adverse Event Description
My son died while taking his math class on Zoom. We are waiting for the autopsy because the doctors did not find anything. He was a healthy boy. He had a good academic index. He wanted to be a civil engineer. He was the best thing in my life.

Lab Data	Current Illness	Adverse Events After Prior Vaccinations
He had no previous symptoms. I was with him one hour before and my ass stant saw him 30 minutes prior and he did not show any irregularities.	None	

Medications At Time Of Vaccination	History/Allergies
None	None/None

At a nation level there's now another actively updated website that keeps track of athletes believed to have died because of covid vaccination. At the time of this report there were 1430 athlete cardiac arrests or serious Issues and 976 of them died after COVID-19 injection:

https://goodsciencing.com/covid/athletes-suffer-cardiac-arrest-die-after-covid-shot/

Just as we looked at deaths associated with all vaccines above, we can also look at all adverse events for all vaccines over all time. VAERS data shows that 64% of all these reports can be attributed to the COVID-19 vaccines alone.

Messages:

- VAERS data in CDC WONDER are updated every Friday. Hence, results for the same query can change from week to week.
- These results are for 2,346,392 total events.

Vaccine	Events Reported	Percent (of 2,346,392)
COVID19 (COVID19 (PFIZER-BIONTECH)) (1200)	887,805	37.84%
COVID19 (COVID19 (MODERNA)) (1201)	509,337	21.71%
COVID19 (COVID19 (JANSSEN)) (1203)	95,742	4.08%
VARICELLA (VARIVAX) (269)	80,037	3.41%
MEASLES + MUMPS + RUBELLA (MMR II) (26)	76,993	3.28%
ZOSTER (SHINGRIX) (1192)	60,837	2.59%
PNEUMO (PNEUMOVAX) (30)	60,624	2.58%
HPV (GARDASIL) (1098)	46,819	2.00%
ZOSTER LIVE (ZOSTAVAX) (1097)	42,610	1.82%
PNEUMO (PREVNAR13) (1141)	40,013	1.71%
INFLUENZA (SEASONAL) (FLUZONE) (7)	36,840	1.57%
HEP B (ENGERIX-B) (38)	34,148	1.46%
INFLUENZA (SEASONAL) (NO BRAND NAME) (44)	30,014	1.28%
PNEUMO (PREVNAR) (1001)	28,503	1.21%
HEP B (RECOMBIVAX HB) (25)	27,779	1.18%
VACCINE NOT SPECIFIED (NO BRAND NAME) (999)	27,184	1.16%
POLIO VIRUS, INACT. (IPOL) (1030)	25,585	1.09%
ROTAVIRUS (ROTATEQ) (1096)	23,949	1.02%
TDAP (ADACEL) (1092)	23,935	1.02%
DTAP (INFANRIX) (286)	23,300	0.99%
HEP A (HAVRIX) (268)	22,959	0.98%
POLIO VIRUS, ORAL (ORIMUNE) (17)	22,419	0.96%
HIB (ACTHIB) (256)	21,992	0.94%
MENINGOCOCCAL CONJUGATE (MENACTRA) (1090)	18,850	0.80%
HPV (GARDASIL 9) (1170)	18,569	0.79%
MEASLES + MUMPS + RUBELLA + VARICELLA (PROQUAD) (1094)	18,569	0.79%
INFLUENZA (SEASONAL) (FLUVIRIN) (262)	18,517	0.79%
INFLUENZA (SEASONAL) (FLUZONE HIGH-DOSE) (1145)	16,545	0.71%
TDAP (BOOSTRIX) (1091)	16,508	0.70%
HEP A (VAQTA) (280)	16,022	0.68%
DTP (NO BRAND NAME) (2)	15,929	0.68%
DTAP (DAPTACEL) (1064)	15,922	0.68%
HIB (HIBTITER) (35)	14,675	0.63%
INFLUENZA (SEASONAL) (FLUZONE QUADRIVALENT) (1162)	14,636	0.62%
DTAP (TRIPEDIA) (242)	14,559	0.62%
TD ADSORBED (NO BRAND NAME) (11)	14,071	0.60%
HIB (PEDVAXHIB) (129)	13,277	0.57%
DTAP + HEPB + IPV (PEDIARIX) (1082)	11,736	0.50%
INFLUENZA (SEASONAL) (FLUARIX QUADRIVALENT) (1161)	10,568	0.45%
ROTAVIRUS (ROTARIX) (1124)	10,129	0.43%
POLIO VIRUS, INACT. (POLIOVAX) (9)	9,948	0.42%
DTAP + IPV + HIB (PENTACEL) (1125)	9,260	0.39%
MENINGOCOCCAL B (BEXSERO) (1165)	9,173	0.39%
COVID19 (COVID19 (UNKNOWN)) (1202)	9,048	0.39%

Published research or case studies addressing vaccine injury from either journals or the media tend to report these adverse events in terms of percentages rather than absolute number of persons affected. Whether the intent is accidental or intentional, reporting of percentages tends to soften impressions on the reader of how dangerous the vaccines actually are compared to legacy vaccines. For example, given the total number of doses administered, the percentage of deaths associated with the vaccine is *less than* 0.005%. This appears to be a very small number, but since there are 641 million doses even a small percentage like this represents almost 32,000 deaths! That's just not acceptable for a treatment where the recipient believes it to be 'safe and effective'.

There is no consolation for the victims and friends and family that lost their loved ones – especially if they were young and fit and may have easily survived a COVID-19 infection with early therapeutic treatment – or perhaps never been infected in the first place. Many people have been infected, have natural immunity and aren't even aware of it. But the policies and medical practice rarely if ever call for antigen testing to determine if a person has immunity. The magnitude of harm, injury other than death caused by these vaccines further exposes the unethical nature of these policies.

Since the beginning of vaccine distribution it's been difficult to establish solid evidence that COVID-19 vaccines provide benefits that exceed harms, since the number of true COVID-19 cases has been obfuscated by inaccurate PCR testing with a high rate of false positives[28] [29], and the true number of deaths caused by COVID-19 infection confounded by the fact that many were actually persons "dying with covid positive tests" rather than "dying from covid infection". Indeed the enigma of correlation vs. causation cuts both ways.

Add to this the confusion surrounding TRUE efficacy of the vaccines and the release of the phase 3 trial results earlier this year. The data sent from Pfizer to the FDA in early 2021 took a FOIA, a lawsuit and court order to get the FDA to release it. The released report[30][31], now accessible by the public, reveals that Pfizer and the FDA have committed a crime, possibly colluding to hide damaging information from the public. The data should have, at the very least, forced the FDA to black label the vaccine. But a more appropriate action would have been a recall. Yet MANY people, now children as young as 6 months old, continue to receive the vaccines! About 13 million more doses received by Americans since the last report.

5.4.VAERS Analysis Updates

To further contrast the disparity of harm between the covid19 vaccines and legacy vaccines, all adverse events from all other vaccines collectively were compared over the 32 year timeline of vaccine tracking in VAERS. This section features work done by another researcher that has set up what appears to be an automated system that acquires weekly data and processes various graphs. The website link to the latest report:

https://vaersanalysis.info/2022/11/04/vaers-summary-for-covid-19-vaccines-through-10-28-2022/ ,

updated 10/28/2022.

The following graph is perhaps the most striking illustration of the disparate nature of the covid-19 vaccines over all others. The blue 'spike' towards the right represents the deaths associated with the covid-19 vaccines in 2021 - when the covid-19 vaccines were rolled out. In 2022 vaccine uptake declined, but cumulatively the associated deaths from covid-19 vaccines in 2021 and 2022 dwarf the cumulative deaths from all other vaccines.

There's just no argument that can excuse the crimes being committed by these corporations and our government on humanity. This is a super crime that demands investigation and accountability by those that allowed it to happen.

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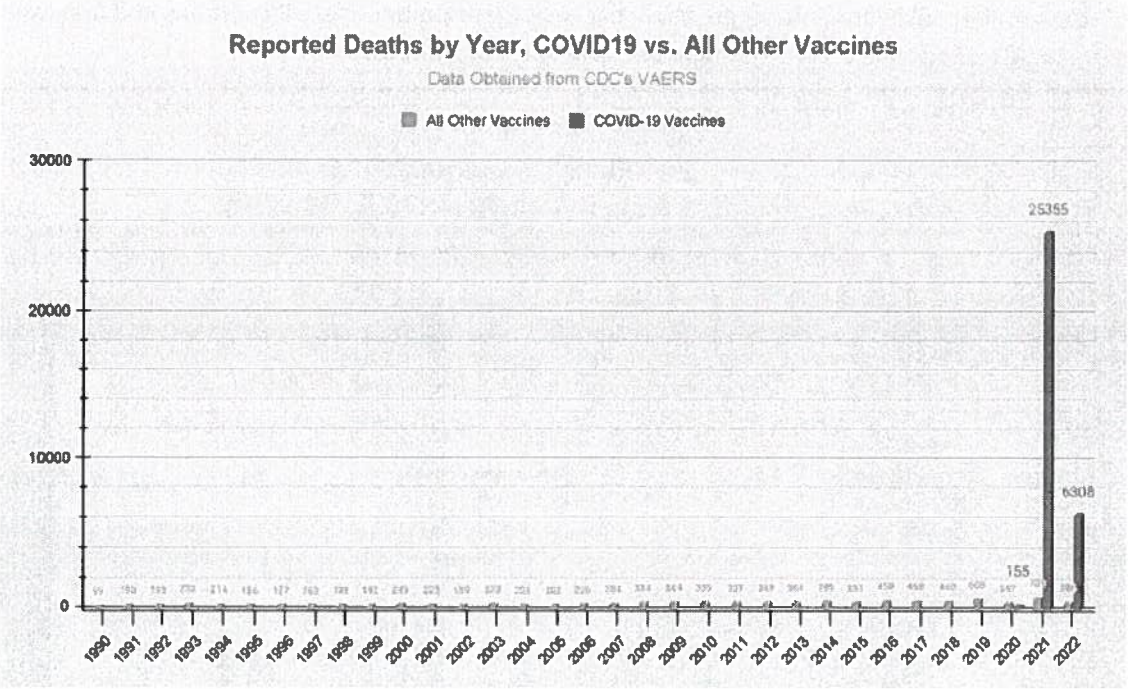
[28] Elena Surkova, Vladyslav Nikolayevskyy, Francis Drobniewski, **False-positive COVID-19 results: hidden problems and costs**, The Lancet Respiratory Medicine, VOLUME 8, ISSUE 12, P1167-1168, DECEMBER 01, 2020 https://www.thelancet.com/action/showPdf?pii=S2213-2600%2820%2930453-7

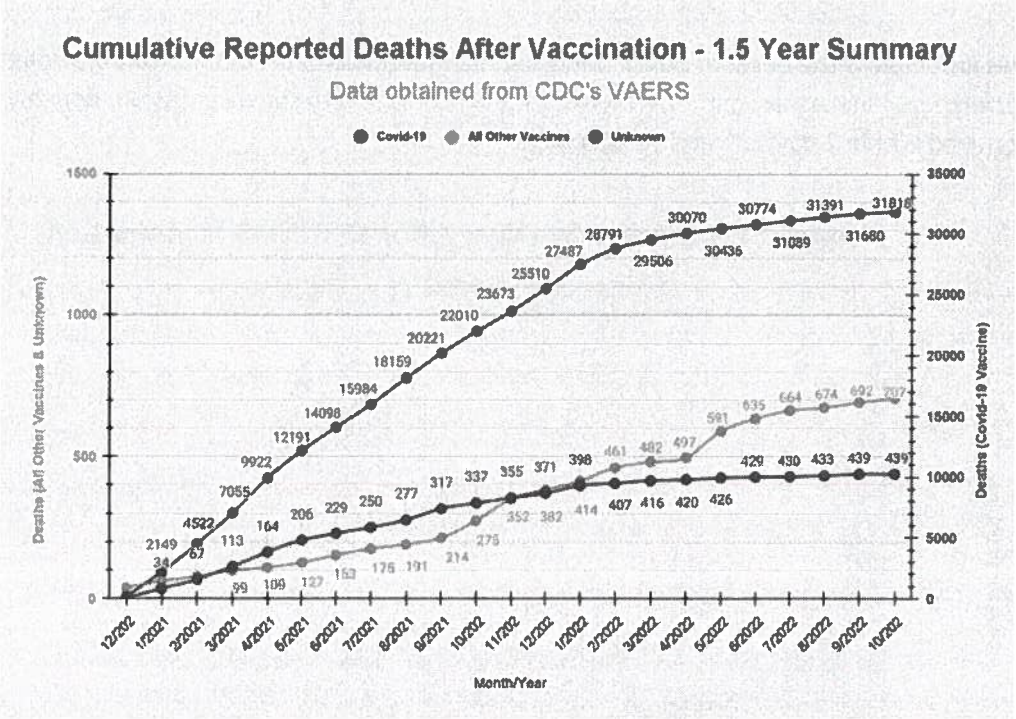
[29] Ferté T, Ramel V, Cazanave C, Lafon ME, Bébéar C, Malvy D, Georges-Walryck A, Dehail P. Accuracy of COVID-19 rapid antigenic tests compared to RT-PCR in a student population: The StudyCov study. J Clin Virol. 2021 Aug;141:104878. doi: 10.1016/j.jcv.2021.104878. Epub 2021 Jun 5. PMID: 34134035; PMCID: PMC8178956. https://pubmed.ncbi.nlm.nih.gov/34134035/

[30] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1063378/Vaccine_Analysis_Print_Pfizer_BioNTech_COVID-19_vaccine_16.03.2022_v3.pdf

[31] CUMULATIVE ANALYSIS OF POST-AUTHORIZATION ADVERSE EVENT REPORTS OF PF-07302048 (BNT162B2) RECEIVED THROUGH 28-FEB-2021

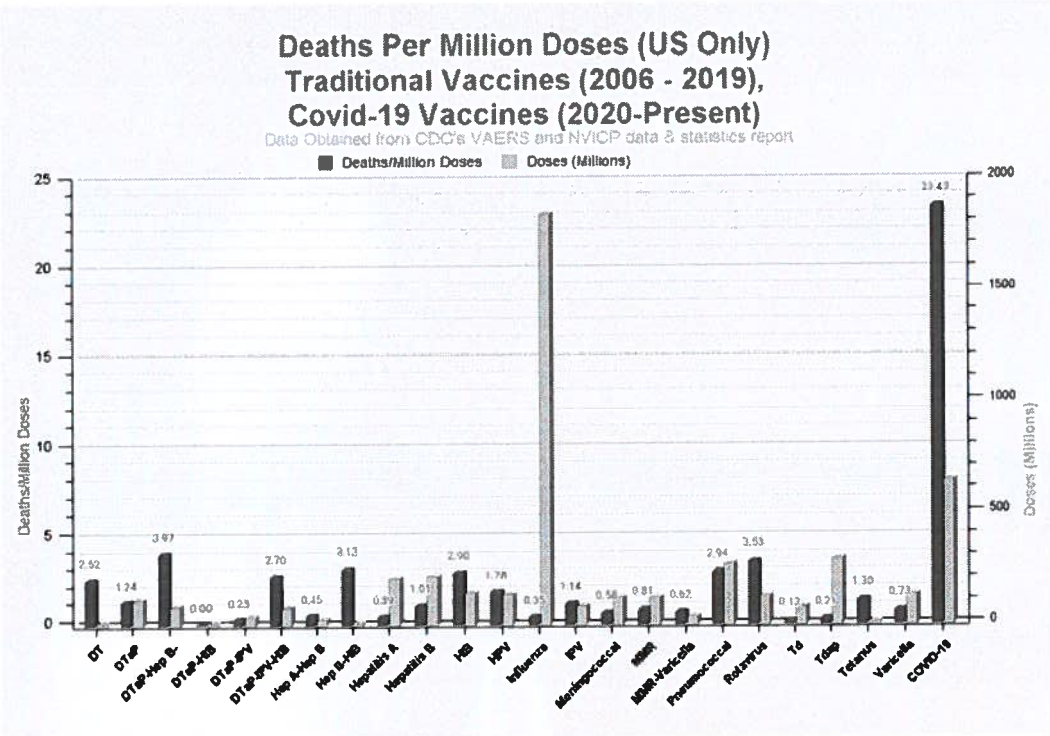


The graph below provides an up to date summary of cumulative deaths comparing the covid 19 vaccines with all other vaccines since the covid-19 vaccines were rolled out, December 2020.

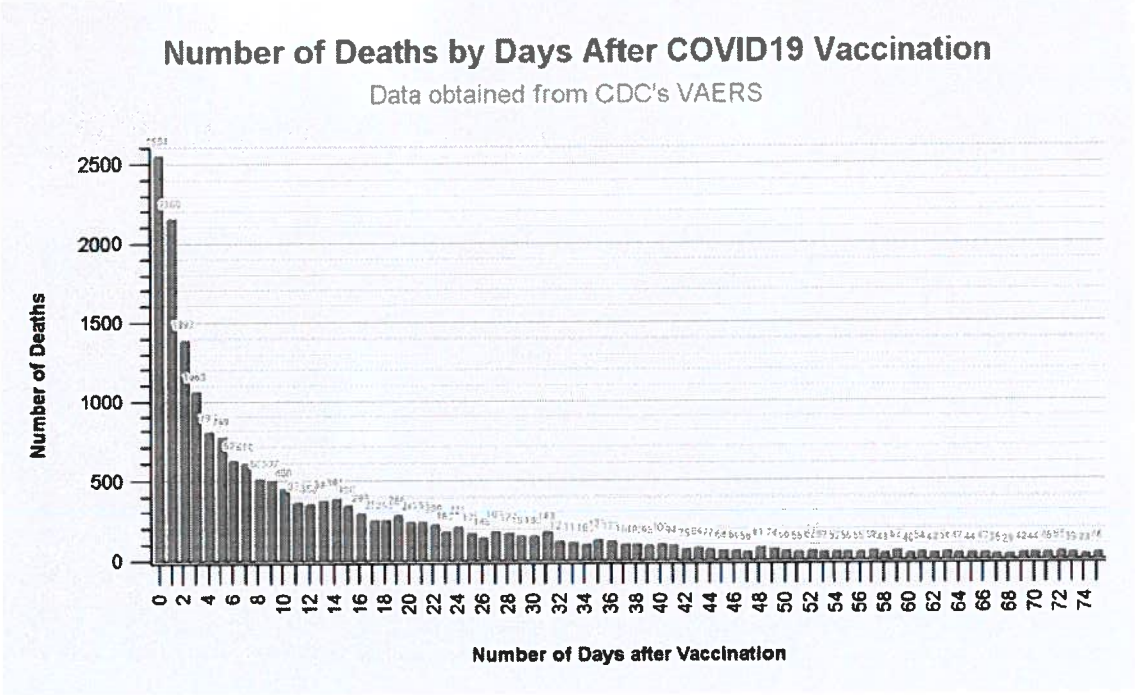


A more 'fair' comparison normalizes the number of deaths relative to the number of associated vaccine doses (deaths per million doses). The following graph still shows the stark truth; COVID-19 vaccines are far deadlier than any other vaccine ever administered. Note the normalized death rate does not agree with

the number calculated above probably because that number uses all locations and may use a different estimate of vaccine doses. The blue line is doses, red, deaths.



This graph plots the onset of death following the immunization event indicating strong temporal correlation, a necessary (although not sufficient) condition to show causation. Roughly 1/3 of these deaths occurred within 2 days of vaccine injection.



Again, to be fair, the 0th and 1st day data may be biased by reporters not knowing exactly which day death occurred so they entered either 0 or 1. This was confirmed by reading actual reports report descriptions for onset of zero and 1 data sets. The descriptions for some of these cases actually indicated longer onset intervals. Nevertheless, the preponderance of remaining reports indicate a trend showing definite temporal correlation.

The following graph reveals D-dimer tests top the list of 'events' reported for covid-19 vaccines. This is because events reported in VAERS are not necessarily outcomes, but can be procedures performed or tests ordered by physicians. This result is probably evidence that medical doctors treating vaccine recipients are truly *anticipating* thrombogenesis from the vaccines. The doctors may not be able to publicly come out and raise objections to the COVID-19 vaccines, but we see here they are acting in interest of their patient's health! High D-dimer indicates that clotting has been triggered in the bloodstream and there is increased risk for further clotting > platelets & fibrin attaching to red blood cells, at first creating 'micro-emboli' , clot structures that flow with the blood stream. These can combine and create larger emboli, and if large enough, can cut off blood supply which can be lethal. D-dimer is clinically used to determine stroke, pulmonary embolism or deep vein thrombosis.

The analysis from the graph indicates that the COVID-19 vaccines have thus far resulted in Fibrin "D-dimer tests" having a higher frequency (X 833) over all other vaccines combined. It also wasn't clear what was meant just by the tag "Fibrin D-dimer". Does that mean high level/low level? VAERS allows query of more detailed information and it further describes this tag as "Fragment D-Dimer" which I believe just means presence of the dimer which is presumably the byproduct of clot decomposition by the enzyme plasmin. There are other associated tags, and perhaps the FIBRIN D DIMER INCREASED tag would have been more appropriate.

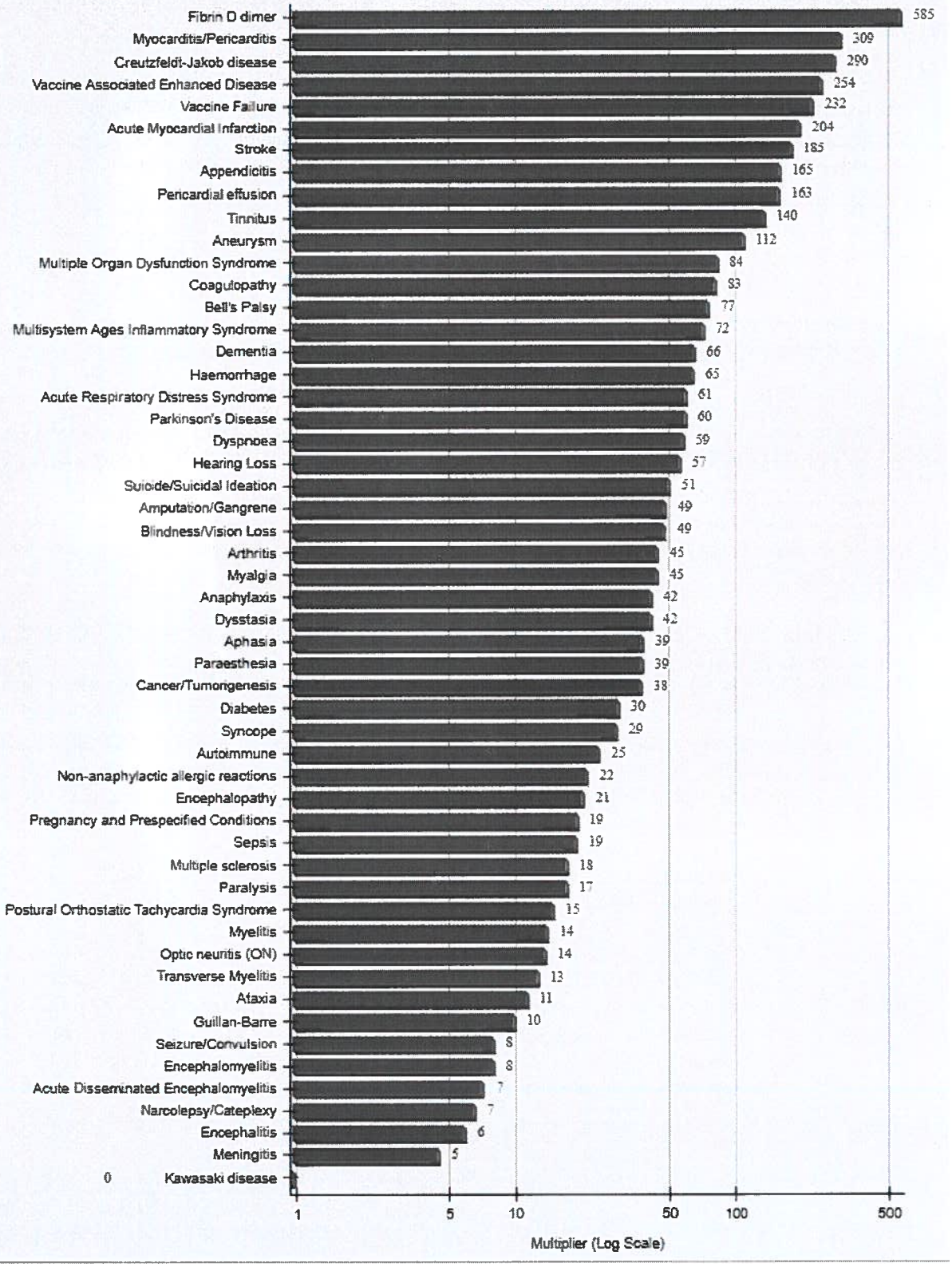
An article by Auditeau et al[32] seems to suggest that D-Dimer test is not recommended as a routine procedure after COVID-19 vaccination:

> *Furthermore, blood count or D-dimer testing follow-up after anti–COVID-19 vaccination is not recommended, except in case of clinical suspicion of vaccine-induced thrombotic thrombocytopenia. This is an extremely rare severe adverse effect of the ChAdOx1 nCoV-19 COVID-19 vaccine (Oxford/AstraZeneca), and the Janssen Ad26.COV2.S COVID-19 vaccine is associated with unusual thrombosis (mostly cerebral vein or splanchnic vein thrombosis). 27, 28 A study focused on global hemostasis parameters following BNT162b2 Pfizer-BioNTech vaccination in healthy volunteers and showed no significant changes at the different time points evaluated before and after vaccination*
>
> *To conclude, physicians must keep in mind that D-dimer assays have low specificity for VTE. For instance, high D-dimer levels can be observed in acute or chronic inflammatory syndrome, recent surgery, trauma, pregnancy, liver diseases, or active malignancy regardless of VTE occurrence. Consequently, D-dimer testing prescription must be strictly limited to the validated indications listed above, and the interpretation will depend on this indication.*

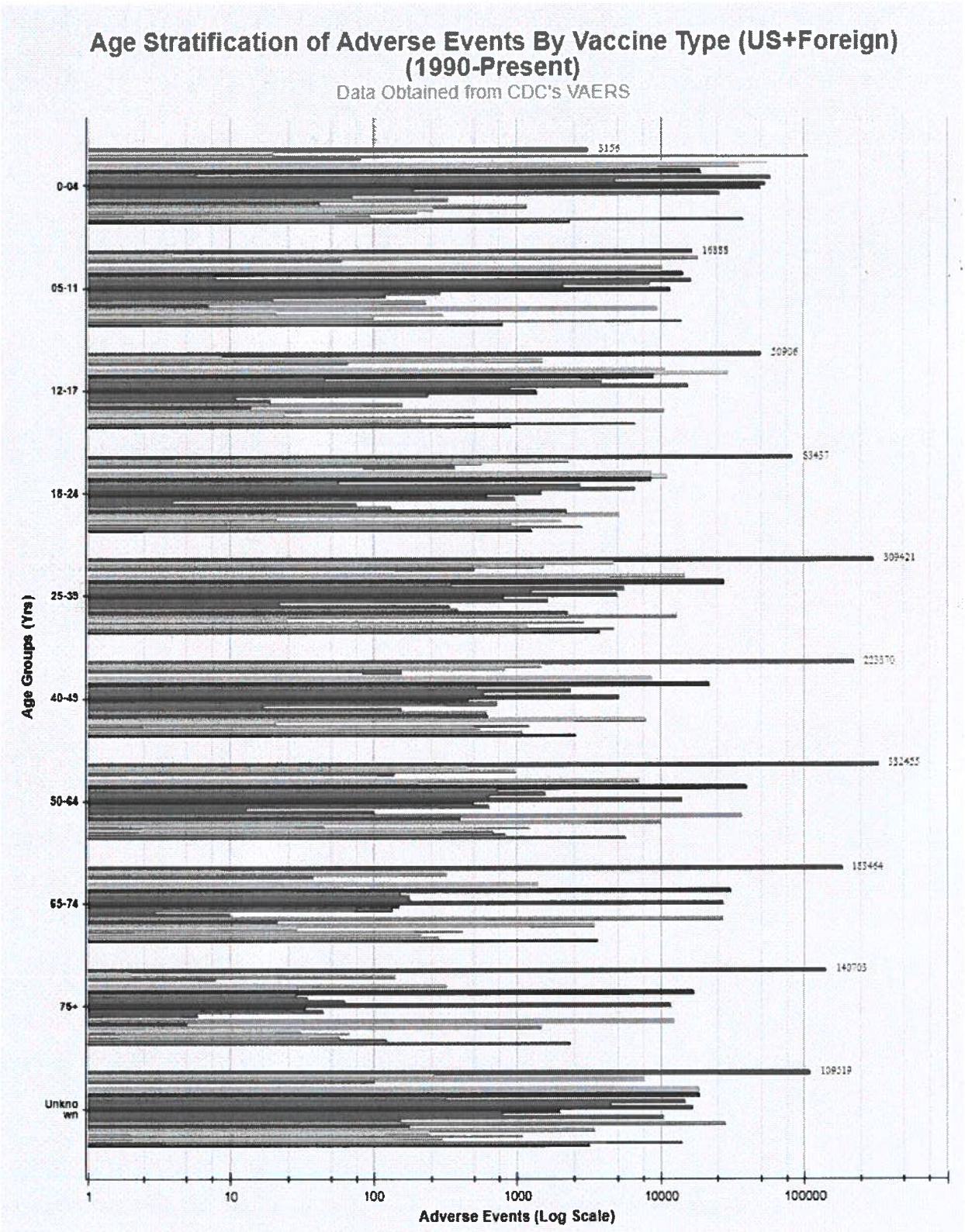
[32] Auditeau C, Khider L, Planquette B, Sanchez O, Smadja DM, Gendron N. **D-dimer testing in clinical practice in the era of COVID-19**. Res Pract Thromb Haemost. 2022 May 25;6(4):e12730. doi: 10.1002/rth2.12730. PMID: 35664536; PMCID: PMC9133433.

Average Annual Adverse Events by Symptom for Covid-19 Vaccines as a Multiple of All Other Vaccines Combined since 1990

(Data from VAERS through 10/28/22)



The following graph compares deaths between all types of vaccines according to age group. Note that the horizontal scale is on a logarithmic scale since COVID-19 vaccine associated deaths above 18 years old would otherwise dwarf all other vaccines. Since the approval of vaccines for children down to 6 months old has happened only very recently, the younger age groups 0-4 and 5-11 are 'catching up' as did the adult injury and death for the adults did in only two months after COVID-19 vaccines were dispatched.


Age Stratification of Adverse Events By Vaccine Type (US+Foreign)
(1990-Present)
Data Obtained from CDC's VAERS
Age Groups (Yrs)
0-04
05-11
12-17
18-24
25-39
40-49
50-64
65-74
75+
Unkno
wn
3156
16885
50906
53457
309421
223370
332455
183464
140703
109519
1
10
100
1000
10000
100000
Adverse Events (Log Scale)

5.5.Reported Specific Adverse Events

5.5.1 Post vaccination prevalent symptoms

The following table reports orders the most prevalent symptoms reported in VAERS after COVID-19 vaccine injection and where at least 1000 cases were reported. Life threatening symptoms or symptoms of particular interest are highlighted. The occurrence of some of these adverse events are then treated in subsequent sections.

Rank	Symptoms	Cases	% Cases
2	SARS-COV-2 TEST	225,918	15.61%
3	HEADACHE	215,589	14.89%
4	COVID-19	186,843	12.91%
5	FATIGUE	186,273	12.87%
6	PYREXIA	179,229	12.38%
7	CHILLS	130,066	8.99%
8	PAIN	126,908	8.77%
9	NAUSEA	117,945	8.15%
10	DIZZINESS	117,004	8.08%
11	PAIN IN EXTREMITY	109,195	7.54%
12	MYALGIA	86,551	5.98%
13	DYSPNOEA	85,097	5.88%
14	ARTHRALGIA	79,704	5.51%
15	VACCINATION FAILURE	76,864	5.31%
16	DRUG INEFFECTIVE	63,882	4.41%
17	ASTHENIA	57,176	3.95%
18	MALAISE	55,926	3.86%
19	RASH	53,510	3.70%
20	VOMITING	50,988	3.52%
21	CHEST PAIN	50,978	3.52%
22	PRURITUS	48,628	3.36%
23	SARS-COV-2 TEST POSITIVE	48,298	3.34%
24	BODY TEMPERATURE	46,054	3.18%
25	INJECTION SITE PAIN	45,850	3.17%
26	PARAESTHESIA	43,780	3.02%
27	DIARRHOEA	41,328	2.86%
28	COUGH	41,309	2.85%
29	LYMPHADENOPATHY	40,611	2.81%
30	BLOOD TEST	39,368	2.72%
31	HYPOAESTHESIA	38,600	2.67%
32	VACCINATION SITE PAIN	36,982	2.55%
33	PALPITATIONS	35,115	2.43%
34	FEELING ABNORMAL	34,298	2.37%

Rank	Symptoms	Cases	% Cases
35	SYNCOPE	34,233	2.36%
36	ELECTROCARDIOGRAM	33,981	2.35%
37	HYPERHIDROSIS	33,093	2.29%
38	URTICARIA	32,117	2.22%
39	ERYTHEMA	31,950	2.21%
40	BLOOD PRESSURE MEASUREMENT	31,426	2.17%
41	EXPIRED PRODUCT ADMINISTERED	29,925	2.07%
42	INJECTION SITE ERYTHEMA	29,671	2.05%
43	CHEST DISCOMFORT	28,617	1.98%
44	PERIPHERAL SWELLING	27,725	1.92%
45	INAPPROPRIATE SCHEDULE OF PRODUCT ADMINISTRATION	27,687	1.91%
46	INTERCHANGE OF VACCINE PRODUCTS	27,211	1.88%
47	PRODUCT STORAGE ERROR	26,934	1.86%
48	IMMUNISATION	25,831	1.78%
49	OFF LABEL USE	25,185	1.74%
50	INJECTION SITE SWELLING	24,899	1.72%
51	BACK PAIN	23,915	1.65%
52	HEART RATE	23,688	1.64%
53	CONDITION AGGRAVATED	23,581	1.63%
54	NO ADVERSE EVENT	23,426	1.62%
55	TINNITUS	23,281	1.61%
56	TREMOR	22,225	1.54%
57	OROPHARYNGEAL PAIN	21,950	1.52%
58	HEART RATE INCREASED	21,376	1.48%
59	TACHYCARDIA	21,307	1.47%
60	LOSS OF CONSCIOUSNESS	21,022	1.45%
61	COMPUTERISED TOMOGRAM	20,401	1.41%
62	DECREASED APPETITE	20,360	1.41%
63	INFLUENZA LIKE ILLNESS	20,014	1.38%
64	INJECTION SITE PRURITUS	19,895	1.37%
65	SWELLING	18,524	1.28%
66	FEELING HOT	17,907	1.24%
67	NECK PAIN	17,735	1.23%
68	MAGNETIC RESONANCE IMAGING	17,532	1.21%
69	MIGRAINE	16,842	1.16%
70	INSOMNIA	16,762	1.16%
71	HYPERTENSION	16,580	1.15%
72	ABDOMINAL PAIN	16,114	1.11%
73	INVESTIGATION	16,096	1.11%
74	DEATH	16,053	1.11%
75	MYOCARDITIS	16,017	1.11%

Rank	Symptoms	Cases	% Cases
76	ECHOCARDIOGRAM	15,805	1.09%
77	MUSCULAR WEAKNESS	15,273	1.06%
78	VERTIGO	15,271	1.05%
79	HEAVY MENSTRUAL BLEEDING	14,933	1.03%
80	INJECTION SITE WARMTH	14,878	1.03%
81	ARRHYTHMIA	14,848	1.03%
82	MUSCLE SPASMS	14,670	1.01%
83	ABDOMINAL PAIN UPPER	14,567	1.01%
84	GAIT DISTURBANCE	14,317	0.99%
85	OXYGEN SATURATION	14,213	0.98%
86	BLOOD PRESSURE INCREASED	14,078	0.97%
87	C-REACTIVE PROTEIN	13,566	0.94%
88	CHEST X-RAY	13,554	0.94%
89	HERPES ZOSTER	13,487	0.93%
90	MOBILITY DECREASED	13,380	0.92%
91	ANXIETY	13,110	0.91%
92	PRODUCT ADMINISTERED TO PATIENT OF INAPPROPRIATE AGE	13,106	0.91%
93	LABORATORY TEST	13,024	0.90%
94	FALL	12,945	0.89%
95	PULMONARY EMBOLISM	12,853	0.89%
96	RASH ERYTHEMATOUS	12,689	0.88%
97	SOMNOLENCE	12,640	0.87%
98	VISION BLURRED	12,534	0.87%
99	LETHARGY	12,162	0.84%
100	SLEEP DISORDER	11,805	0.82%
101	MUSCULOSKELETAL STIFFNESS	11,773	0.81%
102	RHINORRHOEA	11,736	0.81%
103	ULTRASOUND SCAN	11,585	0.80%
104	RASH PRURITIC	11,539	0.80%
105	LIMB DISCOMFORT	11,428	0.79%
106	INJECTION SITE RASH	11,222	0.78%
107	FEELING COLD	11,218	0.77%
108	ILLNESS	10,937	0.76%
109	VACCINATION SITE ERYTHEMA	10,929	0.76%
110	SARS-COV-2 TEST NEGATIVE	10,905	0.75%
111	BURNING SENSATION	10,883	0.75%
112	AXILLARY PAIN	10,808	0.75%
113	SEIZURE	10,807	0.75%
114	PERICARDITIS	10,585	0.73%
115	FULL BLOOD COUNT	10,522	0.73%
116	FLUSHING	10,498	0.73%

Rank	Symptoms	Cases	% Cases
117	SWELLING FACE	10,495	0.73%
118	VACCINATION SITE SWELLING	10,447	0.72%
119	CONFUSIONAL STATE	10,332	0.71%
120	THROMBOSIS	9,994	0.69%
121	INCORRECT DOSE ADMINISTERED	9,959	0.69%
122	BODY TEMPERATURE INCREASED	9,818	0.68%
123	FIBRIN D DIMER	9,800	0.68%
124	SKIN WARM	9,603	0.66%
125	HYPERSENSITIVITY	9,595	0.66%
126	VISUAL IMPAIRMENT	9,486	0.66%
127	IMPAIRED WORK ABILITY	9,364	0.65%
128	PLATELET COUNT	9,312	0.64%
129	FACIAL PARALYSIS	8,890	0.61%
130	MENSTRUATION IRREGULAR	8,782	0.61%
131	EXTRA DOSE ADMINISTERED	8,700	0.60%
132	CEREBROVASCULAR ACCIDENT	8,692	0.60%
133	HYPOTENSION	8,631	0.60%
134	PARAESTHESIA ORAL	8,603	0.59%
135	PALLOR	8,594	0.59%
136	ANAPHYLACTIC REACTION	8,587	0.59%
137	ABDOMINAL DISCOMFORT	8,472	0.59%
138	LYMPH NODE PAIN	8,428	0.58%
139	DEEP VEIN THROMBOSIS	8,399	0.58%
140	LOSS OF PERSONAL INDEPENDENCE IN DAILY ACTIVITIES	8,316	0.57%
141	X-RAY	8,297	0.57%
142	WHITE BLOOD CELL COUNT	8,256	0.57%
143	THROAT TIGHTNESS	8,247	0.57%
144	NASOPHARYNGITIS	8,234	0.57%
145	PRESYNCOPE	8,136	0.56%
146	DYSMENORRHOEA	8,121	0.56%
147	TROPONIN	8,089	0.56%
148	DISCOMFORT	8,030	0.55%
149	THROAT IRRITATION	8,027	0.55%
150	NASAL CONGESTION	7,803	0.54%
151	ATRIAL FIBRILLATION	7,775	0.54%
152	BALANCE DISORDER	7,738	0.53%
153	DYSPHAGIA	7,663	0.53%
154	INFLAMMATION	7,566	0.52%
155	UNEVALUABLE EVENT	7,528	0.52%
156	MAGNETIC RESONANCE IMAGING HEAD	7,356	0.51%
157	SUSPECTED COVID-19	7,340	0.51%

Rank	Symptoms	Cases	% Cases
158	PNEUMONIA	7,239	0.50%
159	COLD SWEAT	7,185	0.50%
160	MENSTRUAL DISORDER	7,165	0.49%
161	LIP SWELLING	7,150	0.49%
162	AGEUSIA	7,067	0.49%
163	CONTUSION	7,052	0.49%
164	COMPUTERISED TOMOGRAM HEAD	6,828	0.47%
165	HOT FLUSH	6,799	0.47%
166	EAR PAIN	6,737	0.47%
167	COVID-19 PNEUMONIA	6,737	0.47%
168	BELL'S PALSY	6,734	0.47%
169	DISTURBANCE IN ATTENTION	6,588	0.46%
170	ANGINA PECTORIS	6,585	0.45%
171	DYSGEUSIA	6,584	0.45%
172	EYE PAIN	6,542	0.45%
173	INJECTION SITE REACTION	6,536	0.45%
174	METABOLIC FUNCTION TEST	6,426	0.44%
175	HYPOAESTHESIA ORAL	6,391	0.44%
176	ULTRASOUND DOPPLER	6,364	0.44%
177	POOR QUALITY PRODUCT ADMINISTERED	6,353	0.44%
178	JOINT SWELLING	6,247	0.43%
179	IMMEDIATE POST-INJECTION REACTION	6,230	0.43%
180	VACCINE BREAKTHROUGH INFECTION	6,212	0.43%
181	HAEMOGLOBIN	6,192	0.43%
182	TENDERNESS	6,156	0.43%
183	URINE ANALYSIS	6,092	0.42%
184	SWOLLEN TONGUE	6,080	0.42%
185	ELECTROCARDIOGRAM NORMAL	6,060	0.42%
186	VACCINATION SITE PRURITUS	6,027	0.42%
187	RESPIRATORY TRACT CONGESTION	6,017	0.42%
188	INFLUENZA	5,967	0.41%
189	NEURALGIA	5,943	0.41%
190	BLOOD GLUCOSE	5,851	0.40%
191	ANOSMIA	5,729	0.40%
192	PHARYNGEAL SWELLING	5,729	0.40%
193	PHYSICAL EXAMINATION	5,729	0.40%
194	UNRESPONSIVE TO STIMULI	5,595	0.39%
195	INJECTION SITE INDURATION	5,577	0.39%
196	RASH MACULAR	5,493	0.38%
197	HEAD DISCOMFORT	5,426	0.37%
198	VACCINATION COMPLICATION	5,395	0.37%
199	VACCINATION SITE WARMTH	5,348	0.37%

Rank	Symptoms	Cases	% Cases
200	ANGIOGRAM	5,339	0.37%
201	UNDERDOSE	5,286	0.37%
202	BLOOD TEST NORMAL	5,260	0.36%
203	BLOOD CREATININE	5,182	0.36%
204	SARS-COV-2 ANTIBODY TEST	5,081	0.35%
205	PRODUCT PREPARATION ISSUE	5,046	0.35%
206	WHEEZING	5,019	0.35%
207	VACCINATION SITE REACTION	4,995	0.35%
208	NIGHT SWEATS	4,908	0.34%
209	MYOCARDIAL INFARCTION	4,849	0.33%
210	OXYGEN SATURATION DECREASED	4,844	0.33%
211	WEIGHT DECREASED	4,834	0.33%
212	PRODUCT TEMPERATURE EXCURSION ISSUE	4,817	0.33%
213	OEDEMA PERIPHERAL	4,751	0.33%
214	C-REACTIVE PROTEIN INCREASED	4,726	0.33%
215	MENSTRUATION DELAYED	4,703	0.32%
216	CHEST X-RAY ABNORMAL	4,581	0.32%
217	EPISTAXIS	4,579	0.32%
218	NEUROLOGICAL EXAMINATION	4,500	0.31%
219	COMPUTERISED TOMOGRAM THORAX	4,489	0.31%
220	HYPOXIA	4,465	0.31%
221	BONE PAIN	4,464	0.31%
222	EYE SWELLING	4,461	0.31%
223	CHEST X-RAY NORMAL	4,432	0.31%
224	MUSCLE TWITCHING	4,335	0.30%
225	DYSPNOEA EXERTIONAL	4,321	0.30%
226	DEHYDRATION	4,285	0.30%
227	DYSSTASIA	4,274	0.30%
228	EXPOSURE DURING PREGNANCY	4,184	0.29%
229	BLOOD PRESSURE DECREASED	4,174	0.29%
230	BREAST PAIN	4,174	0.29%
231	MEMORY IMPAIRMENT	4,155	0.29%
232	HAEMORRHAGE	4,153	0.29%
233	SPECIALIST CONSULTATION	4,151	0.29%
234	ASTHMA	4,149	0.29%
235	MATERNAL EXPOSURE DURING PREGNANCY	4,116	0.28%
236	POSTMENOPAUSAL HAEMORRHAGE	4,090	0.28%
237	GAIT INABILITY	4,055	0.28%
238	TROPONIN INCREASED	4,040	0.28%
239	DISORIENTATION	4,003	0.28%
240	BLOOD THYROID STIMULATING HORMONE	4,000	0.28%
241	INTERMENSTRUAL BLEEDING	3,972	0.27%

Rank	Symptoms	Cases	% Cases
242	RASH PAPULAR	3,935	0.27%
243	EAR DISCOMFORT	3,930	0.27%
244	HYPERSOMNIA	3,886	0.27%
245	BLISTER	3,818	0.26%
246	ELECTROCARDIOGRAM ABNORMAL	3,811	0.26%
247	PHOTOPHOBIA	3,785	0.26%
248	VAGINAL HAEMORRHAGE	3,735	0.26%
249	ANGIOEDEMA	3,726	0.26%
250	SPEECH DISORDER	3,723	0.26%
251	APHASIA	3,697	0.26%
252	MOVEMENT DISORDER	3,697	0.26%
253	ANTICOAGULANT THERAPY	3,684	0.25%
254	GENERAL PHYSICAL HEALTH DETERIORATION	3,668	0.25%
255	VACCINATION SITE RASH	3,647	0.25%
256	ARTHRITIS	3,643	0.25%
257	FIBRIN D DIMER INCREASED	3,637	0.25%
258	INCORRECT PRODUCT FORMULATION ADMINISTERED	3,587	0.25%
259	THROMBOCYTOPENIA	3,575	0.25%
260	SKIN DISCOLOURATION	3,571	0.25%
261	BLOOD CREATINE PHOSPHOKINASE	3,566	0.25%
262	URINARY TRACT INFECTION	3,501	0.24%
263	ACUTE RESPIRATORY FAILURE	3,484	0.24%
264	DRY MOUTH	3,461	0.24%
265	HEART RATE IRREGULAR	3,456	0.24%
266	ALANINE AMINOTRANSFERASE	3,448	0.24%
267	ABORTION SPONTANEOUS	3,441	0.24%
268	PRODUCTIVE COUGH	3,424	0.24%
269	PAIN IN JAW	3,413	0.24%
270	DYSARTHRIA	3,399	0.23%
271	NEUROPATHY PERIPHERAL	3,376	0.23%
272	INTENSIVE CARE	3,361	0.23%
273	PERIPHERAL COLDNESS	3,350	0.23%
274	ACUTE KIDNEY INJURY	3,318	0.23%
275	FULL BLOOD COUNT NORMAL	3,292	0.23%
276	DYSPHONIA	3,290	0.23%
277	AMENORRHOEA	3,287	0.23%
278	ALOPECIA	3,285	0.23%
279	RESPIRATORY DISTRESS	3,272	0.23%
280	DYSPEPSIA	3,261	0.23%
281	DEAFNESS	3,260	0.23%
282	PRODUCT USE ISSUE	3,242	0.22%
283	TASTE DISORDER	3,240	0.22%

Rank	Symptoms	Cases	% Cases
284	ABDOMINAL DISTENSION	3,229	0.22%
285	SNEEZING	3,206	0.22%
286	DISEASE RECURRENCE	3,196	0.22%
287	CARDIAC ARREST	3,177	0.22%
288	BLOOD POTASSIUM	3,146	0.22%
289	INJECTION SITE MASS	3,104	0.21%
290	ASYMPTOMATIC COVID-19	3,083	0.21%
291	MUSCLE TIGHTNESS	3,074	0.21%
292	NERVOUSNESS	3,065	0.21%
293	RESPIRATORY RATE	3,056	0.21%
294	GUILLAIN-BARRE SYNDROME	3,040	0.21%
295	WHITE BLOOD CELL COUNT INCREASED	3,039	0.21%
296	BLOOD GLUCOSE INCREASED	3,036	0.21%
297	SENSITIVE SKIN	3,032	0.21%
298	JOINT RANGE OF MOTION DECREASED	2,972	0.21%
299	PRODUCT DOSE OMISSION ISSUE	2,967	0.20%
300	DEPRESSION	2,966	0.20%
301	HEAD INJURY	2,950	0.20%
302	NEUTROPHIL COUNT	2,940	0.20%
303	AMNESIA	2,916	0.20%
304	HYPOACUSIS	2,902	0.20%
305	ASPARTATE AMINOTRANSFERASE	2,896	0.20%
306	CARDIAC FAILURE	2,896	0.20%
307	OROPHARYNGEAL DISCOMFORT	2,894	0.20%
308	EXPOSURE TO SARS-COV-2	2,891	0.20%
309	RHEUMATOID ARTHRITIS	2,882	0.20%
310	BLOOD SODIUM	2,841	0.20%
311	LABORATORY TEST NORMAL	2,839	0.20%
312	CELLULITIS	2,802	0.19%
313	SENSORY DISTURBANCE	2,787	0.19%
314	HEMIPARESIS	2,786	0.19%
315	PAIN OF SKIN	2,766	0.19%
316	LUMBAR PUNCTURE	2,755	0.19%
317	PERICARDIAL EFFUSION	2,748	0.19%
318	ANTINUCLEAR ANTIBODY	2,747	0.19%
319	INCORRECT ROUTE OF PRODUCT ADMINISTRATION	2,729	0.19%
320	FEELING OF BODY TEMPERATURE CHANGE	2,728	0.19%
321	PLATELET COUNT DECREASED	2,726	0.19%
322	POLYMERASE CHAIN REACTION	2,701	0.19%
323	ANTIBODY TEST	2,655	0.18%
324	ELECTROCARDIOGRAM AMBULATORY	2,654	0.18%
325	CARDIAC FLUTTER	2,653	0.18%

Rank	Symptoms	Cases	% Cases
326	TRANSIENT ISCHAEMIC ATTACK	2,652	0.18%
327	MAGNETIC RESONANCE IMAGING HEART	2,640	0.18%
328	WEIGHT	2,576	0.18%
329	RED BLOOD CELL SEDIMENTATION RATE	2,567	0.18%
330	BRADYCARDIA	2,564	0.18%
331	BLOOD GLUCOSE NORMAL	2,549	0.18%
332	GLOMERULAR FILTRATION RATE	2,547	0.18%
333	PANIC ATTACK	2,530	0.17%
334	DIPLOPIA	2,523	0.17%
335	ACUTE MYOCARDIAL INFARCTION	2,519	0.17%
336	LIVER FUNCTION TEST	2,511	0.17%
337	WRONG PRODUCT ADMINISTERED	2,508	0.17%
338	MUSCULOSKELETAL CHEST PAIN	2,505	0.17%
339	INJECTED LIMB MOBILITY DECREASED	2,502	0.17%
340	INDURATION	2,497	0.17%
341	CEREBRAL INFARCTION	2,491	0.17%
342	OCULAR HYPERAEMIA	2,475	0.17%
343	LYMPHOCYTE COUNT	2,458	0.17%
344	INJECTION SITE BRUISING	2,455	0.17%
345	BIOPSY	2,442	0.17%
346	SKIN BURNING SENSATION	2,426	0.17%
347	PARALYSIS	2,425	0.17%
348	POLYMENORRHOEA	2,424	0.17%
349	HAEMOGLOBIN DECREASED	2,415	0.17%
350	CARDIAC DISORDER	2,414	0.17%
351	COMPUTERISED TOMOGRAM NORMAL	2,413	0.17%
352	THIRST	2,400	0.17%
353	ELECTROENCEPHALOGRAM	2,381	0.16%
354	CONSTIPATION	2,366	0.16%
355	ANAEMIA	2,363	0.16%
356	PROTHROMBIN TIME	2,336	0.16%
357	FACIAL PAIN	2,329	0.16%
358	EPILEPSY	2,328	0.16%
359	JOINT STIFFNESS	2,325	0.16%
360	VITAL SIGNS MEASUREMENT	2,316	0.16%
361	COVID-19 IMMUNISATION	2,305	0.16%
362	TROPONIN I	2,297	0.16%
363	SEPSIS	2,293	0.16%
364	BLOOD UREA	2,280	0.16%
365	SINUSITIS	2,280	0.16%
366	RESTLESSNESS	2,265	0.16%
367	SCAN	2,261	0.16%

Rank	Symptoms	Cases	% Cases
368	RETCHING	2,254	0.16%
369	RESPIRATORY FAILURE	2,251	0.16%
370	INTERNATIONAL NORMALISED RATIO	2,246	0.16%
371	HALLUCINATION	2,243	0.15%
372	BLINDNESS	2,235	0.15%
373	ISCHAEMIC STROKE	2,209	0.15%
374	INFECTION	2,209	0.15%
375	HEART RATE DECREASED	2,198	0.15%
376	HYPERPYREXIA	2,194	0.15%
377	ACTIVATED PARTIAL THROMBOPLASTIN TIME	2,191	0.15%
378	PAROSMIA	2,184	0.15%
379	MUSCULOSKELETAL PAIN	2,180	0.15%
380	ORAL HERPES	2,180	0.15%
381	FEEDING DISORDER	2,174	0.15%
382	VACCINATION SITE MASS	2,171	0.15%
383	IMMUNISATION REACTION	2,169	0.15%
384	DEPRESSED LEVEL OF CONSCIOUSNESS	2,168	0.15%
385	ENDOTRACHEAL INTUBATION	2,155	0.15%
386	OEDEMA	2,138	0.15%
387	DEAFNESS UNILATERAL	2,135	0.15%
388	COMPUTERISED TOMOGRAM THORAX ABNORMAL	2,134	0.15%
389	MUSCULOSKELETAL DISCOMFORT	2,133	0.15%
390	ELECTROMYOGRAM	2,130	0.15%
391	BLOOD TEST ABNORMAL	2,122	0.15%
392	ECHOCARDIOGRAM NORMAL	2,106	0.15%
393	PLEURAL EFFUSION	2,067	0.14%
394	COMA SCALE	2,064	0.14%
395	DYSKINESIA	2,057	0.14%
396	VACCINE POSITIVE RECHALLENGE	2,050	0.14%
397	EXTRASYSTOLES	2,048	0.14%
398	LACRIMATION INCREASED	2,047	0.14%
399	OPHTHALMOLOGICAL EXAMINATION	2,042	0.14%
400	COMPUTERISED TOMOGRAM ABDOMEN	2,036	0.14%
401	GAMMA-GLUTAMYLTRANSFERASE	2,035	0.14%
402	EYE PRURITUS	2,033	0.14%
403	CARDIAC STRESS TEST	1,986	0.14%
404	HYPERTENSIVE CRISIS	1,975	0.14%
405	CIRCULATORY COLLAPSE	1,966	0.14%
406	HYPOKINESIA	1,965	0.14%
407	DIZZINESS POSTURAL	1,963	0.14%
408	LUNG OPACITY	1,956	0.14%
409	NODULE	1,943	0.13%

Rank	Symptoms	Cases	% Cases
410	PETECHIAE	1,930	0.13%
411	FACIAL PARESIS	1,914	0.13%
412	MENTAL STATUS CHANGES	1,907	0.13%
413	BLOOD CREATININE INCREASED	1,899	0.13%
414	EXERCISE TOLERANCE DECREASED	1,895	0.13%
415	CEREBRAL HAEMORRHAGE	1,893	0.13%
416	BLOOD BILIRUBIN	1,889	0.13%
417	BLOOD FIBRINOGEN	1,886	0.13%
418	ABDOMINAL PAIN LOWER	1,877	0.13%
419	HAEMATOCRIT	1,863	0.13%
420	VACCINATION SITE INDURATION	1,843	0.13%
421	BLOOD LACTATE DEHYDROGENASE	1,834	0.13%
422	ULTRASOUND ABDOMEN	1,833	0.13%
423	ECZEMA	1,820	0.13%
424	RED BLOOD CELL COUNT	1,811	0.13%
425	RENAL PAIN	1,806	0.12%
426	ECHOCARDIOGRAM ABNORMAL	1,802	0.12%
427	AUSCULTATION	1,802	0.12%
428	COGNITIVE DISORDER	1,801	0.12%
429	SENSATION OF FOREIGN BODY	1,792	0.12%
430	EYE IRRITATION	1,776	0.12%
431	GLYCOSYLATED HAEMOGLOBIN	1,770	0.12%
432	URINARY INCONTINENCE	1,706	0.12%
433	BEDRIDDEN	1,699	0.12%
434	VENTRICULAR EXTRASYSTOLES	1,697	0.12%
435	CARDIAC MONITORING	1,695	0.12%
436	BRAIN NATRIURETIC PEPTIDE	1,682	0.12%
437	SWELLING OF EYELID	1,672	0.12%
438	IRRITABILITY	1,667	0.12%
439	BLOOD ALKALINE PHOSPHATASE	1,661	0.11%
440	BLOOD CHOLESTEROL	1,655	0.11%
441	SINUS CONGESTION	1,655	0.11%
442	BLOOD LACTIC ACID	1,654	0.11%
443	SKIN EXFOLIATION	1,653	0.11%
444	POLYMYALGIA RHEUMATICA	1,631	0.11%
445	TOOTHACHE	1,626	0.11%
446	ACOUSTIC STIMULATION TESTS	1,623	0.11%
447	SKIN DISORDER	1,623	0.11%
448	OCULAR DISCOMFORT	1,623	0.11%
449	CARDIOVASCULAR DISORDER	1,619	0.11%
450	EJECTION FRACTION	1,619	0.11%
451	PSORIASIS	1,618	0.11%

Rank	Symptoms	Cases	% Cases
452	COMPUTERISED TOMOGRAM HEAD NORMAL	1,606	0.11%
453	COMPUTERISED TOMOGRAM ABNORMAL	1,599	0.11%
454	SUDDEN HEARING LOSS	1,591	0.11%
455	MASS	1,580	0.11%
456	IMPAIRED DRIVING ABILITY	1,577	0.11%
457	DEPRESSED MOOD	1,576	0.11%
458	GASTROINTESTINAL DISORDER	1,564	0.11%
459	HYPERVENTILATION	1,551	0.11%
460	BLOOD CULTURE	1,548	0.11%
461	DRY SKIN	1,539	0.11%
462	HAEMATOCHEZIA	1,539	0.11%
463	SPINAL PAIN	1,536	0.11%
464	INJECTION SITE URTICARIA	1,533	0.11%
465	CRYING	1,528	0.11%
466	N-TERMINAL PROHORMONE BRAIN NATRIURETIC PEPTIDE	1,526	0.11%
467	GASTROOESOPHAGEAL REFLUX DISEASE	1,519	0.10%
468	MAGNETIC RESONANCE IMAGING NORMAL	1,509	0.10%
469	HAEMATOMA	1,502	0.10%
470	POLLAKIURIA	1,502	0.10%
471	AXILLARY MASS	1,495	0.10%
472	OLIGOMENORRHOEA	1,493	0.10%
473	BODY MASS INDEX	1,492	0.10%
474	ADVERSE EVENT	1,492	0.10%
475	IMMUNE THROMBOCYTOPENIA	1,492	0.10%
476	MAGNETIC RESONANCE IMAGING HEAD ABNORMAL	1,490	0.10%
477	BLOOD IMMUNOGLOBULIN G	1,489	0.10%
478	INFLUENZA VIRUS TEST NEGATIVE	1,488	0.10%
479	APPENDICITIS	1,487	0.10%
480	MEAN CELL VOLUME	1,483	0.10%
481	ANAPHYLACTIC SHOCK	1,474	0.10%
482	COLONOSCOPY	1,474	0.10%
483	TROPONIN T	1,467	0.10%
484	RED BLOOD CELL SEDIMENTATION RATE INCREASED	1,466	0.10%
485	BLOOD PRESSURE SYSTOLIC	1,451	0.10%
486	PLATELET COUNT NORMAL	1,449	0.10%
487	FLATULENCE	1,448	0.10%
488	URINE ANALYSIS NORMAL	1,447	0.10%
489	CYANOSIS	1,438	0.10%
490	HIV TEST	1,438	0.10%
491	PRODUCT ADMINISTRATION ERROR	1,435	0.10%
492	DIFFERENTIAL WHITE BLOOD CELL COUNT	1,430	0.10%

Rank	Symptoms	Cases	% Cases
493	MONOPLEGIA	1,430	0.10%
494	SINUS TACHYCARDIA	1,413	0.10%
495	RHEUMATOID FACTOR	1,403	0.10%
496	ANGIOCARDIOGRAM	1,402	0.10%
497	INJECTION SITE INFLAMMATION	1,402	0.10%
498	SERUM FERRITIN	1,400	0.10%
499	EOSINOPHIL COUNT	1,396	0.10%
500	MAGNETIC RESONANCE IMAGING HEAD NORMAL	1,392	0.10%
501	MONOCYTE COUNT	1,391	0.10%
502	EYE MOVEMENT DISORDER	1,389	0.10%
503	LABORATORY TEST ABNORMAL	1,388	0.10%
504	SENSORY LOSS	1,387	0.10%
505	RENAL FUNCTION TEST	1,382	0.10%
506	RESPIRATORY DISORDER	1,382	0.10%
507	TACHYPNOEA	1,379	0.10%
508	HYPOPHAGIA	1,378	0.10%
509	LUNG DISORDER	1,378	0.10%
510	POOR QUALITY SLEEP	1,377	0.10%
511	ULTRASOUND DOPPLER ABNORMAL	1,377	0.10%
512	NERVOUS SYSTEM DISORDER	1,375	0.09%
513	MENTAL IMPAIRMENT	1,374	0.09%
514	ELECTRIC SHOCK SENSATION	1,373	0.09%
515	CARDIAC DISCOMFORT	1,368	0.09%
516	PREGNANCY TEST	1,366	0.09%
517	ALANINE AMINOTRANSFERASE INCREASED	1,347	0.09%
518	LOW DENSITY LIPOPROTEIN	1,344	0.09%
519	ASPARTATE AMINOTRANSFERASE INCREASED	1,342	0.09%
520	LUNG INFILTRATION	1,342	0.09%
521	ALTERED STATE OF CONSCIOUSNESS	1,335	0.09%
522	PAINFUL RESPIRATION	1,334	0.09%
523	DYSURIA	1,329	0.09%
524	HYPERAESTHESIA	1,326	0.09%
525	BLOOD ALBUMIN	1,320	0.09%
526	NEUROLOGICAL SYMPTOM	1,318	0.09%
527	STRESS	1,309	0.09%
528	CARDIO-RESPIRATORY ARREST	1,308	0.09%
529	BLOOD PRESSURE FLUCTUATION	1,306	0.09%
530	MOUTH SWELLING	1,306	0.09%
531	DELIRIUM	1,303	0.09%
532	AUTOIMMUNE DISORDER	1,289	0.09%
533	TENSION HEADACHE	1,279	0.09%
534	EXTENSIVE SWELLING OF VACCINATED LIMB	1,276	0.09%

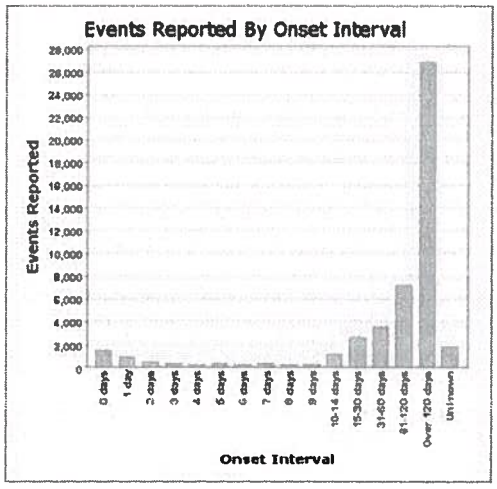
Rank	Symptoms	Cases	% Cases
535	BREAST SWELLING	1,272	0.09%
536	AGITATION	1,270	0.09%
537	TROPONIN NORMAL	1,267	0.09%
538	RENAL FAILURE	1,265	0.09%
539	BRONCHITIS	1,263	0.09%
540	DRY THROAT	1,263	0.09%
541	BLOOD ELECTROLYTES	1,263	0.09%
542	PULMONARY OEDEMA	1,256	0.09%
543	HYPERACUSIS	1,255	0.09%
544	FEAR	1,254	0.09%
545	BLOOD CALCIUM	1,253	0.09%
546	SKIN LESION	1,251	0.09%
547	INFLUENZA B VIRUS TEST	1,246	0.09%
548	SYRINGE ISSUE	1,238	0.09%
549	METABOLIC FUNCTION TEST NORMAL	1,233	0.09%
550	MUSCLE FATIGUE	1,233	0.09%
551	PRODUCT PREPARATION ERROR	1,227	0.08%
552	WEIGHT INCREASED	1,226	0.08%
553	INJECTION SITE NODULE	1,221	0.08%
554	SKIN REACTION	1,218	0.08%
555	CARDIAC FAILURE CONGESTIVE	1,216	0.08%
556	VACCINATION SITE INFLAMMATION	1,216	0.08%
557	GENERALISED TONIC-CLONIC SEIZURE	1,215	0.08%
558	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	1,214	0.08%
559	BIOPSY SKIN	1,213	0.08%
560	WHITE BLOOD CELL COUNT NORMAL	1,211	0.08%
561	HAEMATURIA	1,210	0.08%
562	PARANASAL SINUS DISCOMFORT	1,208	0.08%
563	ANGIOGRAM PULMONARY ABNORMAL	1,201	0.08%
564	VACCINATION SITE MOVEMENT IMPAIRMENT	1,196	0.08%
565	PROCALCITONIN	1,194	0.08%
566	BLOOD URINE PRESENT	1,189	0.08%
567	STOMATITIS	1,182	0.08%
568	OVERDOSE	1,176	0.08%
569	THERAPEUTIC RESPONSE UNEXPECTED	1,176	0.08%
570	WHITE BLOOD CELL COUNT DECREASED	1,159	0.08%
571	COMPUTERISED TOMOGRAM HEAD ABNORMAL	1,153	0.08%
572	ORAL DISCOMFORT	1,149	0.08%
573	DRY EYE	1,146	0.08%
574	PRODUCT ADMINISTERED AT INAPPROPRIATE SITE	1,145	0.08%
575	PROTEIN TOTAL	1,145	0.08%
576	PERIARTHRITIS	1,143	0.08%

Rank	Symptoms	Cases	% Cases
577	PHARYNGEAL PARAESTHESIA	1,143	0.08%
578	BLOOD PRESSURE ABNORMAL	1,142	0.08%
579	SCAN WITH CONTRAST	1,142	0.08%
580	CYTOMEGALOVIRUS TEST	1,137	0.08%
581	LYMPHADENITIS	1,137	0.08%
582	HEMIPLEGIA	1,135	0.08%
583	PULMONARY PAIN	1,135	0.08%
584	POSITRON EMISSION TOMOGRAM	1,120	0.08%
585	SEROLOGY TEST	1,119	0.08%
586	BLOOD TRIGLYCERIDES	1,116	0.08%
587	EYE DISORDER	1,113	0.08%
588	FLANK PAIN	1,107	0.08%
589	LIMB INJURY	1,097	0.08%
590	PELVIC PAIN	1,097	0.08%
591	THYROID FUNCTION TEST	1,094	0.08%
592	CARDIOMEGALY	1,092	0.08%
593	ELECTROCARDIOGRAM ST SEGMENT ELEVATION	1,092	0.08%
594	ORAL PAIN	1,091	0.08%
595	ADVERSE REACTION	1,072	0.07%
596	VACCINATION SITE BRUISING	1,071	0.07%
597	MAGNETIC RESONANCE IMAGING SPINAL	1,068	0.07%
598	HYPOTONIA	1,067	0.07%
599	PERIORBITAL SWELLING	1,065	0.07%
600	MAGNETIC RESONANCE IMAGING ABNORMAL	1,064	0.07%
601	EAR, NOSE AND THROAT EXAMINATION	1,063	0.07%
602	APHONIA	1,059	0.07%
603	PULMONARY THROMBOSIS	1,053	0.07%
604	SUDDEN DEATH	1,053	0.07%
605	COMPUTERISED TOMOGRAM ABDOMEN ABNORMAL	1,052	0.07%
606	BLOOD CREATINE PHOSPHOKINASE MB	1,051	0.07%
607	RESUSCITATION	1,050	0.07%
608	BLOOD POTASSIUM NORMAL	1,046	0.07%
609	CATHETERISATION CARDIAC	1,046	0.07%
610	MECHANICAL URTICARIA	1,046	0.07%
611	ULTRASOUND SCAN ABNORMAL	1,045	0.07%
612	PO2	1,039	0.07%
613	HAEMOPTYSIS	1,035	0.07%
614	CARDIOVASCULAR EXAMINATION	1,035	0.07%
615	STREPTOCOCCUS TEST NEGATIVE	1,034	0.07%
616	BLOOD CREATININE NORMAL	1,031	0.07%
617	HAEMOGLOBIN NORMAL	1,025	0.07%
618	MAMMOGRAM	1,025	0.07%

Rank	Symptoms	Cases	% Cases
619	GASTROINTESTINAL PAIN	1,024	0.07%
620	RASH VESICULAR	1,024	0.07%
621	EYE HAEMORRHAGE	1,023	0.07%
622	BLOOD SODIUM DECREASED	1,021	0.07%
623	CULTURE URINE	1,018	0.07%
624	BLOOD CREATINE PHOSPHOKINASE INCREASED	1,016	0.07%
625	FACE OEDEMA	1,011	0.07%
626	GROIN PAIN	1,011	0.07%
627	FIBROMYALGIA	1,011	0.07%
628	MULTIPLE SCLEROSIS	1,009	0.07%
629	SLUGGISHNESS	1,009	0.07%
630	BLOOD GASES	1,008	0.07%
631	MECHANICAL VENTILATION	1,005	0.07%
632	COLITIS ULCERATIVE	1,004	0.07%
633	HEART RATE ABNORMAL	1,001	0.07%

There are some concerns and questions that result from this VAERS query. When the system was queried for deaths under event category 'death' the system reported almost 32,000 deaths. But when this query was ran under symptoms, death showed as a symptom near or at row 73, but showed only about 16,000 deaths. This means that VAERS reports have two different means of tagging the event of death in the system. The CDC should be FOIA'd to explain full details of this difference and what number is 'correct'.

Another observation is that the number 1 symptom is SARS-COV-2 TEST with 225,918 reports. About 30% of these tests were done within a week after vaccination. Of course this is not a 'symptom' but rather a procedure that's offered as a 'symptom' choice in the VAERS reporting tool. This I assume is because anyone responding to a post vaccination illness by visiting an emergency room, hospital or doctor's office visit will be, by required protocols, to be tested for SARS-COV-2 by nasopharyngeal swab. Furthermore reports can include multiple symptoms. It's just interesting that this ranks highest among all the 'symptoms'. But not surprising. Person gets sick with covid like symptoms – they get tested. The question, was it infection by the virion or reaction to the vaccine? Note also that item 23 is 'SARS-COV-2 TEST POSITIVE' with 48,298 reports. So of all the tests done, about 21% turned out to be positive. Keep in mind these were patients tested after vaccination. Here's the interesting part. Only about 9% of the positive tests occurred within the same time period 30% of the tests were done (1 week). This just confirms that the vaccines indeed not effective in preventing infection. Items 15 & 16, reported 'vaccine failure' or 'drug ineffective' further confirm. Most infections occurred well after the vaccination event. The graph below illustrates when SARS-COV-2 tests were determined as positive; most after 10 days.



The following **numbers** address more specific cumulative adverse events that have been reported to VAERS since the rollout of the COVID-19 vaccines, associated with the COVID19, and that may or may not have led to death **(as of June 10, 2022)**. Published citations and links that relate to these specific events and connected with the COVID-19 vaccine are included as supplementary information.

Item 396 refers to VACCINE RECHALLENGE POSITIVE. Rechallenge refers to the administration of a vaccine after an adverse event has occurred and the adverse event subsequently subsided.[33]

- A positive rechallenge refers to the adverse event recurring after administering the vaccine. To have this occur, the adverse event had to have previously disappeared after period of time in order to proceed with a rechallenge.
- A negative rechallenge means the adverse event does not recur after the vaccine is introduced again.

A positive rechallenge is strong evidence that the vaccine caused the adverse event.

Here is one published incident from a Japanese patient that indicated a positive rechallenge for aphasia:

Yoshida K, Tanaka K, Suto Y, Fukuda H. **Repeated Cardioembolic Stroke after COVID-19 mRNA Vaccination: A Case Report**. J Stroke Cerebrovasc Dis. 2022 Feb;31(2):106233. doi: 10.1016/j.jstrokecerebrovasdis.2021.106233. Epub 2021 Nov 22. PMID: 34883321; PMCID: PMC8606267. https://pubmed.ncbi.nlm.nih.gov/34883321/

The query of prevalent symptoms for the COVID-19 vaccines indicate there's been 2,050 positive rechallenge events reported in VAERS. If these adverse events are further restricted to **serious** events, there are 47. Specific symptoms are highlighted that, because of a positive rechallenge, are considered caused by the vaccines.

[33] https://lifesciencescare.hcltech.com/blog/challenges-prechallenges-dechallenges-and-rechallenges/

Adverse Event Description
multiple bullae present on right ankle/foot 2 days after vaccine administration. Patient had similar event after second dose as well, with multiple bullae present on bilateral lower extremities.
Patient recieved 2 doses of covid vaccine by pfizer. Frist dose was on 1/15/21 (EL8982) and the next day patient was admitted for fever and altered mental status. Spent one week in hospital. Pt recieved the 2nd vaccine for covid on 2/5/21 (EL9265) and then spiked fever and readmitted the very next day for fever and altered mental status. Noted to have a bullous rash over the injection site.
The patient presented a few days after her 2nd Moderna vaccine with angioedema, S/P epinephrine IM x2, steroids, Benadryl. She had a similar presentation 1 month prior after her 1st Moderna vaccine as well, which also resulted in a hospitalization. She elected to get the vaccine again and subsequently came in with the same reaction.
First I got a headache, then I felt extra mucus in my throat. Then I started feeling compression, pressure, and pain in my diaphragm; and then the middle of my chest. Finally, I started coughing, and I wasn't able to breathe. I had told all of the nursing staff that I had anaphylaxis to the first shot, but they acted like they didn't believe me. Also, there was no EMS staff on hand this time, unlike the first time, where they were on site. I think that made the difference in my medical care, because my husband heard the nurses at the facility say they were treating me for anxiety, not anaphylaxis, despite the fact that I was getting worse. The nurses on staff didn't seem to understand or believe that a person could have anaphylaxis from the Covid injection, even though it's on record at the hospital that that's what happened the first time. It wasn't the same staff as last time, which also contributed to the problem. Once the ambulance staff got there, he took me seriously, and finally administered an EpiPen, and also put me on oxygen, which helped a little bit. that was the most comprehensive care I got that day, from someone who was actually listening to me he also took an EKG, which which was normal. When I got to Facility, the treatment wasn't as good as last time, either. Apparently they've been really busy the day before, and all of the staff seemed fatigued because of it. Nobody really checked on me, offered me even ice chips to moisten my mouth, and didn't offer me any assistance in getting to the bathroom, either. a respiratory therapist came in to give me a couple puffs on an albuterol inhaler, and I got a Benadryl shot, but nothing else. I think if I had not taken my coterie of prescriptions to stave off anaphylaxis, it would have been worse. 20 minutes before the shot I took: two aspirin, a CBD capsule, and one each of the following pills - cetirizine, benadryl, famotidine, 20 mg of prednisone, hydroxyzine. I think that's what enabled me to recover with only one EpiPen, instead of two, like last time. if there's a third Moderna shot for the varients, or a booster, I'll try to take all those pills an hour beforehand, and see if having them in my system for a longer period of time we'll make the difference. It will be nice to have *no* anaphylaxis, and skip the hospital trip . Since then, it's taken me about a week to recover fully, the same as after the first shot. I've had problems breathing, fatigue, muscle aches and pains, flushing, fever/chills, and in general just felt like I had the flu.
Major arm pain and UNABLE to lift the arm higher than my shoulder. SAME REACTION AS THE ONE I AM STILL SUFFERING FROM, WHICH WAS BROUGHT ON BY THE FIRST INJECTION IN THE OTHER ARM!!!!!!! I CANNOT LIFT MY ARMS!!!!!!
Patient presented to the ER with complaints of tingling and numbness in the left upper and lower extremities along with the left side of her face. She said this lasted 5 minutes the first time and then it happened again when she laid down to go to sleep, lasting about 3 minutes. She noted these same symptoms last month approximately 2 weeks after her first covid vaccine. She was admitted for observation to the facility to rule out stroke/TIA and had negative tests across the board. Physician attributes symptoms to covid vaccine. Pt was discharged in stable condition.
Narrative: 56 y/o male with history of seizure disorder received second doe of COVID-19 vaccine on 1/28/21 while impatient. The following morning, he told nurses he felt like he had a seizure in his sleep. The nocturnist witnessed an active seizure later that morning, and the patient was transferred to the ICU. A total of 5-6 seizures were documented that morning. According to his chart, he also has a seizure

Adverse Event Description
following his first COVID-19 vaccine. Of noted, the patient has had multiple intermittent breakthrough seizures during his hospitalization since being admitted back in 9/2020.
10 DAYS AFTER INITIAL DOSE PATIENT BECAME VERY SICK WITH VOMITING / DIARRHEA / NAUSEA AND WAS BARELY ABLE TO GET OUT OF BED FOR 3 DAYS, ALSO COULD NOT KEEP AND FOOD OR DRINK DOWN. SYMPTOMS WERE GONE AS QUICK AS THEY OCCURED. ON 5TH DAY AFTER 2ND DOSE PATIENT BEGAN HAVING SAME SYMPTOMS AS THE 1ST DOSE BUT ONLY LASTED 1 DAY, ON DAY 6 SHE WAS FEELING BETTER BUT COMPLAINING OF EXTREME NECK PAIN, UNBEARABLE. ON DAY 3 SHE CAME DOWN WITH THE CHILL AT 5:30 A.M. AND THEN WAS BARELY RESPONSIVE BY 5:35 WHICH WAS DETERMINED TO BE A STROKE.
My first vaccine was Feb 14, 2021, my second Mar 7, 2021. Following both I had <24 hours of headache and lethargy before returning to normal. Symptoms were noted during hikes with cub scouts, so not particularly difficult terrain On March 27 I was very short of breath during an uphill hike and almost gasping at the top. I did no more uphill hiking until the next event May 1, at where I experienced shortness of breath and dizziness on an uphill hike. After resting a few minutes I continued for a brief period before it returned requiring me to back. May 7, short of breath and dizzy while doing yard work requiring ladder climbing May 10, short of breath and dizzy on a quick 1/2 mile walk May 10, visited GP and was admitted to hospital with abnormal ECG
Myocarditis (with chest pain, shortness of breath, dizziness) starting after first dose, worsening after second
Diverticulitis a couple weeks after the first vaccine. I then felt better after being hospitalized and then had the second vaccine and the diverticulitis flared up again.
First vaccine arm little sore Second vaccine arm little sore AND extra tired with chills
Pain in left elbow and loss of strength in left arm. Got worse after the second dose of Moderna on April 18th. Learning to live with it, like an old sports injury. Hoping the pain subsides, if not I will go to the doctor.
After 1st dose, high fever, body ache and fatigue, headache, nausea, dizziness, confusion, general distress. Fatigue, confusion, headaches and body aches lasted several days requiring 12+ hours of sleep per night and 2-3 hour naps during day. no energy, loss of appetite. this lasted 3 weeks. then started to feel better just before getting the second vaccine n 4/7/21 and 11:30am at same location. Severe reaction started at 2am on 4/8/21, with all of the above same symtoms only more severe. I couldn't navigate to the restroom without help of my spouse. Very confused and disorented. Later that day i had trouble taking in enough air. As the days progressed, breathing became more difficult and i had trouble walking. My feet and legs started to ache daily. I had a CT of the chest on 4/16/21 and and EKG. A pulmonary embolism was found in the left lung. I was admitted to the hospital with further testing including a Venous duplex leg bilateral screening. The results showed a deep vein thrombosis in both lower extremities. Treatment consisted of shots of Levenox, followed by prescription Xarelto. It has been over 2 months and I am still fatigued in excess sleeping 4-6 hours more than my usual pattern per night. I have no energy as yet. I have been told this will be a long process of recovery. This has effected all areas of my life.
Dizziness swollen face short of breath and fell in the shower do to dizziness
Dizzy, lightheaded, shakey, nausea ; no screen time; no television; still get episodes until this day
My arm was sore for a few hours after the first second dose, then got tingling sensation in fingers, which went away. The soreness and weakness got worse after the second dose - I cannot lift my arm over shoulder height without assistance and every time I move it there is some pain - similar to a deep bone bruise. After the first dose, the symptoms improved within a day; after the second dose they were worse and have not changed since I got the shot on March 15.

Adverse Event Description
Received first covid vaccine on 3-26-21, had my first ever seizure on 4-5-21, second covid vaccine was given on 4-17-21, second seizure occurred 5-1-21.
first dose 16FEB2021 Red, indurated and swollen - no fever no chills Right arm Lot EN6201 I have photos second dose 10MAR2021 Red indurated and more swollen, significant fatigue set in Left arm. EN6208 I have photos
Immediately after first dose, general muscle pain, heart racing, and blurry vision for at least 24 hours. Also immediate symptoms of severe Lupus Flare. Same symptoms immediately after the second dose. Then on June 26 I developed floaters in my right eye, which is the only new adverse health event I?ve had since the initial reaction.
One week after the first dose of the vaccine I started to get hives that spread all over my legs. The next day the rash was on my stomach. Every day they went from the soles of my feet and worked their way up my body until it reaches the palms of my hands. After this point I have been experiencing facial swelling. After the second dose the hives started again but it was much worse. It started the day after and I also had swelling in my face and lips. I have been referred to an immunologist. I still have hives every day after five months. They are mostly on my legs and thighs. They are big raised splotches which cover large areas. I have never had them on my face since the day after the second dose. I have taken Steroids and I still take Zyrtec every day. It is extremely itchy which was not helped by a topical cream. I also take anxiety medication so that I can sleep. Dose 2: 02/05/2021 LOT#012M20A
headache, some what tiered and slightly lost of appetite from what I recall my mom telling me after her first shot and then same symptoms on her second shot a month later.
Continued soreness at injection site .. to this day its sore in a quarter sized area No taste or smell .. except a metallic taste and smell Lost taste and smell with first vaccine but gained back after a few days but after second vaccine I have not regained smell or taste except the metallic taste and sometimes a metallic smell
Tinnitus. Tinnitus within 24 hours of first dose. Went away. Tinnitus again within 24 hours of second dose, this time persistent. Continue 5o have tinnitus 5 months later. Saw primary care who examined ans referred to ENT. ENT tried does of steroids which did not help. Diagnosis osed with tinnitus.
Rapid hearth rate after 1st and 2nd vaccine. He died .
Rash; swollen face; eyes swollen almost shut; dry, scaly skin on eyelids & undereyes; SOB, extreme trouble breathing; post nasal drip; lung congestion.
About 3 days after the 2nd dose, I started having fever and chills with blotchy skin. I was having difficulty breathing s well. I would have fever and chills for 3-4 hours. Then extreme heat for 3-4 hours. The same cycle as the 1st dose. This lasted 8 days. Then, it pretty much cleared up except for the difficulty breathing. I also had a COVID test done which was negative. I had a pulmonary function test regarding the difficulty breathing. This came back normal. It was about the same as the first dose, but it cleared up a lot quicker. I still have a cough, runny nose, pain in my back, and difficulty breathing.
After my first and second vaccine. I had the same reaction. 1 vaccine 5 days later. Extreme high BP no got go to 240 over 140 pulse 100. Extreme anxiety. Pain and tightness in chest and left arm. 2 vaccine systems were 14 days after vaccine. Same results. Took 36 plus hours for bp to return to normal
Irregular heartbeat that lasted for 10 minutes on both vaccinations 31 Jan 2021 and 05 Mar 2021
Extreme leg weakness with falls beginning the evening of vaccination date. Inability to walk around house without walker and assistance, sleepiness, loss of appetite
Acute Pancreatitis following administration of dose 1. Got worse after second dose and landed in the hospital following second dose.

Adverse Event Description
Patient developed DVT in right calf 2 weeks after first dose of vaccination on 3/4/2021. This occurred again after his second dose on 4/1/2021 with recurrent DVT.
He was sleeping, and on 11/16/21 around 6am all of sudden He started shaking, eyes rolled up and foam was coming out of mouth. I called 911 and they took him to hospital. They said he got grand mal seizure. He also got same reaction after 2nd dose of Moderna Covid Vaccine
"EATING DISORDER; WEIGHT LOSS; VACCINE POSITIVE RECHALLENGE; NAUSEA; PALPITATIONS; FEELING UNWELL; FATIGUE; DIZZINESS; Inappropriate schedule of vaccine administered: 1st dose on 11May2021; 2nd dose on 22Jun2021; This is a spontaneous report received from a contactable reporter(s) (Physician) from the Regulatory Authority -WEB. A 47 year-old female patient received bnt162b2 (COMIRNATY), intramuscular, administration date 22Jun2021 (Lot number: FE2083) at the age of 47 years as dose 2, single for covid-19 immunisation. Relevant medical history included: ""ADHD"" (unspecified if ongoing); ""Epilepsy"" (unspecified if ongoing); ""Allergy"" (unspecified if ongoing); ""Back pain"" (unspecified if ongoing), notes: Back pain prior to vaccination; ""Asthma"" (unspecified if ongoing). Concomitant medication(s) included: RITALIN taken for attention deficit hyperactivity disorder, start date: 18Jan2021; LAMICTAL taken for epilepsy, start date: 2014; TOPIMAX [TOPIRAMATE] taken for epilepsy, start date: 2006; SINGULAIR taken for asthma, hypersensitivity, start date: 2009. Vaccination history included: Comirnaty (dose 1, batch no.FE2083), administration date: 11May2021, for COVID-19 immunisation, reaction(s): ""Bedridden"", ""Nausea"", ""Malaise"", ""Disturbance in attention"", ""Fatigue"", ""Palpitations"", ""Dizziness"", ""Dyspnoea"", ""Memory impairment"". The following information was reported: EATING DISORDER (hospitalization), outcome ""not recovered"", described as ""EATING DISORDER""; PALPITATIONS (hospitalization) with onset 22Jun2021, outcome ""not recovered"", described as ""PALPITATIONS""; MALAISE (hospitalization) with onset 22Jun2021, outcome ""not recovered"", described as ""FEELING UNWELL""; FATIGUE (hospitalization) with onset 22Jun2021, outcome ""not recovered"", described as ""FATIGUE""; DIZZINESS (hospitalization) with onset 22Jun2021, outcome ""not recovered"", described as ""DIZZINESS""; WEIGHT DECREASED (hospitalization), outcome ""not recovered"", described as ""WEIGHT LOSS""; VACCINE POSITIVE RECHALLENGE (hospitalization), outcome ""not recovered"", described as ""VACCINE POSITIVE RECHALLENGE""; NAUSEA (hospitalization) with onset 22Jun2021, outcome ""not recovered"", described as ""NAUSEA""; INAPPROPRIATE SCHEDULE OF PRODUCT ADMINISTRATION (non-serious) with onset 22Jun2021, outcome ""unknown"", described as ""Inappropriate schedule of vaccine administered: 1st dose on 11May2021; 2nd dose on 22Jun2021"". The patient was hospitalized for eating disorder, palpitations, malaise, fatigue, dizziness, weight decreased, vaccine positive rechallenge, nausea (start date: 02Oct2021, discharge date: 11Oct2021, hospitalization duration: 9 day(s)). The Regulatory Authority Center assessed the causal relationship between bnt162b2 (COMIRNATY) and all the reported events as Possible. Reporter Comment: Strong reaction to the injection (first dose) itself, with palpitations, dizziness and feeling unwell. She do not remember so much about the first injection. The same reaction occurred after the second dose. Fatigue lasted for approximately six weeks after the first dose. Persistent fatigue after the second dose as well, with a lot of nausea and eating disorder. Hospitalized 02-11Oct2021 due to fatigue, weight loss, dizziness and nausea. Persistent symptoms and do not manage to complete school. No follow-up attempts are needed. No further information is expected.; Reporter's Comments: Strong reaction to the injection (first dose) itself, with palpitations, dizziness and feeling unwell. She do not remember so much about the first injection. The same reaction occurred after the second dose. Fatigue lasted for approximately six weeks after the first dose. Persistent fatigue after the second dose as well, with a lot of nausea and eating disorder. Hospitalized 02-11Oct2021 due to fatigue, weight loss, dizziness and nausea. Persistent symptoms and do not manage to complete school.; Sender's Comments: Linked Report(s) : NO-PFIZER INC-202101579458 Same patient, different events reported after 1st and 2nd dose Comirnaty"
a1c went up i had no idea until i saw something on social media and i was like that's what happened to me and now that i got my 3rd i see it for myself my eye site is a mess and i was doing fine until the vaccine

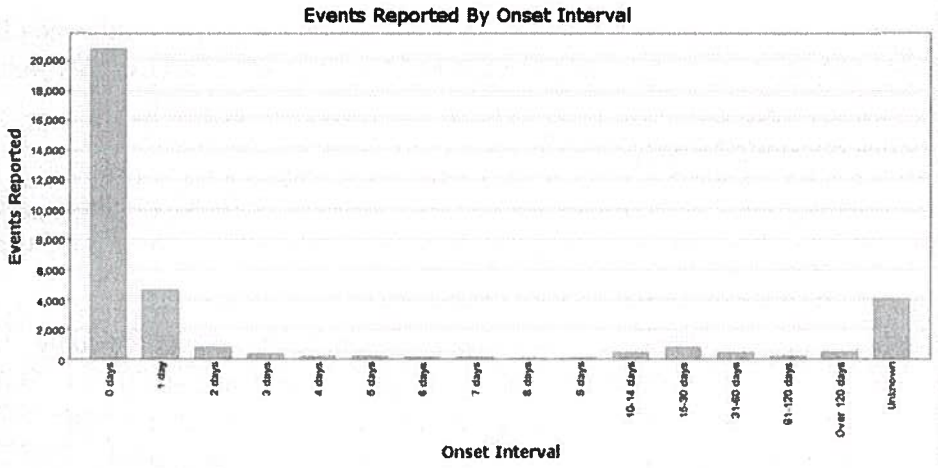
Adverse Event Description
numbness and tingling in fingers and toes my bottom of right foot went numb ringing in my ears brain fogs and this is every time i get my shot i have had all three
Initially reactive left axillary lymph node x 1 week then resolved, followed by diffuse urticaria to extremities, then torso, then neck, head and face. Angioedema. Itchy throat. Lip swelling. Symptoms persisted over the course of a week despite steroids, antihistamines and H2 blockers, in addition to multiple doses of epinephrine.
Rumbling sound in right ear. I previously/currently have sensitive ears. Have to keep water out of them, use cotton in them during cold weather. Was already slight ringing, But the vaccine made it worse, And it hasn't gotten better. This also happened on my 2nd shot, which was Pfizer.
Within 12 hours of all three shots tinnitus in both ears - a roaring sound like a waterfall, fullness in ears, fluttering feeling in both ears
tingling in hands and lightheadedness like drifting off. memory issues and attention issues, seizure-like symptoms both doses.
I have severe muscle and joint aches constantly that keep me from walking, sleeping, and taking care of myself. It gets worse every day instead of better. I feel like my body is breaking down in my lower extremities and back.
Severe spell of Vertigo that feels endless. Dizziness, Nauseous, Vision Spinning, Spinning Sensation, Inability to hold head up and hard to look at anything without being overwhelmed by all symptoms. Same happened with the first dose and lasted for 3 months which contributed to my decision not to get the second dose until regulatory authority took it upon themselves to threaten peoples livelihoods if not fully vaccinated. So I had 5 months between doses and having the same side effects again only stronger this time and will have to push myself as hard as I can just to function in everyday life and work dealing with these symptoms that I know are long term from previous experience.
Ischemic stroke
SEVERE TINNITUS INCREASING IN SEVERITY
On Booster 3 I experienced a severe 9 day Diverticulitis event, thought to be random and surgery was considered, but being in middle of a covid surge, it was avoided. I got a CT abdomen and antibiotics, fever to 104, negative covid test x 3. Then I got Covid shot 4 last week. Within a day I started to experience again symptoms of Diverticulitis, same symptoms, pain, inflamation, abdominal bloating, LLQ pain, fever: I started the Levoquin and gram negative antibiotics within 6 hours of definitive symptoms. They still lasted four solid days, but not to the extent as the first major event after Moderna 3. Moderna 4 had the same time of onset of symptoms, and when the connection was made to the proximity of both events, I felt it important to report this adverse reaction. Going forward what do I do wrt vaccination, a different type or do I pre treat with Levoquin before the vaccine.
After each of my 4 COVID shots, I have experienced vertigo that eventually diminishes to dizzy spells. Each shot it seems to get more intense and last longer. I am already over a month after this shot and still experience dizzy spells. I I did consult with another Dr, and she suggested OTC Zyrtec (cetirizine HCl 10mg). I had mild success with it, so added Flonase (fluticasone propionate 50mcg) and have improved a little after a few days of taking both, though today have been dizzy. I may still act on a referral to a vestibular audiologist.
Since getting the first vaccine injection I have had significant hair loss over the past year and half. At one point it seemed to be growing back but after getting the third vaccine it started to fall out rapidly again.
seizure

It appears that all except maybe one or two of these incident reports were *self reported* and except one that clearly resulted in death (as noted) appears to be reported by friend or family. It's sad that people were convinced or worse coerced to vaccinate. The one incident of death raises an important issue, and one that was recognized as a flaw in V-Safe. VAERS can also miss an incident of death if the reporter was, up to their death, the vaccine recipient. How many of the more serious cases recorded above ultimately led to death? This factor is one of at least several that results in significant under reporting of death in the available systems – death, the most serious adverse event.

5.5.2 Cases of syncope (fainting): 34,327; 61% of cases IMMEDIATELY after injection.

A vagal episode or vasovagal response or vasovagal attack is a malaise mediated by the vagus nerve. When it leads to fainting, also known as a "syncope", it is called a *vasovagal syncope*, which is the most common type of fainting. Vasovagal syncope is most commonly found in adolescents and in older adults but it appears from the VAERS data and publications that COVID-19 vaccines are causing events to occur. Considering that the vaccines are causing many other neurogenic reactions throughout the body, a vasovagal response might not be unexpected. Some try to dismiss the reaction as an outcome of anxiety from vaccination.

Query string: SYNCOPE; SYNCOPE VASOVAGAL



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> *We report a case of a 70-year-old man who presented to the hospital for some syncope, 3 days after his first COVID-19 AstraZeneca Vaccination. Initial electrocardiogram (ECG) showed a long QT interval (QTc = 600 milliseconds). Laboratory tests revealed elevated troponin and lack of evidence of viral infection. Further investigations revealed the vaccine-induced myocarditis and arrhythmias linked to it.*

Kim MS, Jung SY, Ahn JG, Park SJ, Shoenfeld Y, Kronbichler A, Koyanagi A, Dragioti E, Tizaoui K, Hong SH, Jacob L, Salem JE, Yon DK, Lee SW, Ogino S, Kim H, Kim JH, Excler JL, Marks F, Clemens JD, Eisenhut M, Barnett Y, Butler L, Ilie CP, Shin EC, Il Shin J, Smith L. **Comparative safety of mRNA COVID-19 vaccines to influenza vaccines: A pharmacovigilance analysis using WHO international database**. J Med Virol. 2021 Oct 28:10.1002/jmv.27424. doi: 10.1002/jmv.27424. Epub ahead of print. PMID: 34709664; PMCID: PMC8662238. https://pubmed.ncbi.nlm.nih.gov/34709664/

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April 2021. MMWR Morb Mortal Wkly Rep. 2021 May 7;70(18):685-688. doi: 10.15585/mmwr.mm7018e3. PMID: 33956781. https://pubmed.ncbi.nlm.nih.gov/33956781/

> *Syncope after Janssen COVID-19 vaccination was reported to VAERS (8.2 episodes per 100,000 doses). By comparison, after influenza vaccination, the reporting rate of syncope was 0.05 episodes per 100,000 doses.*

The following chart reports incidence of syncope following vaccination for all vaccines sorted by largest number of events. COVID-19 vaccines account for over 65% of all vaccines for all time.

Description
- VAERS data in CDC WONDER are updated every Friday. Hence, results for the same query can change from week to week.
- These results are for 53,152 total events.
- Rows with zero Events Reported are hidden. Use Quick Options above to show zero rows.

Vaccine	Events Reported	Percent (of 53,152)
COVID19 (COVID19 (PFIZER-BIONTECH)) (1200)	22,589	42.50%
COVID19 (COVID19 (MODERNA)) (1201)	8,532	16.05%
HPV (GARDASIL) (1098)	5,363	10.09%
COVID19 (COVID19 (JANSSEN)) (1203)	3,486	6.56%
MENINGOCOCCAL CONJUGATE (MENACTRA) (1090)	1,935	3.64%
HPV (GARDASIL 9) (1170)	1,573	2.96%
MEASLES + MUMPS + RUBELLA (MMR II) (26)	1,287	2.42%
HEP A (HAVRIX) (258)	1,110	2.09%
TDAP (BOOSTRIX) (1091)	1,107	2.08%
TDAP (ADACEL) (1092)	1,022	1.92%
VARICELLA (VARIVAX) (269)	926	1.74%
HEP B (ENGERIX-B) (38)	875	1.65%
HPV (CERVARIX) (1136)	683	1.28%
INFLUENZA (SEASONAL) (FLUZONE) (7)	614	1.16%
TD ADSORBED (NO BRAND NAME) (11)	561	1.06%
ZOSTER (SHINGRIX) (1192)	479	0.90%
HEP B (RECOMBIVAX HB) (25)	475	0.89%
MENINGOCOCCAL CONJUGATE (MENVEO) (1140)	463	0.87%
INFLUENZA (SEASONAL) (NO BRAND NAME) (44)	435	0.82%
INFLUENZA (SEASONAL) (FLUZONE QUADRIVALENT) (1162)	415	0.78%
VACCINE NOT SPECIFIED (NO BRAND NAME) (999)	412	0.78%
PNEUMO (PNEUMOVAX) (30)	409	0.77%
HEP A (VAQTA) (280)	399	0.75%
MENINGOCOCCAL B (BEXSERO) (1165)	363	0.68%
INFLUENZA (SEASONAL) (FLUVIRIN) (262)	347	0.65%
INFLUENZA (SEASONAL) (FLUARIX QUADRIVALENT) (1161)	340	0.64%
POLIO VIRUS, ORAL (ORIMUNE) (17)	334	0.63%
POLIO VIRUS, INACT. (IPOL) (1030)	301	0.57%
HPV (NO BRAND NAME) (1102)	296	0.56%
INFLUENZA (SEASONAL) (FLUCELVAX QUADRIVALENT) (1175)	245	0.46%
PNEUMO (PREVNAR13) (1141)	228	0.43%
HEP A + HEP B (TWINRIX) (1009)	226	0.43%
TYPHOID VI POLYSACCHARIDE (TYPHIM VI) (271)	215	0.40%
MENINGOCOCCAL B (TRUMENBA) (1189)	206	0.39%
INFLUENZA (SEASONAL) (AFLURIA QUADRIVALENT) (1177)	195	0.37%
DTAP (INFANRIX) (286)	176	0.33%
DTP (NO BRAND NAME) (2)	171	0.32%
MENINGOCOCCAL (NO BRAND NAME) (113)	169	0.32%
POLIO VIRUS, INACT. (NO BRAND NAME) (232)	164	0.31%
INFLUENZA (SEASONAL) (FLULAVAL QUADRIVALENT) (1166)	144	0.27%
INFLUENZA (SEASONAL) (AFLURIA) (1121)	129	0.24%
INFLUENZA (H1N1) (H1N1 (MONOVALENT) (SANOFI)) (1132)	126	0.24%
PNEUMO (PREVNAR) (1001)	125	0.24%
MEASLES + MUMPS + RUBELLA (NO BRAND NAME) (114)	123	0.23%
COVID19 (COVID19 (PFIZER-BIONTECH BIVALENT)) (1211)	121	0.23%
TDAP (NO BRAND NAME) (1104)	121	0.23%
INFLUENZA (SEASONAL) (FLUZONE HIGH-DOSE) (1145)	118	0.22%

5.5.3 Cases of anemia, aplastic or autoimmune: 642; 40% within ten days after injection

Most people are not aware that blood is considered a tissue given that many types of cells flow through the fluid plasma as a medium of suspension. Red blood cells (erythrocytes) are the vehicle for the transport of respiratory gases to each cell of the body from the lung. When there is an insufficient number of blood cells or the hemoglobin molecules in the red cells becomes compromised, the life threatening condition is known as anemia.

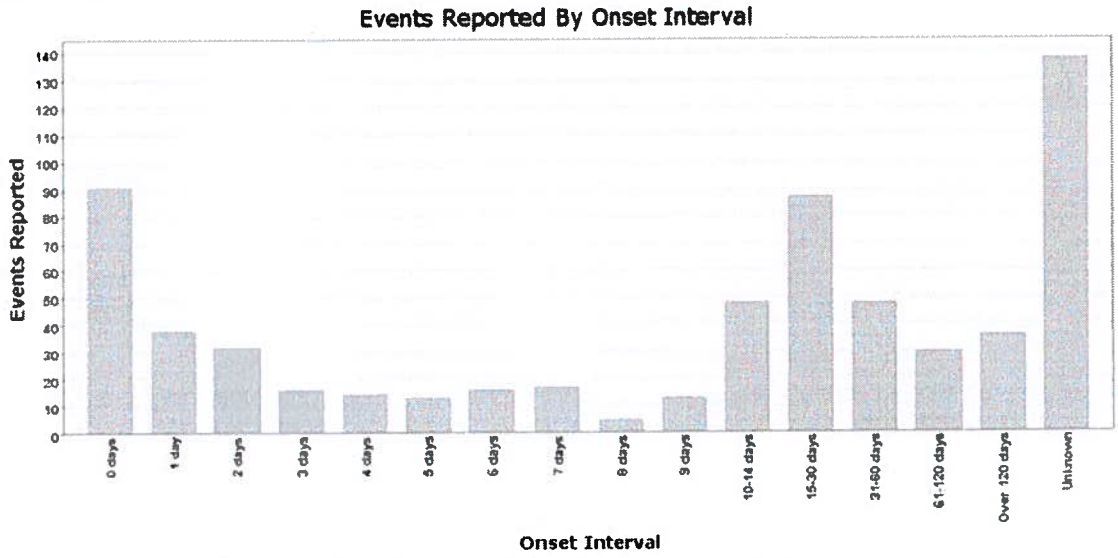
Query string: ANAEMIA HAEMOLYTIC AUTOIMMUNE; APLASTIC ANAEMIA; AUTOIMMUNE ANAEMIA; AUTOIMMUNE HAEMOLYTIC ANAEMIA; HAEMOLYTIC ANAEMIA; HYPOPLASTIC ANAEMIA; LEUKOERYTHROBLASTIC ANAEMIA; MICROANGIOPATHIC HAEMOLYTIC ANAEMIA; MICROCYTIC ANAEMIA;

NEPHROGENIC ANAEMIA; PERNICIOUS ANAEMIA; WARM AUTOIMMUNE HAEMOLYTIC ANAEMIA; WARM TYPE HAEMOLYTIC ANAEMIA

Prevalence of specific symptoms

Messages:
- VAERS data in CDC WONDER are updated every Friday. Hence, results for the same query can change from week to week.
- These results are for 642 total events.
- Rows with zero Events Reported are hidden. Use Quick Options above to show zero rows.

Symptoms	Events Reported	Percent (of 642)
AUTOIMMUNE HAEMOLYTIC ANAEMIA	221	34.42%
HAEMOLYTIC ANAEMIA	173	26.95%
APLASTIC ANAEMIA	110	17.13%
MICROCYTIC ANAEMIA	74	11.53%
PERNICIOUS ANAEMIA	24	3.74%
WARM TYPE HAEMOLYTIC ANAEMIA	14	2.18%
AUTOIMMUNE ANAEMIA	12	1.87%
MICROANGIOPATHIC HAEMOLYTIC ANAEMIA	11	1.71%
NEPHROGENIC ANAEMIA	7	1.09%
WARM AUTOIMMUNE HAEMOLYTIC ANAEMIA	7	1.09%
HYPOPLASTIC ANAEMIA	2	0.31%
LEUKOERYTHROBLASTIC ANAEMIA	1	0.16%



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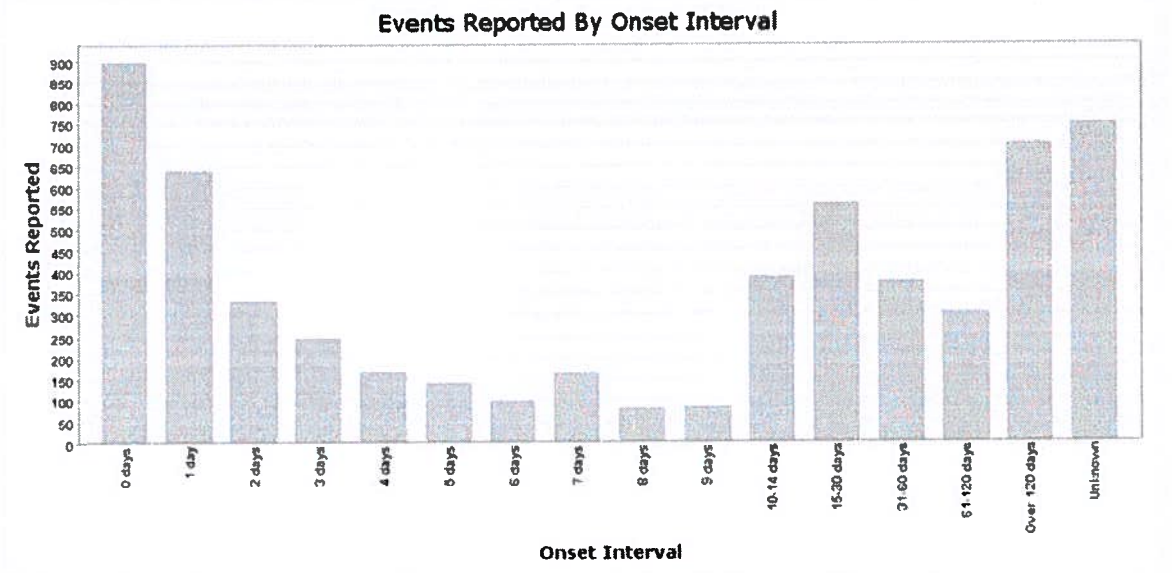
5.5.4 Cases of cardiac death, sudden death or cardiac failure: 5,927; 32% within two days after injection.

The two most prevalent injuries that have been determined a causal outcome of the COVID-19 vaccines are thrombogenic or inflammatory in origin. Heart injuries are not isolated to myocarditis. This section looks at those injuries.

Query string: CARDIAC DEATH; CARDIAC FAILURE; CARDIAC FAILURE ACUTE; CARDIAC FAILURE CONGESTIVE; LEFT VENTRICULAR FAILURE; RIGHT VENTRICULAR FAILURE; SUDDEN CARDIAC DEATH; SUDDEN DEATH



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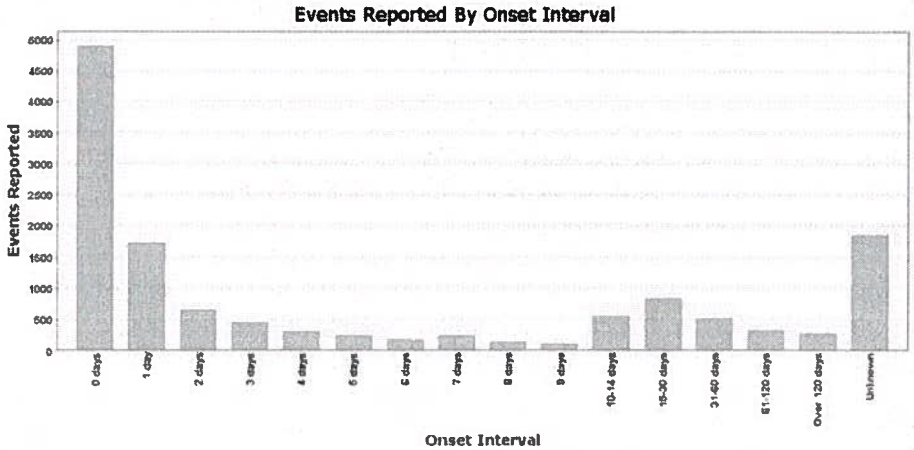
5.5.5 Cases of visual impairment: 13,285; 55% within two days after injection

There are many causes of blindness that need not necessarily be a pathogenesis of the eye. Part of seeing involves proper function of parts of the brain that connect with the function of sight. One of the causes – thrombogenesis, the formation of clots either in the eye or those parts of the brain. COVID-19 vaccines, and more specifically the spike protein have been shown to cause microemboli that can lead to a thrombus that starves the eye or brain of oxygen. COVID-19 vaccines are also known to cause inflammation in multiple organ systems. Another cause of blindness is uveitis, an inflammation of the uvea, the pigmented layer of the eye between the inner retina and the outer fibrous layer composed of the sclera and cornea.

Query string: AMAUROSIS FUGAX; BLINDNESS; BLINDNESS CORTICAL; BLINDNESS TRANSIENT; BLINDNESS UNILATERAL; VISUAL ACUITY REDUCED; VISUAL IMPAIRMENT



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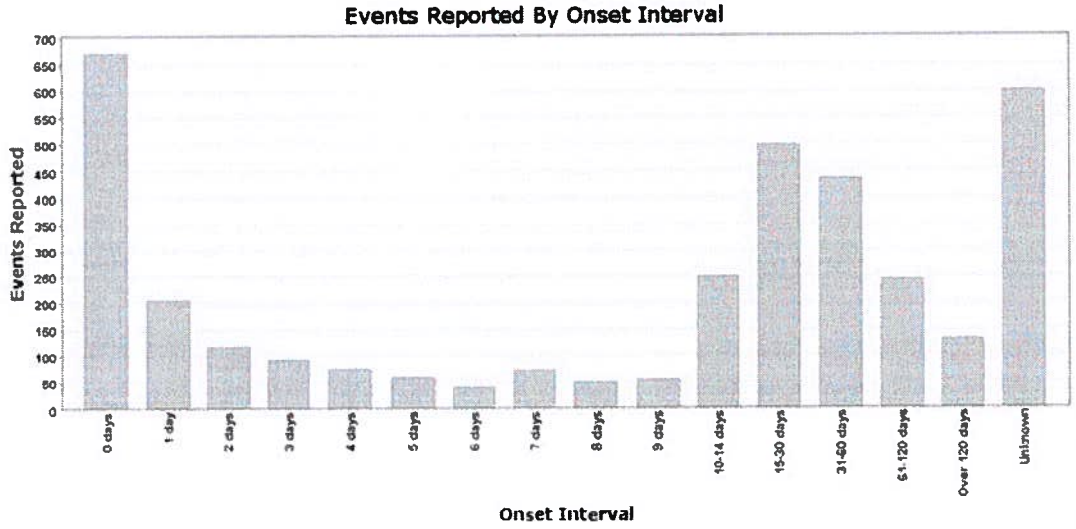
5.5.6 Cases of miscarriage, stillbirth or spontaneous abortion: 3,608; 28% within two days after injection.

Query string :

ABORTION SPONTANEOUS; ABORTION SPONTANEOUS COMPLETE; ABORTION SPONTANEOUS COMPLICATED; ABORTION SPONTANEOUS INCOMPLETE; PREMATURE BABY DEATH; STILLBIRTH



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Zaçe et. al. concludes the vaccines are not affecting fertility. I just mention that for two reasons. One, to demonstrate I do not bias entries in this compendium and Two, to document researchers that failed due diligence when the facts actually crystalize.

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The journal pre-proof by Schwartz et. al. Does not reference V-safe data. The paper supports vaccines for pregnant women without benefit of this data. As of October 16, 2022 the CDC has still not released pregnancy data from V-safe even under court order.

Noé Chartier wrote in the Epoch Times[34] September 1, 2022 that Pfizer abruptly, and without detailed explanation stopped its COVID-19 clinical trials in pregnant women after an internal email was produced as evidence in a recent court case.

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[34] https://www.theepochtimes.com/mkt_app/pfizer-has-stopped-its-covid-vaccine-clinical-trial-in-pregnant-women-internal-email_4700143.html

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The main problem with this South Korean study above is it's a *comparative* study between different COVID-19 vaccines without consideration of the *no vaccine* case. Serious side effects indeed were noted among the vaccinated, but there is no ***control group*** cited; outcomes of unvaccinated pregnant women were not included in the comparisons. And this fact is not pointed out in any of the analyses or conclusions.

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https://doi.org/10.3390/v13081546
https://www.mdpi.com/1999-4915/13/8/1546#cite

The researched medical journal publications on miscarriage, stillbirth or spontaneous abortion associated with Covid-19 vaccines mostly agree with a similar common narrative:

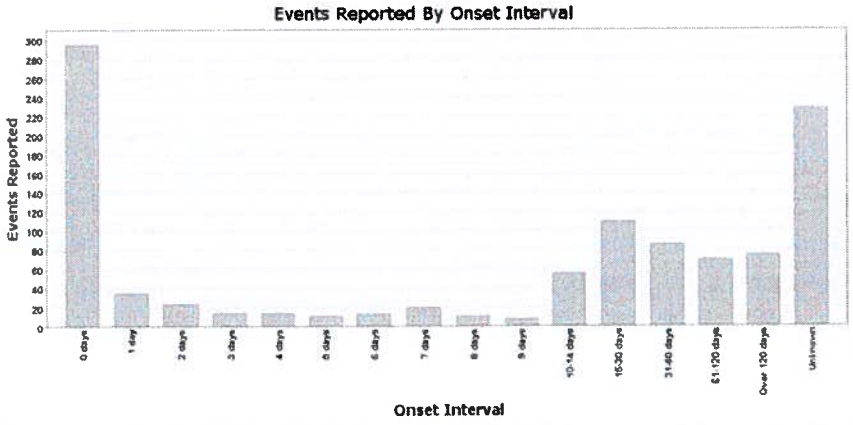
1. "the scientific data suggest no evidence that the COVID-19 vaccines currently used in the United States have any negative effects on female reproductive health" and
2. Nevertheless "the CDC recommended that any American who is pregnant, planning to become pregnant, or currently breastfeeding get vaccinated against COVID-19 as soon as possible"

Some, but most do not mention that the data is lacking relative to the fact that the vaccines have only been out 11 to 12 months (or at time of publication less than that!) and the human gestational time frame is on the same order, 9 months. It takes time to collect and analyze data in this instance for cause and effect. Also not mentioned there are possible adverse events by the vaccine that could indirectly lead to spontaneous abortion or stillbirth - many of the other adverse events listed in this report (e.g. thrombocytopenia, CVST or simply death).

5.5.7 Cases of fetal death or disorders: 1,072; 33% within two days after injection.

Query string:

BIOPSY FOETAL ABNORMAL; BRADYCARDIA FOETAL; CEREBRAL HAEMORRHAGE FOETAL; CEREBRAL INFARCTION FOETAL; FOETAL ANAEMIA; FOETAL ARRHYTHMIA; FOETAL BIOPHYSICAL PROFILE SCORE ABNORMAL; FOETAL CARDIAC ARREST; FOETAL CARDIAC DISORDER; FOETAL CEREBROVASCULAR DISORDER; FOETAL CHROMOSOME ABNORMALITY; FOETAL CYSTIC HYGROMA; FOETAL DAMAGE; FOETAL DEATH; FOETAL DISORDER; FOETAL DISTRESS SYNDROME; FOETAL EXPOSURE DURING PREGNANCY; FOETAL GASTROINTESTINAL TRACT IMAGING ABNORMAL; FOETAL GROWTH ABNORMALITY; FOETAL GROWTH RETARDATION; FOETAL HEART RATE ABNORMAL; FOETAL HEART RATE ACCELERATION ABNORMALITY; FOETAL HEART RATE DECELERATION ABNORMALITY; FOETAL HEART RATE DISORDER; FOETAL HYPOKINESIA; FOETAL MALFORMATION; FOETAL MEGACYSTIS; FOETAL MONITORING ABNORMAL; FOETAL MOVEMENT DISORDER; FOETAL NON-STRESS TEST ABNORMAL; FOETAL PLACENTAL THROMBOSIS; FOETAL RENAL IMAGING ABNORMAL; FOETAL RENAL IMPAIRMENT; FOETAL VASCULAR MALPERFUSION; FOETAL-MATERNAL HAEMORRHAGE; INTRA-UTERINE DEATH; NONREASSURING FOETAL HEART RATE PATTERN; TACHYCARDIA FOETAL; ULTRASOUND FOETAL ABNORMAL



COVID-19 vaccines account for 43% of reported gestational disorders out of all vaccines over all time. Pfizer-BioNtech has the highest effect on gestational disorder reporting 792 cases.

Messages:
- VAERS data in CDC WONDER are updated every Friday. Hence, results for the same query can change from week to week.
- These results are for 2,754 total events.
- Rows with zero Events Reported are hidden. Use Quick Options above to show zero rows.

Vaccine	Events Reported	Percent (of 2,754)
Total	3,171	115.14%
COVID19 (COVID19 (PFIZER-BIONTECH)) (1200)	792	28.76%
COVID19 (COVID19 (MODERNA)) (1201)	287	10.42%
HPV (GARDASIL) (1098)	267	9.69%
INFLUENZA (SEASONAL) (NO BRAND NAME) (44)	227	8.24%
VACCINE NOT SPECIFIED (NO BRAND NAME) (999)	173	6.28%
TDAP (BOOSTRIX) (1091)	135	4.90%
COVID19 (COVID19 (JANSSEN)) (1203)	89	3.23%
MEASLES + MUMPS + RUBELLA (MMR II) (26)	87	3.16%
VARICELLA (VARIVAX) (269)	75	2.72%
TDAP (NO BRAND NAME) (1104)	63	2.29%
INFLUENZA (SEASONAL) (FLUCELVAX QUADRIVALENT) (1175)	59	2.14%
TDAP (ADACEL) (1092)	58	2.11%
MEASLES + MUMPS + RUBELLA (NO BRAND NAME) (114)	50	1.82%
INFLUENZA (H1N1) (H1N1 (MONOVALENT) (UNKNOWN)) (1135)	48	1.74%
HEP B (ENGERIX-B) (38)	47	1.71%
INFLUENZA (SEASONAL) (AFLURIA QUADRIVALENT) (1177)	45	1.63%
HPV (CERVARIX) (1136)	43	1.56%
INFLUENZA (H1N1) (H1N1 (MONOVALENT) (SANOFI)) (1132)	31	1.13%
HEP B (NO BRAND NAME) (110)	28	1.02%
INFLUENZA (SEASONAL) (AFLURIA) (1121)	27	0.98%
INFLUENZA (SEASONAL) (FLUZONE) (7)	27	0.98%
COVID19 (COVID19 (UNKNOWN)) (1202)	25	0.91%
INFLUENZA (H1N1) (H1N1 (MONOVALENT) (NOVARTIS)) (1133)	25	0.91%
HEP A (HAVRIX) (268)	24	0.87%
INFLUENZA (SEASONAL) (FLUVIRIN) (262)	20	0.73%
HEP B (RECOMBIVAX HB) (25)	19	0.69%
INFLUENZA (SEASONAL) (FLUARIX QUADRIVALENT) (1161)	19	0.69%

Citations:

Moro PL, Olson CK, Clark E, Marquez P, Strid P, Ellington S, Zhang B, Mba-Jonas A, Alimchandani M, Cragan J, Moore C. **Post-authorization surveillance of adverse events following COVID-19 vaccines in pregnant persons in the vaccine adverse event reporting system (VAERS), December 2020 - October 2021.** Vaccine. 2022 May 26;40(24):3389-3394. doi: 10.1016/j.vaccine.2022.04.031. Epub 2022 Apr 12. PMID: 35489985; PMCID: PMC9001176.
https://pubmed.ncbi.nlm.nih.gov/35489985/

5.5.8 Cases of placental disorders: 198; 39% within two days after injection

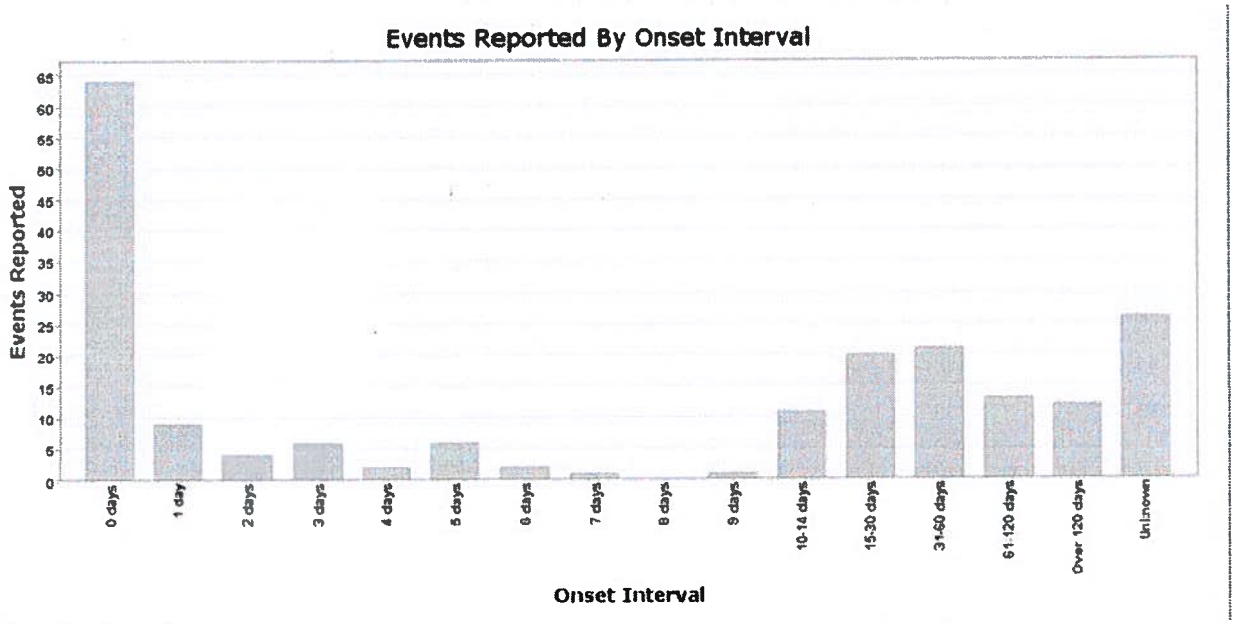
A topic of recent concern are potential effects on gestation, and successful, healthy gestation depends on a healthy and normal functioning placenta: the interface that provides oxygenation and nutrition from mother to fetus. Considering (1) the placenta is composed of a huge mass of vasculature (2) that the COVID-19 vaccines can cause clotting and inflammation and (3) that testing of the vaccines being recommended for pregnant mothers have only been tested on RATS[35] should raise concern.

Query string:

FOETAL PLACENTAL THROMBOSIS; FOETAL VASCULAR MALPERFUSION; PLACENTA ACCRETA; PLACENTA

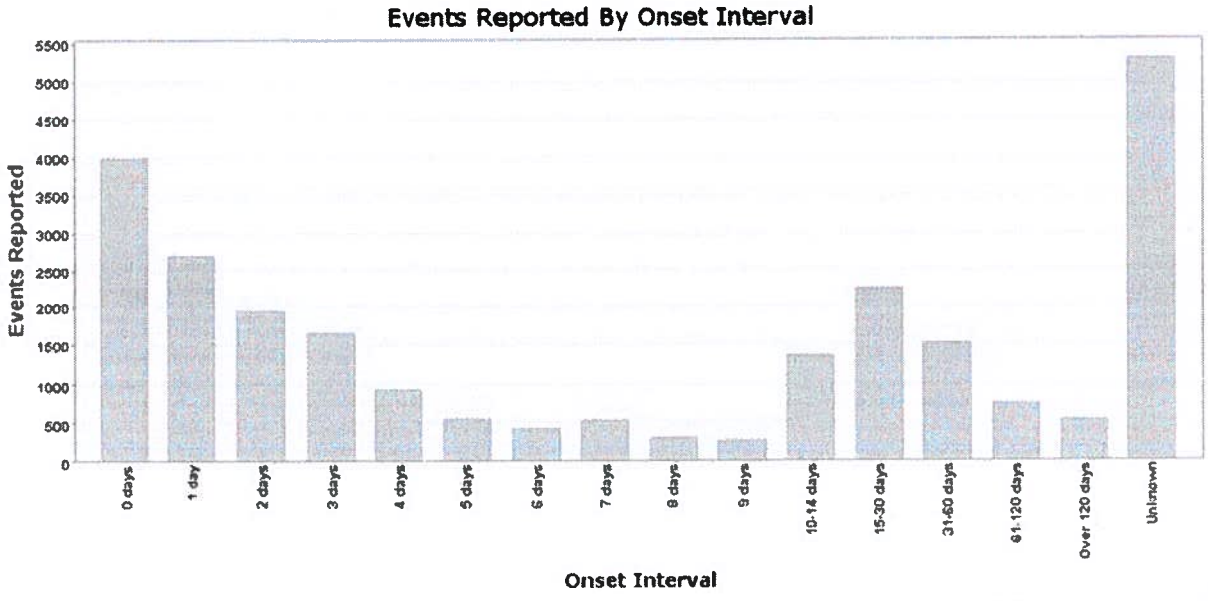
[35] https://icandecide.org/article/pfizers-documents-public-health-and-medical-professionals-for-transparency-documents-november-1-2022/

PRAEVIA; PLACENTA PRAEVIA HAEMORRHAGE; PLACENTAL CALCIFICATION; PLACENTAL CYST; PLACENTAL DISORDER; PLACENTAL INFARCTION; PLACENTAL INSUFFICIENCY; PLACENTAL NECROSIS; PLACENTAL TRANSFUSION SYNDROME; PREMATURE SEPARATION OF PLACENTA; SMALL SIZE PLACENTA



5.5.9 Cases of myocarditis, pericarditis or myopericarditis: 25,127; 35% within two days after injection.

Query string: AUTOIMMUNE MYOCARDITIS; AUTOIMMUNE PERICARDITIS; CHRONIC MYOCARDITIS; EOSINOPHILIC MYOCARDITIS; IMMUNE-MEDIATED MYOCARDITIS; MYOCARDITIS; MYOPERICARDITIS; PERICARDITIS; PLEUROPERICARDITIS



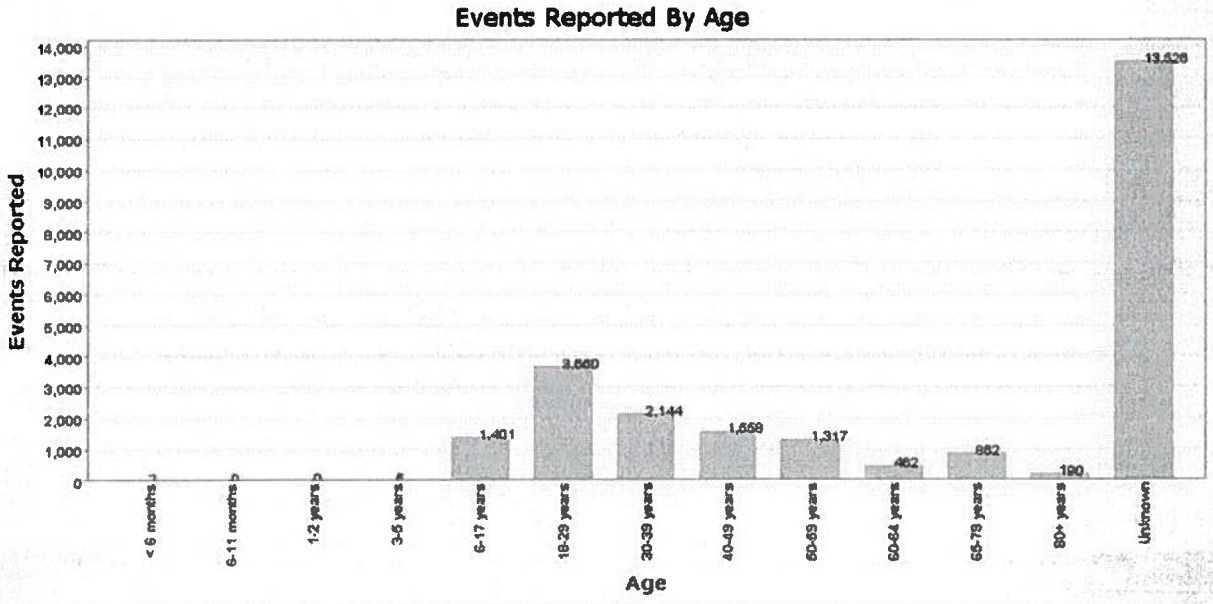
The following chart looks at cases of myocarditis for all vaccines over all time. COVID-19 vaccines account for over 97% of the cases. This is not an acceptable situation.

Messages:

- VAERS data in CDC WONDER are updated every Friday. Hence, results for the same query can change from week to week.
- These results are for 26,330 total events.
- Rows with zero Events Reported are hidden. Use Quick Options above to show zero rows.

Vaccine	Events Reported	Percent (of 26,330)
COVID19 (COVID19 (PFIZER-BIONTECH)) (1200)	19,353	73.50%
COVID19 (COVID19 (MODERNA)) (1201)	5,740	21.80%
COVID19 (COVID19 (JANSSEN)) (1203)	434	1.65%
SMALLPOX (ACAM2000) (1122)	241	0.92%
VACCINE NOT SPECIFIED (NO BRAND NAME) (999)	202	0.77%
SMALLPOX (DRYVAX) (47)	145	0.55%
COVID19 (COVID19 (UNKNOWN)) (1202)	121	0.46%
INFLUENZA (SEASONAL) (NO BRAND NAME) (44)	117	0.44%
ANTHRAX (BIOTHRAX) (1008)	81	0.31%
HEP B (ENGERIX-B) (38)	57	0.22%
ANTHRAX (NO BRAND NAME) (64)	56	0.21%
TYPHOID VI POLYSACCHARIDE (TYPHIM VI) (271)	56	0.21%
SMALLPOX (NO BRAND NAME) (10)	40	0.15%
MEASLES + MUMPS + RUBELLA (MMR II) (26)	34	0.13%
ZOSTER (SHINGRIX) (1192)	31	0.12%
INFLUENZA (SEASONAL) (FLUZONE) (7)	30	0.11%
PNEUMO (PNEUMOVAX) (30)	29	0.11%
HPV (GARDASIL) (1098)	28	0.11%
HEP B (RECOMBIVAX HB) (25)	26	0.10%
HEP A (HAVRIX) (268)	25	0.09%
PNEUMO (PREVNAR13) (1141)	25	0.09%
HPV (GARDASIL 9) (1170)	23	0.09%
MENINGOCOCCAL (NO BRAND NAME) (113)	22	0.08%
TYPHOID VI POLYSACCHARIDE (NO BRAND NAME) (52)	20	0.08%
VARICELLA (VARIVAX) (269)	20	0.08%
HEP B (NO BRAND NAME) (110)	19	0.07%
INFLUENZA (SEASONAL) (FLUMIST) (1085)	18	0.07%

The chart below compares the number of myocarditis cases by age group. Note also that for ages less than 6 years, it's difficult to see, but there are a few cases reported (7 cases < 5 years old). Reports are that although the FDA 'approved' the vaccines, only a small percentage of parents participated in getting their child vaccinated. What is also concerning is the poor record keeping. Why are most events of unknown age? Of those that did record age, the majority of cases occur in young people 18 to 30 years of age.



Myocarditis or any condition involving heart inflammation as a result of COVID-19 vaccine deserves special attention since it's now recognized as a 'signal' in VAERS without further question. Indications are that it is critically and permanently affecting cardio health of our youth without providing any benefit of protection that a legitimate vaccine is expected to offer.

The following chart shows that a male receiving a COVID-19 vaccine are 60% more likely to contract myocarditis than a female.

Messages:
- VAERS data in CDC WONDER are updated every Friday. Hence, results for the same query can change from week to week.
- These results are for 25,127 total events.

Sex	Events Reported	Percent (of 25,127)
Female	9,391	37.37%
Male	15,055	59.92%
Unknown	681	2.71%

On Jan 24, 2022 Senator Ron Johnson of Wisconsin hosted a "Covid 19 Response" panel including renowned doctors and medical experts to provide a "different perspective" on the global pandemic response. The video record is 5 ½ hours long, but it's **strongly recommended that all officials having authority over covid-19 vaccine policies take the time to view it**. Since that meeting and in lieu of the pharmaceutical companies stepping up to take responsibility, Johnson, Braun and Hyde-Smith have begun drafting a bill to address these large numbers of vaccine injuries.[36]

One of the more striking testimonies during the Jan 24 meeting came from Dr. Peter McCullough, a world renowned cardiologist. In the meeting, McCullough mentioned damning evidence that the covid19 vaccines are causing the myocarditis and pericarditis. (index to 17:45) McCullough mentioned about 200 papers have been published addressing the issue of COVID-19 vaccines and cases of myocarditis. Indeed McCullough, and Dr. Jessica Rose in Israel applied the Bradford Hill analysis to VAERS in a paper they co-authored[37] using other associated vaccine injury data to demonstrate causation.

McCullough and other doctors have said it, but it's a well-known fact that myocytes (heart cells) are not replaceable:

> *"Similar to skeletal muscle tissue,* ***cardiac muscle does not regenerate to a great extent. Dead cardiac muscle tissue is replaced by scar tissue, which cannot contract****. As scar tissue accumulates, the heart loses its ability to pump because of the loss of contractile power."* From on-line Anatomy & Physiology, OSU

'Mild Myocarditis' or 'Benign Myocarditis' are oxymoron's; a phrase fabricated by vaccine proponents. It's a lie to soften the true nature of the harmful effects of the vaccine that could forever limit performance of a would-be athlete or lead to long term heart disease. An inflammation of the heart muscle (myocardium). The inflammation can kill tissue, reduce the heart's ability to pump and cause rapid or irregular heart rhythms (arrhythmias). Signs and symptoms of myocarditis include chest pain, fatigue, shortness of breath,

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[36] Countermeasure Injury Compensation Program with respect to COVID–19 vaccines

[37] Jessica Rose PhD, MSc, BSc , Peter A. McCullough MD, MPH , **A Report on Myocarditis Adverse Events in the U.S. Vaccine Adverse Events Reporting System (VAERS) in Association with COVID-19 Injectable Biological Products**, Current Problems in Cardiology (2021), doi: https://doi.org/10.1016/j.cpcardiol.2021.101011 Unpublished Preprint Here

and rapid or irregular heartbeats. In a small percentage of cases persons with myocarditis can be at risk of sudden death following strenuous activity.

Some sufferers of myocarditis may require heart surgery or a heart transplant later in life. And there are no benefits from the vaccine to balance the risk of myocarditis for the younger age groups. Especially now since the vaccines in circulation were designed for the initial Wuhan strain, now extinct. The mainstream media is also culpable, promoting narratives to promote fear and cause coercion. Permanent heart damage does occur, however 'mild' the case might be – and the most vulnerable victims are our children and young adults. Does the risk of Covid-19 sequelae exceed the risk of reduced cardiac capacity for these young people? No one has offered any evidence, any calculations or rigorous analysis that warrants such a decision being made.

The paper McCullough co-authored with Rose completed peer review and was approved for publication, but the publisher, Elsevier, assigned it a "temporary removal" — without any explanation or cause.[38] One can only assume Elsevier purposely removed the publication because it went against the narrative of the political machine established to protect the vaccines or fear they would lose sponsorship or funding from pharma. This was done without consideration of the harm to people they might be causing by limiting essential information.

Here is one paper published by Oster et al addressing the harm of vaccine induced myocarditis:

> Oster ME, Shay DK, Su JR, Gee J, Creech CB, Broder KR, Edwards K, Soslow JH, Dendy JM, Schlaudecker E, Lang SM, Barnett ED, Ruberg FL, Smith MJ, Campbell MJ, Lopes RD, Sperling LS, Baumblatt JA, Thompson DL, Marquez PL, Strid P, Woo J, Pugsley R, Reagan-Steiner S, DeStefano F, Shimabukuro TT. **Myocarditis Cases Reported After mRNA-Based COVID-19 Vaccination in the US From December 2020 to August 2021**. JAMA. 2022 Jan 25, 327(4): 331-340. https://jamanetwork.com/journals/jama/fullarticle/2788346

Oster's yearlong study of vaccine rollout addressed the question: What is the risk of myocarditis after mRNA-based COVID-19 vaccination in the US? The main finding was that, of 1626 adjudicated cases of reported myocarditis, occurring within 7 days after vaccination, exceeded the expected rates across multiple age and sex strata. These rates were highest after the second vaccination in males aged 12 to 15 years (70.7 per million doses of the BNT162b2 vaccine), in males aged 16 to 17 years (105.9 per million doses of the BNT162b2 vaccine), and in males aged 18 to 24 years (52.4 and 56.3 per million doses of the BNT162b2 vaccine and the mRNA-1273 vaccine, respectively). The researchers used as their source of data, the CDC's VAERS database.

Despite persistent castigation of VAERS by vaccine proponents and mass news media narratives, Oster describes how his researchers carefully and procedurally adjudicated data to provide a confident and reliable analysis. They indeed reported the limitations, however most important to note they believe their estimates are low due to the expectation that the biases are in the direction of under-reporting:

[38] https://retractionwatch.com/2021/10/17/paper-linking-covid-19-vaccines-to-myocarditis-is-temporarily-removed-without-explanation/

> *"This study has several limitations. First, although clinicians are required to report serious adverse events after COVID-19 vaccination, including all events leading to hospitalization, VAERS is a passive reporting system. As such, the reports of myocarditis to VAERS may be incomplete, and the quality of the information reported is variable. Missing data for sex, vaccination dose number, and race and ethnicity were not uncommon in the reports received; history of prior SARS-CoV-2 infection also was not known. Furthermore, as a passive system, VAERS data are subject to reporting biases in that both underreporting and over reporting are possible.38 Given the high verification rate of reports of myocarditis to VAERS after mRNA based COVID-19 vaccination, underreporting is more likely. Therefore, the actual rates of myocarditis per million doses of vaccine are likely higher than estimated."*

Oster is one of the few that didn't candy coat his conclusions and warned that the cases are probably being under-reported.

Citations:

The number of citations on vaccine induced myocarditis exploded authorities agreed it was indeed a signal. In this report there are over 200 papers listed, all addressing studies and case reports of COVID-19 vaccine induced myocarditis or pericarditis. Note the term 'fulminant' indicates that the condition requires some means of intervention to ensure sufficient circulation to continue life. Covid vaccination and the outcome of heart inflammation cannot be undone. There is no antidote or treatment that will restore the heart to its original state.

Piras A, Melis G, Cugusi L, Bassareo PP. **Myopericarditis in a Male Adolescent Following the Second Shot of COVID-19 Pfizer m-RNA Vaccine: Typical Example and Analysis of 110 Single Case Reports**. Pediatr Rep. 2022 Sep 26;14(4):401-409. doi: 10.3390/pediatric14040048. PMID: 36278552; PMCID: PMC9589994. https://pubmed.ncbi.nlm.nih.gov/36278552/

Tano E, San Martin S, Girgis S, Martinez-Fernandez Y, Sanchez Vegas C. **Perimyocarditis in Adolescents After Pfizer-BioNTech COVID-19 Vaccine**. J Pediatric Infect Dis Soc. 2021 Nov 11;10(10):962-966. doi: 10.1093/jpids/piab060. PMID: 34319393; PMCID: PMC8344528. https://pubmed.ncbi.nlm.nih.gov/34319393/

Altman NL, Berning AA, Saxon CE, Adamek KE, Wagner JA, Slavov D, Quaife RA, Gill EA, Minobe WA, Jonas ER, Carroll IA, Huebler SP, Raines J, Messenger JC, Ambardekar AV, Mestroni L, Rosenberg RM, Rove J, Campbell TB, Bristow MR. **Myocardial Injury and Altered Gene Expression Associated With SARS-CoV-2 Infection or mRNA Vaccination**. JACC Basic Transl Sci. 2022 Oct 19. doi: 10.1016/j.jacbts.2022.08.005. Epub ahead of print. PMID: 36281440; PMCID: PMC9581498. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9581498/

Altman et al studied 6 cases of myocardial injury in covid infected and vaccinated individuals and discovered an interesting fact regarding differences in gene expression – there was very little difference:

> *A pattern of altered gene expression that was qualitatively identical to COVID-19 patients was found in the post-vaccination patients. Linear discriminant*

analysis yielded a high probability (97.8%) that the post-vaccine aggregate gene expression data were group-indistinguishable from COVID-19 patients. A difference between the post-vaccination subjects and the COVID-19 patients is that BNT162b2 and mRNA-1273 produce isolated S protein, while the COVID-19 patients were exposed to S protein as a component of the full SARS-CoV-2 virion. However, S protein–isolated constructs, as "pseudoviruses," produce the same down-regulation of ACE2 as the full virion,13 , 14 , 29 indicating that it is S or cleaved S1 protein that is signaling ACE2 gene dysregulation. In addition, S protein constructs can produce vascular endothelial cell damage,13 , 37 and S-ACE2 binding results in down-regulation of ACE2 by sequestration into clathrin-coated pits and lysosomal degradation where breakdown products may inflict cell damage and modify gene expression.

Rout A, Suri S, Vorla M, Kalra DK. **Myocarditis associated with COVID-19 and its vaccines - a systematic review**. Prog Cardiovasc Dis. 2022 Oct 21:S0033-0620(22)00104-9. doi: 10.1016/j.pcad.2022.10.004. Epub ahead of print. PMID: 36279947; PMCID: PMC9596182. https://pubmed.ncbi.nlm.nih.gov/36279947/

Sintaroo Watanabe, Rokuro Hama, **SARS-CoV-2 vaccine and increased myocarditis mortality risk: A population based comparative study in Japan**, medRxiv 2022.10.13.22281036; doi: https://doi.org/10.1101/2022.10.13.22281036
https://www.medrxiv.org/content/10.1101/2022.10.13.22281036v1

Conclusion from Sintaroo & Rokuro:

*SARS-CoV-2 vaccination was associated with higher risk of myocarditis death, **not only in young adults but also in all age groups including the elderly**. Considering healthy vaccinee effect, the risk may be 4 times or higher than the apparent risk of myocarditis death. Underreporting should also be considered. Based on this study, risk of myocarditis following SARS-CoV-2 vaccination may be more serious than that reported previously.*

Nakawatase S, Hayashi T, Nakamura S, Makino N, Higuchi Y. **Acute Myopericarditis After the Third Vaccination of BNT162b2 in a Middle-Aged Man**. Cureus. 2022 Sep 6;14(9):e28857. doi: 10.7759/cureus.28857. PMID: 36225402; PMCID: PMC9536864.
https://pubmed.ncbi.nlm.nih.gov/36225402/

Mevorach D, Anis E, Cedar N, Hasin T, Bromberg M, Goldberg L, Levi N, Perzon O, Magadle N, Barhoum B, Parnassa E, Dichtiar R, Hershkovitz Y, Green MS, Ash N, Keinan-Boker L, Alroy-Preis S. **Myocarditis After BNT162b2 COVID-19 Third Booster Vaccine in Israel**. Circulation. 2022 Sep 6;146(10):802-804. doi: 10.1161/CIRCULATIONAHA.122.060961. Epub 2022 Sep 6. PMID: 36067275; PMCID: PMC9439627.
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9439627/

Konno A, Osada Y, Watanabe K, Sakurai K, Aso K. **A case of coronavirus disease 2019 vaccine-related myocarditis with late gadolinium enhancement on cardiac magnetic resonance imaging persisting over acute phase**. Pediatr Int. 2022 Jan;64(1):e15291. doi: 10.1111/ped.15291. PMID: 36074060; PMCID: PMC9539345. https://pubmed.ncbi.nlm.nih.gov/36074060/

Klein BM, Dugan ES, LaCombe AD, Ruthmann NP, Roselli EE, Klein AL, Emery MS. **Complex Management Decisions in a Professional Athlete With Recurrent Pericarditis**. JACC Case Rep. 2022 Sep 7;4(17):1090-1093. doi: 10.1016/j.jaccas.2022.05.015. PMID: 36124145; PMCID: PMC9481902. https://pubmed.ncbi.nlm.nih.gov/36124145/

Klein, et al. Ah. Bless their little clinical hearts❤. They developed a treatment protocol for healing broken hearts💔 ... hearts they destroyed with the vaccines.

Morgan MC, Atri L, Harrell S, Al-Jaroudi W, Berman A. **COVID-19 vaccine-associated myocarditis**. World J Cardiol. 2022 Jul 26;14(7):382-391. doi: 10.4330/wjc.v14.i7.382. PMID: 36161056; PMCID: PMC9350606. https://pubmed.ncbi.nlm.nih.gov/36161056/

Collini V, Imazio M, De Biasio M, Sinagra G. **Coronavirus disease 2019 vaccination-related pericarditis: a single tertiary-center experience**. J Cardiovasc Med (Hagerstown). 2022 Sep 1. doi: 10.2459/JCM.0000000000001365. Epub ahead of print. PMID: 36166325. https://pubmed.ncbi.nlm.nih.gov/36166325/

"It's just mild myocarditis"

Vago H, Szabo L, Szabo Z, Ulakcsai Z, Szogi E, Budai G, Toth A, Juhasz V, Dohy Z, Hoffer K, Becker D, Kiss RG, Nagy GG, Nagy G, Merkely B. **Immunological response and temporal associations in myocarditis after COVID-19 vaccination using cardiac magnetic resonance imaging: An amplified T-cell response at the heart of it?** Front Cardiovasc Med. 2022 Sep 15;9:961031. doi: 10.3389/fcvm.2022.961031. PMID: 36186968; PMCID: PMC9520979. https://pubmed.ncbi.nlm.nih.gov/36186968/

Sdogkos E, Sideri A, Kasmeridis C, Konstantinou T, Vogiatzis I. **Two Cases of Acute Myocarditis in Young Male Adults After mRNA Vaccines Against COVID-19: Similarities and Differences**. Med Arch. 2022 Jun;76(3):215-220. doi: 10.5455/medarh.2022.76.215-220. PMID: 36200112; PMCID: PMC9478807. https://pubmed.ncbi.nlm.nih.gov/36200112/

Rees AR. **Viruses, vaccines and cardiovascular effects**. Br J Cardiol Editorial. 2022 May 31;29(2):16. doi: 10.5837/bjc.2022.016. PMID: 36212794; PMCID: PMC9534113. https://bjcardio.co.uk/2022/05/viruses-vaccines-and-cardiovascular-effects/

Sogbe M, Blanco-Di Matteo A, Di Frisco IM, Bastidas JF, Salterain N, Gavira JJ. **Systemic lupus erythematosus myocarditis after COVID-19 vaccination**. Reumatol Clin. 2022 Jul 28. doi: 10.1016/j.reuma.2022.06.003. Epub ahead of print. PMID: 36211224; PMCID: PMC9525201. https://pubmed.ncbi.nlm.nih.gov/36211224/

Lu J, Zhang X, Xu H, Li Z. Inspiration to mRNA-based COVID-19 vaccination: **Serious adverse case reports with hepatitis B vaccine in real-world**. Front Pediatr. 2022 Sep 23;10:888686. doi: 10.3389/fped.2022.888686. PMID: 36210931; PMCID: PMC9538941. https://pubmed.ncbi.nlm.nih.gov/36210931/

Cavalcante JL, Shaw KE, Gössl M. **Cardiac Magnetic Resonance Imaging Midterm Follow Up of COVID-19 Vaccine-Associated Myocarditis**. JACC Cardiovasc Imaging. 2022 Oct;15(10):1821-1824. doi: 10.1016/j.jcmg.2022.01.008. Epub 2022 Mar 16. PMID: 36202461; PMCID: PMC8925933. https://pubmed.ncbi.nlm.nih.gov/36202461/

The Cavalcante study is an important stake in the sand and should be done more often. It concludes:

> *"Given the novelty of COV19VAM, data on midterm and long-term risks for these patients are lacking. Our study is the first to show a side-by-side systematic comparison of dedicated CMR imaging between the initial diagnosis of acute myocarditis and the approximately 3-month follow-up. This study demonstrated normalization of left ventricular ejection fraction in all patients and resolution of myocardial edema in all patients. There was interval improvement of nonischemic fibrosis seen on late gadolinium enhancement (LGE), albeit fibrosis was still present in 80% of patients. Although this finding could represent vulnerability for adverse cardiovascular long-term events, there were no unfavorable atrial or ventricular arrhythmias seen on a 2-week event monitor placed at 3-month follow-up from the initial diagnosis. "*

Fibrosis indicates heart cells, heart tissue was replaced by scar tissue that lacks the ability to contract and pump blood through the heart. *Dead tissue*. So that means reduced cardiac capacity and the latent risk of heart dis-synchronies later in life. The key question here not posed by the authors; 80%. How many of those 80% with permanent heart damage would have been just fine dealing with the infection instead of the injury induced by the vaccine? We can never answer that question. I'll further remind the medical community: First, do no harm.

Takahashi M, Kondo T, Yamasaki G, Sugimoto M, Asano M, Ueno Y, Nagasaki Y. **An autopsy case report of aortic dissection complicated with histiolymphocytic pericarditis and aortic inflammation after mRNA COVID-19 vaccination**. Leg Med (Tokyo). 2022 Sep 29;59:102154. doi: 10.1016/j.legalmed.2022.102154. Epub ahead of print. PMID: 36191411; PMCID: PMC9519380.
https://pubmed.ncbi.nlm.nih.gov/36191411/

From the autopsy:

Fig. 1. Macroscopic autopsy findings of the heart and the aorta. A: The thick pericardium was incised. The pericardial cavity contained dark red clots showing cardiac tamponade. B: The ascending aorta was dissected. The aortic intima was ruptured horizontally (white arrows). C: The heart had a white villous surface (black arrowheads). (For interpretation of the references to colour in this figure legend, the reader is referred to the web version of this article.)

Voltarelli CL, Silva L, Longo M, Ferraria S, Martins LL, Nazar G, Magalhães T, Miyazima R, Lenci Marques G. **COVID-19-Induced Myocarditis and mRNA Vaccine-Related Pericarditis: A Case Report**. Cureus. 2022 Aug 26;14(8):e28440. doi: 10.7759/cureus.28440. PMID: 36176830; PMCID: PMC9509695.
https://pubmed.ncbi.nlm.nih.gov/36176830/

Chen C, Fu F, Ding L, Fang J, Xiao J. **Booster dose of COVID-19 mRNA vaccine does not increase risks of myocarditis and pericarditis compared with primary vaccination: New insights from the vaccine adverse**

event reporting system. Front Immunol. 2022 Sep 12;13:938322. doi: 10.3389/fimmu.2022.938322. PMID: 36172346; PMCID: PMC9510366. https://pubmed.ncbi.nlm.nih.gov/36172346/

Chen et al fails to ask the question, why? There's no doubt covid-19 vaccines are indeed leading to heart inflammation. No doubt. Asking the question whether it's the first, second, or third shot is a frivolous endeavor compared to the fact it's making people sick period. Consider that a person that's being gradually poisoned with arsenic. They initially build a tolerance, and so to finish them off, larger doses are required. Regardless of that being an explanation - or not, there's no discussion in the paper as to why booster doses might not be as deadly as earlier doses. Different formulation? A more important question that should be on everybody's mind - **why would a Chinese institution (that's tightly connected with the Chinese Communist Party government) be endorsing CDC recommendations in a manner to further encourage the use of COVID-19 vaccines in the United States?**

Dhaduk K, Khosla J, Hussain M, Mangaroliya V, Chauhan S, Ashish K, Gupta R, Pal S. **COVID-19 vaccination and myocarditis: A review of current literature**. World J Virol. 2022 Jul 25;11(4):170-175. doi: 10.5501/wjv.v11.i4.170. PMID: 36159608; PMCID: PMC9372786. https://pubmed.ncbi.nlm.nih.gov/36159608/

Crommelynck S, Thill P. **Pharmacovigilance for COVID-19 vaccines: A 1-year experience in France**. Infect Dis Now. 2022 Sep 21:S2666-9919(22)00210-X. doi: 10.1016/j.idnow.2022.09.018. Epub ahead of print. PMID: 36152793; PMCID: PMC9492382. https://pubmed.ncbi.nlm.nih.gov/36152793/

Zornitzki L, Havakuk O, Rozenbaum Z, Viskin D, Arbel Y, Flint N, Arnold J, Waissengein B, Wolf I, Banai S, Topilsky Y, Laufer-Perl M. **Immune Checkpoint Inhibitor-Induced Myocarditis vs. COVID-19 Vaccine-Induced Myocarditis-Same or Different?** Life (Basel). 2022 Sep 1;12(9):1366. doi: 10.3390/life12091366. PMID: 36143403; PMCID: PMC9501423. https://pubmed.ncbi.nlm.nih.gov/36143403/

The Zornitzki paper presents an important result. They claim there is a difference, albeit both harmful between infection induced and vaccine induced myocarditis. Spike protein connection? The authors suggest more study required.

Massari M, Spila Alegiani S, Morciano C, Spuri M, Marchione P, Felicetti P, Belleudi V, Poggi FR, Lazzeretti M, Ercolanoni M, Clagnan E, Bovo E, Trifirò G, Moretti U, Monaco G, Leoni O, Da Cas R, Heidecker B, Dagan N, Balicer R, Eriksson U, Rosano G, Coats A, Tschöpe C, Kelle S, Poland GA, Frustaci A, Klingel K, Martin P, Hare J, Cooper L, Pantazis A, Imazio M, Prasad S, Lüscher TF. **Myocarditis Following COVID-19 Vaccine: Incidence, Presentation, Diagnosis, Pathophysiology, Therapy, and Outcomes put into Perspective**. Eur J Heart Fail. 2022 Sep 6. doi: 10.1002/ejhf.2669. Epub ahead of print. PMID: 36065751. https://pubmed.ncbi.nlm.nih.gov/36065751/

Khan Z, Pabani UK, Gul A, Muhammad SA, Yousif Y, Abumedian M, Elmahdi O, Gupta A. COVID-19 **Vaccine-Induced Myocarditis: A Systemic Review and Literature Search**. Cureus. 2022 Jul 28;14(7):e27408. doi: 10.7759/cureus.27408. PMID: 36051715; PMCID: PMC9419896. https://pubmed.ncbi.nlm.nih.gov/36051715/

Kawahara H, Endo A, Yamaguchi K, Yoshitomi H, Tanabe K. **Myocarditis After the Third Dose of mRNA-1273 Coronavirus Disease 2019 (COVID-19) Vaccine.** Circ Rep. 2022 Jul 9;4(8):388-389. doi: 10.1253/circrep.CR-22-0049. PMID: 36032383; PMCID: PMC9360982. https://pubmed.ncbi.nlm.nih.gov/36032383/

Petronzelli F, Tartaglia L, Mores N, Zanoni G, Rossi P, Samez S, Zappetti C, Marra AR, Menniti Ippolito F; TheShinISS-Vax|COVID Surveillance Group. **Postmarketing active surveillance of myocarditis and pericarditis following vaccination with COVID-19 mRNA vaccines in persons aged 12 to 39 years in Italy: A multi-database, self-controlled case series study**. PLoS Med. 2022 Jul 28;19(7):e1004056. doi: 10.1371/journal.pmed.1004056. PMID: 35900992; PMCID: PMC9333264. https://pubmed.ncbi.nlm.nih.gov/35900992/

Dini FL, Franzoni F, Scarfò G, Pugliese NR, Imazio M. **Acute pericarditis in patients receiving coronavirus disease 2019 vaccines: a case series from the community**. J Cardiovasc Med (Hagerstown). 2022 Aug 1;23(8):551-558. doi: 10.2459/JCM.0000000000001342. PMID: 35904995. https://pubmed.ncbi.nlm.nih.gov/35904995/

Alizadeh LS, Koch V, Yel I, Grünewald LD, Mathies D, Martin S, Vogl TJ, Rauschning D, Booz C. **A case of myocarditis after COVID-19 vaccination: incidental or consequential**? Heliyon. 2022 May 28;8(6):e09537. doi: 10.1016/j.heliyon.2022.e09537. PMID: 35655920; PMCID: PMC9142175. https://pubmed.ncbi.nlm.nih.gov/35655920/

Iwamuro A, Sasa T, Kawai T, Taguchi M, Izuhara M, Uegaito T, Shioji K. **A 17-year-old male with acute myocarditis following mRNA-1273 vaccination in Japan**. J Cardiol Cases. 2022 Apr 26. doi: 10.1016/j.jccase.2022.03.012. Epub ahead of print. PMID: 35495897; PMCID: PMC9040371. https://pubmed.ncbi.nlm.nih.gov/35495897/

Yamamoto S, Arita Y, Ogasawara N. **Myocarditis Following the Second Dose of COVID-19 Vaccination in a Japanese Adolescent**. Cureus. 2022 Mar 25;14(3):e23474. doi: 10.7759/cureus.23474. PMID: 35475062; PMCID: PMC9035236. https://pubmed.ncbi.nlm.nih.gov/35475062/

Oh TH, Woo SH, Hong S, Lee C, Lee WJ, Jeong SK. **Clinical Features of Patients Presenting to the Emergency Department With Cardiovascular Adverse Reactions After COVID-19 mRNA Vaccination**. J Korean Med Sci. 2022 Mar 7;37(9):e73. doi: 10.3346/jkms.2022.37.e73. PMID: 35257528; PMCID: PMC8901880. https://pubmed.ncbi.nlm.nih.gov/35257528/

Won T, Gilotra NA, Wood MK, Hughes DM, Talor MV, Lovell J, Milstone AM, Steenbergen C, Čiháková D. **Increased Interleukin 18-Dependent Immune Responses Are Associated With Myopericarditis After COVID-19 mRNA Vaccination**. Front Immunol. 2022 Feb 18;13:851620. doi: 10.3389/fimmu.2022.851620. PMID: 35251049; PMCID: PMC8894592. https://pubmed.ncbi.nlm.nih.gov/35251049/

Goyal M, Ray I, Mascarenhas D, Kunal S, Sachdeva RA, Ish P. **Myocarditis post SARS-CoV-2 vaccination: a systematic review**. QJM. 2022 Mar 3:hcac064. doi: 10.1093/qjmed/hcac064. Epub ahead of print. PMID: 35238384; PMCID: PMC8903459. https://pubmed.ncbi.nlm.nih.gov/35238384/

Goyal paper:

> *Myocarditis following COVID-19 vaccination is often mild, seen more commonly in young healthy males and is followed by rapid recovery with*

conservative treatment. The emergence of this adverse event calls for harmonizing case definitions and definite treatment guidelines which require wider research.

AND

Only 6 patients died among 1317 of whom data was available

Nunn S, Kersten J, Tadic M, Wolf A, Gonska B, Hüll E, Dietenberger H, Rottbauer W, Buckert D. **Case Report: Myocarditis After COVID-19 Vaccination - Case Series and Literature Review**. Front Med (Lausanne). 2022 Feb 14;9:836620. doi: 10.3389/fmed.2022.836620. PMID: 35237634; PMCID: PMC8882906. https://pubmed.ncbi.nlm.nih.gov/35237634/
Lee ASY, Balakrishnan IDD, Khoo CY, Ng CT, Loh JKX, Chan LL, Teo LLY, Sim DKL. **Myocarditis Following COVID-19 Vaccination: A Systematic Review (October 2020-October 2021)**. Heart Lung Circ. 2022 Jun;31(6):757-765. doi: 10.1016/j.hlc.2022.02.002. Epub 2022 Feb 25. PMID: 35227610; PMCID: PMC8874750. https://pubmed.ncbi.nlm.nih.gov/35227610/

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Liuzzo G, Volpe M. **Myocarditis after BNT162b2 mRNA SARS-CoV-2 vaccine: low incidence and mild severity**. Eur Heart J. 2022 Jan 28:ehab901. doi: 10.1093/eurheartj/ehab901. Epub ahead of print. PMID: 35090032. https://pubmed.ncbi.nlm.nih.gov/35090032/

Goldman RD. **Myocarditis and pericarditis after COVID-19 messenger RNA vaccines**. Can Fam Physician. 2022 Jan;68(1):17-18. doi: 10.46747/cfp.680117. PMID: 35063975. https://pubmed.ncbi.nlm.nih.gov/35063975/

Wu B, Mittal N, Adler ED, Hong KN. **Acute myocarditis after receiving first dose of BNT162b2 mRNA vaccine**. J Cardiol Cases. 2022 Jan 7. doi: 10.1016/j.jccase.2021.12.009. Epub ahead of print. PMID: 35018202; PMCID: PMC8739668. https://pubmed.ncbi.nlm.nih.gov/35018202/

Saeed S, Käsk L, Rajani R, Larsen TH. **Incidence, clinical presentation and management of myocarditis following mRNA-based Covid-19 vaccines: A brief report**. Cardiology. 2022 Feb 1:1–7. doi: 10.1159/000522216. Epub ahead of print. PMID: 35104821; PMCID: PMC9059023. https://pubmed.ncbi.nlm.nih.gov/35104821/

Bellos I, Karageorgiou V, Viskin D. **Myocarditis following mRNA Covid-19 vaccination: A pooled analysis**. Vaccine. 2022 Mar 15;40(12):1768-1774. doi: 10.1016/j.vaccine.2022.02.017. Epub 2022 Feb 7. PMID: 35153093; PMCID: PMC8818354. https://pubmed.ncbi.nlm.nih.gov/35153093/

Khogali F, Abdelrahman R. **Unusual Presentation of Acute Perimyocarditis Following SARS-COV-2 mRNA-1237 Moderna Vaccination**. Cureus. 2021 Jul 23;13(7):e16590. doi: 10.7759/cureus.16590. PMID:

34447639; PMCID: PMC8381757. https://pubmed.ncbi.nlm.nih.gov/34447639/

Mengesha B, Asenov AG, Hirsh-Raccah B, Amir O, Pappo O, Asleh R. **Severe Acute Myocarditis after the Third (Booster) Dose of mRNA COVID-19 Vaccination**. Vaccines (Basel). 2022 Apr 8;10(4):575. doi: 10.3390/vaccines10040575. PMID: 35455324; PMCID: PMC9024648. https://pubmed.ncbi.nlm.nih.gov/35455324/

Lane S, Yeomans A, Shakir S. **Reports of myocarditis and pericarditis following mRNA COVID-19 vaccination: a systematic review of spontaneously reported data from the UK, Europe and the USA and of the scientific literature**. BMJ Open 2022;12:e059223. doi:10.1136/bmjopen-2021-059223 https://bmjopen.bmj.com/content/bmjopen/12/5/e059223.full.pdf

Chellapandian SB, Turkmen S, Salim I, Chinnakaruppan S, Mohammad J. **Myocarditis following COVID-19 mRNA (mRNA-1273) vaccination**. Clin Case Rep. 2022 Apr 18;10(4):e05741. doi: 10.1002/ccr3.5741. PMID: 35449778; PMCID: PMC9014704. https://pubmed.ncbi.nlm.nih.gov/35449778/

Power JR, Keyt LK, Adler ED. **Myocarditis following COVID-19 vaccination: incidence, mechanisms, and clinical considerations**. Expert Rev Cardiovasc Ther. 2022 Apr 18:1-11. doi: 10.1080/14779072.2022.2066522. Epub ahead of print. PMID: 35414326; PMCID: PMC9115793. https://pubmed.ncbi.nlm.nih.gov/35414326/

Power Paper:

> *Medical history has little influence on the risk-benefit profile of COVID-19 vaccination except in the case of prior myocarditis or pericarditis.*
>
> *A CDC analysis published in June 2021 determined that for every million males age 12–29 who underwent a 2-dose regimen of mRNA COVID-19 vaccine, "11,000 COVID-19 cases, 560 hospitalizations, 138 ICU admissions, and six deaths due to COVID-19 could be prevented, compared with 39–47 expected myocarditis cases after COVID-19 vaccination."" [105] This analysis was based on May 2021 rates of COVID-19 prevalence, morbidity, and mortality and served as the basis for CDC recommendations to vaccinate children age 12–15 [106]. In a more flexible risk-benefit model, Gurdasani et al. estimated that in children age 12– 17, the number of prevented COVID-related hospitalizations exceeds the incidence of mRNA vaccine-associated myocarditis as long as the incidence of COVID-19 is greater than 30/100,000 teenagers per week, a level unseen in England throughout 2021 [107].*

The fault in this analysis is that public health is attempting to treat the population as a whole "for the greater good" and by that philosophy willing to incur vaccine killed or injured cases; cases that may have managed fine from any injury from infection or even infection itself. These protective measures might improve statistical measures but can unnecessarily sacrifice individual health.

Holland DJ, Blazak PL, Martin J, Broom J, Poulter RS, Stanton T. **Myocarditis and Cardiac Complications Associated With COVID-19 and mRNA Vaccination: A Pragmatic Narrative Review to Guide Clinical Practice**. Heart Lung Circ. 2022 Apr 6:S1443-9506(22)00105-6. doi: 10.1016/j.hlc.2022.03.003. Epub ahead of print. PMID: 35398005; PMCID: PMC8984702. https://pubmed.ncbi.nlm.nih.gov/35398005/

Mancini N, Cortigiani L, Aquaro G, Bovenzi FM. **Raro caso di miocardite ed embolia polmonare dopo vaccino a mRNA BNT162b2 [A rare case of myocarditis and pulmonary embolism after BNT162b2 mRNA vaccine]**. G Ital Cardiol (Rome). 2022 Apr;23(4):244-246. Italian. doi: 10.1714/3766.37531. PMID: 35343473. https://pubmed.ncbi.nlm.nih.gov/35343473/

Puchalski M, Kamińska H, Bartoszek M, Brzewski M, Werner B. **COVID-19-Vaccination-Induced Myocarditis in Teenagers: Case Series with Further Follow-Up**. Int J Environ Res Public Health. 2022 Mar 15;19(6):3456. doi: 10.3390/ijerph19063456. PMID: 35329143; PMCID: PMC8954790. https://pubmed.ncbi.nlm.nih.gov/35329143/

Amir G, Rotstein A, Razon Y, Beyersdorf GB, Barak-Corren Y, Godfrey ME, Lakovsky Y, Yaeger-Yarom G, Yarden-Bilavsky H, Birk E. **CMR Imaging 6 Months After Myocarditis Associated with the BNT162b2 mRNA COVID-19 Vaccine**. Pediatr Cardiol. 2022 Mar 23:1–8. doi: 10.1007/s00246-022-02878-0. Epub ahead of print. PMID: 35320390; PMCID: PMC8941830. https://pubmed.ncbi.nlm.nih.gov/35320390/

Amir paper:

> *Late CMR follow up demonstrated resolution of the edema in all patients, while **some had evidence of residual myocardial scarring**.*

So I ask, residual myocardial scarring can be considered a 'mild' effect from vaccination? NO!!!

I'll add that the death of cardiocytes, ANY necrosis of cardiac muscle tissue, which subsequently results in replacement by non-contractile collagenic tissue constitutes PERMANENT diminished reduction in cardiac capacity.

- Reduced athletic ability
- Risk for future serious cardiac events including death
- Increased risk for LVD surgery, heart transplant later in life

Singh A, Nguyen L, Everest S, Afzal S, Shim A. **Acute Pericarditis Post mRNA-1273 COVID Vaccine Booster.** Cureus. 2022 Feb 12;14(2):e22148. doi: 10.7759/cureus.22148. PMID: 35308666; PMCID: PMC8919431. https://pubmed.ncbi.nlm.nih.gov/35308666/

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> *Because fatal cases occur at any age, no case should be dismissed as just having "benign myocarditis," especially if left ventricular ejection fraction is compromised and if it occurs in older female patients.*

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> *Results of this large cohort study indicated that both first and second doses of mRNA vaccines were associated with increased risk of myocarditis and pericarditis. For individuals receiving 2 doses of the same vaccine, risk of myocarditis was highest among young males (aged 16-24 years) after the second dose. These findings are compatible with between 4 and 7 excess events in 28 days per 100 000 vaccinees after BNT162b2, and between 9 and 28 excess events per 100 000 vaccinees after mRNA-1273. This risk should be balanced against the benefits of protecting against severe COVID-19 disease.*

The statement: *This risk should be balanced against the benefits of protecting against severe COVID-19 disease* seems to be a common statement in many of the papers where the findings reveal what appears to be significant risks of harms from the vaccines. Yet none of these studies cite any specific references that actually go to the trouble of a full fledged risk benefit analysis. This is irresponsible and neglectful reporting. Candy coating results and conclusions to get past the peer review and be published. Unethical and immoral.

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[39] The authors were NOT the moving party in this withdrawal of the paper. After the paper passed peer review, and was accepted, the publisher, Elsevier stopped publication with no cause or reason given.

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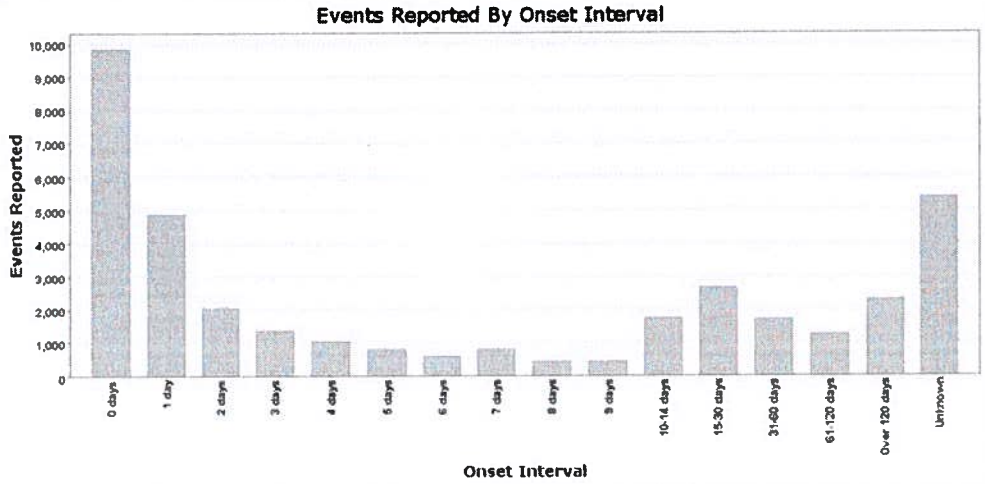
5.5.10 Cases of cardiomyopathies: 37,303; 55% within two days after injection

As mentioned earlier, myocarditis and pericarditis are not the only pathogenesis of the heart.

Query string:

ARRHYTHMIA; ARRHYTHMIA SUPRAVENTRICULAR; ARRHYTHMIC STORM; ARRHYTHMOGENIC RIGHT VENTRICULAR DYSPLASIA; ATRIAL FIBRILLATION; ATRIAL FLUTTER; ATRIAL TACHYCARDIA; CARDIAC ARREST;

CARDIAC DISORDER; CARDIAC DYSFUNCTION; CARDIAC FLUTTER; CARDIO-RESPIRATORY ARREST; CARDIO-RESPIRATORY DISTRESS; CARDIOMYOPATHY; CARDIOVASCULAR DISORDER; HEART INJURY; HEART RATE ABNORMAL; HEART RATE IRREGULAR; INFARCTION



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Nashashibi et al:

COMMENT

High degree AVB is an emergency cardiac manifestation that could occur secondary to ischemic heart disease, cardiomyopathies, medications, cardiac surgery, or infection. Our patient had no evidence of any cause known to be associated with high degree AVB; however, he had a COVID-19 vaccination two days prior to the development of his symptoms.

There are many reports in the literature of patients who developed different symptoms and signs following vaccination similar to those caused by the virus itself, like the classic example following influenza vaccination [4]. These symptoms and signs could develop during the first few days following the vaccination. The mechanism of these symptoms and signs is thought to be an immunologic reaction to a component of the vaccine [5]. It seems that the level of block in our case is infranodal.

Although the COVID-19 vaccine is produced using a different technology than the influenza vaccine, its clinical implementation has just started. Medical personnel should be aware of unusual manifestations following the vaccination that could lead to possible adverse effects, especially in a climate where hundreds of millions of people are expected to receive this type of vaccine.

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> Chida et al: *Here, we reported two cases of VADA that ruptured immediately after the administration of different mRNA antiCOVID-19 vaccines. In both cases, caliber irregularity of the VA was retrospectively identified on MRA before vaccination, suggesting that unruptured VA dissection had already*

developed. Then, these VADAs ruptured immediately after the vaccination.[40]

Jeet Kaur R, Dutta S, Charan J, Bhardwaj P, Tandon A, Yadav D, Islam S, Haque M. **Cardiovascular Adverse Events Reported from COVID-19 Vaccines: A Study Based on WHO Database**. Int J Gen Med. 2021 Jul 27;14:3909-3927. doi: 10.2147/IJGM.S324349. PMID: 34349544; PMCID: PMC8326931. https://pubmed.ncbi.nlm.nih.gov/34349544/

> ***Results**: For the cardiovascular system, 4863 adverse events (AEs) were reported from BNT162b2 Pfizer, 1222 AstraZeneca, Moderna, and other COVID-19 vaccines. Common adverse events observed with vaccines under study were tachycardia (16.41%), flushing (12.17%), hypertension (5.82%), hypotension (3.60%) and peripheral coldness (2.41%). Based on disproportionality analysis (IC025 values), acute myocardial infarction, cardiac arrest, and circulatory collapse were linked to the vaccines in the age group >75 years. Hypertension, severe hypertension, supraventricular tachycardia, sinus tachycardia, and palpitations were associated across all age groups and either gender. Amongst the investigations, abnormal ECG findings raised C-reactive protein, elevated D dimer, and troponin were reported in specific age groups or gender or all subjects.*
>
> ***Conclusion**: Although cardiovascular events have been reported with the COVID-19 vaccines, the causality is yet to be established because such CVS AEs are also usually associated with the general public even without intervention. Hence, people should be administered these vaccines, and sustained monitoring of these AEs should be done.*

OK – so then why didn't the researchers design their study with a control group? Junk Science

Sun CLF, Jaffe E, Levi R. **Increased emergency cardiovascular events among under-40 population in Israel during vaccine rollout and third COVID-19 wave**. Sci Rep. 2022 Apr 28;12(1):6978. doi: 10.1038/s41598-022-10928-z. PMID: 35484304; PMCID: PMC9048615. https://pubmed.ncbi.nlm.nih.gov/35484304/

The Sun paper is in a Nature Journal and was featured in the May 4-10 issue of the Epoch Times

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[40] Although this paper makes no reference to blood pressure in the case reports, see the high incidence of hypertension associated with COVID-19 vaccines in this report which appears to occur immediately after vaccination. Perhaps this was the trigger for aneurysm existing unruptured dissections.

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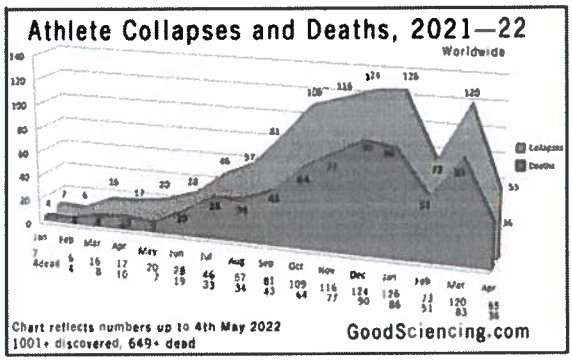
see also a list of athletes killed or injured by the vaccines:

Big List of Athletes After Jab



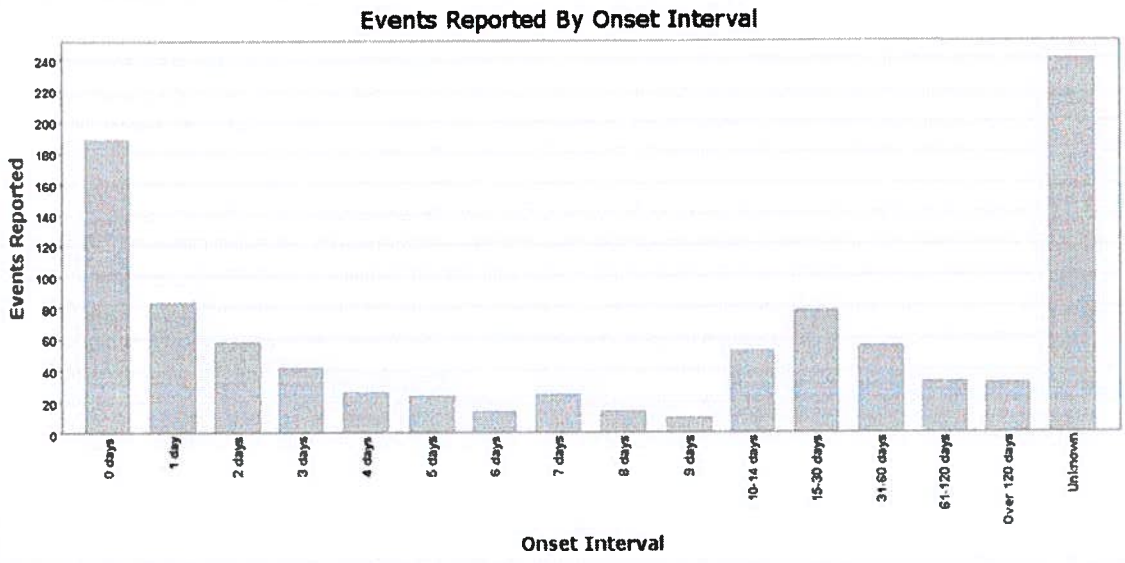
From: https://stevekirsch.substack.com/p/more-troubling-data-for-the-vaccine?s=r

5.5.11 Cases of myositis: 976; 34% within two days after injection

Myositis is a rare disease that involves inflammation of the muscles. This can present with a variety of symptoms such as skin involvement, muscle weakness, and other organ involvement. Systemic symptoms such as weight loss, fatigue, and low fever can also present.

Query string:

AUTOIMMUNE MYOSITIS; DERMATOMYOSITIS; FOCAL MYOSITIS; IMMUNE-MEDIATED MYOSITIS; LUPUS MYOSITIS; MYOSITIS; MYOSITIS OSSIFICANS; NECROTISING MYOSITIS; ORBITAL MYOSITIS; POLYMYOSITIS



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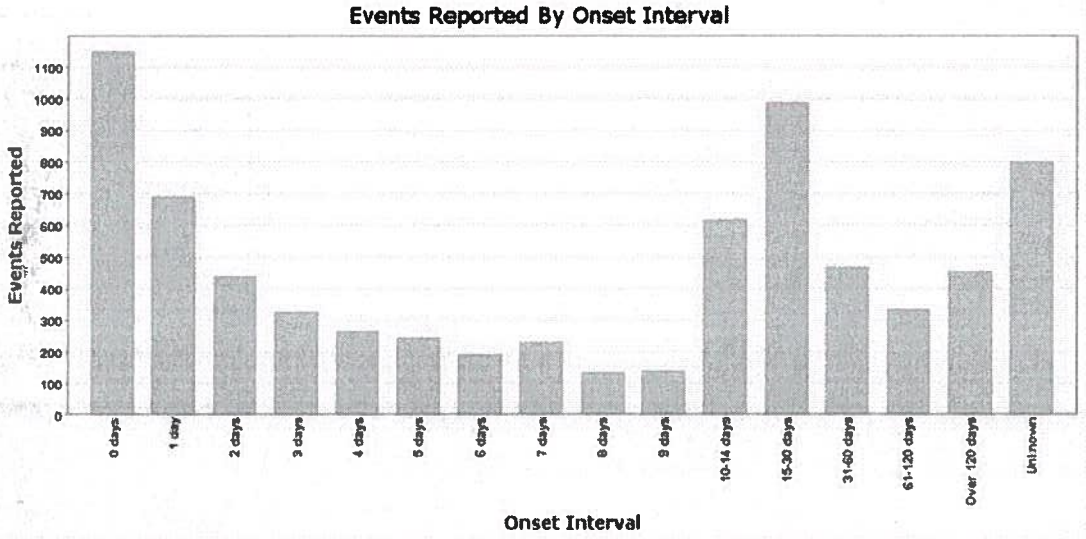
5.5.12 Cases of stroke or ischaemia: 7,456; 31% within two days after injection

Ischemia or ischaemia is a restriction in blood supply to any tissue, muscle group, or organ of the body, causing a shortage of oxygen that is needed for cellular metabolism. Ischemia is generally caused by problems with blood vessels, with resultant damage to or dysfunction of the related tissues. A stroke is a medical condition in which poor blood flow to the brain causes cell death. There are two main types of stroke: ischemic, due to lack of blood flow, and hemorrhagic, due to bleeding.

Query string:

BASAL GANGLIA STROKE; BRAIN STEM ISCHAEMIA; BRAIN STEM STROKE; CEREBELLAR ISCHAEMIA; CEREBELLAR STROKE; CEREBRAL ISCHAEMIA; CEREBRAL SMALL VESSEL ISCHAEMIC DISEASE; ECG SIGNS OF MYOCARDIAL ISCHAEMIA; EMBOLIC STROKE; GASTROINTESTINAL ISCHAEMIA; HAEMORRHAGIC STROKE; HAEMORRHAGIC TRANSFORMATION STROKE; HEPATIC ISCHAEMIA; INTESTINAL ISCHAEMIA; ISCHAEMIA; ISCHAEMIC STROKE; LACUNAR STROKE; MACULAR ISCHAEMIA; MYOCARDIAL ISCHAEMIA; NIH STROKE SCALE ABNORMAL; PERIPHERAL ISCHAEMIA; RENAL ISCHAEMIA; RETINAL ISCHAEMIA; SPINAL CORD ISCHAEMIA; SPINAL STROKE; SPLEEN ISCHAEMIA; SUBENDOCARDIAL ISCHAEMIA; THALAMIC STROKE; THROMBOTIC STROKE; TRANSIENT ISCHAEMIC ATTACK; VACCINATION SITE ISCHAEMIA; VESTIBULAR ISCHAEMIA



For the COVID-19 vaccines, most ischaemic or stroke events were life threatening as shown by % below

Messages:
- VAERS data in CDC WONDER are updated every Friday. Hence, results for the same query can change from week to week.
- These results are for 7,456 total events.

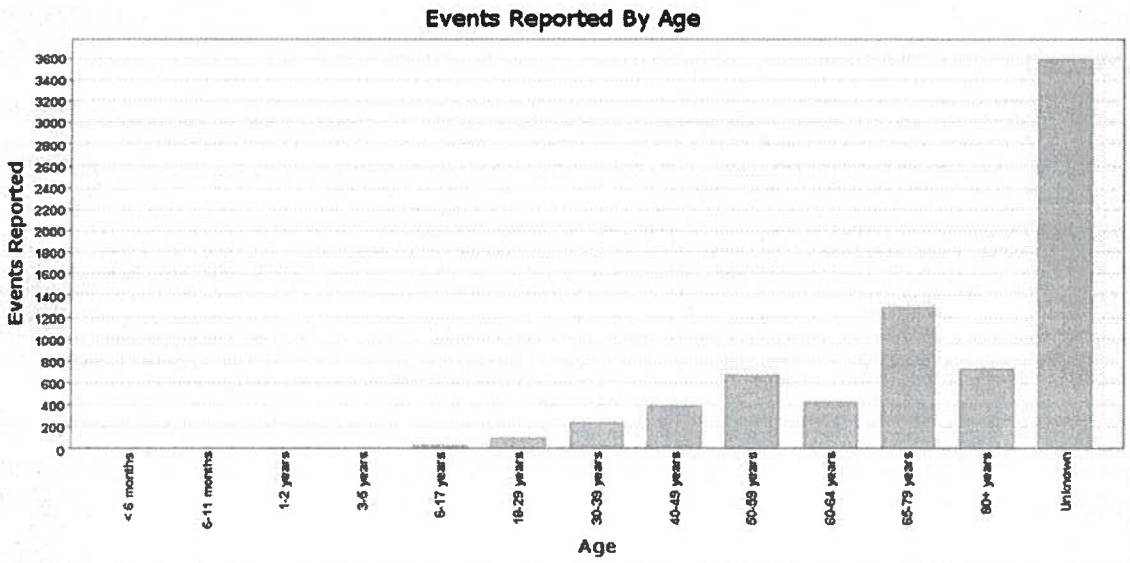
Symptoms	Events Reported	Percent (of 7,456)
TRANSIENT ISCHAEMIC ATTACK	2,661	35.69%
ISCHAEMIC STROKE	2,215	29.71%
CEREBRAL ISCHAEMIA	379	5.08%
HAEMORRHAGIC STROKE	344	4.61%
MYOCARDIAL ISCHAEMIA	343	4.60%
ISCHAEMIA	320	4.29%
EMBOLIC STROKE	247	3.31%
PERIPHERAL ISCHAEMIA	220	2.95%
INTESTINAL ISCHAEMIA	192	2.58%
CEREBRAL SMALL VESSEL ISCHAEMIC DISEASE	175	2.35%
CEREBELLAR STROKE	154	2.07%
LACUNAR STROKE	80	1.07%
BRAIN STEM STROKE	66	0.89%
THROMBOTIC STROKE	57	0.76%
HAEMORRHAGIC TRANSFORMATION STROKE	41	0.55%
BASAL GANGLIA STROKE	37	0.50%
RETINAL ISCHAEMIA	35	0.47%
SPINAL CORD ISCHAEMIA	22	0.30%
CEREBELLAR ISCHAEMIA	22	0.30%
BRAIN STEM ISCHAEMIA	19	0.25%
NIH STROKE SCALE ABNORMAL	12	0.16%
RENAL ISCHAEMIA	11	0.15%
SPINAL STROKE	9	0.12%

98% of all cases of stroke reported for all vaccines over all time are attributed to the COVID-19 vaccines

Messages:
- VAERS data in CDC WONDER are updated every Friday. Hence, results for the same query can change from week to week.
- These results are for 6,040 total events.
- Rows with zero Events Reported are hidden. Use Quick Options above to show zero rows.

Vaccine	Events Reported	Percent (of 6,040)
Total	6,437	106.57%
COVID19 (COVID19 (PFIZER-BIONTECH)) (1200)	4,264	70.60%
COVID19 (COVID19 (MODERNA)) (1201)	1,331	22.04%
COVID19 (COVID19 (JANSSEN)) (1203)	310	5.13%
VACCINE NOT SPECIFIED (NO BRAND NAME) (999)	143	2.37%
ZOSTER LIVE (ZOSTAVAX) (1097)	54	0.89%
INFLUENZA (SEASONAL) (NO BRAND NAME) (44)	32	0.53%
ZOSTER (SHINGRIX) (1192)	31	0.51%
COVID19 (COVID19 (UNKNOWN)) (1202)	22	0.36%
PNEUMO (PREVNAR13) (1141)	22	0.36%
INFLUENZA (SEASONAL) (FLUZONE) (7)	13	0.22%
PNEUMO (PNEUMOVAX) (30)	12	0.20%
HPV (GARDASIL) (1098)	11	0.18%
HEP A (HAVRIX) (268)	10	0.17%
COVID19 (COVID19 (PFIZER-BIONTECH BIVALENT)) (1211)	8	0.13%
INFLUENZA (SEASONAL) (FLUZONE HIGH-DOSE QUADRIVALENT) (1199)	8	0.13%
INFLUENZA (SEASONAL) (FLUVIRIN) (262)	8	0.13%
INFLUENZA (SEASONAL) (FLUZONE HIGH-DOSE) (1145)	7	0.12%
INFLUENZA (SEASONAL) (FLUAD) (1173)	7	0.12%
HPV (NO BRAND NAME) (1102)	6	0.10%
TDAP (ADACEL) (1092)	6	0.10%
INFLUENZA (SEASONAL) (FOREIGN) (1142)	5	0.08%
INFLUENZA (SEASONAL) (FLUARIX) (1089)	5	0.08%
PNEUMO (PREVNAR) (1001)	5	0.08%
TDAP (BOOSTRIX) (1091)	5	0.08%
DTAP (INFANRIX) (286)	4	0.07%
HEP B (ENGERIX-B) (38)	4	0.07%
HPV (CERVARIX) (1136)	4	0.07%
INFLUENZA (H1N1) (H1N1 (MONOVALENT) (UNKNOWN)) (1135)	4	0.07%
MEASLES + MUMPS + RUBELLA (MMR II) (26)	4	0.07%
PNEUMO (NO BRAND NAME) (120)	4	0.07%

For the COVID-19 vaccines, cases of stroke according to age:



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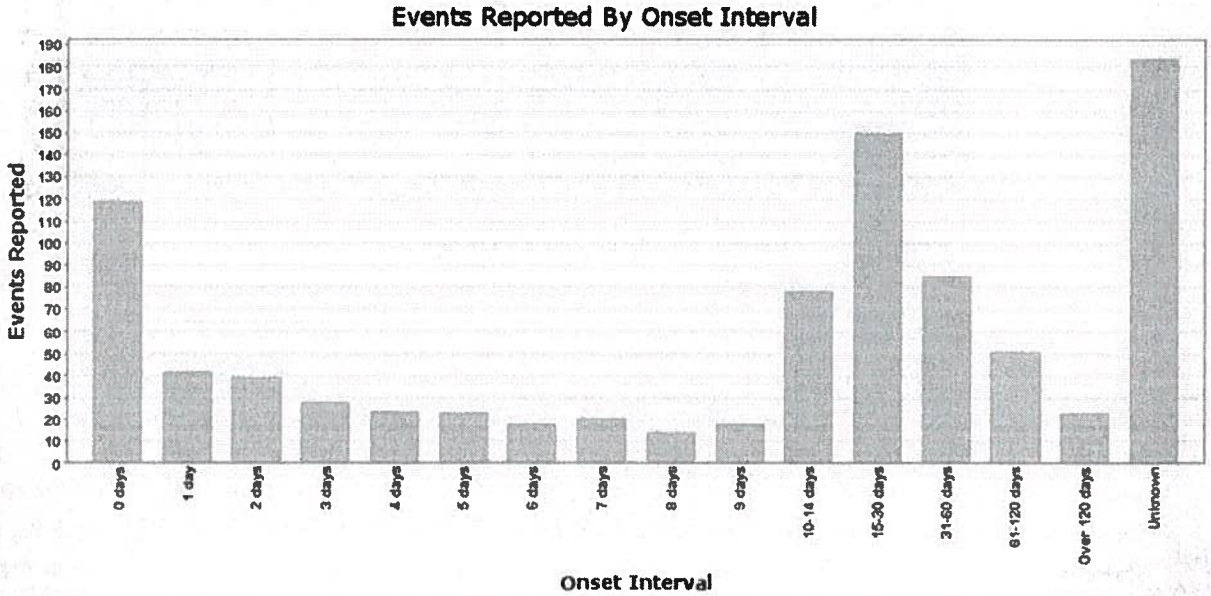
5.5.13 Cases of cerebral venous sinus thrombosis (CVST): 917; 38% within ten days after injection.

Cerebral venous sinus thrombosis, cerebral venous and sinus thrombosis or cerebral venous thrombosis, is the presence of a blood clot in the dural venous sinuses, the cerebral veins, or both. It's a very rare condition. So it does not take very many events to occur for it to be considered a 'signal' in vaccine vigilance. So far officials have not declared it an official signal other than a brief pause by the CDC of the use of the Janssen COVID-19 vaccine in the United States due to six cases of CVST that occurred 6 to 13 days after administration in April of 2021. But then again lifted the pause 10 days later after a safety review.



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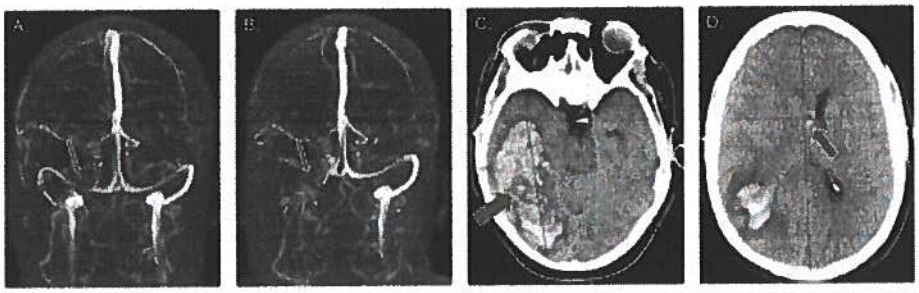

FIGURE 1: Selected relevant neuroimaging.

(A) MRV on hospital day four, revealing a non-obstructing thrombus at the junction of the right transverse and sigmoid sinuses (see arrow). (B) MRV on hospital day 10 with interval progression of the thrombus in the right transverse and sigmoid sinuses without flow (see arrow). (C) CT without contrast, showing a large occipital and temporal lobe intraparenchymal hematoma. (D) The different axial cut of the same CT without contrast shows 7 mm of midline shift (arrow) and intraventricular extension of the hematoma (arrow). MRV: magnetic resonance venogram; CT: computed tomography; mm: millimeters

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> In Kowarz et al: *In some rare cases, cerebral venous sinus thromboses (CVST) have been reported as a severe side effect occurring 4–14 days after the first vaccination and were often accompanied by thrombocytopenia. Besides CVST, splanchnic vein thromboses (SVT) and other thromboembolic events have been observed.* ***These events only occurred following vaccination with adenoviral vector-based vaccines*** *but not following vaccination with mRNA-based vaccines. Meanwhile, scientists have proposed an immune-based pathomechanism and the condition has been coined vaccine-induced immune thrombotic thrombocytopenia (VITT). Here, we describe an unexpected mechanism that could explain thromboembolic events occurring with DNA-based but not with RNA-based vaccines.* ***We show that DNA-encoded mRNA coding for Spike protein can be spliced in a way that the transmembrane anchor of Spike is lost, so that nearly full-length Spike is secreted from cells. Secreted Spike variants could potentially initiate severe side effects when binding to cells via the ACE2 receptor.***

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Cerebral Vein Thrombosis With Vaccine-Induced Immune Thrombotic Thrombocytopenia
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5.5.14 Cases of thrombocytopenia or purpura: 6,210; 41% within ten days after injection.

Thrombocytopenia is a condition characterized by abnormally low levels of platelets, also known as thrombocytes, in the blood. It is the most common coagulation disorder among intensive care patients and is seen in 20% of medical patients and a third of surgical patients. Thrombocytopenia has been determined by authorities to be an official 'signal' – a causal side effect of the COVID-19 vaccines.

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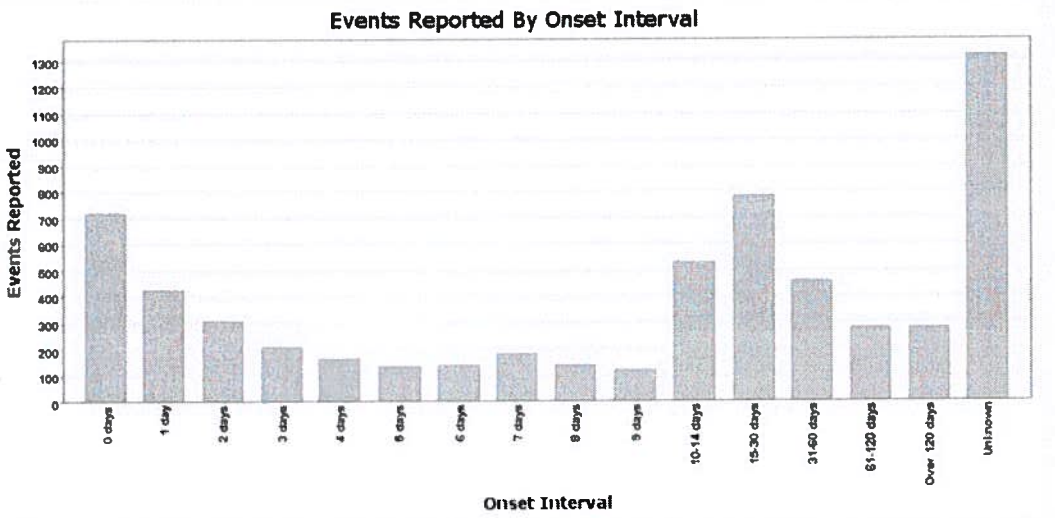

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In the abstract: "... the benefits of vaccination outweigh the risks" bu nowhere in Beltrami-Moreira's review do they justify that statement. *Just trust us, we are the experts*. It's common knowledge, right? Papers shrouded in fog and founded on a base of sand.

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Theodore E Warkentin, MD, BSc(Med), FRCP(C), FACP, FRCP(Edin)Adam Cuker, MD, MSSection Editor:Mark Crowther, MD, MScDeputy Editor:Jennifer S Tirnauer, MD **COVID-19: Vaccine-induced immune thrombotic thrombocytopenia (VITT)** UpToDate https://www.uptodate.com/contents/covid-19-vaccine-induced-immune-thrombotic-thrombocytopenia-vitt#!

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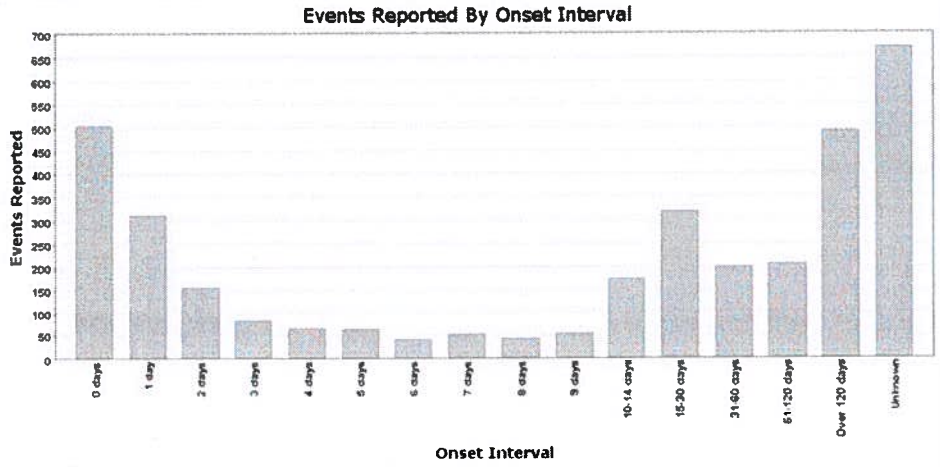
5.5.15 Cases of renal failure or disorder: 3,451; 29% within two days after injection.

Query string:

GLOMERULAR VASCULAR DISORDER; GLOMERULONEPHRITIS; GLOMERULONEPHRITIS ACUTE; GLOMERULONEPHRITIS CHRONIC; GLOMERULONEPHRITIS FOCAL; HAEMOLYTIC URAEMIC SYNDROME; KIDNEY ENLARGEMENT; NEPHRITIS; NEPHROPATHY; RENAL ARTERY OCCLUSION; RENAL ARTERY STENOSIS; RENAL ARTERY THROMBOSIS; RENAL ATROPHY; RENAL CORTICAL NECROSIS; RENAL DISORDER; RENAL EMBOLISM; RENAL FAILURE; RENAL FAILURE ACUTE; RENAL IMPAIRMENT; RENAL INFARCT; RENAL INJURY; RENAL ISCHAEMIA; RENAL NECROSIS; RENAL TUBULAR DISORDER; RENAL TUBULAR INJURY; RENAL TUBULAR NECROSIS; RENAL VASCULAR THROMBOSIS; RENAL VASCULITIS; RENAL VEIN EMBOLISM; RENAL VEIN OCCLUSION; RENAL VEIN THROMBOSIS; RENAL VENOUS CONGESTION; URETHRITIS



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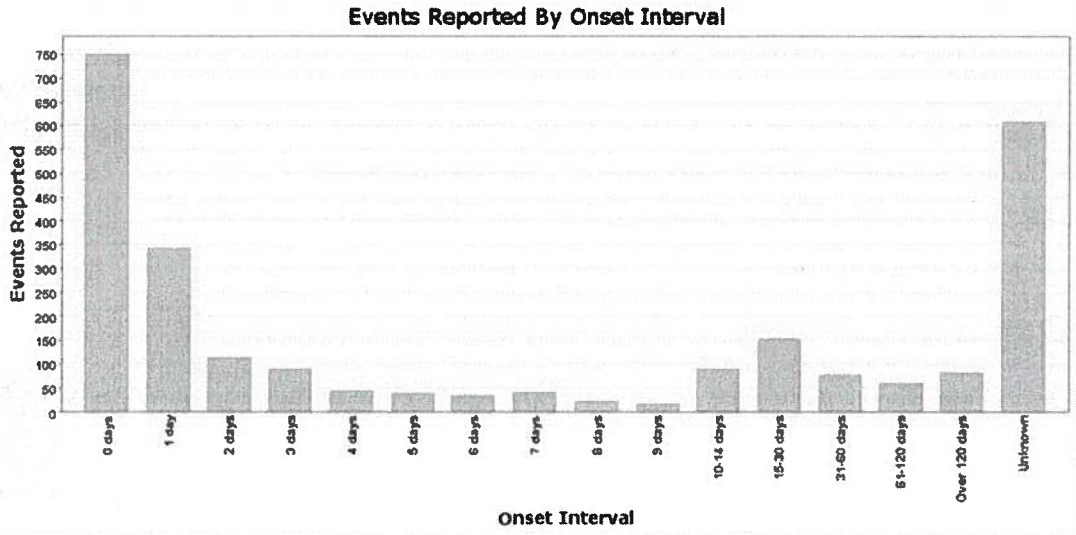
5.5.16 Cases of paralysis or catatonia: 2,564; 47% within two days after injection.

Catatonia is a complex neuropsychiatric behavioral syndrome that is characterized by abnormal movements, immobility, abnormal behaviors, and withdrawal. The onset of catatonia can be acute or subtle and symptoms can wax, wane, or change during episodes.

Query string:

ASCENDING FLACCID PARALYSIS; CATATONIA; PARALYSIS; PARALYSIS FLACCID; PERIPHERAL PARALYSIS; PHRENIC NERVE PARALYSIS; RESPIRATORY PARALYSIS



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> Note in the case presented by Kazi, not mentioned in the abstract, the patient had been vaccinated with Moderna COVID-19 vaccine 9 days before manifestation of adverse reactions. "*Our patient presented with psychosis about 23 days after receiving the COVID-19 vaccine and 21 days after the onset of other COVID-19 symptoms*"

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https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8599934/pdf/fneur-12-764197.pdf

5.5.17 Cases of zoster infection: 14,851, 48% within 10 days of injection

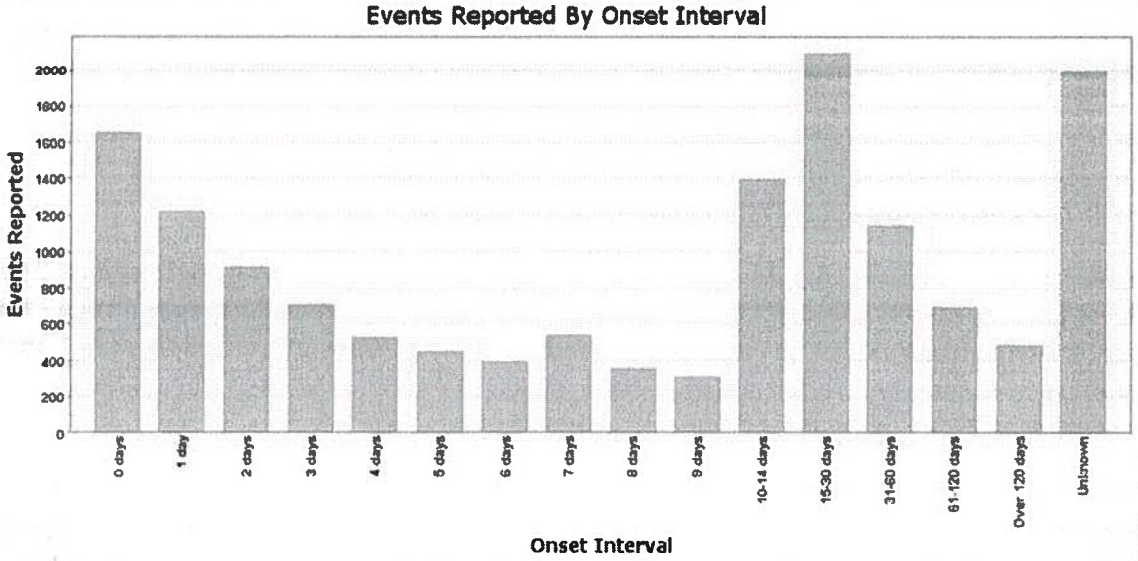
Herpes zoster, also known as shingles, is caused by the reactivation of the varicella-zoster virus (VZV), the same virus that causes varicella (chickenpox).

Primary infection with VZV causes varicella. Once the illness resolves, the virus remains latent in the dorsal root ganglia. VZV can reactive later in a person's life and cause a painful, maculopapular rash called herpes zoster.

There's still a question of whether COVID-19 vaccines are triggering shingles. The number of cases reported and strong temporal correlation tend to infer there is a connection.

Query:

GENITAL HERPES ZOSTER; HERPES ZOSTER; HERPES ZOSTER INFECTION NEUROLOGICAL; HERPES ZOSTER MENINGITIS; HERPES ZOSTER MENINGOENCEPHALITIS; HERPES ZOSTER MENINGOMYELITIS; HERPES ZOSTER MENINGORADICULITIS; HERPES ZOSTER MULTI-DERMATOMAL; HERPES ZOSTER NECROTISING RETINOPATHY; HERPES ZOSTER OPHTHALMIC; HERPES ZOSTER OTICUS; HERPES ZOSTER PHARYNGITIS; OPHTHALMIC HERPES ZOSTER; ORAL HERPES ZOSTER; VARICELLA VIRUS TEST POSITIVE; VARICELLA ZOSTER OESOPHAGITIS; VARICELLA ZOSTER PNEUMONIA; VARICELLA ZOSTER VIRUS INFECTION; VARICELLA ZOSTER VIRUS SEROLOGY POSITIVE



The following table shows a breakdown of the specific symptoms included in the query. These are mostly zoster herpes, so the return of varicella. The covid vaccines are triggering shingles.

Messages:

- VAERS data in CDC WONDER are updated every Friday. Hence, results for the same query can change from week to week.
- These results are for 14,851 total events.
- Rows with zero Events Reported are hidden. Use Quick Options above to show zero rows.

Symptoms	Events Reported	Percent (of 14,851)
HERPES ZOSTER	13,520	91.04%
OPHTHALMIC HERPES ZOSTER	960	6.46%
HERPES ZOSTER OTICUS	295	1.99%
VARICELLA ZOSTER VIRUS INFECTION	169	1.14%
VARICELLA VIRUS TEST POSITIVE	106	0.71%
HERPES ZOSTER MENINGITIS	66	0.44%
HERPES ZOSTER INFECTION NEUROLOGICAL	33	0.22%
HERPES ZOSTER MENINGOENCEPHALITIS	32	0.22%
GENITAL HERPES ZOSTER	22	0.15%
HERPES ZOSTER MENINGORADICULITIS	7	0.05%
ORAL HERPES ZOSTER	5	0.03%
HERPES ZOSTER PHARYNGITIS	4	0.03%
HERPES ZOSTER MENINGOMYELITIS	4	0.03%
VARICELLA ZOSTER PNEUMONIA	2	0.01%
VARICELLA ZOSTER OESOPHAGITIS	1	0.01%
HERPES ZOSTER NECROTISING RETINOPATHY	1	0.01%

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From Vallianou et al:

> ***Abstract***
>
> *Reactivation of varicella-zoster virus (VZV) has been reported after the administration of different vaccine platforms against SARS-CoV-2, also among individuals without known immunosuppressive states. Herein, we describe for the first time a case of herpes zoster after mRNA vaccination against SARS-CoV-2 in a 53-year-old immunocompetent adult without any known comorbidities, who was previously vaccinated with a live attenuated zoster vaccine.* ***The fact that the patient had no history of varicella and had been tested seronegative for VZV prior to immunization with the live attenuated zoster vaccine further contribute to the challenge of this unusual case****. This advocates for a high level of vigilance on the part of clinicians regarding this rare complication among receivers of COVID-19 vaccines.*

This is very troubling. They just do not know. With the COVID-19 experimental 'vaccines' they are unnecessarily putting people at risk for zoster infection and the serious complications that go along with that infection. What's more is that the labeling currently does not include the risk of contracting shingles. It's a definite signal in VAERS. The supplier of the COVID-19 vaccines have failed to provide proper informed consent and the FDA have failed to enforce that labeling.

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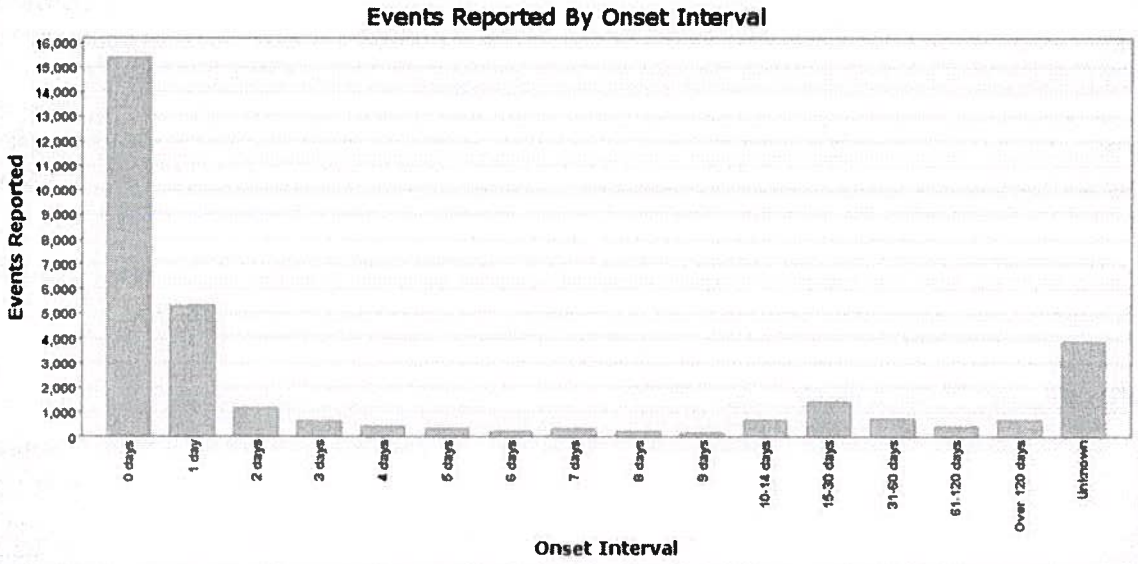
5.5.18 Cases of neurological pathologies: 32,225; 68% within 2 days of injection.

Next to direct thrombogenic harms, injuries to the nervous system rank second, but many of those injuries were predisposed by thrombogenesis that starved nerve cells of oxygen. There's no doubt many if not all the reports are caused by the vaccines by the large number of reports and the very high, often IMMEDIATE or near immediate temporal correlation.

Query string:

AKINESIA; ATAXIA; ATHETOSIS; ATONIC SEIZURES; BRADYKINESIA; BRADYPHRENIA; DYSKINESIA; DYSKINESIA OESOPHAGEAL; DYSMETRIA; DYSPHONIA; DYSTONIA; DYSTONIC TREMOR; HYPOKINESIA; MYOCLONUS; NEUROLOGICAL EXAMINATION ABNORMAL; NEUROLOGICAL SYMPTOM; SPASMODIC DYSPHONIA; TIC; TREMOR



The COVID-19 vaccines account for 55% of all neurological adverse events out of all vaccines for all time

Messages:

- VAERS data in CDC WONDER are updated every Friday. Hence, results for the same query can change from week to week.
- These results are for 59,370 total events.
- Rows with zero Events Reported are hidden. Use Quick Options above to show zero rows.

Vaccine	Events Reported	Percent (of 59,370)
COVID19 (COVID19 (PFIZER-BIONTECH)) (1200)	19,208	32.35%
COVID19 (COVID19 (MODERNA)) (1201)	10,764	18.13%
COVID19 (COVID19 (JANSSEN)) (1203)	2,933	4.94%
MEASLES + MUMPS + RUBELLA (MMR II) (26)	2,207	3.72%
HPV (GARDASIL) (1098)	1,953	3.29%
INFLUENZA (SEASONAL) (FLUZONE) (7)	1,782	3.00%
POLIO VIRUS, ORAL (ORIMUNE) (17)	1,499	2.52%
HEP B (ENGERIX-B) (38)	1,463	2.46%
ZOSTER (SHINGRIX) (1192)	1,435	2.42%
INFLUENZA (SEASONAL) (NO BRAND NAME) (44)	1,370	2.31%
PNEUMO (PNEUMOVAX) (30)	1,355	2.28%
PNEUMO (PREVNAR13) (1141)	1,228	2.07%
PNEUMO (PREVNAR) (1001)	1,202	2.02%
DTP (NO BRAND NAME) (2)	1,106	1.86%
VARICELLA (VARIVAX) (269)	1,046	1.76%
HEP B (RECOMBIVAX HB) (25)	999	1.68%
HIB (ACTHIB) (256)	910	1.53%
HIB (HIBTITER) (35)	873	1.47%
TD ADSORBED (NO BRAND NAME) (11)	827	1.39%
MENINGOCOCCAL CONJUGATE (MENACTRA) (1090)	813	1.37%
INFLUENZA (SEASONAL) (FLUZONE HIGH-DOSE) (1145)	799	1.35%
HEP A (HAVRIX) (268)	780	1.31%
VACCINE NOT SPECIFIED (NO BRAND NAME) (999)	769	1.30%
TDAP (ADACEL) (1092)	708	1.19%
DTAP (INFANRIX) (286)	684	1.15%

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It's almost amusing, Fasano in his lumped structure view of the world, categorizes people into three categories to analyze and determine a means to overcome the scourge of *misinformation* and *hesitancy*. She's hypnotized by a restricted set of narratives not realizing she herself is an agent of disinformation.

I was never an antivaxxer ... before covid. So which of Fasano's 3 categories do I fit into? If she were to look at her patients with kindness and compassion rather than a cold clinical categorization perhaps she might see the truth many of the pages this report expose. The Hippocratic Oath says "First do no harm". Think – or be damned.

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Conclusion: Safavi et al *"observational study suggests that a variety of neuropathic symptoms may manifest after SARS-CoV-2 vaccinations and in some patients might be an immune-mediated process."*

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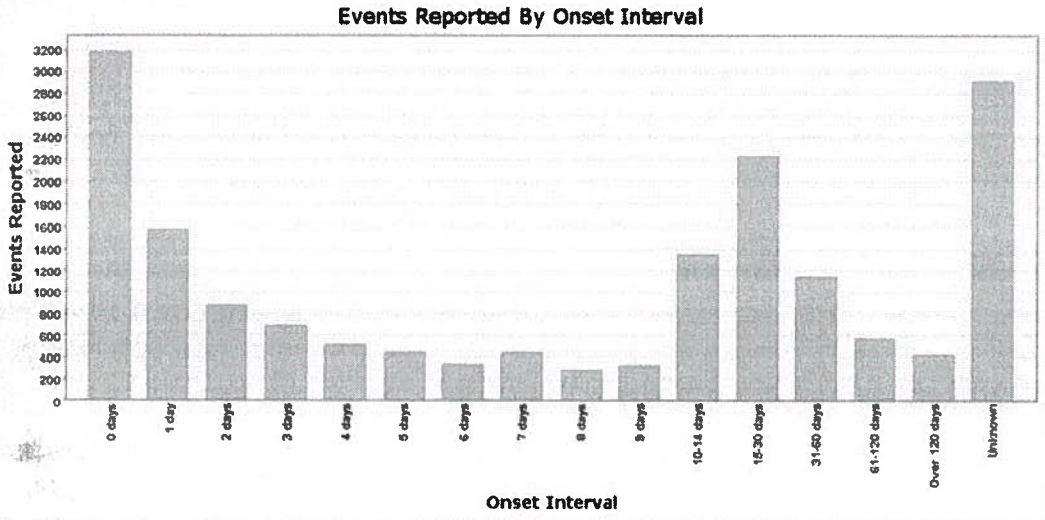
5.5.19 Cases of Guillain-Barré syndrome or Bell's Palsy: 17,354; 50% within 10 days after injection.

Guillain–Barré syndrome is a rapid-onset muscle weakness caused by the immune system damaging the peripheral nervous system. Typically, both sides of the body are involved, and the initial symptoms are changes in sensation or pain often in the back along with muscle weakness, beginning in the feet and hands, often spreading to the arms and upper body. Bell's palsy is a type of facial paralysis that results in a temporary inability to control the facial muscles on the affected side of the face. In most cases, the weakness is temporary and significantly improves over weeks. Symptoms can vary from mild to severe.

Query string:

BELL'S PALSY; FACIAL PALSY; FACIAL PARALYSIS; GUILLAIN-BARRE SYNDROME



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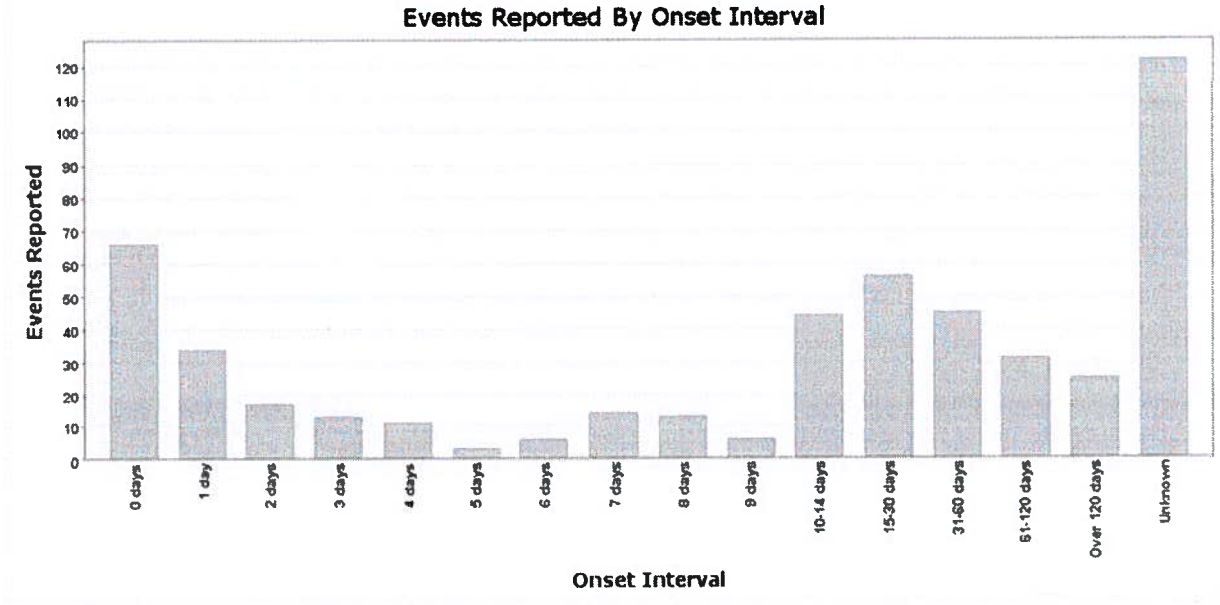
5.5.20 Cases of myasthenia gravis: 506; 23% within 2 days after injection

Myasthenia gravis is a long-term neuromuscular junction disease that leads to varying degrees of skeletal muscle weakness. The most commonly affected muscles are those of the eyes, face, and swallowing. It can result in double vision, drooping eyelids, trouble talking, and trouble walking.



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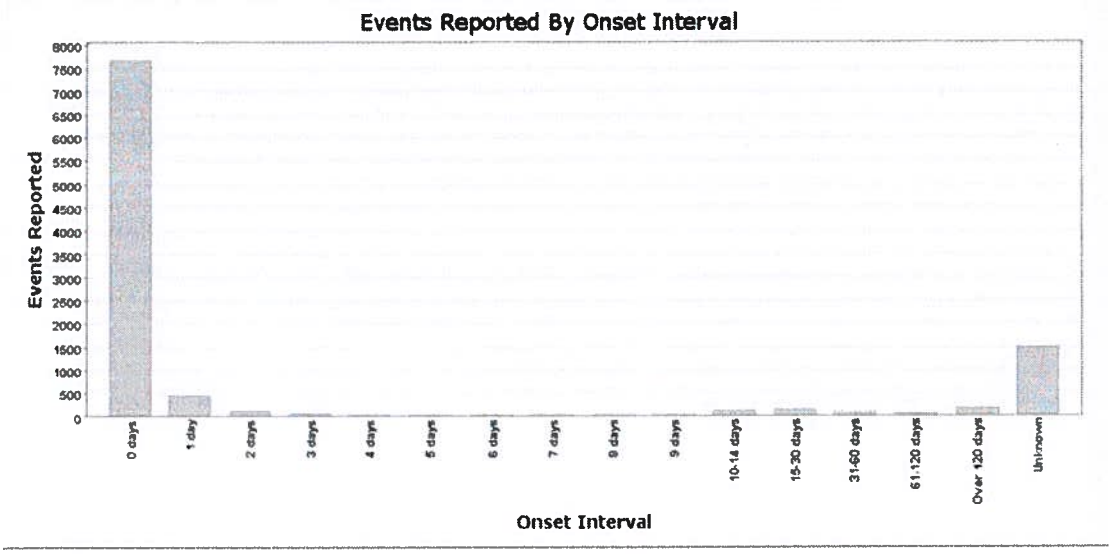
5.5.21 Cases of anaphylaxis: 10,583; 73% within same day of injection

Anaphylaxis is a serious, potentially fatal allergic reaction and medical emergency that is rapid in onset and requires immediate medical attention. Anaphylaxis causes the immune system to release a flood of chemicals that can cause shock — blood pressure drops suddenly and the airways narrow, blocking breathing.

Query string:

ANAPHYLACTIC REACTION; ANAPHYLACTIC SHOCK; ANAPHYLAXIS TREATMENT; SHOCK



The immediate or same day anaphylaxis or shock is so temporally close to the vaccination that it cannot be dismissed as a cause. Furthermore we can see that 73% of all adverse events of all vaccines over all time can be attributed to the COVID-19 vaccines.

Messages:

- VAERS data in CDC WONDER are updated every Friday. Hence, results for the same query can change from week to week.
- These results are for 14,686 total events.
- Rows with zero Events Reported are hidden. Use Quick Options above to show zero rows.

Vaccine ⇩	➡ Events Reported ⇧⇩	⬅ Percent (of 14,686) ⇧⇩
COVID19 (COVID19 (PFIZER-BIONTECH)) (1200)	8,132	55.37%
COVID19 (COVID19 (MODERNA)) (1201)	2,146	14.61%
COVID19 (COVID19 (JANSSEN)) (1203)	385	2.62%
MEASLES + MUMPS + RUBELLA (MMR II) (26)	341	2.32%
INFLUENZA (SEASONAL) (NO BRAND NAME) (44)	324	2.21%
PNEUMO (PNEUMOVAX) (30)	268	1.82%
HPV (GARDASIL) (1098)	231	1.57%
INFLUENZA (SEASONAL) (FLUZONE) (7)	216	1.47%
VACCINE NOT SPECIFIED (NO BRAND NAME) (999)	214	1.46%
PNEUMO (PREVNAR13) (1141)	200	1.36%
VARICELLA (VARIVAX) (269)	179	1.22%
HEP B (ENGERIX-B) (38)	172	1.17%
HIB (ACTHIB) (256)	171	1.16%
PNEUMO (PREVNAR) (1001)	131	0.89%
HPV (CERVARIX) (1136)	130	0.89%
ROTAVIRUS (ROTARIX) (1124)	129	0.88%
HEP A (HAVRIX) (268)	118	0.80%
POLIO VIRUS, INACT. (IPOL) (1030)	105	0.71%
HEP B (RECOMBIVAX HB) (25)	100	0.68%
HEP B (NO BRAND NAME) (110)	93	0.63%
TDAP (BOOSTRIX) (1091)	89	0.61%
DTAP (INFANRIX) (286)	85	0.58%
DTP (NO BRAND NAME) (2)	84	0.57%
POLIO VIRUS, ORAL (ORIMUNE) (17)	79	0.54%
ZOSTER (SHINGRIX) (1192)	74	0.50%

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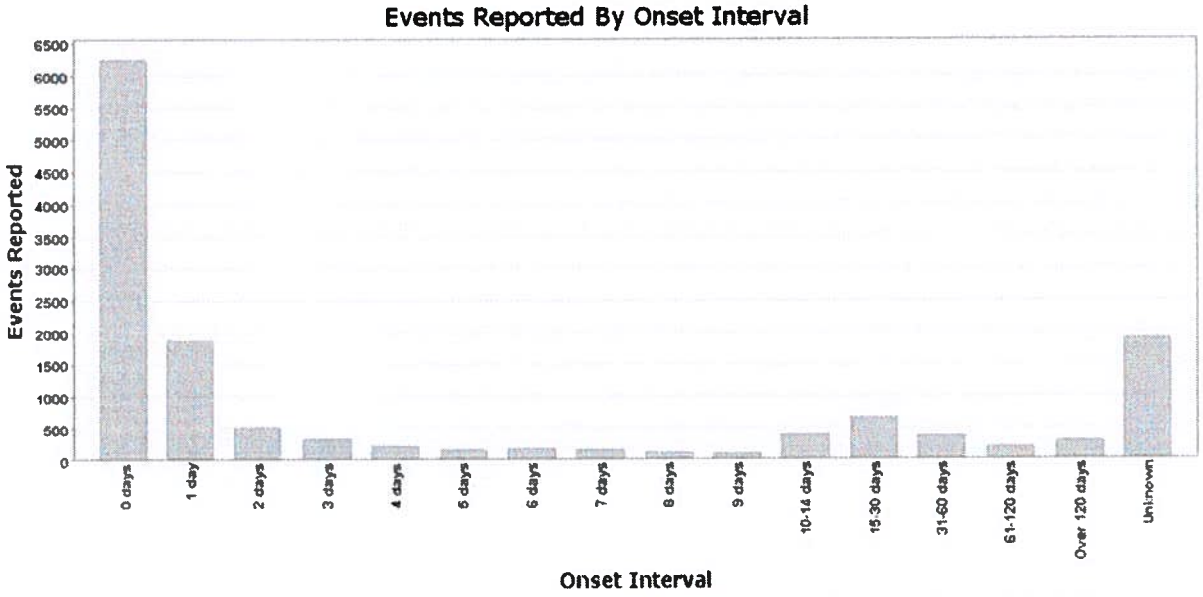
5.5.22 Cases of convulsions or seizure: 13,742 ; 59% within 1 day after injection.

A convulsion is a medical condition where the body muscles contract and relax rapidly and repeatedly, resulting in uncontrolled shaking. Because epileptic seizures typically include convulsions, the term convulsion is sometimes used as a synonym for seizure. The large number of reports and high to immediate temporal correlation are strong evidence inferring these events are being casused by the vaccines.

Query string:

ATONIC SEIZURES; AUTONOMIC SEIZURE; CLONIC CONVULSION; COMPLEX PARTIAL SEIZURES; CONVULSION; CONVULSIONS LOCAL; ENCEPHALITIS; FACIOBRACHIAL DYSTONIC SEIZURE; GELASTIC SEIZURE; GENERALISED ONSET NON-MOTOR SEIZURE; GENERALISED TONIC-CLONIC SEIZURE; GRAND MAL CONVULSION; PARTIAL SEIZURES; SEIZURE; SEIZURE ANOXIC; SEIZURE CLUSTER; SEIZURE LIKE PHENOMENA; SIMPLE PARTIAL SEIZURES; STATUS EPILEPTICUS; TONIC CONVULSION



Pfizer-BioNTech and Moderna COVID-19 vaccines account for more than one third of all adverse reactions involving convulsions or seizures out of all the vaccines for all time.

Messages:

- VAERS data in CDC WONDER are updated every Friday. Hence, results for the same query can change from week to week.
- These results are for 37,417 total events.
- Rows with zero Events Reported are hidden. Use Quick Options above to show zero rows.

Vaccine	Events Reported	Percent (of 37,417)
COVID19 (COVID19 (PFIZER-BIONTECH)) (1200)	9,275	24.79%
MEASLES + MUMPS + RUBELLA (MMR II) (26)	3,702	9.89%
COVID19 (COVID19 (MODERNA)) (1201)	3,565	9.53%
HPV (GARDASIL) (1098)	2,310	6.17%
POLIO VIRUS, ORAL (ORIMUNE) (17)	2,203	5.89%
PNEUMO (PREVNAR) (1001)	1,988	5.31%
PNEUMO (PREVNAR13) (1141)	1,930	5.16%
DTP (NO BRAND NAME) (2)	1,665	4.45%
HIB (ACTHIB) (256)	1,637	4.38%
HIB (HIBTITER) (35)	1,589	4.25%
VARICELLA (VARIVAX) (269)	1,576	4.21%
DTAP (INFANRIX) (286)	1,199	3.20%
COVID19 (COVID19 (JANSSEN)) (1203)	1,158	3.09%
HEP B (ENGERIX-B) (38)	1,139	3.04%
HEP B (RECOMBIVAX HB) (25)	1,024	2.74%
DTP (TRI-IMMUNOL) (22)	930	2.49%
HEP A (HAVRIX) (268)	920	2.46%
INFLUENZA (SEASONAL) (FLUZONE) (7)	859	2.30%
POLIO VIRUS, INACT. (IPOL) (1030)	826	2.21%
ROTAVIRUS (ROTATEQ) (1096)	819	2.19%
DTAP + HEPB + IPV (PEDIARIX) (1082)	752	2.01%
DTAP (TRIPEDIA) (242)	708	1.89%
MENINGOCOCCAL CONJUGATE (MENACTRA) (1090)	680	1.82%
HIB (PEDVAXHIB) (129)	670	1.79%

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Avasarala, et al E published in June, but will publish in the journal this November. Their abstract damns the covid vaccines:

> *The incidence of new-onset seizures, which we defined as* ***de novo seizures*** *occurring within 4 weeks of receiving any of the US Food and Drug Administration-approved COVID-19 vaccinations as reported in patient-reported data compiled in the US Centers for Disease Control and Prevention Vaccine Adverse Events Reporting System Data (CDC VAERS), has not been explored. The VAERS database contains de-identified patient-reported adverse events following vaccination and represents post-marketing surveillance and analysis of vaccine safety. After adjusting for time at risk, this resulted in estimated incidence rates of 3.19 seizures per 100 000 persons per year for the COVID-19 vaccine and 0.090 seizures per 100 000 persons per year for the influenza vaccines. A data-driven, individualized dataset that is comprehensive and coupled with a longitudinal follow-up in larger numbers of vaccinated individuals is needed to expand on our preliminary findings of vaccine-related seizures.*

.. so 35 times more likely to suffer a seizure from a covid-19 vaccine than from influenza vaccine.

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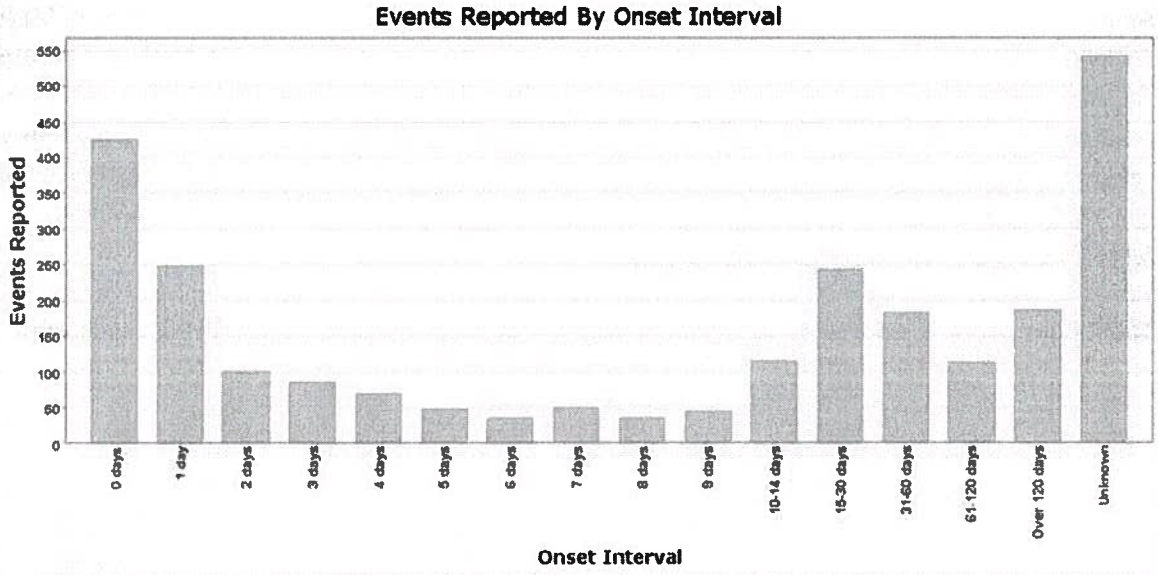
5.5.23 Cases of hepatitis failure or disorder: 2,533; 31% within 2 days after injection

Hepatitis is inflammation of the liver tissue.

Query string:

ACUTE HEPATIC FAILURE; ADENOVIRUS INFECTION; ADENOVIRUS TEST POSITIVE; AUTOIMMUNE HEPATITIS; DRUG-INDUCED LIVER INJURY; HEPATIC ADENOMA; HEPATIC ANGIOSARCOMA; HEPATIC ARTERY EMBOLISM; HEPATIC ARTERY THROMBOSIS; HEPATIC CANCER; HEPATIC CANCER RECURRENT; HEPATIC FAILURE; HEPATIC FIBROSIS; HEPATIC HAEMORRHAGE; HEPATIC HYPERTROPHY; HEPATIC INFARCTION; HEPATIC ISCHAEMIA; HEPATIC MASS; HEPATIC NECROSIS; HEPATIC NEOPLASM; HEPATIC NEOPLASM MALIGNANT; HEPATIC NEOPLASM MALIGNANT NON-RESECTABLE; HEPATIC PAIN; HEPATIC STEATOSIS; HEPATIC VASCULAR THROMBOSIS; HEPATIC VEIN OCCLUSION; HEPATIC VEIN THROMBOSIS; HEPATITIS; HEPATITIS FULMINANT; IMMUNE-MEDIATED HEPATIC DISORDER; IMMUNE-MEDIATED HEPATITIS; ISCHAEMIC HEPATITIS; LIVER DISORDER; LIVER INJURY; VENOOCCLUSIVE LIVER DISEASE



There are 4,133 adverse events of liver injury recorded for all vaccines over all time but the COVID-19 vaccines alone account for 2,692 of those events – that's over 65% of all injuries.

Messages:

- **VAERS data in CDC WONDER are updated every Friday. Hence, results for the same query can change from week to week.**
- **These results are for 4,133 total events.**
- **Rows with zero Events Reported are hidden. Use Quick Options above to show zero rows.**

Vaccine	Events Reported	Percent (of 4,133)
COVID19 (COVID19 (PFIZER-BIONTECH)) (1200)	1,867	45.17%
COVID19 (COVID19 (MODERNA)) (1201)	684	16.55%
HEP B (ENGERIX-B) (38)	288	6.97%
HEP B (RECOMBIVAX HB) (25)	181	4.38%
COVID19 (COVID19 (JANSSEN)) (1203)	141	3.41%
VACCINE NOT SPECIFIED (NO BRAND NAME) (999)	118	2.86%
HEP A (HAVRIX) (268)	104	2.52%
HEP A + HEP B (TWINRIX) (1009)	99	2.40%
HPV (GARDASIL) (1098)	81	1.96%
HEP B (NO BRAND NAME) (110)	74	1.79%
ROTAVIRUS (ROTARIX) (1124)	73	1.77%
MEASLES + MUMPS + RUBELLA (MMR II) (26)	69	1.67%
PNEUMO (PREVNAR13) (1141)	69	1.67%
INFLUENZA (SEASONAL) (NO BRAND NAME) (44)	66	1.60%
PNEUMO (PNEUMOVAX) (30)	53	1.28%
HIB (ACTHIB) (256)	50	1.21%
VARICELLA (VARIVAX) (269)	41	0.99%
PNEUMO (PREVNAR) (1001)	35	0.85%
HEP A (VAQTA) (280)	34	0.82%
ZOSTER (SHINGRIX) (1192)	29	0.70%
ROTAVIRUS (ROTATEQ) (1096)	28	0.68%
HEP A (NO BRAND NAME) (279)	23	0.56%
HEP B (FOREIGN) (24)	22	0.53%
INFLUENZA (SEASONAL) (FLUZONE) (7)	22	0.53%

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The Alhumaid paper ends with a very brief and, if you are a scientist, an unsatisfying conclusion:

> *Reported evidence of liver diseases post-COIVD-19 vaccination should not discourage vaccination against this worldwide pandemic. The number of reported cases is relatively very small in relation to the hundreds of millions of vaccinations that have occurred and the protective benefits offered by COVID-19 vaccination far outweigh the risks.*

When you you use relative risk you discount the importance of individuals that actually suffered a vaccine

injury. Give us NUMBERS. Yes background is important, but what is the onset interval, temporal correlation of this group to the vaccination event?

We didn't ask for a vaccine endorsement. This is supposed to be a scientific paper. But if anyone were to actually read the paper they'd see that the authors offer no formal risk-benefit analysis to arrive at these final conclusions. They chant the same mantra that gets them published: COVID-19 vaccine benefits ... "far outweigh the risks". BS.

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> *"So far, the cause of these cases is unknown and many hypotheses remain open, but hepatitis A-E viruses and COVID-19 vaccines have been ruled out."*

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The Boettler paper was featured in the May 4-10 issue of the Epoch Times

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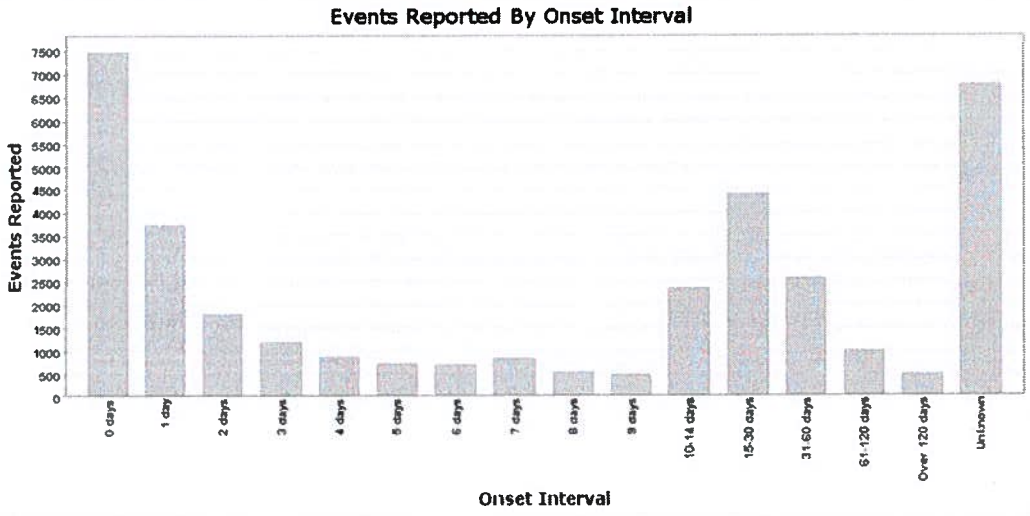
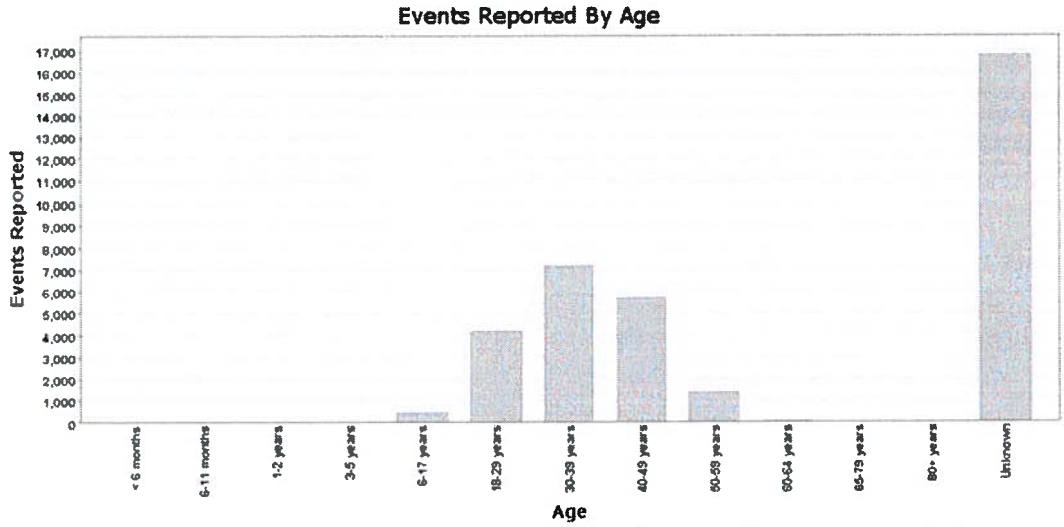
5.5.24 Cases of menstrual disorders: 35,895; 51% within ten days of injection

A decidual cast is a large piece of tissue that passes through the vaginal canal and has the shape of the uterus.

Query string:

ABNORMAL MENSTRUAL CLOTS; AMENORRHOEA; DECIDUAL CAST; DYSMENORRHOEA; HEAVY MENSTRUAL BLEEDING; INTERMENSTRUAL BLEEDING; MENOMETRORRHAGIA; MENORRHAGIA; MENSTRUAL DISORDER; MENSTRUATION DELAYED; MENSTRUATION IRREGULAR; METRORRHAGIA; OLIGOMENORRHOEA; POLYMENORRHOEA





A separate, focused query on **POST MENOPAUSAL HEMHORAGE** reveals 4,106 cases with the following temporal distribution of onset

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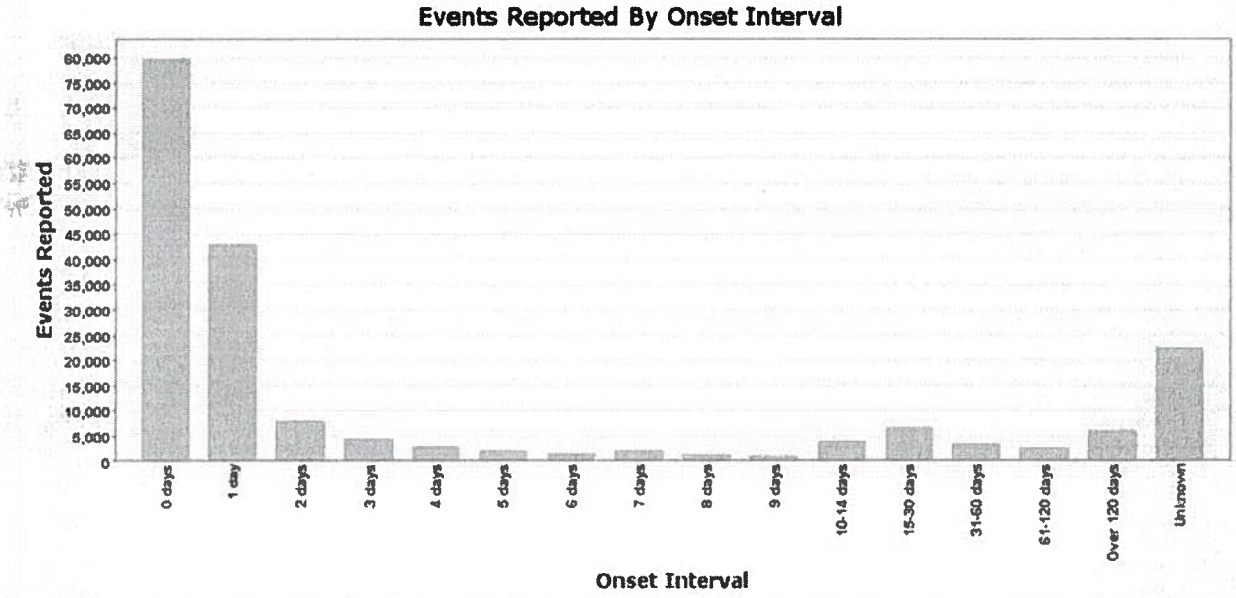
5.5.25 Cases of digestive system disorders: 190,429; 69% within two days of injection

Query string:

ABDOMINAL DISCOMFORT; ABDOMINAL DISTENSION; ABDOMINAL PAIN; ABDOMINAL PAIN LOWER; ABDOMINAL PAIN UPPER; ABDOMINAL RIGIDITY; ABDOMINAL SYMPTOM; ABDOMINAL TENDERNESS; DIARRHOEA; DIARRHOEA HAEMORRHAGIC; GALLBLADDER ENLARGEMENT; GALLBLADDER PAIN; GASTRIC DISORDER; GASTRIC MUCOSAL HYPERTROPHY; GASTRITIS; GASTRITIS HAEMORRHAGIC; GASTRODUODENITIS; GASTROINTESTINAL DISORDER; GASTROINTESTINAL HAEMORRHAGE; GASTROINTESTINAL INFLAMMATION; GASTROINTESTINAL ISCHAEMIA; GASTROINTESTINAL PAIN; NAUSEA; VOMITING



Prevalence over this set of symptoms mostly nausea, vomiting and diarrhea

Messages:
- VAERS data in CDC WONDER are updated every Friday. Hence, results for the same query can change from week to week.
- These results are for 190,429 total events.
- Rows with zero Events Reported are hidden. Use Quick Options above to show zero rows.

Symptoms	Events Reported	Percent (of 190,429)
NAUSEA	118,223	62.08%
VOMITING	51,164	26.87%
DIARRHOEA	41,431	21.76%
ABDOMINAL PAIN	16,173	8.49%
ABDOMINAL PAIN UPPER	14,600	7.67%
ABDOMINAL DISCOMFORT	8,489	4.46%
ABDOMINAL DISTENSION	3,235	1.70%
ABDOMINAL PAIN LOWER	1,882	0.99%
GASTROINTESTINAL DISORDER	1,575	0.83%
GASTROINTESTINAL PAIN	1,030	0.54%
GASTRITIS	667	0.35%
GASTROINTESTINAL HAEMORRHAGE	648	0.34%
DIARRHOEA HAEMORRHAGIC	503	0.26%
GASTRIC DISORDER	388	0.20%
ABDOMINAL TENDERNESS	233	0.12%
GASTROINTESTINAL INFLAMMATION	211	0.11%
ABDOMINAL RIGIDITY	154	0.08%
GALLBLADDER ENLARGEMENT	54	0.03%
ABDOMINAL SYMPTOM	36	0.02%
GASTRITIS HAEMORRHAGIC	3	0.00%
GASTRIC MUCOSAL HYPERTROPHY	1	0.00%
GASTROINTESTINAL ISCHAEMIA	1	0.00%

Comparing to all vaccines over all time, the COVID-19 vaccines alone account for almost 69% of gastrointestinal symptoms.

Messages:
- VAERS data in CDC WONDER are updated every Friday. Hence, results for the same query can change from week to week.
- These results are for 283,895 total events.
- Rows with zero Events Reported are hidden. Use Quick Options above to show zero rows.

Vaccine	Events Reported	Percent (of 283,895)
COVID19 (COVID19 (PFIZER-BIONTECH)) (1200)	112,517	39.63%
COVID19 (COVID19 (MODERNA)) (1201)	68,226	24.03%
COVID19 (COVID19 (JANSSEN)) (1203)	14,717	5.18%
ZOSTER (SHINGRIX) (1192)	9,090	3.20%
HPV (GARDASIL) (1098)	6,492	2.29%
MEASLES + MUMPS + RUBELLA (MMR II) (26)	5,672	2.00%
HEP B (ENGERIX-B) (38)	4,720	1.66%
ROTAVIRUS (ROTATEQ) (1096)	4,510	1.59%
PNEUMO (PNEUMOVAX) (30)	4,442	1.56%
PNEUMO (PREVNAR13) (1141)	4,430	1.56%
INFLUENZA (SEASONAL) (FLUZONE) (7)	4,071	1.43%
INFLUENZA (SEASONAL) (NO BRAND NAME) (44)	3,953	1.39%
VACCINE NOT SPECIFIED (NO BRAND NAME) (999)	3,473	1.22%
ROTAVIRUS (ROTARIX) (1124)	3,422	1.21%
VARICELLA (VARIVAX) (269)	3,357	1.18%
HEP B (RECOMBIVAX HB) (25)	3,285	1.16%
PNEUMO (PREVNAR) (1001)	3,217	1.13%
TDAP (ADACEL) (1092)	3,047	1.07%
MENINGOCOCCAL CONJUGATE (MENACTRA) (1090)	2,580	0.91%
HIB (ACTHIB) (256)	2,417	0.85%
HEP A (HAVRIX) (268)	2,396	0.84%
POLIO VIRUS, ORAL (ORIMUNE) (17)	2,326	0.82%
INFLUENZA (SEASONAL) (FLUZONE HIGH-DOSE) (1145)	1,919	0.68%

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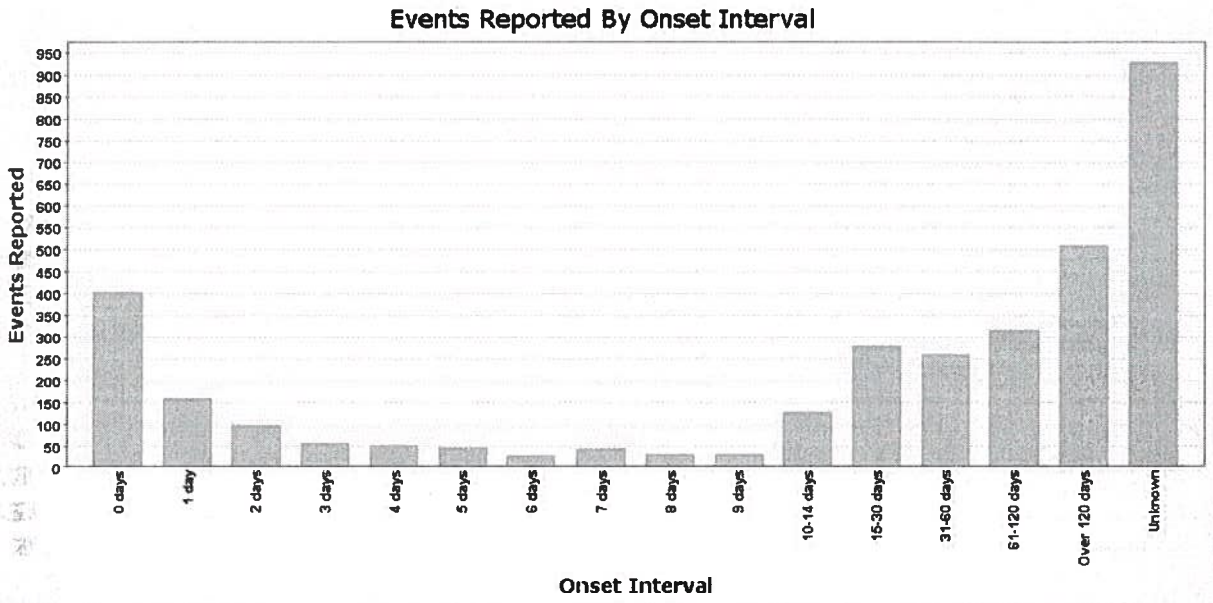
5.5.26 All cases of cancer: 3,350;

Query string:

ABDOMINAL NEOPLASM; ACINIC CELL CARCINOMA OF SALIVARY GLAND; ADENOCARCINOMA; ADENOCARCINOMA GASTRIC; ADENOCARCINOMA METASTATIC; ADENOCARCINOMA OF APPENDIX; ADENOCARCINOMA OF COLON; ADENOCARCINOMA OF THE CERVIX; ADENOCARCINOMA PANCREAS; ADENOID CYSTIC CARCINOMA; ADRENAL GLAND CANCER; ADRENAL GLAND CANCER METASTATIC; ALPHA TUMOUR NECROSIS FACTOR; ALPHA TUMOUR NECROSIS FACTOR INCREASED; ANAL CANCER; ANAL CANCER STAGE 0; ANAPLASTIC THYROID CANCER; APPENDIX CANCER; BASAL CELL CARCINOMA; BASOSQUAMOUS CARCINOMA; BILE DUCT CANCER; BLADDER CANCER; BLADDER CANCER RECURRENT; BLADDER NEOPLASM; BLADDER NEOPLASM SURGERY; BLADDER TRANSITIONAL CELL CARCINOMA; BLADDER TUMOUR ANTIGEN; BONE CANCER; BONE CANCER METASTATIC; BONE GIANT CELL TUMOUR; BONE GIANT CELL TUMOUR MALIGNANT; BONE NEOPLASM MALIGNANT; BORDERLINE OVARIAN TUMOUR; BRAIN NEOPLASM; BRAIN NEOPLASM MALIGNANT; BREAST CANCER; BREAST CANCER FEMALE; BREAST CANCER MALE; BREAST CANCER METASTATIC; BREAST CANCER RECURRENT; BREAST CANCER STAGE I; BREAST NEOPLASM;

BRONCHIAL CARCINOMA; BURKITT'S LYMPHOMA STAGE I; CARCINOID TUMOUR; CARCINOID TUMOUR OF THE GASTROINTESTINAL TRACT; CARCINOID TUMOUR PULMONARY; CERVIX CANCER METASTATIC; CERVIX CARCINOMA; CERVIX CARCINOMA RECURRENT; CERVIX CARCINOMA STAGE 0; CERVIX CARCINOMA STAGE I; CHOLANGIOCARCINOMA; CLEAR CELL RENAL CELL CARCINOMA; COLON CANCER; COLON CANCER METASTATIC; COLORECTAL ADENOCARCINOMA; COLORECTAL CANCER; COLORECTAL CANCER METASTATIC; CYSTADENOCARCINOMA PANCREAS; DUCTAL ADENOCARCINOMA OF PANCREAS; ENDOMETRIAL ADENOCARCINOMA; ENDOMETRIAL CANCER; ENDOMETRIAL CANCER STAGE I; EPIGLOTTIC CANCER; EXTRADURAL NEOPLASM; EYELID TUMOUR; FALLOPIAN TUBE CANCER; FALLOPIAN TUBE CANCER METASTATIC; GALLBLADDER ADENOCARCINOMA; GALLBLADDER CANCER; GALLBLADDER CANCER METASTATIC; GALLBLADDER NEOPLASM; GASTRIC CANCER; GASTRIC CANCER STAGE I; GASTROINTESTINAL ADENOCARCINOMA; GASTROINTESTINAL CANCER METASTATIC; GASTROINTESTINAL CARCINOMA; GASTROINTESTINAL STROMAL TUMOUR; GINGIVAL CANCER; GRANULAR CELL TUMOUR; HEAD AND NECK CANCER METASTATIC; HEPATIC CANCER; HEPATIC CANCER METASTATIC; HEPATIC CANCER RECURRENT; HEPATIC NEOPLASM; HEPATIC NEOPLASM MALIGNANT; HEPATIC NEOPLASM MALIGNANT NON-RESECTABLE; HEPATOCELLULAR CARCINOMA; HER2 POSITIVE BREAST CANCER; HUERTHLE CELL CARCINOMA; INFLAMMATORY CARCINOMA OF THE BREAST; INTESTINAL ADENOCARCINOMA; INVASIVE BREAST CARCINOMA; INVASIVE DUCTAL BREAST CARCINOMA; INVASIVE LOBULAR BREAST CARCINOMA; INVASIVE PAPILLARY BREAST CARCINOMA; KERATINISING SQUAMOUS CELL CARCINOMA OF NASOPHARYNX; KERATOACANTHOMA; LARGE CELL LUNG CANCER; LARYNGEAL CANCER; LIP AND/OR ORAL CAVITY CANCER; LIP AND/OR ORAL CAVITY CANCER RECURRENT; LUNG ADENOCARCINOMA; LUNG ADENOCARCINOMA METASTATIC; LUNG ADENOCARCINOMA RECURRENT; LUNG CARCINOMA CELL TYPE UNSPECIFIED RECURRENT; LUNG CARCINOMA CELL TYPE UNSPECIFIED STAGE 0; LUNG NEOPLASM MALIGNANT; LUNG SQUAMOUS CELL CARCINOMA STAGE IV; LYMPHANGIOSIS CARCINOMATOSA; LYMPHOMA; MALIGNANT PERITONEAL NEOPLASM; MEDULLARY THYROID CANCER; METASTATIC CARCINOID TUMOUR; METASTATIC LYMPHOMA; METASTATIC NEOPLASM; METASTATIC RENAL CELL CARCINOMA; METASTATIC SQUAMOUS CELL CARCINOMA; MUCINOUS ADENOCARCINOMA OF APPENDIX; MUCINOUS BREAST CARCINOMA; NASAL CAVITY CANCER; NASOPHARYNGEAL CANCER; NASOPHARYNGEAL CANCER METASTATIC; NASOPHARYNGEAL TUMOUR; NEOPLASM; NEOPLASM MALIGNANT; NEOPLASM PROGRESSION; NEOPLASM SKIN; NEPHROBLASTOMA; NEUROENDOCRINE CARCINOMA; NEUROENDOCRINE CARCINOMA METASTATIC; NEUROENDOCRINE CARCINOMA OF THE SKIN; NEUROENDOCRINE TUMOUR; NEUROENDOCRINE TUMOUR OF THE RECTUM; NON-SMALL CELL LUNG CANCER; NON-SMALL CELL LUNG CANCER METASTATIC; OESOPHAGEAL ADENOCARCINOMA; OESOPHAGEAL CANCER METASTATIC; OESOPHAGEAL CARCINOMA; OESOPHAGEAL SQUAMOUS CELL CARCINOMA; OROPHARYNGEAL SQUAMOUS CELL CARCINOMA; OVARIAN CANCER; OVARIAN CANCER METASTATIC; OVARIAN CANCER RECURRENT; OVARIAN CLEAR CELL CARCINOMA; OVARIAN EPITHELIAL CANCER; OVARIAN GERM CELL CANCER; OVARIAN GERM CELL TUMOUR; OVARIAN GRANULOSA CELL TUMOUR; PANCREATIC CARCINOMA; PANCREATIC CARCINOMA METASTATIC; PAPILLARY CYSTADENOMA LYMPHOMATOSUM; PAPILLARY RENAL CELL CARCINOMA; PAPILLARY THYROID CANCER; PARAGANGLION NEOPLASM; PARATHYROID TUMOUR; PELVIC NEOPLASM; PILOMATRIX CARCINOMA; PITUITARY CANCER METASTATIC; PITUITARY TUMOUR; PROSTATE CANCER; PROSTATE CANCER RECURRENT; PROSTATE CANCER STAGE I; RECTAL ADENOCARCINOMA; RECTAL CANCER; RECTAL CANCER METASTATIC; RECTOSIGMOID CANCER; RECURRENT CANCER; RENAL CANCER; RENAL CANCER METASTATIC; RENAL CANCER RECURRENT; RENAL CELL CARCINOMA; RENAL CELL CARCINOMA RECURRENT; RENAL CELL CARCINOMA STAGE UNSPECIFIED; RENAL NEOPLASM; RETROPERITONEAL CANCER; RHABDOID TUMOUR; SALIVARY GLAND CANCER; SALIVARY GLAND NEOPLASM; SCROTAL CANCER; SKIN CANCER; SKIN NEOPLASM EXCISION; SKIN SQUAMOUS CELL CARCINOMA METASTATIC; SMALL CELL CARCINOMA; SMALL CELL LUNG CANCER; SMALL CELL LUNG CANCER METASTATIC; SMALL INTESTINE ADENOCARCINOMA; SMALL INTESTINE CARCINOMA; SOFT TISSUE SARCOMA; SQUAMOUS CELL CARCINOMA; SQUAMOUS CELL CARCINOMA OF

HEAD AND NECK; SQUAMOUS CELL CARCINOMA OF LUNG; SQUAMOUS CELL CARCINOMA OF PHARYNX; SQUAMOUS CELL CARCINOMA OF SKIN; SQUAMOUS CELL CARCINOMA OF THE CERVIX; SQUAMOUS CELL CARCINOMA OF THE ORAL CAVITY; SQUAMOUS CELL CARCINOMA OF THE TONGUE; TESTICULAR GERM CELL CANCER; TESTICULAR GERM CELL TUMOUR; TESTIS CANCER; THROAT CANCER; THYROID CANCER; THYROID CANCER METASTATIC; THYROID CANCER RECURRENT; THYROID CANCER STAGE 0; THYROID GLAND CANCER; THYROID NEOPLASM; TONGUE CANCER METASTATIC; TONGUE CANCER RECURRENT; TONGUE NEOPLASM MALIGNANT STAGE UNSPECIFIED; TONSIL CANCER METASTATIC; TRACHEAL CANCER; TRANSITIONAL CELL CARCINOMA; TRANSITIONAL CELL CARCINOMA METASTATIC; TRANSITIONAL CELL CARCINOMA URETHRA; TRIPLE POSITIVE BREAST CANCER; TUBULAR BREAST CARCINOMA; URETERIC CANCER; UTERINE CANCER; VAGINAL CANCER; VAGINAL CANCER RECURRENT; VAGINAL CANCER STAGE 0; VULVAL CANCER; VULVAL CANCER METASTATIC; VULVAL CANCER STAGE 0



Of all cancers reported to VAERS for all vaccines over all time, COVID-19 vaccines account for almost 77% of reports. But this may be due to the sheer number of vaccinations.

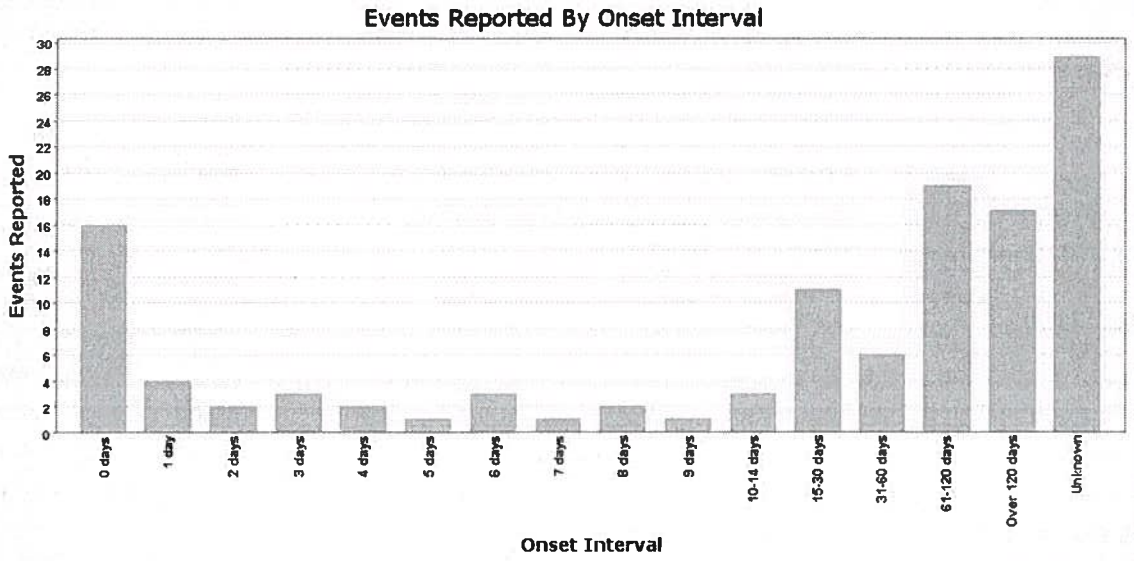
Messages:
- VAERS data in CDC WONDER are updated every Friday. Hence, results for the same query can change from week to week.
- These results are for 4,692 total events.
- Rows with zero Events Reported are hidden. Use Quick Options above to show zero rows.

Vaccine	Events Reported	Percent (of 4,692)
COVID19 (COVID19 (PFIZER-BIONTECH)) (1200)	2,554	54.43%
COVID19 (COVID19 (MODERNA)) (1201)	901	19.20%
HPV (GARDASIL) (1098)	293	6.24%
VACCINE NOT SPECIFIED (NO BRAND NAME) (999)	142	3.03%
COVID19 (COVID19 (JANSSEN)) (1203)	137	2.92%
ZOSTER (SHINGRIX) (1192)	130	2.77%
INFLUENZA (SEASONAL) (NO BRAND NAME) (44)	91	1.94%
ZOSTER LIVE (ZOSTAVAX) (1097)	84	1.79%
PNEUMO (PNEUMOVAX) (30)	74	1.58%
HEP B (ENGERIX-B) (38)	66	1.41%
HPV (GARDASIL 9) (1170)	56	1.19%
HPV (NO BRAND NAME) (1102)	52	1.11%
HPV (CERVARIX) (1136)	51	1.09%
MEASLES + MUMPS + RUBELLA (MMR II) (26)	42	0.90%
POLIO VIRUS, ORAL (ORIMUNE) (17)	38	0.81%
PNEUMO (PREVNAR13) (1141)	37	0.79%
HEP B (NO BRAND NAME) (110)	33	0.70%
HEP B (RECOMBIVAX HB) (25)	32	0.68%
COVID19 (COVID19 (UNKNOWN)) (1202)	26	0.55%
HEP A + HEP B (TWINRIX) (1009)	25	0.53%
INFLUENZA (SEASONAL) (FLUZONE) (7)	24	0.51%
VARICELLA (VARIVAX) (269)	24	0.51%
PNEUMO (PREVNAR) (1001)	18	0.38%
HEP A (HAVRIX) (268)	16	0.34%
PNEUMO (NO BRAND NAME) (120)	16	0.34%
HIB (ACTHIB) (256)	15	0.32%
INFLUENZA (SEASONAL) (FLUARIX) (1089)	15	0.32%
POLIO VIRUS, INACT. (NO BRAND NAME) (232)	15	0.32%

If the query is restricted to recurrent cancer reports, they number 120.

Query string:

ACUTE LYMPHOCYTIC LEUKAEMIA RECURRENT; ACUTE MYELOID LEUKAEMIA RECURRENT; ANGIOIMMUNOBLASTIC T-CELL LYMPHOMA RECURRENT; B-CELL LYMPHOMA RECURRENT; BLADDER CANCER RECURRENT; BREAST CANCER RECURRENT; CHRONIC LYMPHOCYTIC LEUKAEMIA RECURRENT; CHRONIC MYELOID LEUKAEMIA RECURRENT; DIFFUSE LARGE B-CELL LYMPHOMA RECURRENT; HEPATIC CANCER RECURRENT; LEUKAEMIA RECURRENT; LIP AND/OR ORAL CAVITY CANCER RECURRENT; LUNG ADENOCARCINOMA RECURRENT; LUNG CARCINOMA CELL TYPE UNSPECIFIED RECURRENT; MANTLE CELL LYMPHOMA RECURRENT; MELANOMA RECURRENT; NON-HODGKIN'S LYMPHOMA RECURRENT; OVARIAN CANCER RECURRENT; PROSTATE CANCER RECURRENT; RECURRENT CANCER; RECURRENT SUBAREOLAR BREAST ABSCESS; RENAL CANCER RECURRENT; RENAL CELL CARCINOMA RECURRENT; T-CELL LYMPHOMA RECURRENT; THYROID CANCER RECURRENT; TONGUE CANCER RECURRENT; VAGINAL CANCER RECURRENT



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Conclusions

So far publications other than in-vitro studies do not address even the possibility that recurrent cancers might connect in vaccinated persons that subsequently repond with suppressed immune systems. Since most cancers respond with a significant delay from the 'trigger', it may take years to determine any connection to the vaccines, if ever. In-vitro studies can only set the foundation of plausibility for further study. The question that needs to be answered:

How could pharma and regulators in haste, release such a drug (it is not a vaccine) for public consumption at large without establishing a sufficient body of carcinogenicity, mutagenicity and genotoxicity data?

The danger or threat from COVID-19 infection (according to latest figures) just does not seem to warrant a hasty release. Show me a rigorous risk-benefit analysis [My opinion]

5.5.27 Cases of breathing compromised: 94,309; 54% within two days of injection

Query string:

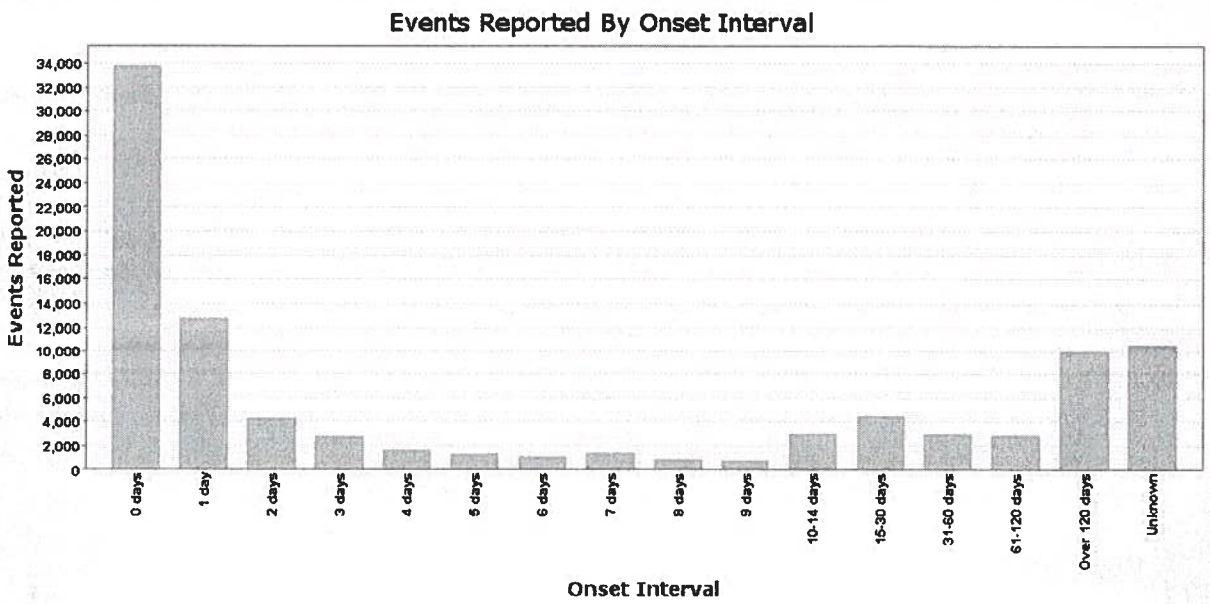
ASTHMA; ASTHMATIC CRISIS; DYSPNOEA; HYPOPNOEA; HYPOVENTILATION; HYPOXIA; RESPIRATORY ARREST; STATUS ASTHMATICUS; WHEEZING

Prevalence of symptoms show more than 90% of these cases was shortness of breath, but 5% leading to hpoxia; a life threatening situation.

Messages:
- VAERS data in CDC WONDER are updated every Friday. Hence, results for the same query can change from week to week.
- These results are for 94,309 total events.

Symptoms	Events Reported	Percent (of 94,309)
DYSPNOEA	85,370	90.52%
WHEEZING	5,040	5.34%
HYPOXIA	4,494	4.77%
ASTHMA	4,165	4.42%
HYPOPNOEA	899	0.95%
RESPIRATORY ARREST	798	0.85%
ASTHMATIC CRISIS	307	0.33%
HYPOVENTILATION	130	0.14%
STATUS ASTHMATICUS	16	0.02%

The onset of symptoms show more than a third of the reports were immediate or on the same day as vaccination.



Comparing to all vaccines over all time, the COVID-19 vaccines account for over 80% of cases reported.

Messages:

- VAERS data in CDC WONDER are updated every Friday. Hence, results for the same query can change from week to week.
- These results are for 125,070 total events.
- Rows with zero Events Reported are hidden. Use Quick Options above to show zero rows.

Vaccine	Events Reported	Percent (of 125,070)
COVID19 (COVID19 (PFIZER-BIONTECH)) (1200)	63,603	50.85%
COVID19 (COVID19 (MODERNA)) (1201)	30,507	24.39%
COVID19 (COVID19 (JANSSEN)) (1203)	6,426	5.14%
INFLUENZA (SEASONAL) (FLUZONE) (7)	2,615	2.09%
MEASLES + MUMPS + RUBELLA (MMR II) (26)	2,169	1.73%
INFLUENZA (SEASONAL) (NO BRAND NAME) (44)	2,032	1.62%
PNEUMO (PNEUMOVAX) (30)	1,769	1.41%
HPV (GARDASIL) (1098)	1,720	1.38%
VACCINE NOT SPECIFIED (NO BRAND NAME) (999)	1,647	1.32%
HEP B (ENGERIX-B) (38)	1,527	1.22%
PNEUMO (PREVNAR13) (1141)	1,415	1.13%
VARICELLA (VARIVAX) (269)	1,370	1.10%
PNEUMO (PREVNAR) (1001)	1,040	0.83%
HEP B (RECOMBIVAX HB) (25)	1,022	0.82%
ZOSTER (SHINGRIX) (1192)	895	0.72%
INFLUENZA (SEASONAL) (FLUVIRIN) (262)	873	0.70%
POLIO VIRUS, ORAL (ORIMUNE) (17)	856	0.68%
TDAP (ADACEL) (1092)	771	0.62%
INFLUENZA (SEASONAL) (FLUZONE HIGH-DOSE) (1145)	739	0.59%
HEP A (HAVRIX) (268)	715	0.57%
HIB (ACTHIB) (256)	701	0.56%
POLIO VIRUS, INACT. (IPOL) (1030)	649	0.52%
MENINGOCOCCAL CONJUGATE (MENACTRA) (1090)	634	0.51%
DTAP (INFANRIX) (286)	612	0.49%
DTP (NO BRAND NAME) (2)	606	0.48%
TDAP (BOOSTRIX) (1091)	569	0.45%
ROTAVIRUS (ROTATEQ) (1096)	547	0.44%
HIB (HIBTITER) (35)	526	0.42%

Citations:

Marta Colaneri, Maria De Filippo, Amelia Licari, Alessia Marseglia, Laura Maiocchi, Alessandra Ricciardi, Angelo Corsico, Gianluigi Marseglia, Mario Umberto Mondelli, Raffaele Bruno, **COVID vaccination and asthma exacerbation: might there be a link?**, International Journal of Infectious Diseases, Volume 112,

2021, Pages 243-246, ISSN 1201-9712, https://doi.org/10.1016/j.ijid.2021.09.026, https://www.sciencedirect.com/science/article/pii/S1201971221007335

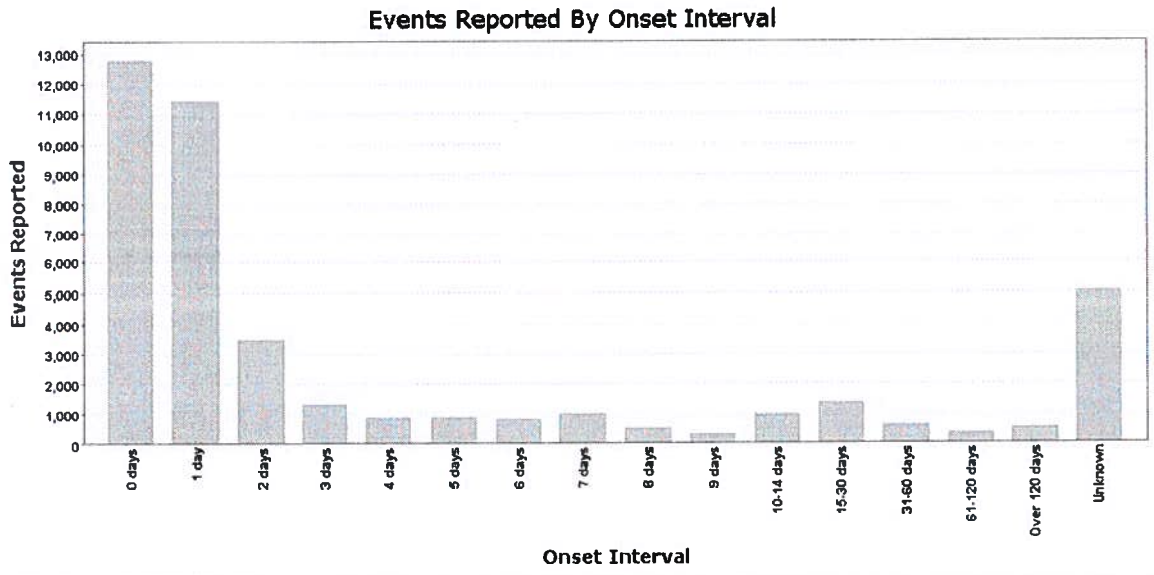
5.5.28 Cases of lymphadenopathy or lymphadenitis: 42,331; 66% within two days of injection

Lymphadenopathy or adenopathy is a disease of the lymph nodes, in which they are abnormal in size or consistency. Lymphadenopathy of an inflammatory type is lymphadenitis, producing swollen or enlarged lymph nodes. In clinical practice, the distinction between lymphadenopathy and lymphadenitis is rarely made and the words are usually treated as synonymous.

One of the problems discovered in COVID-19 vaccination is that lymphadenitis, a confirmed reaction to the vaccine, is causing false positives in breast cancer screenings and has led to either unnecessary biopsy or surgery. Other reactions appear to be more harmful. The sheer number of reports and high temporal correlation suggests these adverse events are being caused by the vaccines.

Query string:

ABDOMINAL LYMPHADENOPATHY; ADMINISTRATION SITE LYMPHADENOPATHY; ANGIOIMMUNOBLASTIC T-CELL LYMPHOMA; APPLICATION SITE LYMPHADENOPATHY; DERMATOPATHIC LYMPHADENOPATHY; GRANULOMATOUS LYMPHADENITIS; HILAR LYMPHADENOPATHY; HISTIOCYTIC NECROTISING LYMPHADENITIS; INJECTION SITE LYMPHADENOPATHY; LYMPHADENITIS; LYMPHADENOPATHY; LYMPHADENOPATHY MEDIASTINAL; MESENTERIC LYMPHADENOPATHY; NECROTIC LYMPHADENOPATHY; NECROTISING GRANULOMATOUS LYMPHADENITIS; PARATRACHEAL LYMPHADENOPATHY; PERSISTENT GENERALISED LYMPHADENOPATHY; RETROPERITONEAL LYMPHADENOPATHY; VACCINATION SITE LYMPHADENOPATHY



Over 80% reported cases for all vaccines, all time are specific to COVID-19 vaccinations alone.

Messages:
- VAERS data in CDC WONDER are updated every Friday. Hence, results for the same query can change from week to week.
- These results are for 52,989 total events.
- Rows with zero Events Reported are hidden. Use Quick Options above to show zero rows.

Vaccine	Events Reported	Percent (of 52,989)
COVID19 (COVID19 (PFIZER-BIONTECH)) (1200)	28,642	54.05%
COVID19 (COVID19 (MODERNA)) (1201)	13,691	25.84%
MEASLES + MUMPS + RUBELLA (MMR II) (26)	1,740	3.28%
COVID19 (COVID19 (JANSSEN)) (1203)	908	1.71%
HPV (GARDASIL) (1098)	610	1.15%
PNEUMO (PNEUMOVAX) (30)	580	1.09%
TDAP (ADACEL) (1092)	546	1.03%
ZOSTER (SHINGRIX) (1192)	538	1.02%
HEP B (ENGERIX-B) (38)	476	0.90%
VARICELLA (VARIVAX) (269)	464	0.88%
INFLUENZA (SEASONAL) (NO BRAND NAME) (44)	432	0.82%
INFLUENZA (SEASONAL) (FLUZONE) (7)	432	0.82%
VACCINE NOT SPECIFIED (NO BRAND NAME) (999)	429	0.81%
TD ADSORBED (NO BRAND NAME) (11)	412	0.78%
SMALLPOX (DRYVAX) (47)	351	0.66%
HEP B (RECOMBIVAX HB) (25)	308	0.58%
MEASLES + MUMPS + RUBELLA (NO BRAND NAME) (114)	266	0.50%
PNEUMO (PREVNAR13) (1141)	255	0.48%
POLIO VIRUS, ORAL (ORIMUNE) (17)	230	0.43%
TDAP (BOOSTRIX) (1091)	222	0.42%
HEP A (HAVRIX) (268)	201	0.38%
ZOSTER LIVE (ZOSTAVAX) (1097)	184	0.35%
INFLUENZA (SEASONAL) (FLUVIRIN) (262)	179	0.34%
MENINGOCOCCAL CONJUGATE (MENACTRA) (1090)	178	0.34%
ANTHRAX (BIOTHRAX) (1008)	165	0.31%
DTAP (INFANRIX) (286)	162	0.31%
INFLUENZA (SEASONAL) (FLUZONE QUADRIVALENT) (1162)	148	0.28%

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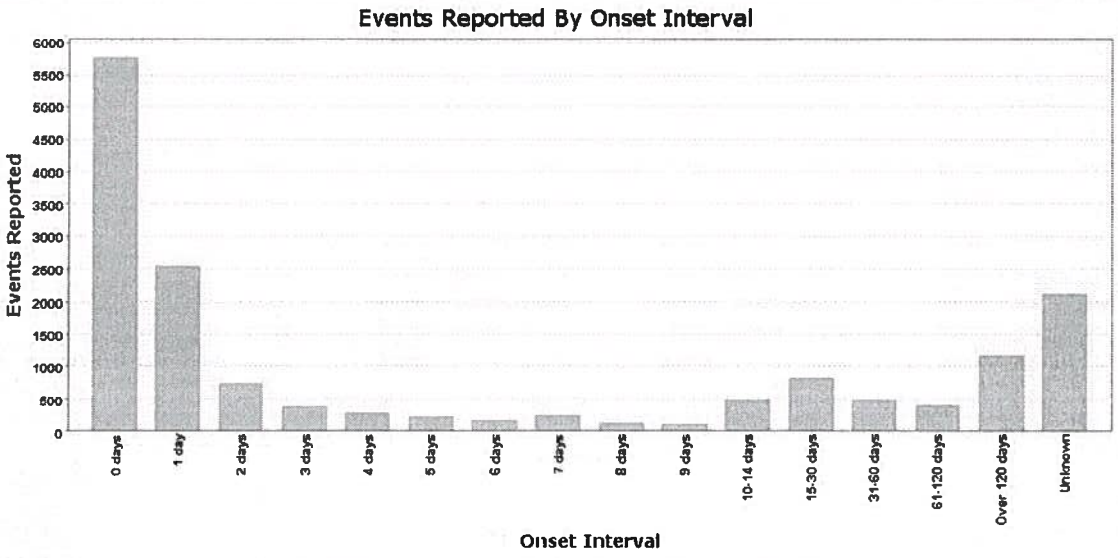
5.5.29 Cases of cognitive disorder, confusional state or dementia: 16,022; 56% within two days of injection

Query string:

COGNITIVE DISORDER; CONFUSIONAL STATE; DEMENTIA; FOCAL DYSCOGNITIVE SEIZURES; MEMORY IMPAIRMENT; NEUROPSYCHIATRIC SYMPTOMS; POSTICTAL STATE; PRESENILE DEMENTIA; PSEUDODEMENTIA; VASCULAR COGNITIVE IMPAIRMENT; VASCULAR DEMENTIA



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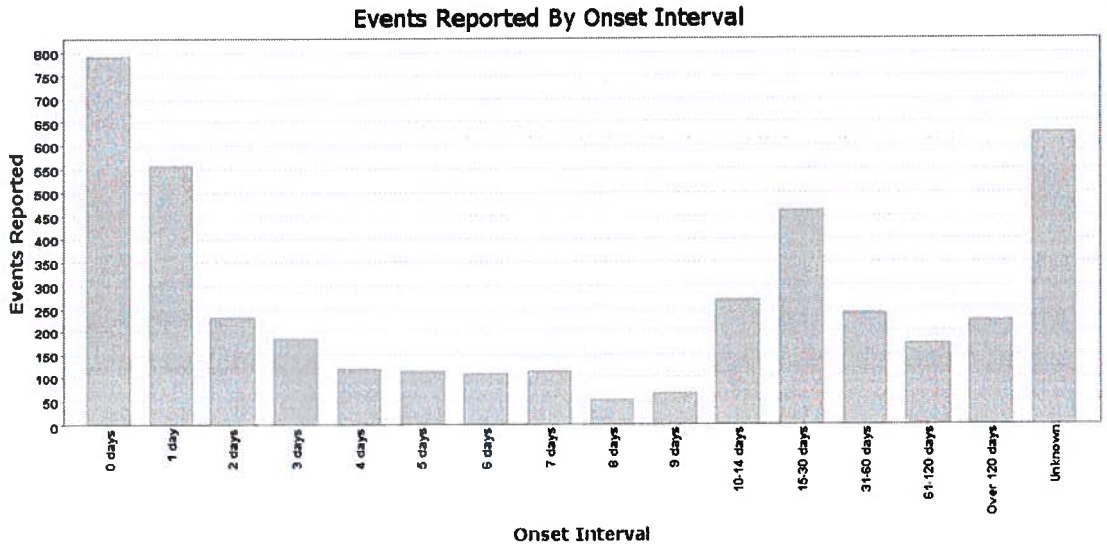
5.5.30 Cases of intracranial hemorrhage or brain bleed: 4,336; 37% within two days of injection

Query string:

BASAL GANGLIA HAEMORRHAGE; BRAIN STEM HAEMORRHAGE; CEREBELLAR HAEMORRHAGE; CEREBRAL HAEMORRHAGE; CEREBRAL MICROHAEMORRHAGE; CORNEAL BLEEDING; EAR HAEMORRHAGE; EYE HAEMORRHAGE; HAEMORRHAGE INTRACRANIAL; IRIS HAEMORRHAGE; OPTIC DISC HAEMORRHAGE; OPTIC NERVE SHEATH HAEMORRHAGE; PARANASAL SINUS HAEMORRHAGE; PITUITARY HAEMORRHAGE; RETINAL HAEMORRHAGE; SUBARACHNOID HAEMORRHAGE; SUBDURAL HAEMORRHAGE; SUBGALEAL HAEMORRHAGE; THALAMUS HAEMORRHAGE; TRAUMATIC INTRACRANIAL HAEMORRHAGE



Prevalence of symptoms of bleeding in the brain appear to be the eye and cerebrum. Consider that the COVID-19 vaccines lead to high incidence of hypertension (see section 5.5.42) and so small vasculature in the eyes, ears and nasal sinuses may present immediate noticeable symptoms and more delayed determination from internal bleeding.

Messages:

- VAERS data in CDC WONDER are updated every Friday. Hence, results for the same query can change from week to week.
- These results are for 4,336 total events.
- Rows with zero Events Reported are hidden. Use Quick Options above to show zero rows.

Symptoms	Events Reported	Percent (of 4,336)
CEREBRAL HAEMORRHAGE	1,894	43.68%
EYE HAEMORRHAGE	1,033	23.82%
SUBARACHNOID HAEMORRHAGE	628	14.48%
RETINAL HAEMORRHAGE	227	5.24%
HAEMORRHAGE INTRACRANIAL	204	4.70%
EAR HAEMORRHAGE	115	2.65%
CEREBELLAR HAEMORRHAGE	79	1.82%
BRAIN STEM HAEMORRHAGE	72	1.66%
SUBDURAL HAEMORRHAGE	68	1.57%
THALAMUS HAEMORRHAGE	62	1.43%
BASAL GANGLIA HAEMORRHAGE	62	1.43%
CEREBRAL MICROHAEMORRHAGE	24	0.55%
TRAUMATIC INTRACRANIAL HAEMORRHAGE	14	0.32%
CORNEAL BLEEDING	12	0.28%
OPTIC DISC HAEMORRHAGE	10	0.23%
PARANASAL SINUS HAEMORRHAGE	7	0.16%
OPTIC NERVE SHEATH HAEMORRHAGE	5	0.12%
PITUITARY HAEMORRHAGE	5	0.12%
SUBGALEAL HAEMORRHAGE	1	0.02%

Citations:

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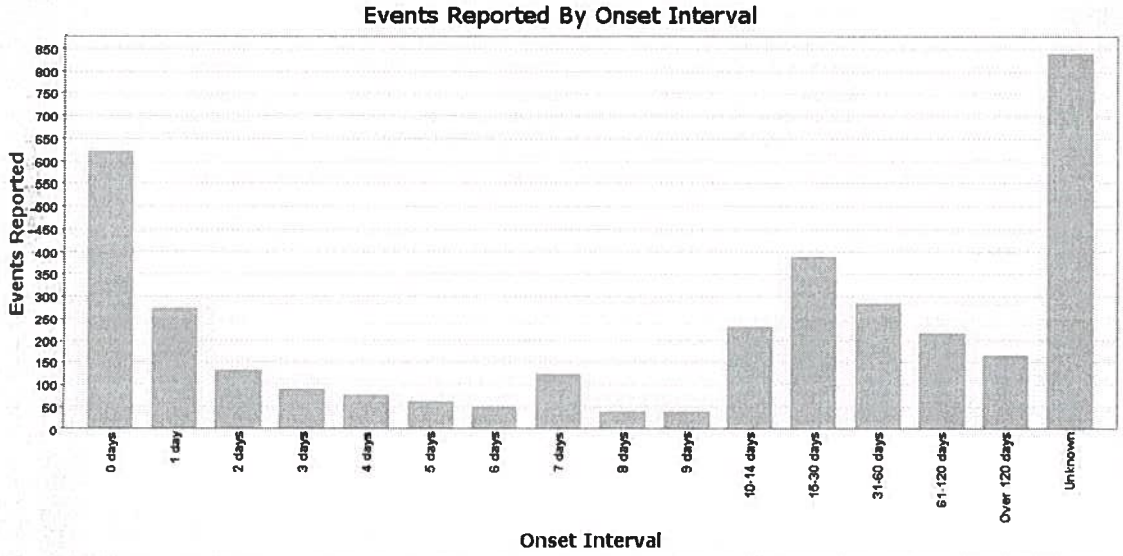
Purkayastha P, Mckechnie C, Kalkur P, et al **Rare case of COVID-19 vaccine-associated intracranial hemorrhage with venous sinus thrombosis** BMJ Case Reports CP 2021;14:e245092. https://casereports.bmj.com/content/bmjcr/14/9/e245092.full.pdf

5.5.31 Cases of alopecia (hair loss): 3,609; 28% within two days of injection

Hair loss (alopecia) can affect just your scalp or your entire body, and it can be temporary or permanent. It can be the result of heredity, hormonal changes, medical conditions or a normal part of aging. So if there is a connection it might be COVID-19 vaccines affecting hormones.

Query string:

ALOPECIA; ALOPECIA AREATA; ALOPECIA EFFLUVIUM; ALOPECIA SCARRING; ALOPECIA TOTALIS; ALOPECIA UNIVERSALIS; DIFFUSE ALOPECIA; NON-SCARRING ALOPECIA



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35223675; PMCID: PMC8844677. https://pubmed.ncbi.nlm.nih.gov/35223675/

*Here, we report the case of a patient with a **rapid onset of alopecia areata immediately after receiving the second dose of the COVID-19 vaccine***

May Lee M, Bertolani M, Pierobon E, Lotti T, Feliciani C, Satolli F. **Alopecia areata following COVID-19 vaccination: vaccine-induced autoimmunity?** Int J Dermatol. 2022 May;61(5):634-635. doi: 10.1111/ijd.16113. Epub 2022 Feb 2. PMID: 35107173. https://pubmed.ncbi.nlm.nih.gov/35107173/

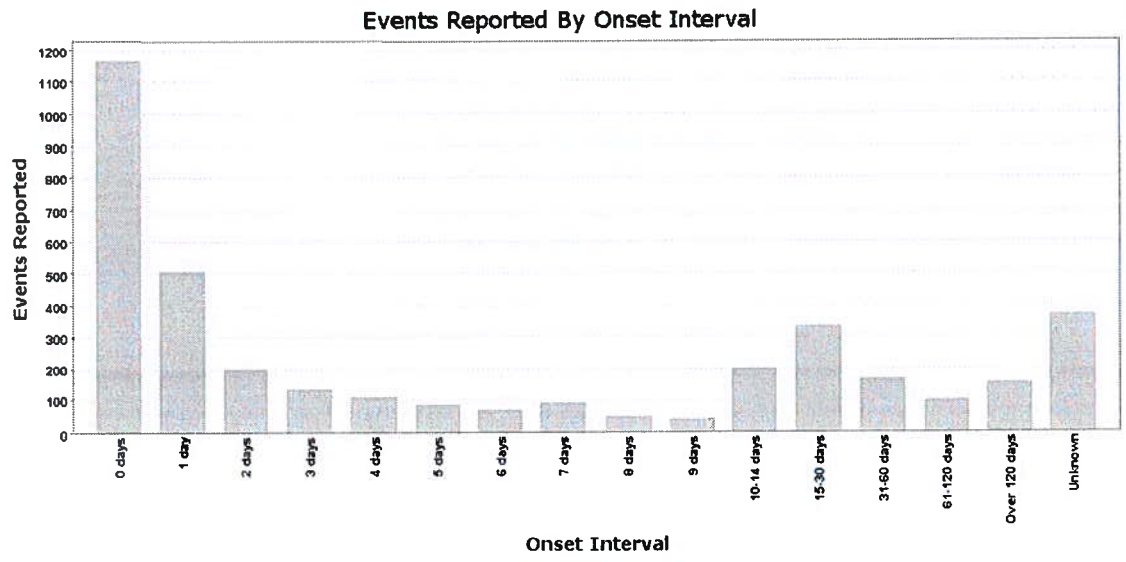
Rossi A, Magri F, Michelini S, Caro G, Di Fraia M, Fortuna MC, Pellacani G, Carlesimo M. **Recurrence of alopecia areata after covid-19 vaccination: A report of three cases in Italy**. J Cosmet Dermatol. 2021 Dec;20(12):3753-3757. doi: 10.1111/jocd.14581. Epub 2021 Nov 6. PMID: 34741583. https://pubmed.ncbi.nlm.nih.gov/34741583/

5.5.32 Cases of aphasia: 3,744; 50% within two days of injection

Aphasia is an inability to comprehend or formulate language because of damage to specific brain regions. The major causes are stroke and head trauma; prevalence is hard to determine but aphasia due to stroke is estimated to be 0.1–0.4% in the Global North.

Query string:

APHASIA; TRANSIENT APHASIA



Note that less than 1% of reported cases are transient aphasia meaning that the outcome is permanent inability to comprehend or formulate language because of damage to specific brain regions. Likely thrombogenic damage.

Citations:

Saleh M, Zimmermann J, Lehnen NC, Pötzsch B, Weller JM. **Late-Onset Vaccine-Induced Immune Thombotic Thrombocytopenia (VITT) with Cerebral Venous Sinus Thrombosis**. J Stroke Cerebrovasc Dis. 2022 Apr;31(4):106311. doi: 10.1016/j.jstrokecerebrovasdis.2022.106311. Epub 2022 Jan 29. PMID: 35093626; PMCID: PMC8799476. https://pubmed.ncbi.nlm.nih.gov/35093626/

Yoshida K, Tanaka K, Suto Y, Fukuda H. **Repeated Cardioembolic Stroke after COVID-19 mRNA Vaccination: A Case Report**. J Stroke Cerebrovasc Dis. 2022 Feb;31(2):106233. doi: 10.1016/j.jstrokecerebrovasdis.2021.106233. Epub 2021 Nov 22. PMID: 34883321; PMCID: PMC8606267. https://pubmed.ncbi.nlm.nih.gov/34883321/

Yoshida et al; a report of aphasia involving positive vaccine rechallenge providing string evidence of causation.

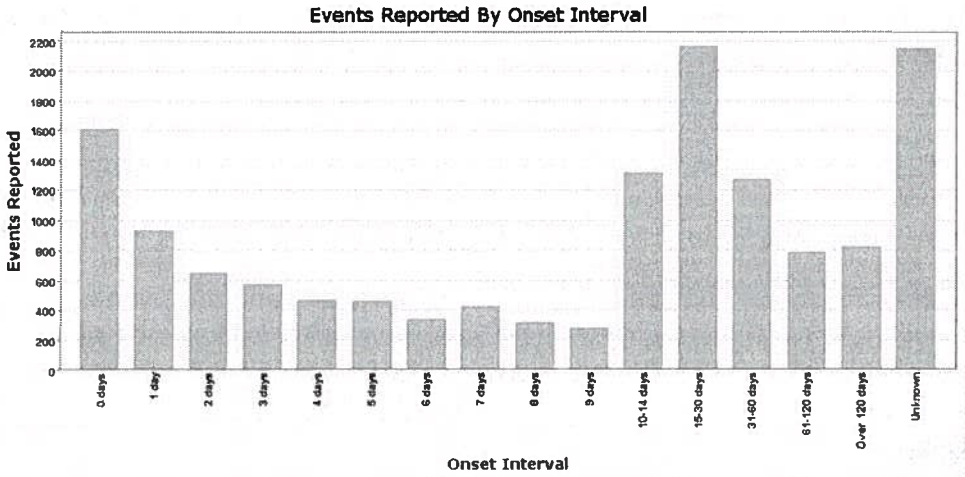
Aphasia can be caused by the COVID vaccine Steve Kirsch, March 30, 2022

5.5.33 Cases of pulmonary embolism, pulmonary thromboembolism or pulmonary thrombus: 14,562; 42% within 10 days of injection

Pulmonary embolism is a blockage of an artery in the lungs by a substance that has moved from elsewhere in the body through the bloodstream. Symptoms of a PE may include shortness of breath, chest pain particularly upon breathing in, and coughing up blood.

Query string:

CARDIOPULMONARY FAILURE; EMBOLISM; EMBOLISM ARTERIAL; EMBOLISM VENOUS; PULMONARY ARTERY OCCLUSION; PULMONARY ARTERY THROMBOSIS; PULMONARY EMBOLISM; PULMONARY INFARCTION; PULMONARY MICROEMBOLI; PULMONARY THROMBOSIS; PULMONARY VEIN OCCLUSION; PULMONARY VENO-OCCLUSIVE DISEASE; PULMONARY VENOUS THROMBOSIS; VASCULAR RESISTANCE PULMONARY INCREASED



Prevalence of symptoms: Pulmonary embolism and thrombosis top the reports with over 95% of the cases reported.

Messages:
- VAERS data in CDC WONDER are updated every Friday. Hence, results for the same query can change from week to week.
- These results are for 14,562 total events.

Symptoms	Events Reported	Percent (of 14,562)
PULMONARY EMBOLISM	12,872	88.39%
PULMONARY THROMBOSIS	1,059	7.27%
EMBOLISM	495	3.40%
PULMONARY INFARCTION	440	3.02%
EMBOLISM VENOUS	142	0.98%
CARDIOPULMONARY FAILURE	82	0.56%
EMBOLISM ARTERIAL	75	0.52%
PULMONARY ARTERY THROMBOSIS	64	0.44%
PULMONARY MICROEMBOLI	20	0.14%
PULMONARY ARTERY OCCLUSION	18	0.12%
PULMONARY VENOUS THROMBOSIS	12	0.08%
VASCULAR RESISTANCE PULMONARY INCREASED	2	0.01%
PULMONARY VENO-OCCLUSIVE DISEASE	1	0.01%
PULMONARY VEIN OCCLUSION	1	0.01%

Citations:

Ogunkoya JO, Ogunmola MI, Ogunlade AF, Ladele AE. **COVID-19 Vaccination Associated Bilateral Pulmonary Embolism: Cause or Coincidence**. Case Rep Pulmonol. 2022 Sep 29;2022:9596285. doi: 10.1155/2022/9596285. PMID: 36212801; PMCID: PMC9536966. https://pubmed.ncbi.nlm.nih.gov/36212801/

Ogunkoya et al:

> *"Bilateral acute pulmonary embolism is rare all over the world. Its association with COVID-19 vaccine administration is even rarer. However, the clinical presentations and investigation findings are similar to the descriptions available in the literature for unilateral APE."*

Since the deployment of COVID-19 vaccines, the word 'rare' has been overused in the literature to the point it no longer has any meaningful impact.

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5.5.34 Cases of Creutzfeld-Jakob Disease (Mad Cow Disease): 73; 33% within 10 days of injection

Creutzfeldt - Jakob disease (CJD) is a rare prion mediated disease that, up till now, has been contracted by humans that consume infected meat, usually beef. A query of all vaccines over all time shows vaccines associated with 74 cases and almost all of those cases associated with COVID-19 Vaccines. Also note that if a cases of CJD breaks out associated with beef consumption – that makes news. The cases leave little doubt the illness caused by the vaccines.

The Vaccine Adverse Event Reporting System (VAERS) Results

Cases of CJD, All Vaccines, All Time

Data current as of 10/14/2022

Request Form | Results | Map | Chart | Report | About

Dataset Documentation | Other Data Access | Help for Results | Printing Tips | Help with Exports

Save | Export | Reset

Quick Options | More Options

Top | Notes | Citation | Query Criteria

Messages:

- VAERS data in CDC WONDER are updated every Friday. Hence, results for the same query can change from week to week.
- These results are for 74 total events.
- Rows with zero Events Reported are hidden. Use Quick Options above to show zero rows.

Vaccine	Events Reported	Percent (of 74)
COVID19 (COVID19 (PFIZER-BIONTECH)) (1200)	60	81.08%
COVID19 (COVID19 (MODERNA)) (1201)	12	16.22%
ZOSTER (SHINGRIX) (1192)	2	2.70%
VACCINE NOT SPECIFIED (NO BRAND NAME) (999)	2	2.70%
COVID19 (COVID19 (JANSSEN)) (1203)	1	1.35%
INFLUENZA (SEASONAL) (FLUZONE HIGH-DOSE) (1145)	1	1.35%
ZOSTER LIVE (ZOSTAVAX) (1097)	1	1.35%

Note: Submitting a report to VAERS does not mean that healthcare personnel or the vaccine caused or contributed to the adverse event (possible side effect).

Top | Options | Notes | Citation | Query Criteria

In January of 2022, Tetz and Tetz identified the presence of prion-like domains in the SARS-CoV-2 spike protein and published in the journal Microbiology. Tetz determined that these domains play a significant role in the binding strength of the ACE-2 receptor; 10 to 20 fold over other viruses and that it may explain why Omicron was substantially less pathogenic than the original Wuhan strain. They also concluded that the pattern in SARS-CoV-2 for the Wuhan variant presents a potential risk of CJD. Following the work of Tetz and Tetz, Moret-Chalmin et al confirmed their discovery but furthermore determined these prion structures exist in the vaccines since they were based on the Wuhan variant.

Tetz, George, and Victor Tetz (2022). **Prion-like Domains in Spike Protein of SARS-CoV-2 Differ across Its Variants and Enable Changes in Affinity to ACE2**. Microorganisms 10(2): 280. https://pubmed.ncbi.nlm.nih.gov/35208734/

Moret-Chalmin, Claire, Montagnier, Luc & Perez, Jean-Claude (2022). **Towards the emergence of a new form of the neurodegenerative Creutzfeldt-Jakob disease: Twenty six cases of CJD declared a few days after a COVID-19 "vaccine" Jab**. Researchgate. https://www.researchgate.net/publication/363484655_Towards_the_emergence_of_a_new_form_of_the_neurodegenerative_Creutzfeldt-Jakob_disease_Twenty_six_cases_of_CJD_declared_a_few_days_after_a_COVID-19_vaccine_Jab

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Actis GC, Ribaldone DG, Pellicano R. **COVID vaccine's hot problems: erratic serious blood clotting, ill-defined prion-like reactogenicity of the spike, unclear roles of other factors**. Minerva Med. 2021 Dec;112(6):695-697. doi: 10.23736/S0026-4806.21.07769-7. PMID: 35168305. https://pubmed.ncbi.nlm.nih.gov/35168305/

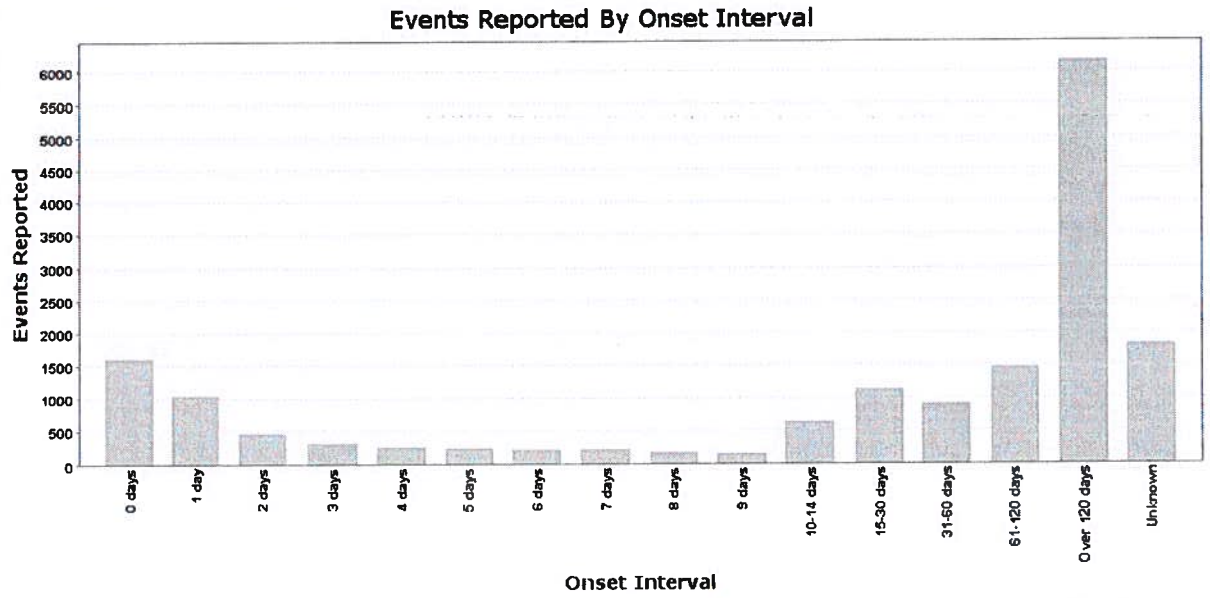
5.5.35 Cases of pneumonia or pulmonary edema: 16,770; 28% within 10 days of injection

Pneumonia is an inflammatory condition of the lung primarily affecting the small air sacs known as alveoli. Symptoms typically include some combination of productive or dry cough, chest pain, fever, and difficulty breathing.

Query string:

ACUTE PULMONARY OEDEMA; ATYPICAL PNEUMONIA; BRONCHIAL OEDEMA; BRONCHOPNEUMONIA; BRONCHOPULMONARY DISEASE; CORONAVIRUS PNEUMONIA; COVID-19 PNEUMONIA; EMBOLIC PNEUMONIA; EOSINOPHILIC PNEUMONIA; EOSINOPHILIC PNEUMONIA ACUTE; LUNG OPACITY; ORGANISING PNEUMONIA; PNEUMONIA; PNEUMONIA PRIMARY ATYPICAL; PULMONARY CONGESTION; PULMONARY OEDEMA; RESPIRATORY TRACT OEDEMA

Most reports came in after 4 months of injection



The considered symtoms were ordered according to prevalence with pneumonia and COVID-19 pneumonia accounting for more than 80% of reports. If most reported cases occurred after 4 months and a large percentage were COVID-19 pneumonia, doesn't this imply the vaccine did not protect the recipient from a dangerous infection. The narrative: it reduces 'severity' of symptoms. How does one evaluate, measure severity? Vaccines traditionally prevent infection, not reduce severity. That's what therapeutics are supposed to do.

Messages:

- VAERS data in CDC WONDER are updated every Friday. Hence, results for the same query can change from week to week.
- These results are for 16,770 total events.
- Rows with zero Events Reported are hidden. Use Quick Options above to show zero rows.

Symptoms	Events Reported	Percent (of 16,770)
PNEUMONIA	7,279	43.40%
COVID-19 PNEUMONIA	6,757	40.29%
LUNG OPACITY	1,967	11.73%
PULMONARY OEDEMA	1,258	7.50%
PULMONARY CONGESTION	808	4.82%
ATYPICAL PNEUMONIA	238	1.42%
ACUTE PULMONARY OEDEMA	229	1.37%
ORGANISING PNEUMONIA	127	0.76%
RESPIRATORY TRACT OEDEMA	85	0.51%
EOSINOPHILIC PNEUMONIA	39	0.23%
CORONAVIRUS PNEUMONIA	15	0.09%
BRONCHIAL OEDEMA	7	0.04%
EOSINOPHILIC PNEUMONIA ACUTE	6	0.04%
BRONCHOPULMONARY DISEASE	4	0.02%
EMBOLIC PNEUMONIA	2	0.01%

Citations:

Yoshikawa T, Tomomatsu K, Okazaki E, Takeuchi T, Horio Y, Kondo Y, Oguma T, Asano K. **COVID-19 vaccine-associated organizing pneumonia**. Respirol Case Rep. 2022 Mar 29;10(5):e0944. doi: 10.1002/rcr2.944. PMID: 35386579; PMCID: PMC8965045. https://pubmed.ncbi.nlm.nih.gov/35386579/

Dr Alex Stoyanov MBBS (Hons) MSc , Dr Graeme Thompson MBBS (Hons) , Dr Monique Lee MBBS (Hons) , Professor Connie Katelaris MBBS PhD , **Delayed hypersensitivity to the Comirnaty COVID-19 vaccine presenting with pneumonitis and rash**, Annals of Allergy, Asthma Immunology (2021), doi:

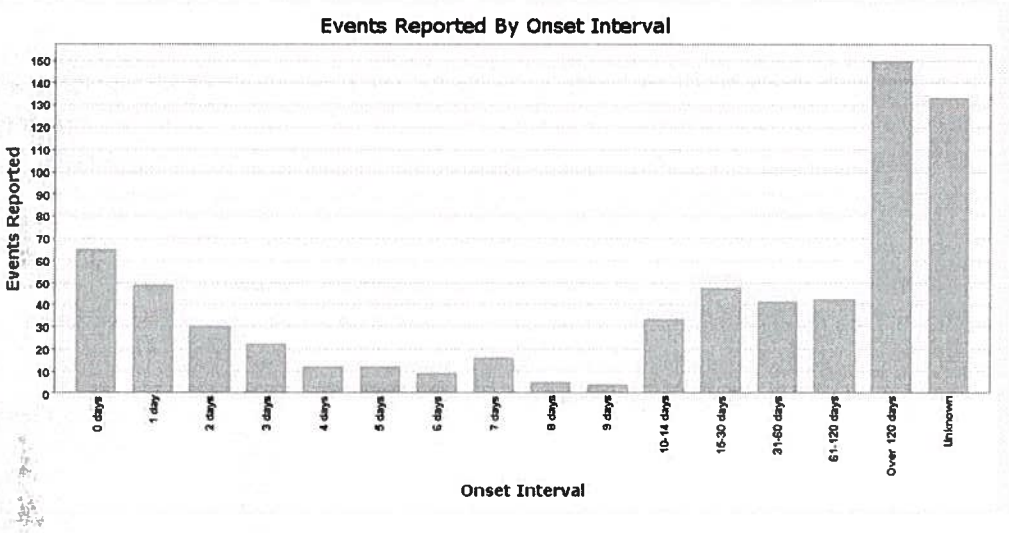
https://doi.org/10.1016/j.anai.2021.11.014
https://www.annallergy.org/action/showPdf?pii=S1081-1206%2821%2901274-6

5.5.36 Cases of interstitial lung disease: 670; 33% within 10 days of injection

Interstitial lung disease, or diffuse parenchymal lung disease, is a group of respiratory diseases affecting the interstitium of the lungs. It concerns alveolar epithelium, pulmonary capillary endothelium, basement membrane, and perivascular and perilymphatic tissues.

Query string:

ACUTE INTERSTITIAL PNEUMONITIS; IDIOPATHIC INTERSTITIAL PNEUMONIA; INTERSTITIAL LUNG DISEASE



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Park JY, Kim JH, Park S, Hwang YI, Kim HI, Jang SH, Jung KS, Kim YK, Kim HA, Lee IJ. **Clinical characteristics of patients with COVID-19 vaccine-related pneumonitis: a case series and literature review.** Korean J Intern Med. 2022 Sep;37(5):989-1001. doi: 10.3904/kjim.2022.072. Epub 2022 Aug 22. PMID: 35989064. https://pubmed.ncbi.nlm.nih.gov/35989064/

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DeDent AM, Farrand E **Vaccine-induced interstitial lung disease: a rare reaction to COVID-19 vaccination** Thorax Published Online First: 11 September 2021. doi: 10.1136/thoraxjnl-2021-217985 https://thorax.bmj.com/content/thoraxjnl/early/2021/09/11/thoraxjnl-2021-217985.full.pdf

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Ayumi Yoshifuji, Kota Ishioka, Yuya Masuzawa, Shuntaro Suda, Saori Murata, Yoshifumi Uwamino, Motoko Fujino, Hiromi Miyahara, Naoki Hasegawa, Munekazu Ryuzaki, Haruhiko Hoshino, Kazuhiko Sekine, **COVID-19 vaccine induced interstitial lung disease**, Journal of Infection and Chemotherapy, Volume 28, Issue 1, 2022, Pages 95-98, ISSN 1341-321X, https://doi.org/10.1016/j.jiac.2021.09.010 https://www.sciencedirect.com/science/article/pii/S1341321X21002592

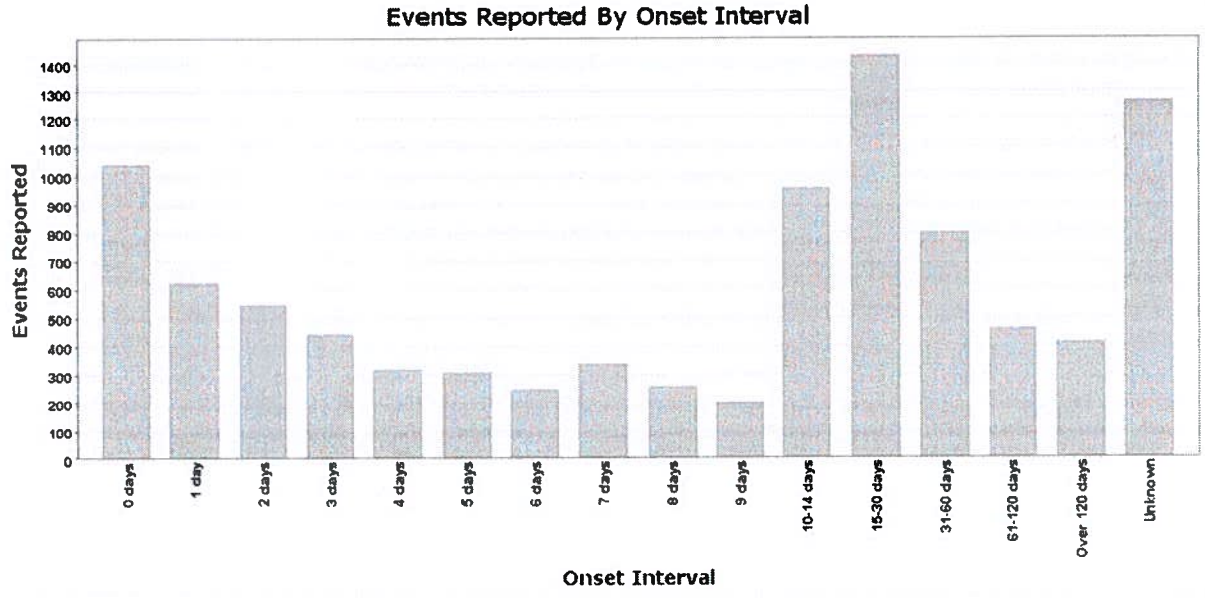
Shinichi Matsuzaki, Hiroyuki Kamiya, Ichiro Inoshima, Yasutaka Hirasawa, Osamu Tago, Masashi Arai, **COVID-19 mRNA Vaccine-induced Pneumonitis: A Case Report**, Internal Medicine, Article ID 8310-21, [Advance publication] Released October 26, 2021, Online ISSN 1349-7235, Print ISSN 0918-2918, https://www.jstage.jst.go.jp/article/internalmedicine/advpub/0/advpub_8310-21/_pdf/-char/en

5.5.37 Cases of deep vein thrombosis (DVT), phlebitis or thrombophlebitis: 9,640; 45% within 10 days of injection

Deep vein thrombosis is a type of venous thrombosis involving the formation of a blood clot in a deep vein, most commonly in the legs or pelvis. A minority of DVTs occur in the arms. Symptoms can include pain, swelling, redness, and enlarged veins in the affected area, but some DVTs have no symptoms.

Query string:

DEEP VEIN THROMBOSIS; PERIPHLEBITIS; PHLEBITIS; PHLEBITIS DEEP; PORTAL VEIN PHLEBITIS; THROMBOPHLEBITIS; THROMBOPHLEBITIS MIGRANS; THROMBOPHLEBITIS SEPTIC; VARICOPHLEBITIS



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Lorente E. **Idiopathic Ipsilateral External Jugular Vein Thrombophlebitis After Coronavirus Disease (COVID-19) Vaccination**. AJR Am J Roentgenol. 2021 Sep;217(3):767. doi: 10.2214/AJR.21.25708. Epub 2021 Jul 22. PMID: 33624509. https://pubmed.ncbi.nlm.nih.gov/33624509/

Roncati L, Manenti A, Corsi L. **A Three-Case Series of Thrombotic Deaths in Patients over 50 with Comorbidities Temporally after modRNA COVID-19 Vaccination**. Pathogens. 2022 Apr 3;11(4):435. doi: 10.3390/pathogens11040435. PMID: 35456110; PMCID: PMC9032304. https://pubmed.ncbi.nlm.nih.gov/35456110/

Vallone MG, Falcón AL, Castro HM, Ferraris A, Cantarella RF, Staneloni MI, Aliperti VI, Ferloni A, Mezzarobba D, Vázquez FJ, Ratti MFG. **Thrombotic events following Covid-19 vaccines compared to Influenza vaccines**. Eur J Intern Med. 2022 May;99:82-88. doi: 10.1016/j.ejim.2022.03.002. Epub 2022 Mar 9. PMID: 35288031; PMCID: PMC8904150. https://pubmed.ncbi.nlm.nih.gov/35288031/

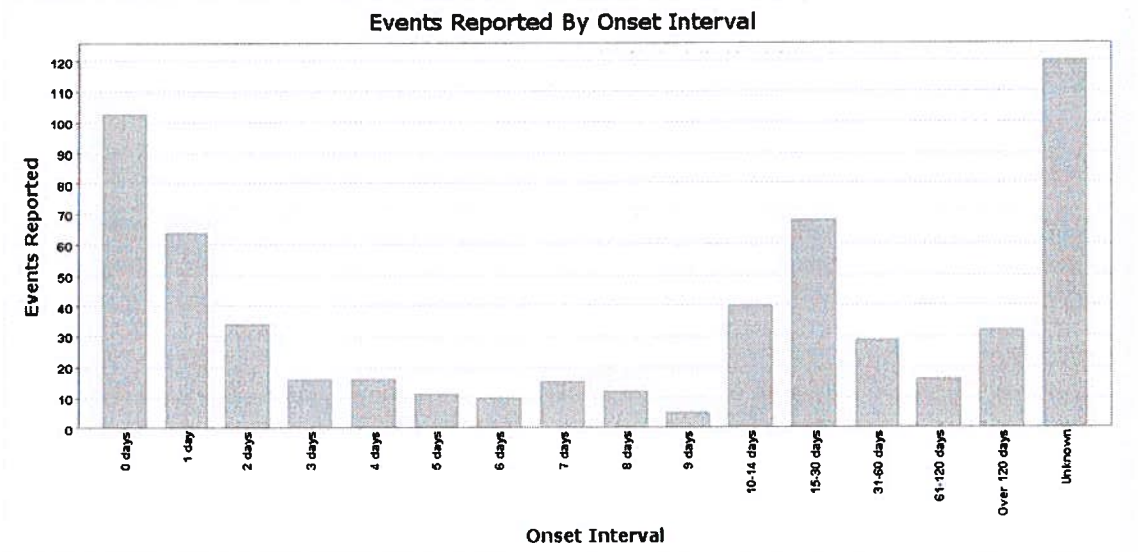
The Vallone study found twice the number of thrombotic events for covid-19 vaccines over flu vaccines; statistically significant, and cited the following conclusion:

> *This study shows a significant increase in thrombotic events in subjects vaccinated with Covid-19 vaccines in comparison to a control group. The clinical implication of these findings should be interpreted with caution, in light of the high effectiveness of vaccination and the inherent risk of thrombosis from Covid-19 infection itself.*[41]

Bhan C, Bheesham N, Shakuntulla F, Sharma M, Sun C, Weinstein M. **An unusual presentation of acute deep vein thrombosis after the Moderna COVID-19 vaccine-a case report**. Ann Transl Med. 2021 Oct;9(20):1605. doi: 10.21037/atm-21-2772. PMID: 34790811; PMCID: PMC8576696. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8576696/pdf/atm-09-20-1605.pdf

[41] This last sentence candy coats the conclusion, and the paper further offers no substantial statistics to firmly support their claims of benefits & risks. Rhetoric. In legal terms: *hearsay*.

5.5.38 Cases of coma or brain death: 591; 34% within 2 days of injection



Citations:

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Uzun G, Bohnert BN, Althaus K, Nann D, Nadalin S, Heyne N, Fend F, Haap M, Bakchoul T. **Organ Donation From a Brain Dead Donor With Vaccine-induced Immune Thrombotic Thrombocytopenia After Ad26.COV2.S: The Risk of Organ Microthrombi**. Transplantation. 2022 Mar 1;106(3):e178-e180. doi: 10.1097/TP.0000000000004039. PMID: 34974451; PMCID: PMC8862669. https://pubmed.ncbi.nlm.nih.gov/34974451/

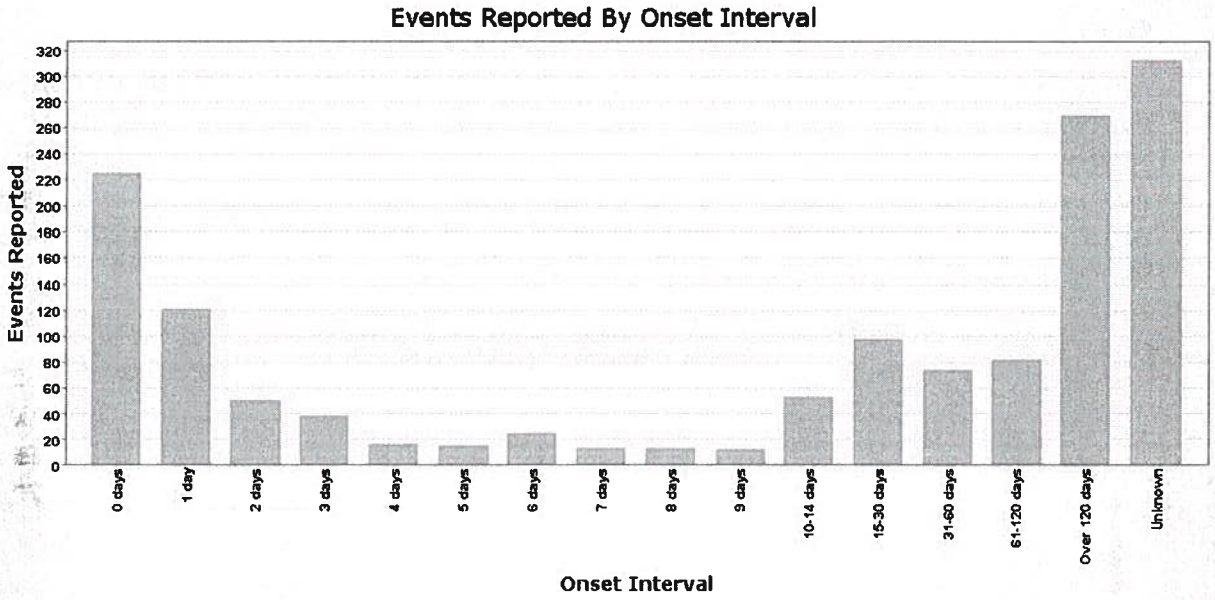
Guditi S, Setty G, Verma M, Reddy R, Devraj R, Raju SB, Gokhale GK. **Vaccine-Induced Thrombotic Thrombocytopenia Due to Coronavirus Disease 2019 Vaccine From a Deceased Donor: A Case Report**. Transplant Proc. 2021 Nov 12:S0041-1345(21)00794-6. doi: 10.1016/j.transproceed.2021.11.002. Epub ahead of print. PMID: 34916063; PMCID: PMC8585593. https://pubmed.ncbi.nlm.nih.gov/34916063/

5.5.39 Cases of diabetes: 1,417; 48% within ten days of injection

Diabetes, also known as diabetes mellitus, is a group of metabolic disorders characterized by a high blood sugar level over a prolonged period of time. Symptoms often include frequent urination, increased thirst and increased appetite. If left untreated, diabetes can cause many health complications

Query string:

DIABETES MELLITUS; DIABETES MELLITUS INSULIN-DEPENDENT; DIABETES MELLITUS NON-INSULIN-DEPENDENT; INSULIN RESISTANT DIABETES; INSULIN-REQUIRING TYPE 2 DIABETES MELLITUS; INSULIN-REQUIRING TYPE II DIABETES MELLITUS; LATENT AUTOIMMUNE DIABETES IN ADULTS; PANCREATOGENOUS DIABETES; TYPE 2 DIABETES MELLITUS



Citations:

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Abu-Rumaileh et al concludes:

> *"While Pfizer-BioNTech COVID-19 vaccine appears to be relatively safe, the vaccine might trigger an immune response that may have unmasked the patient's underlying pre-diabetes. As of the time of writing this report, no cases of new-onset diabetes after COVID-19 vaccine were found in the literature. Based on this report, regulatory bodies should consider close monitoring of COVID-19 vaccines effect on metabolic profile including the risk of new-onset DM-II"*

Kshetree B, Lee J, Acharya S. **COVID-19 Vaccine-Induced Rapid Progression of Prediabetes to Ketosis-Prone Diabetes Mellitus in an Elderly Male.** Cureus. 2022 Sep 6;14(9):e28830. doi: 10.7759/cureus.28830. PMID: 36225440; PMCID: PMC9535996. https://pubmed.ncbi.nlm.nih.gov/36225440/

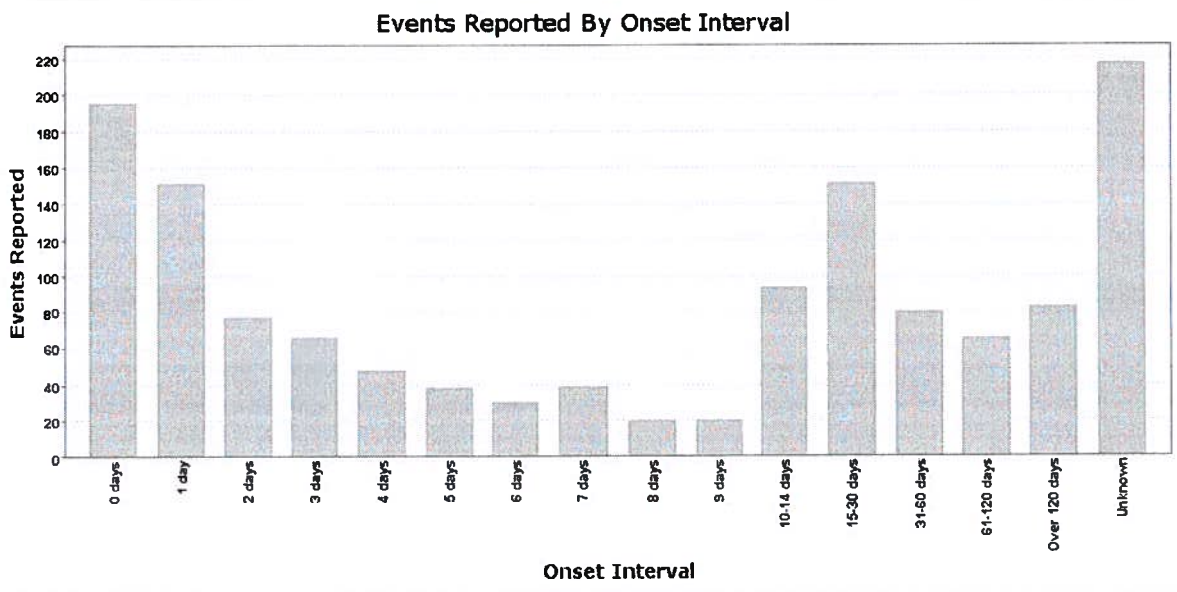
> *This case reports the rapid progression of prediabetes to **Type 1** rather than Type 2 DM and highlights the **possibility of dysglycemia after COVID-19 vaccines** and calls for measures to prevent or early management of these side effects.*

5.5.40 Cases of pancreatitis: 1,374; 32% within 2 days of injection

Pancreatitis is a condition characterized by inflammation of the pancreas. The pancreas produces digestive enzymes and a number of hormones. There are two main types: acute pancreatitis, and chronic pancreatitis.

Query string:

AUTOIMMUNE PANCREATITIS; EXOCRINE PANCREATIC FUNCTION TEST ABNORMAL; IMMUNE-MEDIATED PANCREATITIS; OBSTRUCTIVE PANCREATITIS; OEDEMATOUS PANCREATITIS; PANCREATIC ATROPHY; PANCREATIC DISORDER; PANCREATIC DUCT OBSTRUCTION; PANCREATIC ENLARGEMENT; PANCREATIC ENZYMES ABNORMAL; PANCREATIC FAILURE; PANCREATIC INFARCTION; PANCREATIC INJURY; PANCREATIC INSUFFICIENCY; PANCREATITIS; PANCREATITIS ACUTE; PANCREATITIS HAEMORRHAGIC; PANCREATITIS NECROTISING; SUBACUTE PANCREATITIS



Citations:

Kalra RK, Jayadeep S, Ball AL. **Acute Pancreatitis in an Adolescent Following COVID Vaccination.** Clin Pediatr (Phila). 2022 Mar;61(3):236-240. doi: 10.1177/00099228211067678. Epub 2022 Jan 26. PMID: 35081801. https://pubmed.ncbi.nlm.nih.gov/35081801/

Cacdac R, Jamali A, Jamali R, Nemovi K, Vosoughi K, Bayraktutar Z. **Acute pancreatitis as an adverse effect of COVID-19 vaccination**. SAGE Open Med Case Rep. 2022 Oct 24;10:2050313X221131169. doi: 10.1177/2050313X221131169. PMID: 36313269; PMCID: PMC9608244. https://pubmed.ncbi.nlm.nih.gov/36313269/

Walter T, Connor S, Stedman C, Doogue M. **A case of acute necrotising pancreatitis following the second dose of Pfizer-BioNTech COVID-19 mRNA vaccine**. Br J Clin Pharmacol. 2022 Mar;88(3):1385-1386. doi: 10.1111/bcp.15039. Epub 2021 Aug 22. PMID: 34423463; PMCID: PMC8653364. https://pubmed.ncbi.nlm.nih.gov/34423463/

Ozaka S, Kodera T, Ariki S, Kobayashi T, Murakami K. **Acute pancreatitis soon after COVID-19 vaccination: A case report**. Medicine (Baltimore). 2022 Jan 14;101(2):e28471. doi: 10.1097/MD.0000000000028471. PMID: 35029194; PMCID: PMC8757977. https://pubmed.ncbi.nlm.nih.gov/35029194/

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Sinagra E, Shahini E, Crispino F, Macaione I, Guarnotta V, Marasà M, Testai S, Pallio S, Albano D, Facciorusso A, Maida M. **COVID-19 and the Pancreas: A Narrative Review**. Life (Basel). 2022 Aug 23;12(9):1292. doi: 10.3390/life12091292. PMID: 36143329; PMCID: PMC9504204. https://pubmed.ncbi.nlm.nih.gov/36143329/

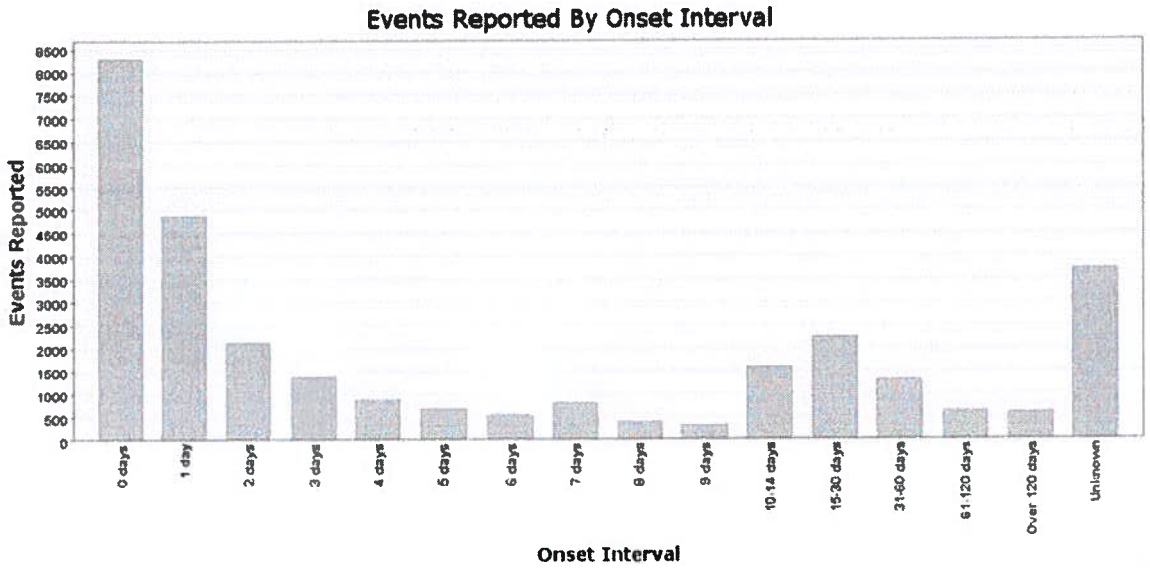
Parkash O, Sharko A, Farooqi A, Ying GW, Sura P. **Acute Pancreatitis: A Possible Side Effect of COVID-19 Vaccine**. Cureus. 2021;13(4):e14741. Published 2021 Apr 28. doi:10.7759/cureus.14741 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8163516/pdf/cureus-0013-00000014741.pdf

5.5.41 Cases of hearing disorder: 30,417; 50% within 2 days of injection

Tinnitus is the perception of sound when no corresponding external sound is present. Nearly everyone will experience a faint "normal tinnitus" in a completely quiet room but it is only of concern if it is bothersome or interferes with normal hearing or correlated with other problems.

Query string:

ACOUSTIC STIMULATION TESTS ABNORMAL; AUDITORY DISORDER; AUDITORY NERVE DISORDER; AUDITORY NEUROPATHY SPECTRUM DISORDER; BRAIN STEM AUDITORY EVOKED RESPONSE ABNORMAL; CENTRAL AUDITORY PROCESSING DISORDER; DEAFNESS; DEAFNESS BILATERAL; DEAFNESS NEUROSENSORY; DEAFNESS UNILATERAL; HALLUCINATION, AUDITORY; HEARING DISABILITY; HEARING IMPAIRED; HYPERACUSIS; HYPOACUSIS; MIXED DEAFNESS; SUDDEN HEARING LOSS; TINNITUS



The most prevalent symptoms in this symptom category include tinnitus, deafness or partial deafness reported as almost 100% of reports.

Messages:

- VAERS data in CDC WONDER are updated every Friday. Hence, results for the same query can change from week to week.
- These results are for 30,417 total events.
- Rows with zero Events Reported are hidden. Use Quick Options above to show zero rows.

Symptoms	Events Reported	Percent (of 30,417)
TINNITUS	23,432	77.04%
DEAFNESS	3,293	10.83%
HYPOACUSIS	2,917	9.59%
DEAFNESS UNILATERAL	2,164	7.11%
SUDDEN HEARING LOSS	1,604	5.27%
HYPERACUSIS	1,268	4.17%
ACOUSTIC STIMULATION TESTS ABNORMAL	630	2.07%
DEAFNESS NEUROSENSORY	578	1.90%
DEAFNESS BILATERAL	290	0.95%
HALLUCINATION, AUDITORY	253	0.83%
AUDITORY DISORDER	178	0.59%
HEARING DISABILITY	34	0.11%
AUDITORY NERVE DISORDER	18	0.06%
MIXED DEAFNESS	5	0.02%
BRAIN STEM AUDITORY EVOKED RESPONSE ABNORMAL	3	0.01%
CENTRAL AUDITORY PROCESSING DISORDER	2	0.01%
AUDITORY NEUROPATHY SPECTRUM DISORDER	1	0.00%

COVID-19 vaccines account for almost 89% of all hearing related adverse events compared to all vaccines over all time.

Messages:

- VAERS data in CDC WONDER are updated every Friday. Hence, results for the same query can change from week to week.
- These results are for 35,843 total events.
- Rows with zero Events Reported are hidden. Use Quick Options above to show zero rows.

Vaccine	Events Reported	Percent (of 35,843)
COVID19 (COVID19 (PFIZER-BIONTECH)) (1200)	19,939	55.63%
COVID19 (COVID19 (MODERNA)) (1201)	9,661	26.95%
COVID19 (COVID19 (JANSSEN)) (1203)	2,139	5.97%
HPV (GARDASIL) (1098)	552	1.54%
ZOSTER (SHINGRIX) (1192)	538	1.50%
VACCINE NOT SPECIFIED (NO BRAND NAME) (999)	374	1.04%
ZOSTER LIVE (ZOSTAVAX) (1097)	370	1.03%
MEASLES + MUMPS + RUBELLA (MMR II) (26)	300	0.84%
HEP B (ENGERIX-B) (38)	273	0.76%
INFLUENZA (SEASONAL) (NO BRAND NAME) (44)	233	0.65%
INFLUENZA (SEASONAL) (FLUZONE) (7)	182	0.51%
HPV (CERVARIX) (1136)	179	0.50%
HPV (GARDASIL 9) (1170)	162	0.45%
PNEUMO (PNEUMOVAX) (30)	151	0.42%
MENINGOCOCCAL CONJUGATE (MENACTRA) (1090)	145	0.40%
TDAP (ADACEL) (1092)	131	0.37%
INFLUENZA (SEASONAL) (FLUZONE QUADRIVALENT) (1162)	121	0.34%
TDAP (BOOSTRIX) (1091)	121	0.34%
ANTHRAX (BIOTHRAX) (1008)	111	0.31%
HEP A (HAVRIX) (268)	111	0.31%
HEP B (RECOMBIVAX HB) (25)	109	0.30%
PNEUMO (PREVNAR13) (1141)	109	0.30%
INFLUENZA (SEASONAL) (FLUVIRIN) (262)	106	0.30%
VARICELLA (VARIVAX) (269)	103	0.29%
COVID19 (COVID19 (UNKNOWN)) (1202)	102	0.28%
INFLUENZA (SEASONAL) (FLUARIX QUADRIVALENT) (1161)	100	0.28%
INFLUENZA (SEASONAL) (FLUZONE HIGH-DOSE) (1145)	92	0.26%
COVID19 (COVID19 (PFIZER-BIONTECH BIVALENT)) (1211)	82	0.23%
INFLUENZA (SEASONAL) (FLUCELVAX QUADRIVALENT) (1175)	79	0.22%
LYME (LYMERIX) (302)	73	0.20%
ANTHRAX (NO BRAND NAME) (64)	65	0.18%
TD ADSORBED (NO BRAND NAME) (11)	64	0.18%
COVID19 (COVID19 (MODERNA BIVALENT)) (1212)	62	0.17%
MEASLES + MUMPS + RUBELLA (NO BRAND NAME) (114)	62	0.17%
HEP A + HEP B (TWINRIX) (1009)	60	0.17%
HEP-B (NO BRAND NAME) (110)	60	0.17%
INFLUENZA (SEASONAL) (AFLURIA QUADRIVALENT) (1177)	58	0.16%
PNEUMO (PREVNAR) (1001)	57	0.16%
POLIO VIRUS, INACT. (IPOL) (1030)	53	0.15%
INFLUENZA (SEASONAL) (AFLURIA) (1121)	48	0.13%
DTAP (INFANRIX) (286)	47	0.13%
DTP (NO BRAND NAME) (2)	46	0.13%
HIB (ACTHIB) (256)	44	0.12%
TYPHOID VI POLYSACCHARIDE (TYPHIM VI) (271)	44	0.12%
INFLUENZA (SEASONAL) (FLUARIX) (1089)	42	0.12%
MENINGOCOCCAL CONJUGATE (MENVEO) (1140)	41	0.11%

Citations:

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Chen C, Fu F, Ding L, Xiao J. **Hearing disorder following COVID-19 vaccination: A pharmacovigilance analysis using the Vaccine Adverse Event Reporting System**. J Clin Pharm Ther. 2022 Sep

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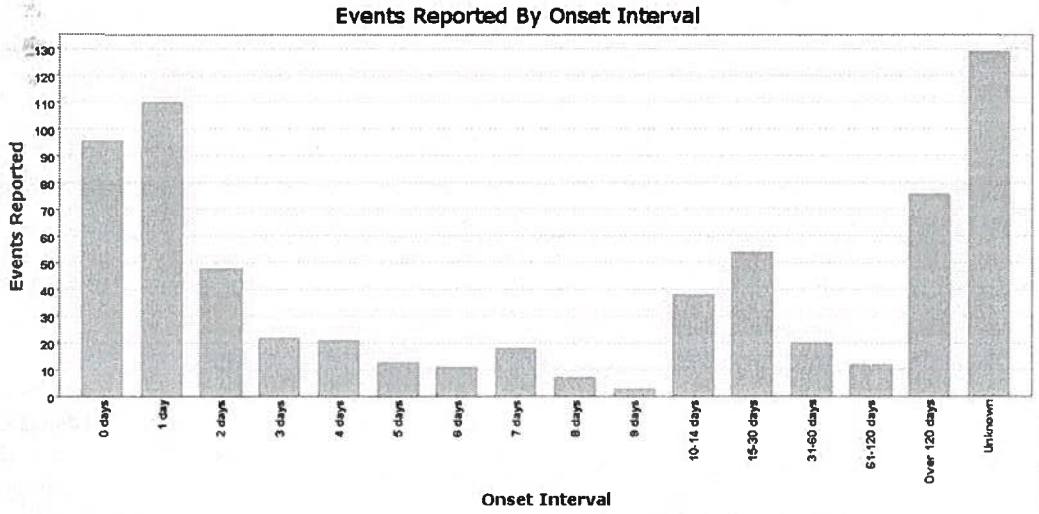
5.5.42 Cases of rhabdomyolysis: 678; 39% within 2 days of injection

Rhabdomyolysis is a condition in which damaged skeletal muscle breaks down rapidly. Symptoms may include muscle pains, weakness, vomiting, and confusion. There may be tea-colored urine or an irregular heartbeat. Some of the muscle breakdown products, such as the protein myoglobin, are harmful to the kidneys and may lead to kidney failure.



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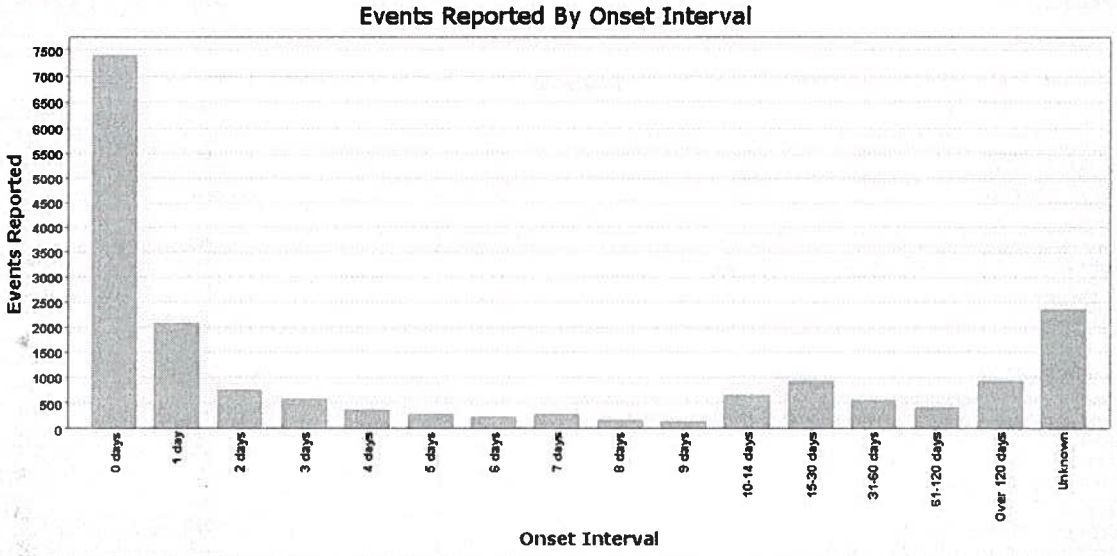
5.5.43 Cases of hypertension: 18,125; 52% within <u>1 day of injection</u>.

<u>Query string:</u>

ACCELERATED HYPERTENSION; BLOOD PRESSURE ABNORMAL; BLOOD PRESSURE AMBULATORY ABNORMAL; BLOOD PRESSURE DIASTOLIC ABNORMAL; BLOOD PRESSURE ORTHOSTATIC ABNORMAL; BLOOD PRESSURE SYSTOLIC ABNORMAL; DIASTOLIC HYPERTENSION; ESSENTIAL HYPERTENSION; HYPERTENSION; HYPERTENSIVE URGENCY



For COVID-19 vaccines, Pfizer accounts for over 70% of the cases of hypertension, but this may only be due to Pfizer being the the major vaccine distributed.

Messages:
- VAERS data in CDC WONDER are updated every Friday. Hence, results for the same query can change from week to week.
- These results are for 18,125 total events.

Vaccine ⇓	⇒ Events Reported ⇧⇩	⇐ Percent (of 18,125) ⇧⇩
COVID19 (COVID19 (PFIZER-BIONTECH)) (1200)	12,863	70.97%
COVID19 (COVID19 (MODERNA)) (1201)	4,784	26.39%
COVID19 (COVID19 (JANSSEN)) (1203)	1,041	5.74%
COVID19 (COVID19 (UNKNOWN)) (1202)	85	0.47%
COVID19 (COVID19 (PFIZER-BIONTECH BIVALENT)) (1211)	43	0.24%
COVID19 (COVID19 (MODERNA BIVALENT)) (1212)	18	0.10%
COVID19 (COVID19 (NOVAVAX)) (1210)	1	0.01%

If we compare to all vaccines over all time, the COVID-19 vaccines account for almost 90% of reported cases of hypertension. This fact together with the fact that increased blood pressure occurs within 1 day of injection may be a predisposing factor to many of the other injuries listed in this report.

Messages:

- VAERS data in CDC WONDER are updated every Friday. Hence, results for the same query can change from week to week.
- These results are for 21,095 total events.
- Rows with zero Events Reported are hidden. Use Quick Options above to show zero rows.

Vaccine	Events Reported	Percent (of 21,095)
COVID19 (COVID19 (PFIZER-BIONTECH)) (1200)	12,863	60.98%
COVID19 (COVID19 (MODERNA)) (1201)	4,784	22.68%
COVID19 (COVID19 (JANSSEN)) (1203)	1,041	4.93%
HEP B (ENGERIX-B) (38)	284	1.35%
VACCINE NOT SPECIFIED (NO BRAND NAME) (999)	272	1.29%
INFLUENZA (SEASONAL) (NO BRAND NAME) (44)	247	1.17%
INFLUENZA (SEASONAL) (FLUZONE) (7)	227	1.08%
PNEUMO (PNEUMOVAX) (30)	190	0.90%
HEP B (RECOMBIVAX HB) (25)	182	0.86%
MEASLES + MUMPS + RUBELLA (MMR II) (26)	147	0.70%
ZOSTER (SHINGRIX) (1192)	137	0.65%
TD ADSORBED (NO BRAND NAME) (11)	117	0.55%
HPV (GARDASIL) (1098)	113	0.54%
ANTHRAX (BIOTHRAX) (1008)	103	0.49%
COVID19 (COVID19 (UNKNOWN)) (1202)	85	0.40%
ZOSTER LIVE (ZOSTAVAX) (1097)	83	0.39%
INFLUENZA (SEASONAL) (FLUVIRIN) (262)	82	0.39%
PNEUMO (PREVNAR13) (1141)	73	0.35%
INFLUENZA (SEASONAL) (FLUSHIELD) (261)	72	0.34%
HEP A (HAVRIX) (268)	68	0.32%
INFLUENZA (SEASONAL) (FLUZONE HIGH-DOSE) (1145)	59	0.28%
TDAP (ADACEL) (1092)	56	0.27%
VARICELLA (VARIVAX) (269)	51	0.24%
HEP A + HEP B (TWINRIX) (1009)	46	0.22%
COVID19 (COVID19 (PFIZER-BIONTECH BIVALENT)) (1211)	43	0.20%
TDAP (BOOSTRIX) (1091)	42	0.20%
SMALLPOX (DRYVAX) (47)	41	0.19%
HEP B (NO BRAND NAME) (110)	39	0.18%
POLIO VIRUS, ORAL (ORIMUNE) (17)	39	0.18%
INFLUENZA (SEASONAL) (FLUARIX QUADRIVALENT) (1161)	37	0.18%
TYPHOID VI POLYSACCHARIDE (TYPHIM VI) (271)	37	0.18%
INFLUENZA (SEASONAL) (FLUZONE QUADRIVALENT) (1162)	36	0.17%
ANTHRAX (NO BRAND NAME) (64)	34	0.16%
INFLUENZA (SEASONAL) (FLUARIX) (1089)	33	0.16%
HPV (GARDASIL 9) (1170)	31	0.15%
LYME (LYMERIX) (302)	29	0.14%
PNEUMO (NO BRAND NAME) (120)	29	0.14%
INFLUENZA (SEASONAL) (AFLURIA) (1121)	28	0.13%

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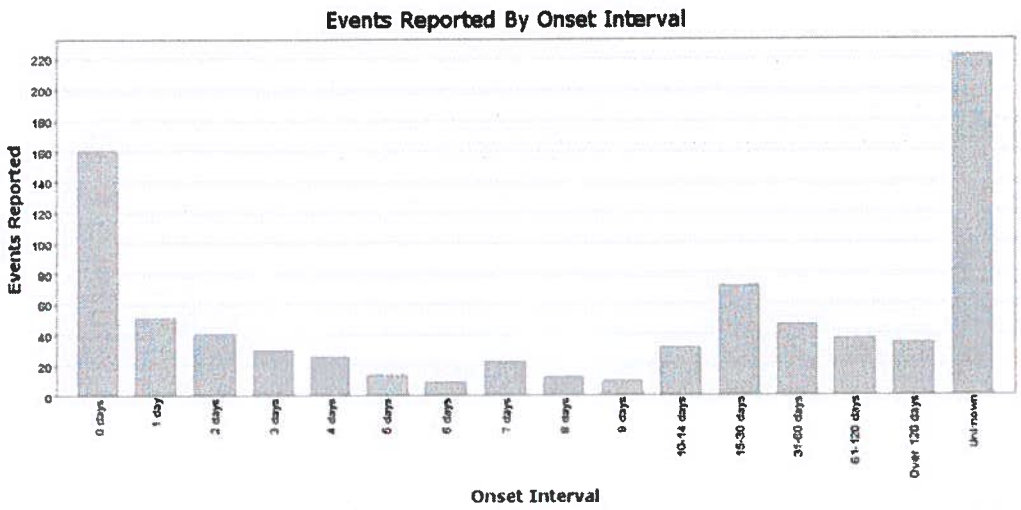
5.5.44 Cases of Lupus: 818; 46% within one day of injection

Lupus, technically known as systemic lupus erythematosus, is an autoimmune disease in which the body's immune system mistakenly attacks healthy tissue in many parts of the body. Symptoms vary among people and may be mild to severe.

Search Query:

ACUTE CUTANEOUS LUPUS ERYTHEMATOSUS; CENTRAL NERVOUS SYSTEM LUPUS; CUTANEOUS LUPUS ERYTHEMATOSUS; LUPUS ANTICOAGULANT HYPOPROTHROMBINAEMIA SYNDROME; LUPUS CYSTITIS; LUPUS ENDOCARDITIS; LUPUS ENTERITIS; LUPUS HEPATITIS; LUPUS MILIARIS DISSEMINATUS FACIEI; LUPUS MYOSITIS; LUPUS NEPHRITIS; LUPUS VASCULITIS; LUPUS VULGARIS; LUPUS-LIKE SYNDROME; PERICARDITIS LUPUS; SUBACUTE CUTANEOUS LUPUS ERYTHEMATOSUS; SYSTEMIC LUPUS ERYTHEMATOSUS; SYSTEMIC LUPUS ERYTHEMATOSUS RASH



Prevalent symtoms in this symptom category:

Messages:

- **VAERS data in CDC WONDER are updated every Friday. Hence, results for the same query can change from week to week.**
- **These results are for 818 total events.**
- **Rows with zero Events Reported are hidden. Use Quick Options above to show zero rows.**

Symptoms	Events Reported	Percent (of 818)
Total	**833**	**101.83%**
SYSTEMIC LUPUS ERYTHEMATOSUS	646	78.97%
CUTANEOUS LUPUS ERYTHEMATOSUS	45	5.50%
LUPUS-LIKE SYNDROME	43	5.26%
LUPUS NEPHRITIS	29	3.55%
SYSTEMIC LUPUS ERYTHEMATOSUS RASH	26	3.18%
SUBACUTE CUTANEOUS LUPUS ERYTHEMATOSUS	21	2.57%
ACUTE CUTANEOUS LUPUS ERYTHEMATOSUS	9	1.10%
LUPUS VASCULITIS	2	0.24%
LUPUS ENDOCARDITIS	2	0.24%
CENTRAL NERVOUS SYSTEM LUPUS	2	0.24%
LUPUS ANTICOAGULANT HYPOPROTHROMBINAEMIA SYNDROME	2	0.24%
LUPUS VULGARIS	1	0.12%
LUPUS MILIARIS DISSEMINATUS FACIEI	1	0.12%
PERICARDITIS LUPUS	1	0.12%
LUPUS HEPATITIS	1	0.12%
LUPUS CYSTITIS	1	0.12%
LUPUS MYOSITIS	1	0.12%

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5.5.45 Cases of Multisystem Inflammatory Syndrome: 353; 18% within 2 days of injection.

Since the COVID-19 pandemic, Multisystem Inflammatory Syndrome has now been seprated into two contexts for medical discussion:

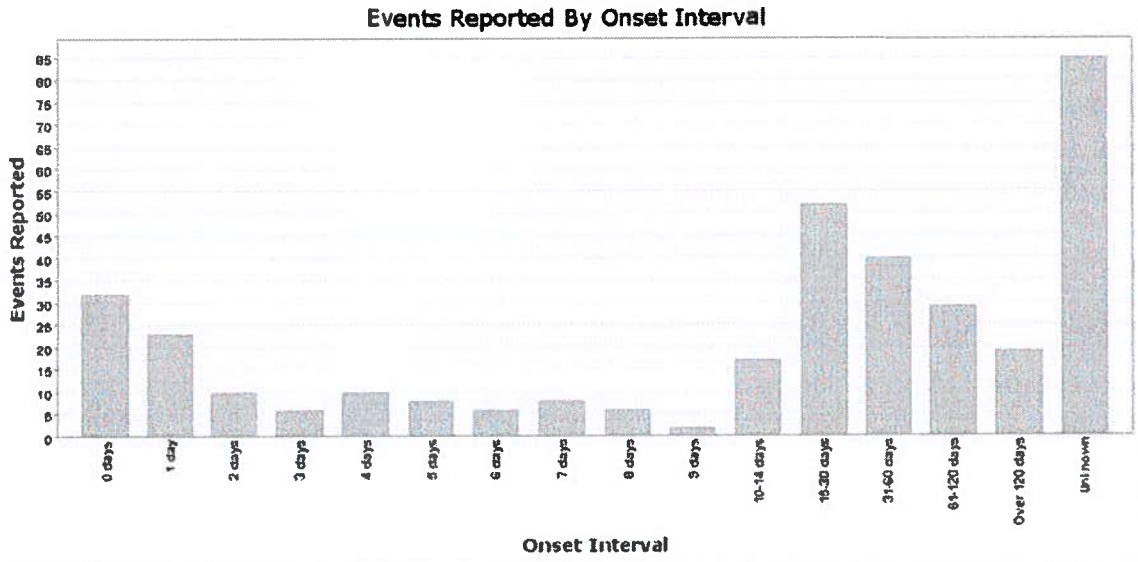
Multisystem Inflammatory Syndrome in adults, **MIS**, is a condition that's associated with COVID-19 infection. In MIS, inflammation affects multiple parts of your body, which can include the heart, brain, kidneys, liver, digestive tract, lungs, skin, and eyes

Multisystem inflammatory syndrome in children, **MIS-C**, or *paediatric inflammatory multisystem syndrome*, or systemic inflammatory syndrome in COVID-19 infection, is a rare systemic illness involving persistent fever and extreme inflammation following exposure to SARS-CoV-2, the virus responsible for COVID-19

MIS, and in particular MIS-C has been in the news and published literature as a concern initially associated with infection but some question whether COVID-19 vaccination is also causing cases. Indeed VAERS currently shows relatively few reported cases presumably induced by vaccines. The largest number of reported cases in VAERS are in the youngest age groups were the children were given the Pfizer-BioNtech vaccine.

Query string:

MULTISYSTEM INFLAMMATORY SYNDROME; MULTISYSTEM INFLAMMATORY SYNDROME IN ADULTS; MULTISYSTEM INFLAMMATORY SYNDROME IN CHILDREN



Messages:

- VAERS data in CDC WONDER are updated every Friday. Hence, results for the same query can change from week to week.
- These results are for 353 total events.
- Rows with zero Events Reported are hidden. Use Quick Options above to show zero rows.

Vaccine	Age	Events Reported	Percent (of 353)
COVID19 (COVID19 (JANSSEN)) (1203)	18-29 years	1	0.28%
	30-39 years	1	0.28%
	65-79 years	1	0.28%
	Unknown	4	1.13%
COVID19 (COVID19 (MODERNA)) (1201)	6-17 years	5	1.42%
	18-29 years	8	2.27%
	30-39 years	4	1.13%
	40-49 years	2	0.57%
	50-59 years	6	1.70%
	60-64 years	1	0.28%
	65-79 years	8	2.27%
	Unknown	5	1.42%
COVID19 (COVID19 (PFIZER-BIONTECH)) (1200)	1-2 years	1	0.28%
	3-5 years	15	4.25%
	6-17 years	166	47.03%
	18-29 years	12	3.40%
	30-39 years	2	0.57%
	40-49 years	3	0.85%
	50-59 years	4	1.13%
	60-64 years	2	0.57%
	65-79 years	5	1.42%
	80+ years	2	0.57%
	Unknown	125	35.41%
COVID19 (COVID19 (UNKNOWN)) (1202)	6-17 years	1	0.28%
	Unknown	4	1.13%
COVID19 (COVID19 (MODERNA BIVALENT)) (1212)	40-49 years	1	0.28%
COVID19 (COVID19 (PFIZER-BIONTECH BIVALENT)) (1211)	60-64 years	1	0.28%

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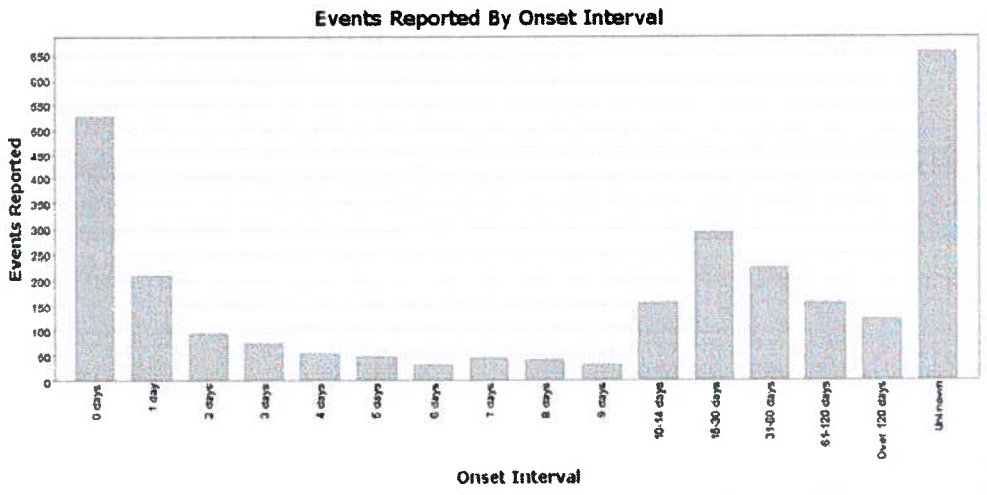
There was great concern for MIS-C from SARS-Cov-2, but after vaccines were 'approved' for children it was found that the vaccine itself could cause MIS-C. The number of papers, studies just provided here suggest that the number of vaccine associated MIS cases are under-reported in VAERS.

5.5.46 Cases of auto-immune or auto-inflammatory disorder: 2,764; 30% within 2 days of injection.

Autoinflammatory disorders refer to problems with the immune system, which usually fights off viruses, bacteria, and infection, but in this consideration possible response to the vaccine. The problem causes immune cells to attack the body - by mistake. This can cause swelling that produces fever, rash, joint swelling, or serious buildup of a blood protein in the organs.

Query string:

AUTOIMMUNE ANAEMIA; AUTOIMMUNE ARTHRITIS; AUTOIMMUNE BLISTERING DISEASE; AUTOIMMUNE CHOLANGITIS; AUTOIMMUNE COLITIS; AUTOIMMUNE DEMYELINATING DISEASE; AUTOIMMUNE DERMATITIS; AUTOIMMUNE DISORDER; AUTOIMMUNE ENCEPHALOPATHY; AUTOIMMUNE ENDOCRINE DISORDER; AUTOIMMUNE ENTEROPATHY; AUTOIMMUNE EYE DISORDER; AUTOIMMUNE HAEMOLYTIC ANAEMIA; AUTOIMMUNE HEPARIN-INDUCED THROMBOCYTOPENIA; AUTOIMMUNE HEPATITIS; AUTOIMMUNE HYPOTHYROIDISM; AUTOIMMUNE INNER EAR DISEASE; AUTOIMMUNE LUNG DISEASE; AUTOIMMUNE LYMPHOPROLIFERATIVE SYNDROME; AUTOIMMUNE MYOCARDITIS; AUTOIMMUNE MYOSITIS; AUTOIMMUNE NEPHRITIS; AUTOIMMUNE NEUROPATHY; AUTOIMMUNE NEUTROPENIA; AUTOIMMUNE PANCREATITIS; AUTOIMMUNE PANCYTOPENIA; AUTOIMMUNE PERICARDITIS; AUTOIMMUNE RETINOPATHY; AUTOIMMUNE THROMBOCYTOPENIA; AUTOIMMUNE THYROID DISORDER; AUTOIMMUNE THYROIDITIS; AUTOIMMUNE UVEITIS; AUTOINFLAMMATORY DISEASE



Prevalent symptoms:

Most reports are just grouped under the general disorder which may be systemic autoimmune response or specific systems not noted. But other than that the three top specific response are in the thyroid, the liver and the blood accounting for 43% of all reports.

Messages:
- VAERS data in CDC WONDER are updated every Friday. Hence, results for the same query can change from week to week.
- These results are for 2,764 total events.
- Rows with zero Events Reported are hidden. Use Quick Options above to show zero rows.

Symptoms	Events Reported	Percent (of 2,764)
AUTOIMMUNE DISORDER	1,308	47.32%
AUTOIMMUNE THYROIDITIS	606	21.92%
AUTOIMMUNE HEPATITIS	350	12.66%
AUTOIMMUNE HAEMOLYTIC ANAEMIA	221	8.00%
AUTOIMMUNE MYOSITIS	54	1.95%
AUTOIMMUNE ARTHRITIS	37	1.34%
AUTOIMMUNE PANCREATITIS	33	1.19%
AUTOIMMUNE NEUROPATHY	27	0.98%
AUTOIMMUNE THYROID DISORDER	27	0.98%
AUTOINFLAMMATORY DISEASE	24	0.87%
AUTOIMMUNE ENCEPHALOPATHY	19	0.69%
AUTOIMMUNE HYPOTHYROIDISM	13	0.47%
AUTOIMMUNE NEUTROPENIA	12	0.43%
AUTOIMMUNE ANAEMIA	12	0.43%
AUTOIMMUNE DEMYELINATING DISEASE	11	0.40%
AUTOIMMUNE INNER EAR DISEASE	7	0.25%
AUTOIMMUNE DERMATITIS	7	0.25%
AUTOIMMUNE COLITIS	7	0.25%
AUTOIMMUNE LUNG DISEASE	7	0.25%
AUTOIMMUNE UVEITIS	6	0.22%
AUTOIMMUNE EYE DISORDER	6	0.22%
AUTOIMMUNE BLISTERING DISEASE	6	0.22%
AUTOIMMUNE MYOCARDITIS	5	0.18%
AUTOIMMUNE LYMPHOPROLIFERATIVE SYNDROME	3	0.11%
AUTOIMMUNE PERICARDITIS	2	0.07%
AUTOIMMUNE CHOLANGITIS	2	0.07%
AUTOIMMUNE PANCYTOPENIA	1	0.04%
AUTOIMMUNE HEPARIN-INDUCED THROMBOCYTOPENIA	1	0.04%

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Case History from Jackson et al:

> *A male in his teens with a history of liver transplant for biliary atresia (aged 2 years) and autoimmune haemolytic anaemia (AIHA, aged 6 years) presented*

with jaundice, dark urine, fatigue and chest discomfort that began 48 hours after the first dose of SARS-CoV-2 Pfizer-BioNTech vaccine (BNT162b2 mRNA)

Despite this poor kid's concerning medical history they jabbed him anyway and within two days' time he's faced with a life threatening condition (HUS). But that's OK. They just removed his spleen and gave him another drug that puts him at risk for meningitis. And at least he's vaccinated. [sarcasm]

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Isabel Garrido, Susana Lopes, Manuel Sobrinho Simões, Rodrigo Liberal, Joanne Lopes, Fátima Carneiro, Guilherme Macedo, **Autoimmune hepatitis after COVID-19 vaccine – more than a coincidence, Journal of**

Autoimmunity, Volume 125, 2021,102741,ISSN 0896-8411
https://www.sciencedirect.com/science/article/pii/S0896841121001499

5.5.47 Summary Discussion – Adverse Events

Unlike mathematics, where propositions can be *proven* with certainty, scientific hypotheses in the strict sense can never be proven. Hypotheses can only be *supported* by presenting evidence that sufficiently *infers* their truth or else *falsified* by as little as one instance of a counter example. Mathematical proof, except for practicing skills, never requires *repetition*. Once a mathematical problem is proven, it is proven forever.

The good practice of science requires continual repetition and challenge, even when a hypothesis has been falsified; something could have been improperly assumed or a fact, assumption or detail missed. Mathematics is exact, science is not. There is no 'proof' in science. This fact places considerable burden on scientists, much more so than the mathematician.

These differences between mathematics and science immediately raise the question: what is considered *sufficient* to warrant a hypothesis as highly probable? Scientists rely on statistical measures such as confidence intervals (CI), but proper use of metrics often requires the associated (and assumed) statistical models (distributions) represent the reality of the data set. Too often they do not. For vaccines, and in particular the COVID-19 vaccines, most adverse events occur in the 'noise' over the entirety of data and very often exist on *fat tailed*[42] distributions. These distributions are NOT the normal (Gaussian) distibutions that are more often the assumed case. For fat tailed distributions, what matters is not so much the frequency of occurrence, but rather the *consequences* of these events. There is far too much attention looking for high frequency of occurrence, the so called *signal* over consequence. Just because measurements may not meet the threshold to qualify as a signal doesn't mean some or most of the measurements are not caused by the vaccine. This is particularly true if the distribution is actually fat tailed and a Gaussian distrubition is assumed.

The consequences for the vaccines, which Bayesian enthusiasts may label 'outliers' to the statistics may very well include cases of the suffering and lost human lives. Too many - fooled by randomness and statistics, as Taleb puts it. Don't look at the data! Manage the victims! But too many victims managed by silencing their voice.

Searching PubMed (https://pubmed.ncbi.nlm.nih.gov/) with the search string:

((covid-19 vaccine) OR (covid 19 vaccine) OR (covid-19 vaccines) OR (covid 19 vaccines)) AND ((adverse reaction) OR injury OR death OR VAERS)

This search brings up 4,592 papers (as of November 12), of course all having been published after December of 2020. This number is overwhelming in such a short time period. It's over 6 papers a day continually for 2 years! We cannot expect the medical community and researchers to digest so much information, let alone be aware that such a body of work exists to effectively address the

[42] Taleb NN, Bar-Yam Y, Cirillo P. **On single point forecasts for fat-tailed variables**. Int J Forecast. 2020;10.1016/j.ijforecast.2020.08.008. doi:10.1016/j.ijforecast.2020.08.008
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7572356/

horrific outcomes unfolding. This is the signal everyone needs to be seeing. This is why vaccination campaigns need to be stopped NOW.

PubMed unfortunately does not track publications by day or month, only year. But by publishing this compendium report on a monthly basis there is a sense that the publication numbers have been growing exponentially. The intent of this report is to make public health officials and other readers aware that, despite the public narrative, the vaccines are causing significant harm and death. It is hoped that this report will at least awaken curiosity for them to do their own research and confirm – or else deny – in their own minds the reality of the situation. We can't wait 10 years to assimilate the data. We need to heed early warning signs.

A high percentage of many of the adverse events noted above having occurred within 2 days of injection of a COVID-19 vaccine and others happening immediately substantiates strong temporal correlation[43], but as many will point out, correlation may not necessarily imply causation. Correlation however is a *necessary* condition for causation. Causation is not easy to determine, but scientists typically use the *Bradford Hill* criteria to test for causation. One publication by MacIntyre applies this criteria to thrombocytopenia to successfully argue indeed these events are being caused by the vaccines:

> MacIntyre, C.R., 2021. **Using the Bradford-Hill criteria to assess causality in the association between CHADOX1 NCOV-19 vaccine and thrombotic immune thrombocytopenia.** Global Biosecurity, 3(1), p.None. DOI: http://doi.org/10.31646/gbio.109

Thrombocytopenia is one of the several adverse events in VAERS that that's even been now accepted by the vaccine manufacturers as a strong signal, and now written as a risk in their FACT sheet for informed consent. Thrombocytopenia has been attributed to many of the deaths reported. MacIntyre concludes his study that indeed the vaccines are causing thrombocytopenia:

> *"**In summary, all criteria for causation are met**, with consistency, specificity, temporality and biological plausibility being very clearly met. Strength of association is met, but more data required to establish the precise estimate of the association, as case ascertainment may be variable between countries, resulting in varied estimates of incidence rates from 25 to 0.5 per 100,000 (2, 4). The application of the modified Bradford-Hill criteria to VITT following **CHADOX1 NCOV- vaccine strongly supports a causal relationship**."*

Myocarditis is now also listed in the vaccine FACT sheets as a risk; particularly the number of cases in young male adults. A great number of published and peer reviewed papers, many cited above substantiate causation and should give pause to immediately stop vaccination, at least for these higher risk age groups and revisit the benefit risk analysis. It appears the vaccine manufacturers are NOT taking that action, and the FDA is not enforcing it. But lives appear to be at risk. With such poor response, more doctors, scientists

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[43] Imran Sulemankhil, Mohammad Abdelrahman, Smita I. Negi, **Temporal association between the COVID-19 Ad26.COV2.S vaccine and acute myocarditis: A case report and literature review**, Cardiovascular Revascularization Medicine, 2021,: https://www.sciencedirect.com/science/article/pii/S1553838921005789

and public health officials must break from the political paralysis that's binding truth for the welfare of a generation. Publications should not hold back in spreading this truth.

An Israeli study by Mevorach et. al. also establishes a causal relationship, increased risk of myocarditis in young male persons receiving the Pfizer BioNtech mRNA vaccines:

Liu R, Pan J, Zhang C, Sun X. **Cardiovascular Complications of COVID-19 Vaccines**. Front Cardiovasc Med. 2022 Mar 18;9:840929. doi: 10.3389/fcvm.2022.840929. PMID: 35369340; PMCID: PMC8971371. https://pubmed.ncbi.nlm.nih.gov/35369340/

Mevorach D, Anis E, Cedar N, et al. **Myocarditis after BNT162b2 mRNA Vaccine against Covid-19 in Israel**. N Engl J Med. 2021;385(23):2140-2149. doi:10.1056/NEJMoa2109730 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8531987/pdf/NEJMoa2109730.pdf

They write:

> *"The incidence of myocarditis, although low, increased after the receipt of the BNT162b2 vaccine, particularly after the second dose among young male recipients. The clinical presentation of myocarditis after vaccination was usually mild."*

But as I've mentioned above using 'mild' to describe myocarditis is misdirection if not disinformation. Myocarditis leads to necrosis of cardiac tissue. The dead tissue is replaced with collagen fibers (scar tissue). Scar tissue, unlike healthy myocytes, cannot function to contract the heart. This causes permanent diminished cardiac output however small that might be. The changes might not result in death or injury of the person but the changes could be a deciding factor in athletic ability especially in peak performers. Describing myocarditis as 'mild' is medical malfeasance, and the authors are clearly softening the tone for publication so that the paper is not rejected in peer review. The present academic dogma is choking scientific expression and harming individuals as much as are the contagion, the vaccines and policy.

Many researchers will do anything to get published; including omission of conclusions that reflect proper interpretation of the data, and 'bending' or biasing truth to satisfy the editors. Their published legacy will defame, not fame them in the history books; they are instrumental participants in sacrificing lives. History will regard them as self-indulging enemies of mankind during this tumultuous time. [opinion]

Considering a preponderance of evidence that COVID-19 vaccines are causing harm, the prudent response by officials should at least be NOT demanding that everyone be vaccinated or arranging expensive and intrusive measures to track vaccinated individuals (vaccine passports). These are the same officials that perpetuate the narrative "Trust the Science" But the evidence is showing that the vaccines are causing harm.

Acting with force and coercion on the premise of the 'higher authority' is an act of malice. It's the practice of mindless zealots, not ethical leaders. We need only to look at history to realize very bad decisions have been made by public health officials in crusades to 'save lives' or 'make lives better'. Some have been by unwitting, intelligent people. But others are more surreptitious by their actions; driven by power and the promise of lucrative profit. [opinion]

Recall the Thalidomide tragedy in the 50's and how long that took to come to an end? From a Nov 2021 report on CNN:

> *"This year, the Covid vaccine has brought in revenue of $24.3 billion. And Pfizer said it expects a total of $36 billion from the vaccine for all of 2021 -- nearly $12 billion more in revenue the final quarter of the year. And it said based on contracts it now has signed it expects revenue $29 billion from the Covid vaccine in 2022. And that's not necessarily all it will bring in."*

This figure now well exceeds $40 billion. When this amount money is involved, there's lots to go around, and it's difficult to NOT have corruption and influence that's counterproductive to health and welfare of the nation. As the [illicit] drug cartels have shown, money buys loyalty, obedience and protection.

This website https://www.topmastersinpublichealth.com/10-biggest-medical-scandals-in-history/ chronicles the 10 biggest medical scandals in history last updated in 2017. But these numbers will pale compared to what VAERS alone reports. The COVID-19 vaccine assault on humanity will be the largest ever. [opinion]

Lastly something never mentioned in regulatory discussions of the risk benefit analyses is how these analyses properly account for the now factual side effects (e.g. myocarditis, anaphylaxis, thrombocytopenia, etc.) and the selected treatments (mitigations) for the side effects. These are never mentioned in the decisions to move forward with continuing vaccination. When you think about it the problem is overwhelmingly complex, but the appearance, at least what is offered in the public meetings is these concerns are dismissed with simplified assumptions and literally hand waving explanations. They provide no confidence whatsoever of a legitimate operation.

5.5.48 Vaccine site complications or complaints

For the COVID-19 vaccines there's been **141,861** complications or compliants reported in VAERS. The prevalence of vaccination site symptoms are reported in the following table:

Messages:
- VAERS data in CDC WONDER are updated every Friday. Hence, results for the same query can change from week to week.
- These results are for 141,861 total events.

Symptoms	Events Reported	Percent (of 141,861)
VACCINATION FAILURE	76,991	54.27%
VACCINATION SITE PAIN	37,075	26.13%
VACCINATION SITE ERYTHEMA	10,942	7.71%
VACCINATION SITE SWELLING	10,469	7.38%
VACCINATION SITE PRURITUS	6,034	4.25%
VACCINATION COMPLICATION	5,414	3.82%
VACCINATION SITE WARMTH	5,354	3.77%
VACCINATION SITE REACTION	5,010	3.53%
VACCINATION SITE RASH	3,650	2.57%
VACCINATION SITE MASS	2,177	1.53%
VACCINATION SITE INDURATION	1,846	1.30%
VACCINATION SITE INFLAMMATION	1,219	0.86%
VACCINATION SITE MOVEMENT IMPAIRMENT	1,197	0.84%
VACCINATION SITE BRUISING	1,073	0.76%
VACCINATION SITE DISCOMFORT	675	0.48%
VACCINATION SITE OEDEMA	622	0.44%
VACCINATION SITE HAEMORRHAGE	557	0.39%
VACCINATION SITE LYMPHADENOPATHY	553	0.39%
VACCINATION SITE URTICARIA	521	0.37%
VACCINATION SITE DISCOLOURATION	491	0.35%
VACCINATION ERROR	471	0.33%
VACCINATION SITE PARAESTHESIA	355	0.25%
VACCINATION SITE HAEMATOMA	330	0.23%
VACCINATION SITE HYPOAESTHESIA	306	0.22%
VACCINATION SITE CELLULITIS	219	0.15%
VACCINATION SITE NODULE	205	0.14%
VACCINATION SITE VESICLES	191	0.13%
VACCINATION SITE JOINT MOVEMENT IMPAIRMENT	182	0.13%
VACCINATION SITE JOINT PAIN	164	0.12%
VACCINATION SITE IRRITATION	126	0.09%
VACCINATION SITE INFECTION	103	0.07%
VACCINATION SITE HYPERSENSITIVITY	93	0.07%
VACCINATION SITE DISCHARGE	87	0.06%
VACCINATION SITE HYPERAESTHESIA	60	0.04%
VACCINATION SITE ABSCESS	57	0.04%
VACCINATION SITE SCAR	55	0.04%
VACCINATION SITE DYSAESTHESIA	47	0.03%
VACCINATION SITE SCAB	45	0.03%
VACCINATION SITE COLDNESS	45	0.03%
VACCINATION SITE JOINT ERYTHEMA	44	0.03%
VACCINATION SITE PAPULE	41	0.03%
VACCINATION SITE INJURY	40	0.03%
VACCINATION SITE JOINT SWELLING	40	0.03%
VACCINATION SITE ANAESTHESIA	39	0.03%
VACCINATION SITE EXTRAVASATION	34	0.02%
VACCINATION SITE NECROSIS	32	0.02%
VACCINATION SITE NERVE DAMAGE	28	0.02%
VACCINATION SITE PUSTULE	20	0.01%
VACCINATION SITE MACULE	19	0.01%
VACCINATION SITE PLAQUE	18	0.01%
VACCINATION SITE STREAKING	17	0.01%
VACCINATION SITE THROMBOSIS	17	0.01%

Of these same set of symptoms, we can see that the Pfizer and Moderna vaccines account for over 90% of those reports, but that's probably due to the fact that these vaccines had the largest distribution.

Messages:
- VAERS data in CDC WONDER are updated every Friday. Hence, results for the same query can change from week to week.
- These results are for 141,861 total events.

Vaccine	Events Reported	Percent (of 141,861)
COVID19 (COVID19 (PFIZER-BIONTECH)) (1200)	95,214	67.12%
COVID19 (COVID19 (MODERNA)) (1201)	34,128	24.06%
COVID19 (COVID19 (JANSSEN)) (1203)	12,895	9.09%
COVID19 (COVID19 (UNKNOWN)) (1202)	243	0.17%
COVID19 (COVID19 (PFIZER-BIONTECH BIVALENT)) (1211)	41	0.03%
COVID19 (COVID19 (MODERNA BIVALENT)) (1212)	33	0.02%
COVID19 (COVID19 (NOVAVAX)) (1210)	2	0.00%

To put the numbers in perspective we can also compare the same set of symptoms for all vaccines over all time:

Messages:

- VAERS data in CDC WONDER are updated every Friday. Hence, results for the same query can change from week to week.
- These results are for 162,062 total events.
- Rows with zero Events Reported are hidden. Use Quick Options above to show zero rows.

Vaccine	Events Reported	Percent (of 162,062)
COVID19 (COVID19 (PFIZER-BIONTECH)) (1200)	95,214	58.75%
COVID19 (COVID19 (MODERNA)) (1201)	34,128	21.06%
COVID19 (COVID19 (JANSSEN)) (1203)	12,895	7.96%
ZOSTER (NO BRAND NAME) (1103)	3,228	1.99%
ZOSTER (SHINGRIX) (1192)	2,012	1.24%
PNEUMO (PREVNAR13) (1141)	1,509	0.93%
PNEUMO (PNEUMOVAX) (30)	1,501	0.93%
ROTAVIRUS (ROTARIX) (1124)	1,406	0.87%
VACCINE NOT SPECIFIED (NO BRAND NAME) (999)	1,324	0.82%
HEP B (NO BRAND NAME) (110)	1,048	0.65%
INFLUENZA (SEASONAL) (NO BRAND NAME) (44)	1,036	0.64%
ZOSTER LIVE (ZOSTAVAX) (1097)	859	0.53%
VARICELLA (VARIVAX) (269)	773	0.48%
MEASLES + MUMPS + RUBELLA (MMR II) (26)	676	0.42%
TDAP (BOOSTRIX) (1091)	638	0.39%
MENINGOCOCCAL B (BEXSERO) (1165)	549	0.34%
HIB (ACTHIB) (256)	471	0.29%
HPV (GARDASIL) (1098)	444	0.27%
HEP B (ENGERIX-B) (38)	437	0.27%
TDAP (ADACEL) (1092)	371	0.23%
INFLUENZA (SEASONAL) (FLUZONE) (7)	356	0.22%
ROTAVIRUS (ROTATEQ) (1096)	346	0.21%
MENINGOCOCCAL (NO BRAND NAME) (113)	317	0.20%
INFLUENZA (SEASONAL) (FLUZONE HIGH-DOSE) (1145)	294	0.18%
PNEUMO (PREVNAR) (1001)	292	0.18%
INFLUENZA (SEASONAL) (FLUZONE QUADRIVALENT) (1162)	288	0.18%
MEASLES + MUMPS + RUBELLA (NO BRAND NAME) (114)	284	0.18%
DTAP (INFANRIX) (286)	270	0.17%
HEP A (HAVRIX) (268)	268	0.17%
ROTAVIRUS (NO BRAND NAME) (1099)	267	0.16%
INFLUENZA (SEASONAL) (FLUARIX QUADRIVALENT) (1161)	263	0.16%
COVID19 (COVID19 (UNKNOWN)) (1202)	243	0.15%
MEASLES + MUMPS + RUBELLA + VARICELLA (PROQUAD) (1094)	238	0.15%
DTP (NO BRAND NAME) (2)	233	0.14%
PNEUMO (NO BRAND NAME) (120)	214	0.13%
HPV (GARDASIL 9) (1170)	213	0.13%
DTAP-IPV-HEPB-HIB (INFANRIX HEXA) (1139)	211	0.13%
MENINGOCOCCAL CONJUGATE (MENACTRA) (1090)	211	0.13%
MENINGOCOCCAL CONJUGATE (MENVEO) (1140)	196	0.12%
INFLUENZA (SEASONAL) (FLUCELVAX QUADRIVALENT) (1175)	190	0.12%
INFLUENZA (SEASONAL) (FLUVIRIN) (262)	185	0.11%
DTAP (DAPTACEL) (1064)	183	0.11%
DTAP + IPV (KINRIX) (1126)	169	0.10%
POLIO VIRUS, INACT. (IPOL) (1030)	169	0.10%
VARICELLA (NO BRAND NAME) (1062)	164	0.10%
DTAP + IPV (UNKNOWN) (1164)	160	0.10%
SMALLPOX (DRYVAX) (47)	154	0.10%
INFLUENZA (SEASONAL) (FLUARIX) (1089)	149	0.09%

So then VAERS currently reports **162,062 vaccine site complications or complaints** for all vaccines over all time with the COVID-19 vaccines alone reporting **142,137** complications or complaints (almost 88% of vaccination site complications for all vaccines over all time). This evidence tends to support the allegations by the Italian Pharmacologists, Cosentino and Marino that the COVID-19 'vaccines' indeed are not vaccines but rather drugs by the nature of their pharmacodynamics.

One of the issues that has come up over COVID-19 vaccinations are reports that nurses or doctors are not aspirating with the syringe prior to injection of the vaccine. This process, recommended by the manufacturers, is intended to test whether the selected injection site is indeed restricted to an intramuscular compartment and not into a vein where the vaccine contents could distribute systemically rather than remain locally at the injection site.

Some speculate, regardless of reason, which the lack of aspirating the syringe might be leading to many of the adverse events being reported. The process is not difficult. It simply requires the nurse to draw the syringe outward after the needle is inserted. If no blood is seen, then the needle is inside muscle tissue. There's at least one paper that addresses the question:

Rzymski P, Fal A. **To aspirate or not to aspirate? Considerations for the COVID-19 vaccines.** Pharmacol Rep. 2022 Mar 23:1–5. doi: 10.1007/s43440-022-00361-4. Epub ahead of print. PMID: 35320581; PMCID: PMC8941363. https://pubmed.ncbi.nlm.nih.gov/35320581/

5.5.49 Other Reported Symptoms

There have been concerns of other issues voiced in discussions outside the mainstream channels that were largely ignored but deserve at least some mention since VAERS does provide these symptoms for search. Some of the more credible concerns are addressed here.

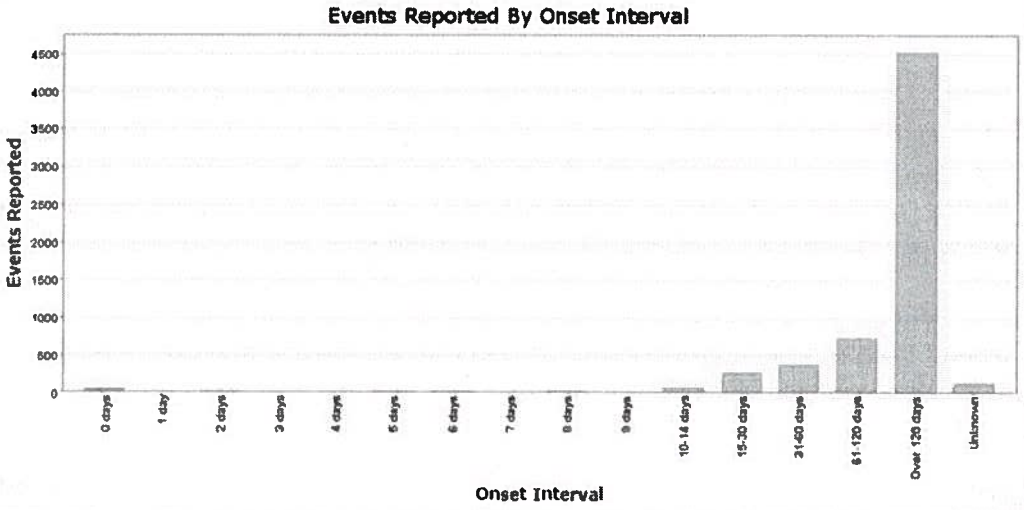
VAERS currently reports:

46 cases of **Vaccine Associated Enhanced Disease.** This includes both VACCINE ASSOCIATED ENHANCED DISEASE and VACCINE ASSOCIATED ENHANCED RESPIRATORY DISEASE

4 case of **Vaccine Virus Shedding (**note two months ago VAERS reported 48 cases**)**

6,293 Vaccine Breakthrough Infections, considering that Omicron BA.4 and BA.5 variants were reporting high breakthrough cases in the news

The distribution of the onset of breakthrough infections is plotted below showing most were reported after 4 months from vaccination.



It's well published now that the COVID-19 vaccines offer little to no protection from delta or omicron variants of the virus. But the number of reported COVID-19 vaccination breakthrough infection incidents aligns with reports that the vaccinated, if expressing flu-like symptoms, are NOT being routinely tested for COVID-19[44]. That is a political, not a medical or epidemiological decision. The figures would further spoil the narrative that the COVID-19 vaccines are effective.

[44] Carolyn Crist CDC: Fully Vaccinated Can Skip Routine COVID Testing WebMD June 4, 2021

Further citations of publications on these subjects:

Khalil F, Badshah M, Perinkulam Sathyanarayanan S, Lamfers R. **Breakthrough Severe COVID-19 Infection After Triple Dose Pfizer Vaccination**. S D Med. 2022 Apr;75(4):171-174. PMID: 35709349. https://pubmed.ncbi.nlm.nih.gov/35709349/

Ventura MI, Azizian A, Evans SE, Velasquez S, Arguello JC, Warburton K. **Vaccine breakthrough infections with SARS-CoV-2: Why older adults need booster vaccinations**. Public Health Pract (Oxf). 2022 Dec;4:100307. doi: 10.1016/j.puhip.2022.100307. Epub 2022 Sep 7. PMID: 36092529; PMCID: PMC9448684. https://pubmed.ncbi.nlm.nih.gov/36092529/

Bigay J, Le Grand R, Martinon F, Maisonnasse P. **Vaccine-associated enhanced disease in humans and animal models: Lessons and challenges for vaccine development**. Front Microbiol. 2022 Aug 10;13:932408. doi: 10.3389/fmicb.2022.932408. PMID: 36033843; PMCID: PMC9399815. https://pubmed.ncbi.nlm.nih.gov/36033843/

Ning W, Xu W, Cong X, Fan H, Gilkeson G, Wu X, Hughes H, Jiang W. **COVID-19 mRNA vaccine BNT162b2 induces autoantibodies against type I interferons in a healthy woman**. J Autoimmun. 2022 Aug 18;132:102896. doi: 10.1016/j.jaut.2022.102896. Epub ahead of print. PMID: 36029717; PMCID: PMC9385769. https://pubmed.ncbi.nlm.nih.gov/36029717/

Ebenig A, Muraleedharan S, Kazmierski J, Todt D, Auste A, Anzaghe M, Gömer A, Postmus D, Gogesch P, Niles M, Plesker R, Miskey C, Gellhorn Serra M, Breithaupt A, Hörner C, Kruip C, Ehmann R, Ivics Z, Waibler Z, Pfaender S, Wyler E, Landthaler M, Kupke A, Nouailles G, Goffinet C, Brown RJP, Mühlebach MD. **Vaccine-associated enhanced respiratory pathology in COVID-19 hamsters after TH2-biased immunization**. Cell Rep. 2022 Aug 16;40(7):111214. doi: 10.1016/j.celrep.2022.111214. Epub 2022 Aug 3. PMID: 35952673; PMCID: PMC9346010. https://pubmed.ncbi.nlm.nih.gov/35952673/

Taquet M, Dercon Q, Harrison PJ. **Six-month sequelae of post-vaccination SARS-CoV-2 infection: A retrospective cohort study of 10,024[45] breakthrough infections**. Brain Behav Immun. 2022 Apr 18;103:154-162. doi: 10.1016/j.bbi.2022.04.013. Epub ahead of print. PMID: 35447302; PMCID: PMC9013695. https://pubmed.ncbi.nlm.nih.gov/35447302/

Gazit S, Shlezinger R, Perez G, Lotan R, Peretz A, Ben-Tov A, Herzel E, Alapi H, Cohen D, Muhsen K, Chodick G, Patalon T. **SARS-CoV-2 Naturally Acquired Immunity vs. Vaccine-induced Immunity, Reinfections versus Breakthrough Infections: a Retrospective Cohort Study**. Clin Infect Dis. 2022 Apr 5:ciac262. doi: 10.1093/cid/ciac262. Epub ahead of print. PMID: 35380632. https://pubmed.ncbi.nlm.nih.gov/35380632/

Kim AHJ, Nakamura MC. COVID-19 **Breakthrough Infection Among Immunocompromised Persons**. JAMA Intern Med. 2021 Dec 28. doi: 10.1001/jamainternmed.2021.7033. Epub ahead of print. PMID: 34962552. https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2787647

Sun J, Zheng Q, Madhira V, Olex AL, Anzalone AJ, Vinson A, Singh JA, French E, Abraham AG, Mathew J, Safdar N, Agarwal G, Fitzgerald KC, Singh N, Topaloglu U, Chute CG, Mannon RB, Kirk GD, Patel RC; National COVID Cohort Collaborative (N3C) Consortium. **Association Between Immune Dysfunction and COVID-19 Breakthrough Infection After SARS-CoV-2 Vaccination in the US**. JAMA Intern Med. 2021 Dec

[45] Note the discrepancy of breakthrough infections this report offers vs what was reported in VAERS above (4076 at the date of this report, 5/7/2022).

28. doi: 10.1001/jamainternmed.2021.7024. Epub ahead of print. PMID: 34962505.
https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2787643

Joan Chung, MD, **A Case of Breakthrough COVID-19 Requiring Hospitalization**, Proceedings of UCLA Health -VOLUME 25 (2021)-
https://proceedings.med.ucla.edu/wp-content/uploads/2021/10/Chung-A210614JC-BLM-formatted.pdf

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These references that follow do not necessarily relate to the cited adverse events queried from VAERS listed above. They rather introduce other general or specific topics surrounding COVID-19 vaccine injury.

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The study by Klein et al largely written by doctors from Kaiser Permanente and includes two officials from the CDC. It involves a huge cohort. While they mention myocarditis and VITT, they downplay the numbers using relative risk reduction statistics. A HUGE cohort of 6.2 million and not once is the word 'death' mentioned. Try searching the paper yourself. It's conspicuously missing. You would think that if you wanted to dispel concerns for the nearly 32,000 deaths (as of Oct 2022) that have been reported in VAERS you would offer some analysis, some explanation, some comment regarding the elephant in the room. [opinion]

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From Pandit et al:

> *"A total of 111 reports were reviewed, with summaries of the reported key side effects discussed, including seizures, myocarditis, stroke, multisystem inflammatory syndrome in children (MIS-C), chest pain, hematuria, menstrual disorder, appendicitis, behavioral and otological side effects, etc."*

But wait .. they did need to get published so ...

> *"We have no intention of repudiating the overwhelming public health benefits of the COVID-19 vaccines. Vaccines play a major role in controlling the spread and impact of infectious diseases. Considering COVID-19 infection and its complications, vaccination in the pediatric population and pregnant women is needed to minimize the ongoing spread and evolution of the COVID-19 pandemic in the pediatric population"*

After all the observed side effects only < 0.2% (111 kids). Once again they have to throw the innocent virgins into the volcano to appease the vaccine gods. Nuremberg - note Pandit et al in the list for the tribunals.

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Tandon et al, in conclusion:

> *"Vaccination remains the best and safest way to protect against serious illness and death from COVID-19. It remains unclear that any other treatment will have success in changing the natural history of the disease"*

UNBELIEVABLE. Candy coated conclusion to get published. Follow the narrative to tickle the peer reviewer's fancy. They make this conclusion yet their paper NOWHERE provides data on outcomes of unvaccinated patients. So how can they make this claim? Hearsay? The CDC told them? [opinion][46]

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[46] I'll apologize for not sparing the reader hyperbole. But somehow I had to communicate my exhaustion over the persistent rhetoric I'm seeing authors use to mis direct attention from the obvious results data dictates. Why do they do this? Obviously to get published. These are intended to be *scientific* studies. If you've reached this point in the report I commend your patience. Please shoot me an email to let me know you've made it this far. Thanks for your time.

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Dobson speaks about Science as though it were absolute and incorruptible. That the 'recipients of science' and their reluctance to obey authority are the problem. That every scientist is pure at heart and not influenced by economic, political or egotistical influence to publish. Absolutely no benefit of the doubt that Junk Science[47] exists and that the peer review process has been hijacked by political narrative, corporate and government influence.

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In Al-Qaza, et al. - **Outrageous claim**!! – they conclude the reason women are more susceptible are psychological factors. How did this get past peer review?

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The Elisha paper says: Subjective perceptions of physicians, nurses, and researchers involved with vaccines through practice and/or research and who take a critical view on vaccines reported being subjected to a variety of censorship and suppression tactics, including:

- retraction of papers pointing to vaccine safety problems
- negative publicity
- difficulty in obtaining research funding
- calls for dismissal
- summonses to official hearings
- suspension of medical licenses, and
- self-censorship

Scientific discourse is a hallmark of science and its suppression endangers proper interpretation of the facts by propping up a false impression of scientific consensus.

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Regarding the Röltgen paper, on Feb 8, 2022 Dr. Schooley, an Infectious Disease Specialist at UCSD, was guest speaker at the County Board of Supervisors meeting on agenda item 16, the monthly COVID-19 status report from Wilma Wooten, SDC HHS . Schooley addressed immunology as it relates to SARS-Cov-2 infections, the variants and vaccination. In his presentation he explained how the mRNA introduced by the vaccine degrades in 12 hours and that the spike protein, an agent produced by the body's own cells after being reprogrammed by vaccine induced mRNA, disappears over 48 hours. He also mentioned that the mRNA coding, although originally coded to address the initial Wuhan strain, still provides protection from the delta and omicron variants. But only a week after Schooley's tutorial, Röltgen's work was published indicating significantly longer residence time.

The residence time of mRNA introduced by the vaccine and the subsequent spike protein antigen synthesized by cells is significantly longer than 12 days. The study detected presence of both factors for up to 60 days in some subjects; that's when the study ended. So it's very possible residence time could be much longer.

Main results from the Röltgen paper:

- Viral variant infection elicits variant-specific antibodies, but prior mRNA vaccination imprints serological responses toward Wuhan-Hu-1 rather than variant antigens. (that's the initial Wuhan strain)

- In contrast to disrupted germinal centers (GCs) in lymph nodes during infection, mRNA vaccination stimulates robust GCs containing vaccine mRNA and spike antigen up to 8 weeks post vaccination in some cases.

- Another fact, not pointed out by the researchers, however obvious from the context of the paper is they actually found the mRNA from the vaccine in lymph nodes. This is evidence the vaccine does not stay in the injection site. It indeed travels throughout the body – which was not intended by the vaccine designers! (another reason for the FDA to step in)

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> *Large-scale COVID-19 vaccinations are currently underway in many countries in response to the COVID-19 pandemic. Here, we report, besides generation of neutralizing antibodies, consistent alterations in hemoglobin A1c, serum sodium and potassium levels, coagulation profiles, and renal functions in healthy volunteers after vaccination with an inactivated SARS-CoV-2 vaccine. Similar changes had also been reported in COVID-19 patients, suggesting that vaccination mimicked an infection. Single-cell mRNA sequencing (scRNA-seq) of peripheral blood mononuclear cells (PBMCs) before and 28 days after the first inoculation also* ***revealed consistent alterations in gene expression of many different immune cell types. Reduction of CD8+ T cells and increase in classic monocyte contents were exemplary. Moreover, scRNA-seq revealed increased NF-κB signaling and reduced type I interferon responses****, which were confirmed by biological assays and also had been reported to occur after SARS-CoV-2 infection with aggravating symptoms. Altogether, our study recommends additional caution when vaccinating people with pre-existing clinical conditions, including diabetes, electrolyte imbalances, renal dysfunction, and coagulation disorders.*

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6. Excess Death, All Cause Mortality

The problem with determining the difference between causality and correlation is there may be many inputs to the system that can also lead to adverse effects and which may not be observable or even known. The benefit of excess all-cause mortality (aka excess deaths) analysis is it doesn't care about inputs. It assumes ALL inputs and depends on a historical trend to determine if more recent outcomes are falling out of line with the trend. So at least several researchers in public health have turned to this tool.

An extraordinary number of people died in the first quarter of 2022, April 25, 2022
https://hagstofa.is/utgafur/frettasafn/mannfjoldi/mannfjoldinn-a-1-arsfjordungi-2022/

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7. 'Spikopathy' – Death by spike protein

This section addresses questions regarding the spike protein, also called the S-protein or S-glycoprotein. It's the protein that exists either on the surface of the intact virion (e.g. SARS-CoV-2) or the outcome of the body's cells manufacturing it in isolation and instructed by mRNA vaccines. The most typical questions that come up include:

Is the spike protein a cytotoxin?

Is the spike protein in the virion any different than the spike protein produced from vaccines?

What's the difference in body load or dosing between infection and vaccination?

By this time most of the world is somewhat familiar with the basic morphology of the SARS-Cov-2 corona virus and particularly the 'spike protein', the small flower-like structures that cover the surface of the virus. These structures are known to be the means by which the virus attaches itself to the host cell, and through a process called endocytosis, injects viral mRNA into the cell to hijack the cell's protein factory to produce replicas of the virus. The mechanism of the mRNA vaccines also hijacks the cell's protein factory, but rather than producing the full virus, only the spike protein is expressed to stimulate immune response.

Peter McCullough recently claimed[48] that the COVID-19 vaccine-produced Spike protein (aka S protein) is at least as pathogenic, if not more as the Spike protein that exists on the SARS-CoV-2 virus. The presence of spike protein in the body, long after covid infection might explain 'long covid' manifesting in many organ

[48] https://www.americaoutloud.com/accumulating-spike-protein-threatens-the-health-of-billions/

systems of the body. So you really have to ask, if the spike protein is pathogenic, why on earth would scientists and vaccine developers dare to use it to stimulate immune response?

A casual search on the internet asking the question: "Is the covid-19 spike protein cytotoxic?" results in a barrage of 'fact checker' websites that largely reject any position that spike protein might have toxic effects on cells. A Wikipedia page[49] titled "Coronavirus spike protein" includes a paragraph labeled "Misinformation" where it's claimed the spike protein from vaccine is NOT cytotoxic:

> *"During the COVID-19 pandemic, anti-vaccination misinformation about COVID-19 circulated on social media platforms related to the spike protein's role in COVID-19 vaccines. Spike proteins were said to be dangerously "cytotoxic" and mRNA vaccines containing them therefore in themselves dangerous. Spike proteins are not cytotoxic or dangerous. Spike proteins were also said to be "shed" by vaccinated people, in an erroneous allusion to the phenomenon of vaccine-induced viral shedding, which is a rare effect of live-virus vaccines unlike those used for COVID-19. "Shedding" of spike proteins is not possible"* [6 September 2022]

But Wikipedia's only two references cited to support this assertion are NOT scientific publications, rather more 'waving arm' fact checker type articles without substantiated references. It seems authors, and the fact checkers are casually dismissing this possibility and neglected other resources that indeed refer to the spike protein as toxic or pathogenic such as this paper published in Microorganisms[50]:

> *"... other properties of spike protein, such as toxicity, can intensify the pathogenicity of SARS-CoV-2. For example, the spike protein of SARS-CoV-2 can induce coagulation of the platelets in the blood stream of severely infected patients"* and
> *"Apart from the toxicity of the S protein, the S1 domain is highly mutable and may*
> *not be a suitable candidate [*Delta & Lambda*] for drug targeting"*
>
> and
>
> *"Toxicity of the S protein to stimulate thrombosis is the notable concern in current mRNA and adenovirus vaccines which express the S protein. Toxicity of the S protein can result in stimulation of platelet activity and the release of coagulation factors, which may cause thrombosis in infected individuals. Due to high mutation in the S protein, which may cause immune escape in new variants and a toxicity property, the investigation of alternative proteins or treatment other than spike-based vaccines to stimulate an immune response*

[49] https://en.wikipedia.org/wiki/Coronavirus_spike_protein
[50] Moghaddar M, et al. **Severity, Pathogenicity and Transmissibility of Delta and Lambda Variants of SARS-CoV-2, Toxicity of Spike Protein and Possibilities for Future Prevention of COVID-19**. Microorganisms. 2021; 9(10):2167. https://doi.org/10.3390/microorganisms9102167

is suggested"

In March of 2021, Lei et al[51] published the results of an *in-vivo* study (mice) revealing the impact of S protein on mitochondrial function:

> *"Confocal images of ECs treated with S1 protein revealed increased mitochondrial fragmentation, indicating altered mitochondrial dynamic"*

More specifically, they measured and found reduced basal mitochondrial respiration, ATP production, and maximal respiration as a result of introducing the S protein. They concluded for the SARS-Cov-2 virion that:

> *"... S protein alone can damage endothelium, manifested by impaired mitochondrial function".*

So the spike glycoprotein molecule alone from the SARS-Cov-2 virus can damage endothelial cells, cells that exist in the tissues of many critical organ systems throughout the body including heart muscle, kidneys and liver.

To better appreciate the consequences of this outcome, one needs to understand the essential role of mitochondria; subcellular structures that exist within every cell of the body. Mitochondria are the power plants of cellular respiration. They are dynamic *organelles* capable of changing their organization and shape based on intracellular and extracellular signals to optimize respiration. By balancing cycles of fusion and fission, mitochondria can regulate their morphology. ***Mitochondrial fragmentation*** is the result of decreased fusion and increased fission in mitochondria. It is characterized by a large number of smaller mitochondria—as opposed to a network of highly interconnected and elongated mitochondria, which is the product of increased fusion.

Mitochondrial fragmentation is a necessary function for mitophagy (the elimination of mitochondria in removal of naturally dying cells), since smaller mitochondria are more easily engulfed by auto-phagosomes than larger ones and require less energy to be auto-phagocytosed. The fragmented state predominates during periods of high stress as well as before and after the release of apoptogenic factors which signal for cell death (apoptosis). Another study suggests mounting evidence that mitochondrial dysfunction (fragmentation) is also an early and causal event in neurodegeneration[52]. Many of the adverse events resulting from COVID-19 vaccination and accounted for in this report involve neurogenic disease.

On August 18 a self-published paper, *Vascular and organ damage induced by mRNA vaccines: irrefutable proof of causality*[53] was issued through social media channels. The authors, Michael Palmer, MD and Sucharit Bhakdi, MD, are well respected doctors with many years of experience and knowledge however they are unable to publish after being black-balled by institutional publication venues. Bhakdi and Palmer make a clear argument the spike protein is the central factor of pathology from the vaccines, and indeed they appear to have made a convincing connection between the spike protein and vasculature damage.

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[51] https://www.ahajournals.org/doi/10.1161/CIRCRESAHA.121.318902

[52] Knott, A., Perkins, G., Schwarzenbacher, R. et al. Mitochondrial fragmentation in neurodegeneration. Nat Rev Neurosci 9, 505–518 (2008). https://doi.org/10.1038/nrn2417

[53] https://doctors4covidethics.org/vascular-and-organ-damage-induced-by-mrna-vaccines-irrefutable-proof-of-causality/

"Vaccine-induced expression of the spike protein induces autoimmune-like inflammation" and that can lead to organ damage and death. The website hosting the paper offers a good point to point summary of the paper:

1. Most of the evidence presented here is from the work of pathologist Prof. Arne Burkhardt, MD
2. Pfizer's own animal experiments show that the vaccine quickly distributes throughout the body
3. Expression of viral proteins can be detected with immunohistochemistry
4. Expression of spike protein in shoulder muscle after vaccine injection
5. Coronavirus particles contain two prominent proteins: spike (S) and nucleocapsid (N)
6. Infected persons express the nucleocapsid protein (and also the spike protein)
7. Injected persons express only the spike protein, which implicates the vaccine
8. Expression of spike protein within the walls of small blood vessels
9. Endothelial stripping and destruction of a small blood vessel after vaccination
10. A crack in the wall of the aorta, lined by clusters of lymphocytes, leading to aortic rupture
11. Healthy heart muscle tissue, and lymphocytic myocarditis
12. Lymphocytic infiltration and proliferative inflammation in lung tissue
13. Vaccine-induced expression of spike protein in a bronchial biopsy nine months after vaccination
14. The Pfizer vaccine mRNA gets copied ("reverse-transcribed") into DNA and inserted into the cellular genome

In their summary the investigators claim their evidence demonstrates the complete chain of causation:

- Injection
- rapid distribution of the vaccine through the bloodstream,
- widespread spike protein expression, prominently in blood vessels, and
- autoimmune-like inflammation and organ damage.

Lastly, a study published by Italian doctors comparing blood samples between vaccinated and unvaccinated patients (Cepelli et al) show 94% of the vaccinated sample (over 1000 subjects) showed aggregation of erythrocytes and the presence of particles of various shapes and sizes of unclear origin one month after the mRNA inoculation. The doctors claim to have replicated the work of a Korean group (Lei et al referenced above) having observed similar findings however improved by the use of dark-field microscopy. There were 948 vaccinated abnormal cases where they observed *"tubular/fibrous formations and frequently also crystalline and lamellar formations with extremely complex but consistently similar morphologies"*. The paper [7] is yet another indictment of many on the safety of Pfizer and Moderna mRNA COVID-19 vaccines. These results SHOULD cause great alarm. The authors speculate that the spike protein, among other vaccine components may be the cause of the coagulation observed in their blood samples. They conclude

> *"..., such abrupt changes as we have documented in the peripheral blood profile of 948 patients have never been observed after inoculation by any vaccines in the past according to our clinical experience. The sudden transition, usually at*

the time of a second mRNA from a state of perfect normalcy to a pathological one, with accompanying hemolysis, visible packing and stacking of red blood cells in conjunction with the formation of gigantic conglomerate foreign structures, some of them appearing as graphene family super structures, is unprecedented. Such phenomena have never been seen before"

The 'stacking' of red blood cells is normally observed however in capillary samples where red blood cells self-assemble to properly allow flow through the tight space of capillary vasculature. This is known as the Rouleaux effect. Rouleaux stacking should never occur in in the larger vessels where blood flow rates are large. Results indicate the presence of something foreign in the blood or a change in physiology signaling the stacking. *Spikopathy*?

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Clinical Science.
DOI: 10.1042/CS20210735

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Altman et al:

> *"Spike protein can produce cell damage and altered gene expression, and myocardial injury or myocarditis can occur during COVID-19 or after mRNA vaccination."*

[18] Felipe Cuspoca A, Isaac Estrada P, Velez-van-Meerbeke A. **MOLECULAR MIMICRY OF SARS-COV-2 SPIKE PROTEIN IN THE NERVOUS SYSTEM: A BIOINFORMATICS APPROACH**. Comput Struct Biotechnol J. 2022 Oct 27. doi: 10.1016/j.csbj.2022.10.022. Epub ahead of print. PMID: 36317085; PMCID: PMC9605789. https://pubmed.ncbi.nlm.nih.gov/36317085/

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8. Revisiting Effectiveness of the COVID-19 Vaccines

The fact that the COVID-19 vaccines are causing significant injury and death, and accepting the flawed policy that it's ok to injure some to protect others is an egregious act by public health officials. But wait, there's more. We can still ask the basic question: are the vaccines really providing protection? This question more pertinent than ever considering the vaccines were designed to vector the initial Wuhan strain of SARS-Cov2, which no longer exists.

Even the phase 3 Pfizer and Moderna vaccine trials, accepted by the FDA is flawed since the studies used deceptive relative risk reduction (RRR) metrics. In a paper by Brown[54] Brown demonstrated in simple

[54] Brown RB. **Outcome Reporting Bias in COVID-19 mRNA Vaccine Clinical Trials**. Medicina (Kaunas). 2021 Feb 26;57(3):199. doi: 10.3390/medicina57030199. PMID: 33652582; PMCID: PMC7996517.

language and mathematics that the number needed to vaccinate to prevent one COVID-19 infection was roughly between 80 to 120 persons. That was for the initial Wuhan strain. Just how effective now are the vaccines at preventing infection or else the severity of infection? More recently the EPOCH Times[55] addressed this very question by listing summaries of 44 published papers that collectively show evidence the vaccines are NOT effective. The article summaries and links to the original papers are offered here as evidence the vaccines were never effective:

1) Gazit et al. out of Israel showed that "SARS-CoV-2-naïve vaccinees had a **13-fold (95% CI, 8-21) increased risk for breakthrough infection with the Delta variant** compared to those previously infected." When adjusting for the time of disease/vaccine, there was a 27-fold increased risk (95% CI, 13-57).

2) Ignoring the risk of infection, given that someone was infected, Acharya et al. found "**no significant difference in cycle threshold values between vaccinated and unvaccinated**, asymptomatic and symptomatic groups infected with SARS-CoV-2 Delta."

3) Riemersma et al. found "**no difference in viral loads when comparing unvaccinated individuals** to those who have vaccine "breakthrough" infections. Furthermore, individuals with vaccine breakthrough infections frequently test positive with viral loads consistent with the ability to shed infectious viruses." Results indicate that "if vaccinated individuals become infected with the delta variant, they may be sources of SARS-CoV-2 transmission to others." They reported "low Ct values (<25) in 212 of 310 fully vaccinated (68%) and 246 of 389 (63%) unvaccinated individuals. Testing a subset of these low-Ct samples revealed infectious SARS-CoV-2 in 15 of 17 specimens (88%) from unvaccinated individuals and 37 of 39 (95%) from vaccinated people."

4) In a study from Qatar, Chemaitelly et al. reported vaccine efficacy (Pfizer) against severe and fatal disease, with efficacy in the 85-95% range at least until 24 weeks after the second dose. As a contrast, **the efficacy against infection waned down to around 30% at 15-19 weeks after the second dose**.

5) From Wisconsin, Riemersma et al. reported that **vaccinated individuals who get infected with the Delta variant can transmit SARS-CoV-2 to others**. They found an elevated viral load in the unvaccinated and vaccinated symptomatic persons (68% and 69% respectively, 158/232 and 156/225). Moreover, in the asymptomatic persons, they uncovered elevated viral loads (29% and 82% respectively) in the unvaccinated and the vaccinated respectively. This suggests that the vaccinated can be infected, harbor, cultivate, and transmit the virus readily and unknowingly.

6) Subramanian reported that "at the country-level, there appears to be no discernable relationship between percentage of population fully vaccinated and new COVID-19 cases." When comparing 2947

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[55] Paul Alexander of the Brownstone Institute, **44 Studies on Vaccine Efficacy That Raise Doubts on Vaccine Mandates,** March 19.2022 https://www.theepochtimes.com/44-studies-on-vaccine-efficacy-that-raise-doubts-on-vaccine-mandates_4348494.html?est=gYnejqpgBhlRYe8DWNMS6DtsftRxBdG34hlgoSzz5Zdb5BcGfM82X8DjTvXf1y0nLRk3cW4%3D

counties in the United States, there were slightly less cases in more vaccinated locations. In other words, there is no clear discernable relationship.

7) Chau et al. looked at transmission of SARS-CoV-2 Delta variant among vaccinated healthcare workers in Vietnam. Of 69 healthcare workers that tested positive for SARS-CoV-2, 62 participated in the clinical study, all of whom recovered. For 23 of them, complete-genome sequences were obtained, and all belonged to the Delta variant. "Viral loads of breakthrough Delta variant infection cases were 251 times higher than those of cases infected with old strains detected between March-April 2020".

8) In Barnstable, Massachusetts, Brown et al found that among **469 cases of COVID-19, 74% were fully vaccinated**, and that "**the vaccinated had on average more virus in their nose than the unvaccinated who were infected.**"

9) Reporting on a nosocomial hospital outbreak in Finland, Hetemäli et al. observed that "both symptomatic and asymptomatic infections were found among vaccinated health care workers, and secondary transmission occurred from those with symptomatic infections despite use of personal protective equipment."

10) In a hospital outbreak investigation in Israel, Shitrit et al. observed "high transmissibility of the SARS-CoV-2 Delta variant among twice vaccinated and masked individuals." They added that "**this suggests some waning of immunity**, albeit still providing protection for individuals without comorbidities."

11) In the UK COVID-19 vaccine Surveillance Report for week #42, it was noted that there is "waning of the N antibody response over time" and "that N antibody levels appear to be lower in individuals who acquire infection following 2 doses of vaccination." The same report (Table 2, page 13), shows the in the older age groups above 30, the double vaccinated persons have greater infection risk than the unvaccinated, presumably because **the latter group include more people with stronger natural immunity from prior Covid disease**. As a contrast, the vaccinated people had a lower risk of death than the unvaccinated, across all age groups, indicating that vaccines provide more protection against death than against infection. See also UK PHE reports 43, 44, 45, 46 for similar data.

12) In Israel, Levin et al. "conducted a 6-month longitudinal prospective study involving vaccinated health care workers who were tested monthly for the presence of anti-spike IgG and neutralizing antibodies". They found that "six months after receipt of the second dose of the BNT162b2 vaccine, humoral response was substantially decreased, especially among men, among persons 65 years of age or older, and among persons with immunosuppression."

13) In a study from New York State, Rosenberg et al. reported that "During May 3–July 25, 2021, the overall age-adjusted vaccine effectiveness against hospitalization in New York was relatively stable 89.5%–95.1%). The overall age-adjusted vaccine effectiveness against infection for all New York adults declined from 91.8% to 75.0%."

14) Suthar et al. noted that "Our data demonstrate a **substantial waning of antibody responses** and T cell immunity to SARS-CoV-2 and its variants, at 6 months following the second immunization with the BNT162b2 vaccine."

15) In a study from Umeå University in Sweden, Nordström et al. observed that "vaccine effectiveness of BNT162b2 against infection waned progressively from 92% (95% CI, 92-93, P<0·001) at day 15-30 to 47% (95% CI, 39-55, P<0·001) at day 121-180, and from day 211 and onwards **no effectiveness could be detected** (23%; 95% CI, -2-41, P=0·07)."

16) Yahi et al. have reported that "in the case of the Delta variant, neutralizing antibodies have a decreased affinity for the spike protein, whereas facilitating antibodies display a strikingly increased affinity. Thus, antibody dependent enhancement may be a concern for people receiving vaccines based on the original Wuhan strain spike sequence."

17) Goldberg et al. (BNT162b2 Vaccine in Israel) reported that "immunity against the delta variant of SARS-CoV-2 waned in all age groups a few months after receipt of the second dose of vaccine."

18) Singanayagam et al. examined the transmission and viral load kinetics in vaccinated and unvaccinated individuals with mild delta variant infection in the community. They found that (in 602 community contacts (identified via the UK contract-tracing system) of 471 UK COVID-19 index cases were recruited to the Assessment of Transmission and Contagiousness of COVID-19 in Contacts cohort study and contributed 8145 upper respiratory tract samples from daily sampling for up to 20 days) "vaccination reduces the risk of delta variant infection and accelerates viral clearance. Nonetheless, fully vaccinated individuals with breakthrough infections have peak viral load similar to unvaccinated cases and can efficiently transmit infection in household settings, including to fully vaccinated contacts."

19) Keehner et al. in NEJM, has recently reported on the resurgence of SARS-CoV-2 infection in a highly vaccinated health system workforce. Vaccination with mRNA vaccines began in mid-December 2020; by March, 76% of the workforce had been fully vaccinated, and by July, the percentage had risen to 87%. Infections had decreased dramatically by early February 2021..."coincident with the end of California's mask mandate on June 15 and the rapid dominance of the B.1.617.2 (delta) variant that first emerged in mid-April and accounted for over 95% of UCSDH isolates by the end of July, infections increased rapidly, including cases among fully vaccinated persons...researchers reported that the "dramatic change in vaccine effectiveness from June to July is likely to be due to both the emergence of the delta variant and waning immunity over time."

20) Juthani et al. sought to describe the impact of vaccination on admission to hospital in patients with confirmed SARS-CoV-2 infection using real-world data collected by the Yale New Haven Health System. "Patients were considered fully vaccinated if the final dose (either second dose of BNT162b2 or mRNA-1273, or first dose of Ad.26.COV2.S) was administered at least 14 days before symptom onset or a positive PCR test for SARS-CoV-2. In total, we identified 969 patients who were admitted to a Yale New Haven Health System hospital with a confirmed positive PCR test for SARS-CoV-2"...Researchers reported "a higher number of patients with severe or critical illness in those who received the BNT162b2 vaccine than in those who received mRNA-1273 or Ad.26.COV2.S..."

21) A very recent study published by the CDC reported that a majority (53%) of patients who were hospitalized with Covid-19-like illnesses were already fully vaccinated with two-dose RNA shots. Table 1 reveals that among the 20,101 immunocompromised adults hospitalized with Covid-19, 10,564 (53%) were fully-vaccinated with the Pfizer or Moderna vaccine (Vaccination was defined as having received exactly 2 doses of an mRNA-based COVID-19 vaccine ≥14 days before the hospitalization index date, which was the date of respiratory specimen collection associated with the most recent positive or negative SARS-CoV-2 test result before the hospitalization or the hospitalization date if testing only occurred after the admission). This highlights the ongoing challenges faced with Delta breakthrough when vaccinated.

22) Eyre, 2021 looked at The impact of SARS-CoV-2 vaccination on Alpha & Delta variant transmission. They reported that "while vaccination still lowers the risk of infection, similar viral loads in vaccinated and unvaccinated individuals infected with Delta question how much vaccination prevents onward transmission... transmission reductions declined over time since second vaccination, for Delta reaching similar levels to unvaccinated individuals by 12 weeks for ChAdOx1 and attenuating substantially for BNT162b2. Protection from vaccination in contacts also declined in the 3 months after second vaccination...vaccination reduces transmission of Delta, but by less than the Initial Wuhan strain."

23) Levine-Tiefenbrun, 2021 looked at Viral loads of Delta-variant SARS-CoV-2 breakthrough infections after vaccination and booster with BNT162b2, and reported the viral load reduction effectiveness declines with time after vaccination, "significantly decreasing at 3 months after vaccination and effectively vanishing after about 6 months."

24) Puranik, 2021 looked at a Comparison of two highly-effective mRNA vaccines for COVID-19 during periods of Alpha and Delta variant prevalence, reporting "In July, vaccine effectiveness against hospitalization has remained high (mRNA-1273: 81%, 95% CI: 33–96.3%; BNT162b2: 75%, 95% CI: 24–93.9%), but effectiveness against infection was lower for both vaccines (mRNA-1273: 76%, 95% CI: 58–87%; BNT162b2: 42%, 95% CI: 13–62%), with a more pronounced reduction for BNT162b2."

25) Saade, 2021 looked at Live virus neutralization testing in convalescent patients and subjects vaccinated against 19A, 20B, 20I/501Y.V1 and 20H/501Y.V2 isolates of SARS-CoV-2, and reported as "Assessed the neutralizing capacity of antibodies to prevent cell infection, using a live virus neutralization test with different strains [19A (initial one), 20B (B.1.1.241 lineage), 20I/501Y.V1 (B.1.1.7 lineage), and 20H/501Y.V2 (B.1.351 lineage)] in serum samples collected from different populations: two-dose vaccinated COVID-19-naive healthcare workers (HCWs; Pfizer-BioNTech BNT161b2), 6-months post mild COVID-19 HCWs, and critical COVID-19 patients... finding of the present study is the reduced neutralizing response observed towards the 20H/501Y.V2 variant in fully immunized subjects with the BNT162b2 vaccine by comparison to the wild type and 20I/501Y.V1 variant."

26) Canaday, 2021 looked at Significant reduction in humoral immunity among healthcare workers and nursing home residents 6 months after COVID-19 BNT162b2 mRNA vaccination, reporting "Anti-spike, anti-RBD and neutralization levels dropped more than 84% over 6 months' time in all groups irrespective of prior SARS-CoV-2 infection. At 6 months post-vaccine, 70% of the infection-naive NH

residents had neutralization titers at or below the lower limit of detection compared to 16% at 2 weeks after full vaccination. These data demonstrate a significant reduction in levels of antibody in all groups. In particular, those infection-naive NH residents had lower initial post-vaccination humoral immunity immediately and exhibited the greatest declines 6 months later."

27) Israel, 2021 looked at Large-scale study of antibody titer decay following BNT162b2 mRNA vaccine or SARS-CoV-2 infection, and reported as "To determine the kinetics of SARS-CoV-2 IgG antibodies following administration of two doses of BNT162b2 vaccine, or SARS-CoV-2 infection in unvaccinated individuals...In vaccinated subjects, antibody titers decreased by up to 40% each subsequent month while in convalescents they decreased by less than 5% per month. Six months after BNT162b2 vaccination 16.1% subjects had antibody levels below the sero-positivity threshold of <50 AU/mL, while only 10.8% of convalescent patients were below <50 AU/mL threshold after 9 months from SARS-CoV-2 infection."

28) Eyran, 2020 examined The longitudinal kinetics of antibodies in COVID-19 recovered patients over 14 months, and found "a significantly faster decay in naïve vaccinees compared to recovered patients suggesting that the serological memory following natural infection is more robust compared to vaccination. Our data highlights the differences between serological memory induced by natural infection vs. vaccination."

29) Salvatore et al. examined the transmission potential of vaccinated and unvaccinated persons infected with the SARS-CoV-2 Delta variant in a federal prison, July-August 2021. They found a total of 978 specimens were provided by 95 participants, "of whom 78 (82%) were fully vaccinated and 17 (18%) were not fully vaccinated....clinicians and public health practitioners should consider vaccinated persons who become infected with SARS-CoV-2 to be no less infectious than unvaccinated persons."

30) Andeweg et al. analyzed 28,578 sequenced SARS-CoV-2 samples from individuals with known immune status obtained through national community testing in the Netherlands from March to August 2021. They found evidence for an "increased risk of infection by the Beta (B.1.351), Gamma (P.1), or Delta (B.1.617.2) variants compared to the Alpha (B.1.1.7) variant after vaccination. No clear differences were found between vaccines. However, the effect was larger in the first 14-59 days after complete vaccination compared to 60 days and longer. In contrast to vaccine-induced immunity, no increased risk for reinfection with Beta, Gamma or Delta variants relative to Initial Wuhan strain was found in individuals with infection-induced immunity."

31) Di Fusco et al. conducted an evaluation of COVID-19 vaccine breakthrough infections among immunocompromised patients fully vaccinated with BNT162b2. "COVID-19 vaccine breakthrough infections were examined in fully vaccinated (≥14 days after 2nd dose) IC individuals (IC cohort), 12 mutually exclusive IC condition groups, and a non-IC cohort." They found that "of 1,277,747 individuals ≥16 years of age who received 2 BNT162b2 doses, 225,796 (17.7%) were identified as IC (median age: 58 years; 56.3% female). The most prevalent IC conditions were solid malignancy (32.0%), kidney disease (19.5%), and rheumatologic/inflammatory conditions (16.7%). Among the fully vaccinated IC and non-IC cohorts, a total of 978 breakthrough infections were observed during the study period; 124 (12.7%) resulted in hospitalization and 2 (0.2%) were inpatient deaths. IC individuals accounted for

38.2% (*N* = 374) of all breakthrough infections, 59.7% (*N* = 74) of all hospitalizations, and 100% (*N* = 2) of inpatient deaths. The proportion with breakthrough infections was 3 times higher in the IC cohort compared to the non-IC cohort (*N* = 374 [0.18%] vs. *N* = 604 [0.06%]; unadjusted incidence rates were 0.89 and 0.34 per 100 person-years, respectively."

32) Mallapaty (NATURE) reported that the protective effect of being vaccinated if you already had infection is "relatively small, and dwindles alarmingly at three months after the receipt of the second shot." Mallapaty further adds what we have been warning the public health community which is that persons infected with Delta have about the same levels of viral genetic materials in their noses "regardless of whether they'd previously been vaccinated, suggesting that vaccinated and unvaccinated people might be equally infectious." Mallapaty reported on testing data from 139,164 close contacts of 95,716 people infected with SARS-CoV-2 between January and August 2021 in the United Kingdom, and at a time when the Alpha and Delta variants were competing for dominance. The finding was that "although the vaccines did offer some protection against infection and onward transmission, Delta dampened that effect. A person who was fully vaccinated and then had a 'breakthrough' Delta infection was almost twice as likely to pass on the virus as someone who was infected with Alpha. And that was on top of the higher risk of having a breakthrough infection caused by Delta than one caused by Alpha."

33) Chia et al. reported that PCR cycle threshold (Ct) values were "similar between both vaccinated and unvaccinated groups at diagnosis, but viral loads decreased faster in vaccinated individuals. Early, robust boosting of anti-spike protein antibodies was observed in vaccinated patients, however, these titers were significantly lower against B.1.617.2 as compared with the wildtype vaccine strain."

34) Wilhelm et al. reported on reduced neutralization of SARS-CoV-2 omicron variant by vaccine sera and monoclonal antibodies. "*in vitro* findings using authentic SARS-CoV-2 variants indicate that in contrast to the currently circulating Delta variant, the neutralization efficacy of vaccine-elicited sera against Omicron was severely reduced highlighting T-cell mediated immunity as essential barrier to prevent severe COVID-19."

35) CDC reported on the details for 43 cases of COVID-19 attributed to the Omicron variant. They found that "34 (79%) occurred in persons who completed the primary series of an FDA-authorized or approved COVID-19 vaccine ≥14 days before symptom onset or receipt of a positive SARS-CoV-2 test result."

36) Dejnirattisai et al. presented live neutralization titres against SARS-CoV-2 Omicron variant, and examined it relative to neutralization against the Victoria, Beta and Delta variants. They reported a significant drop in "neutralization titres in recipients of both AZD1222 and BNT16b2 primary courses, with evidence of some recipients failing to neutralize at all."

37) Cele et al. assessed whether Omicron variant escapes antibody neutralization "elicited by the Pfizer BNT162b2 mRNA vaccine in people who were vaccinated only or vaccinated and previously infected." They reported that Omicron variant "still required the ACE2 receptor to infect but had extensive escape of Pfizer elicited neutralization."

38) Holm Hansen et al.'s Denmark study looked at vaccine effectiveness against SARS-CoV-2 infection with the Omicron or Delta variants following a two-dose or booster BNT162b2 or mRNA-1273 vaccination series. A key finding was reported as "VE against Omicron was 55.2% initially following primary BNT162b2 vaccination, but waned quickly thereafter. Although estimated with less precision, VE against Omicron after primary mRNA-1273 vaccination similarly indicated a rapid decline in protection. By comparison, both vaccines showed higher, longer-lasting protection against Delta." In other words, the vaccine that has failed against Delta is even far worse for Omicron. The table and figure below paint a devastating picture. See where the green dot is (Omicron variant) in the vertical lines (blue is Delta) and the 2 edges of the bars (upper and lower lips) 91 days out for Omicron (3 months). Both Pfizer and Moderna show negative efficacy for Omicron at 31 days (both are below the 'line of no effect' or '0'). The comparative table is even more devastating for it shows how much less vaccine effectiveness there is for Omicron. For example, at 1-30 days, Pfizer showed 55.2% effectiveness for Omicron versus 86.7% for Delta, and for the same period, Moderna showed 36.7% effectiveness for Omicron versus 88.2% for Delta.

39) UK reporting showed that boosters protect against symptomatic COVID-19 caused by Omicron for about 10 weeks; the UK Health Security Agency reported protection against symptomatic COVID-19 caused by the variant dropped from 70% to 45% following a Pfizer booster for those initially vaccinated with the shot developed by Pfizer with BioNTech. Specifically reporting by the UK Health Security Agency showed "Among those who received an AstraZeneca primary course, vaccine effectiveness was around 60% 2 to 4 weeks after either a Pfizer or Moderna booster, then dropped to 35% with a Pfizer booster and 45% with a Moderna booster by 10 weeks after the booster. Among those who received a Pfizer primary course, vaccine effectiveness was around 70% after a Pfizer booster, dropping to 45% after 10-plus weeks and stayed around 70 to 75% after a Moderna booster up to 9 weeks after booster."

40) Buchan et al. used a test-negative design to assess vaccine effectiveness against OMICRON or DELTA variants (regardless of symptoms or severity) during November 22 and December 19, 2021. They included persons who had received at least 2 COVID-19 vaccine doses (with at least 1 mRNA vaccine dose for the primary series) and applied multivariable logistic regression modelling analysis to "estimate the effectiveness of two or three doses by time since the latest dose." They included 3,442 Omicron-positive cases, 9,201 Delta-positive cases, and 471,545 test-negative controls. Following 2 doses, "vaccine effectiveness against Delta infection declined steadily over time but recovered to 93% (95%CI, 92-94%) ≥7 days after receiving an mRNA vaccine for the third dose. In contrast, **receipt of 2 doses of COVID-19 vaccines was not protective against Omicron**. Vaccine effectiveness against Omicron was 37% (95%CI, 19-50%) ≥7 days after receiving an mRNA vaccine for the third dose."

41) Public Health Scotland COVID-19 & Winter Statistical Report (Publication date: 19 January 2022) provided startling data on page 38 (case rates), page 44 (hospitalization), and page 50 (deaths), showing that the vaccination has failed Delta but critically, is failing omicron. The 2nd inoculation data is of particular concern. Table 14 age-standardized case data is very troubling for it shows across the multiple weeks of study that across each dose (1 vs 2 vs 3 booster inoculations) that the vaccinated are greatly more infected than the unvaccinated, with the 2nd dose being alarmingly elevated (see grey rows). Age-standardized rates of acute hospital admissions are stunningly elevated after 2nd inoculation (over the

unvaccinated) during January 2022. Looking at table 16 that reports on the number of confirmed COVID-19 related deaths by vaccination status, we again observe massive elevation in death at the 2nd inoculation. **This data indicates to us that the vaccine is associated with infection and is not optimally working against omicron and that the protection is limited, waning rapidly**.

42) The UK's COVID-19 vaccine surveillance report Week 3, 20 January 2022, raises very serious concern as to the failure of the vaccines on Delta (which is basically now being replaced by omicron for dominance) and omicron. When we look at table 9, page 34 (COVID-19 cases by vaccination status between week 51 2021 and week 2 2022), we see greater case numbers for the 2nd and 3rd inoculations. The important table on page 38, Figure 12 (unadjusted rates of COVID-19 infection, hospitalization and death in vaccinated and unvaccinated populations) shows us a continual pattern in the UK data over the last 2 to 3 to 4 months, with **the present reporting showing that persons in receipt of the 3rd inoculation (booster) at far greater risk of infection/cases than the unvaccinated** (30 years of age and above age strata).

43) In the recent UK Public Health surveillance reports Week 9, Week 8, as well as week 7 (UK COVID-19 vaccine surveillance report Week 7 17 February 2022), week 6 (COVID-19 vaccine surveillance report Week 6 10 February 2022) and week 5 for 2022 (COVID-19 vaccine surveillance report Week 5 3 February 2022) as well as the reports accumulated for 2021 since vaccine roll-out, **we see that the vaccinated are at higher risk of infection and especially for age groups above 18 years old, as well as hospitalization and even death**. This is particularly marked for those in receipt of double vaccinations. There is increased risk of death for those who are triple vaccinated and especially as age increases. The same pattern emerges in the Scottish data.

44.) Regev-Yochay et al. in Israel looked at (publication date March 16th 2022) the immunogenicity and safety of a fourth dose (4th) of either BNT162b2 (Pfizer–BioNTech) or mRNA-1273 (Moderna) administered 4 months after the third dose in a series of three BNT162b2 doses). This was an open-label, nonrandomized clinical study assessing the 4th dose in terms of need beyond the 3rd dose. Among the '1050 eligible health care workers enrolled in the Sheba HCW COVID-19 Cohort, 154 received the fourth dose of BNT162b2 and, 1 week later, 120 received mRNA-1273. For each participant, two age-matched controls were selected from the remaining eligible participants'. Overall, 25.0% of the participants in the control group were infected with the omicron variant, as compared with 18.3% of the participants in the BNT162b2 group and 20.7% of those in the mRNA-1273 group. **Vaccine efficacy against any SARS-CoV-2 infection was 30%** (95% confidence interval [CI], −9 to 55) for BNT162b2 and 11% (95% CI, −43 to 44) for mRNA-1273

The article concludes:

> *What these studies show, are that vaccines are important to reduce severe disease and death, but unable to prevent the disease from spreading and eventually infect[ing] most of us. That is, while the vaccines [may] provide individual benefits to the vaccinee, and especially to older high-risk people, the public benefit of universal vaccination is in grave doubt. As such, Covid vaccines should not be expected to contribute to*

eliminating the communal spread of the virus or the reaching of herd immunity. This unravels the rationale for vaccine mandates and passports.

And here are other papers that address the concern on effectiveness of the COVID-19 vaccines:

Saadh MJ, Jaber SA. **Efficacy of COVID-19 vaccines**. Microb Pathog. 2022 Oct;171:105729. doi: 10.1016/j.micpath.2022.105729. Epub 2022 Sep 2. PMID: 36058411; PMCID: PMC9436781. https://pubmed.ncbi.nlm.nih.gov/36058411/

Kislaya I, Machado A, Magalhães S, Rodrigues AP, Franco R, Leite PP, Dias CM, Nunes B. **COVID-19 mRNA vaccine effectiveness (second and first booster dose) against hospitalisation and death during Omicron BA.5 circulation: cohort study based on electronic health records**, Portugal, May to July 2022. Euro Surveill. 2022 Sep;27(37):2200697. doi: 10.2807/1560-7917.ES.2022.27.37.2200697. PMID: 36111555; PMCID: PMC9479470. https://pubmed.ncbi.nlm.nih.gov/36111555/

Buchan SA, Chung H, Brown KA, Austin PC, Fell DB, Gubbay JB, Nasreen S, Schwartz KL, Sundaram ME, Tadrous M, Wilson K, Wilson SE, Kwong JC. **Estimated Effectiveness of COVID-19 Vaccines Against Omicron or Delta Symptomatic Infection and Severe Outcomes**. JAMA Netw Open. 2022 Sep 1;5(9):e2232760. doi: 10.1001/jamanetworkopen.2022.32760. PMID: 36136332. https://pubmed.ncbi.nlm.nih.gov/36136332/

Ioannou GN, Bohnert ASB, O'Hare AM, Boyko EJ, Maciejewski ML, Smith VA, Bowling CB, Viglianti E, Iwashyna TJ, Hynes DM, Berry K; COVID-19 Observational Research Collaboratory (CORC)*. **Effectiveness of mRNA COVID-19 Vaccine Boosters Against Infection, Hospitalization, and Death: A Target Trial Emulation in the Omicron (B.1.1.529) Variant Era**. Ann Intern Med. 2022 Oct 11. doi: 10.7326/M22-1856. Epub ahead of print. PMID: 36215715. https://pubmed.ncbi.nlm.nih.gov/36215715/

Chi WY, Li YD, Huang HC, Chan TEH, Chow SY, Su JH, Ferrall L, Hung CF, Wu TC. **COVID-19 vaccine update: vaccine effectiveness, SARS-CoV-2 variants, boosters, adverse effects, and immune correlates of protection**. J Biomed Sci. 2022 Oct 15;29(1):82. doi: 10.1186/s12929-022-00853-8. PMID: 36243868. https://pubmed.ncbi.nlm.nih.gov/36243868/

Pilar T V Florentino, Tristan Millington, Thiago Cerqueira-Silva, Chris Robertson, Vinicius de Araújo Oliveira, Juracy B S Júnior, Flávia J O Alves, Gerson O Penna, Srinivasa Vital Katikireddi, Viviane S Boaventura, Guilherme L Werneck, Neil Pearce, Colin McCowan, Christopher Sullivan, Utkarsh Agrawal, Zoe Grange, Lewis D Ritchie, Colin R Simpson, Aziz Sheikh, Mauricio L Barreto, Igor Rudan, Manoel Barral-Netto, Enny S Paixão, **Vaccine effectiveness of two-dose BNT162b2 against symptomatic and severe COVID-19 among adolescents in Brazil and Scotland over time: a test-negative case-control , study**, The Lancet, Infectious disease, August 8, 2022, https://www.thelancet.com/journals/laninf/article/PIIS1473-3099(22)00451-0/fulltext

Pavan M, Bassani D, Sturlese M, Moro S. **From the Wuhan-Hu-1 strain to the XD and XE variants: is targeting the SARS-CoV-2 spike protein still a pharmaceutically relevant option against COVID-19?** J

Enzyme Inhib Med Chem. 2022 Dec;37(1):1704-1714. doi: 10.1080/14756366.2022.2081847. PMID: 35695095. https://pubmed.ncbi.nlm.nih.gov/35695095/

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Ssemaganda A, Nguyen HM, Nuhu F, Jahan N, Card CM, Kiazyk S, Severini G, Keynan Y, Su RC, Ji H, Abrenica B, McLaren PJ, Ball TB, Bullard J, Van Caeseele P, Stein D, McKinnon LR. **Expansion of cytotoxic tissue-resident CD8+ T cells and CCR6+CD161+ CD4+ T cells in the nasal mucosa following mRNA COVID-19 vaccination**. Nat Commun. 2022 Jun 10;13(1):3357. doi: 10.1038/s41467-022-30913-4. PMID: 35688805. https://pubmed.ncbi.nlm.nih.gov/35688805/ [57]

Kouhpayeh H, Ansari H. **Adverse events following COVID-19 vaccination: A systematic review and meta-analysis**. Int Immunopharmacol. 2022 May 30;109:108906. doi: 10.1016/j.intimp.2022.108906. Epub ahead of print. PMID: 35671640; PMCID: PMC9148928. https://pubmed.ncbi.nlm.nih.gov/35671640/

Singh H, Dahiya N, Yadav M, Sehrawat N. **Emergence of SARS-CoV-2 New Variants and Their Clinical Significance**. Can J Infect Dis Med Microbiol. 2022 May 28;2022:7336309. doi: 10.1155/2022/7336309. PMID: 35669528; PMCID: PMC9167142. https://pubmed.ncbi.nlm.nih.gov/35669528/

> Singh et al: *These new strains occur due to unique mutations in the spike protein, which modify SARS-CoV-2 transmission and infection capabilities, limiting the efficacy of the COVID-19 vaccination. Hence, there is a need to find a potential vaccine against it.*

Buisson Y. **Covid-19, an unfinished story**. Presse Med. 2022 Jun 3:104131. doi: 10.1016/j.lpm.2022.104131. Epub ahead of print. PMID: 35667598. https://pubmed.ncbi.nlm.nih.gov/35667598/

Salari N, Vepa A, Daneshkhah A, Darvishi N, Ghasemi H, Khunti K, Mohammadi M. **Efficacy of COVID-19 vaccines by race and ethnicity**. Public Health. 2022 May 5;208:14-17. doi: 10.1016/j.puhe.2022.04.009. Epub ahead of print. PMID: 35660280; PMCID: PMC9069229. https://pubmed.ncbi.nlm.nih.gov/35660280/

Wang K, Wang L, Li M, Xie B, He L, Wang M, Zhang R, Hou N, Zhang Y, Jia F. **Real-Word Effectiveness of Global COVID-19 Vaccines Against SARS-CoV-2 Variants: A Systematic Review and Meta-Analysis**. Front Med (Lausanne). 2022 May 19;9:820544. doi: 10.3389/fmed.2022.820544. PMID: 35665358; PMCID: PMC9160927. https://pubmed.ncbi.nlm.nih.gov/35665358/

Leong C, Jin L, Kim D, Kim J, Teo YY, Ho TH. **Assessing the impact of novelty and conformity on hesitancy**

[56] Note this paper was supported by grants from Janssen Vaccines & Prevention B.V., NH/NIH HHS/United States, the National Institute of Allergy and Infectious Diseases and the Biomedical Advanced Research and Development Authority

[57] This study was supported by the Bill and Melinda Gates Foundation

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Olliaro P, Torreele E, Vaillant M. **COVID-19 vaccine efficacy and effectiveness-the elephant (not) in the room**. Lancet Microbe. 2021 Jul;2(7):e279-e280. doi: 10.1016/S2666-5247(21)00069-0. Epub 2021 Apr 20. Erratum in: Lancet Microbe. 2021 Jul;2(7):e288. PMID: 33899038; PMCID: PMC8057721. https://pubmed.ncbi.nlm.nih.gov/33899038/

Dean Follmann, Holly E. Janes, Olive D. Buhule, Honghong Zhou, Bethany Girard, Kristen Marks, Karen Kotloff, Michaël Desjardins, Lawrence Corey, Kathleen M. Neuzil, Jacqueline M. Miller, Hana M. El Sahly, Lindsey R. Baden, **Anti-nucleocapsid antibodies following SARS-CoV-2 infection in the blinded phase of the mRNA-1273 Covid-19 vaccine efficacy clinical trial**, , medRxiv 2022.04.18.22271936; doi: https://doi.org/10.1101/2022.04.18.22271936

The Follmann study, et. al. looked at two sides of the Moderna Phase 3 vaccine trial: the vaccinated group and the control group. They looked at unvaccinated people having Covid, versus vaccinated people having so called "break-through Covid infections". The question that they asked, was: do the vaccinated acquire the same full-spectrum immunity as the unvaccinated? The answer was no. Vaccinated people were much LESS likely to develop broad natural immunity, compared to unvaccinated people. Discussed here: https://igorchudov.substack.com/p/moderna-knew-vaccinated-people-will?r=47l49&s=r&utm_campaign=post&utm_medium=email

Singanayagam A, Hakki S, Dunning J, Madon KJ, Crone MA, Koycheva A, Derqui-Fernandez N, Barnett JL, Whitfield MG, Varro R, Charlett A, Kundu R, Fenn J, Cutajar J, Quinn V, Conibear E, Barclay W, Freemont PS, Taylor GP, Ahmad S, Zambon M, Ferguson NM, Lalvani A; ATACCC Study Investigators. **Community transmission and viral load kinetics of the SARS-CoV-2 delta (B.1.617.2) variant in vaccinated and unvaccinated individuals in the UK: a prospective, longitudinal, cohort study**. Lancet Infect Dis. 2022 Feb;22(2):183-195. doi: 10.1016/S1473-3099(21)00648-4. Epub 2021 Oct 29. Erratum in: Lancet Infect Dis. 2021 Dec;21(12):e363. PMID: 34756186; PMCID: PMC8554486. https://pubmed.ncbi.nlm.nih.gov/34756186/

And on September 1, the CDC ACIP released a slide deck from a recent briefing on "COVID-19 Vaccine Effectiveness during Omicron". In their summary, little could be said regarding effectiveness of COVID-19 vaccines on preventing Omicron infection[59]. They make the unsubstantiated statement: "effectiveness against severe disease" NOT noting that Omicron infection does not cause severe disease as compared to influenza. Candy coated conclusions.

[58] It's interesting to consider the word 'novel' is nowhere found in product labeling of the vaccines however present in disclosure of investment risks for the company's FY 2021 SEC 10-K filings. Investors can sue; vaccine recipients

[59] https://www.documentcloud.org/documents/22273715-cdc-slides-sept-1

9. COVID-19 Vaccine Induced Deaths; Evidence from Autopsy

Presently medical examiners or coroners commonly determine cause and manner of death without an autopsy examination. Some death certificates generated in this way may not state the correct root cause and manner of death. One recent study[60] recognizing this issue determined that about one third of cases considered report an incorrect cause of death. It demonstrated even experienced forensic pathologists can generate erroneous death certificates for cases that are not autopsied and it pointed out that non-natural or atypical causes of death can easily be missed. The San Diego County Medical Examiner's Office explains that deaths of a sudden and unexpected nature must be investigated by their office according to California Government Code Section 27491 and the Health and Safety Code 102850[61]. But if the death occurs after a brief illness or in a hospital the attending physician may attribute cause as natural having occurred as an outcome of the illness, and so the COD by superficial examination and without autopsy.

In pre-covid times this process might have been acceptable, but in 2020 the landscape changed drastically. We are in a state of emergency stemming from a pandemic presumably caused by a novel, dangerous contagion. In this new landscape it's critical to know, with high confidence, the root cause of death. Was death *due* to covid, the infection itself? Or was the death due to other causes; perhaps an underlying illness that covid infection merely aggravated? These questions are not new, but without autopsy, they cannot be properly answered, and as such the statistics of covid caused fatalities may be significantly over estimated.

Secondly we must consider another risk. The suggested panacea for the contagion, the covid vaccines. Regardless of whether they are truly 'safe and effective' or not, the fact is the global administration of these vaccines has further modified that landscape. With nearly 70% of the global population vaccinated we have diminished, virtually eliminated a proper control group. Millions have received the vaccines, and even without doubt, autopsy should be brought back as a routine procedure and vaccination status should be a variable of consideration.

The motivating reason NOW to have routine autopsy are the increasing number of reports by morticians that are either unable or having difficulty infusing embalming fluid into their corpses. Then subsequently discovering the cause: unusually long and fibrous clots blocking the vessels[62]. The embalmers claim the clot formations are unlike anything seen before the covid era. The constituents of these clots have been analyzed by mass spectrometry and determined they are not composed of materials expected from natural, postmortem clotting. In other words these clots probably existed before the subject's death and may have even been the underlying root cause of death. But if that is so, that would be an *unnatural* death, and so by law and policy should be addressed by the medical examiner.

The unfortunate situation however is there is no law or policy requiring a morticians to report to the Medical Examiner's office any findings of unusual nature in the subjects they prepare for burial. On the

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[60] Nashelsky MB, Lawrence CH. Accuracy of cause of death determination without forensic autopsy examination. Am J Forensic Med Pathol. 2003 Dec;24(4):313-9. doi: 10.1097/01.paf.0000097857.50734.c3. PMID: 14634467.

[61] https://www.sandiegocounty.gov/content/sdc/me/families/theprocess.html

[62] https://www.theepochtimes.com/mkt_app/embalmers-have-been-finding-numerous-long-fibrous-clots-that-lack-post-mortem-characteristics_4696015.html

contrary, laws limit or else forbid sharing of information between these parties. So in this new landscape spawned by the pandemic, legacy process could be perpetuating further injury and death by hiding the mechanisms and assuming they do not to exist. In most minds the vaccines are safe and effective, so why bother? Consider in the news NOW, the historically high excess deaths across the globe that still have no firm explanation. Autopsy would be a step in the right direction. Policies that require morticians to report unusual findings would be a step in the right direction.

Prior vaccine injury reports submitted to the county have speculated that many vaccinated people could be ambulatory with these undetected clots in their vasculature, but not necessarily expressing life threatening symptoms if the victim does not stress activity. The body is an amazing system that adapts to adverse conditions to maintain homeostasis. But more minor symptoms like brain fog might manifest – and be tolerated. But if an individual in this condition exerts themselves to extreme oxygen demand, such as the case of many of these young athletes, circulatory turbulence and mechanical stresses could lead to an embolus and sudden stroke or pulmonary embolism.

The study that examined these unusual clots further determined they cannot be easily broken down and eliminated by natural body enzymes such as plasmin. So they may exist for months or years - literally physiological time bombs. Perhaps the rash of many sudden deaths in the last year that is occurring in young athletes were caused by these clots. In fact some were uncovered, extracted in surgery that experienced events but survived. But for those that didn't survive, the phrase on the death certificate: "as determined by autopsy" seems to be nearly non-existent nowadays.

Even before the covid era there was concern and criticism over the lack of autopsies. ProPublica's Postmortem[63] sums the problem up:

> *"Hospital autopsies have become a rarity. As a result, experts say, diagnostic errors are missed, opportunities to improve medical treatment are lost, and health-care statistics are skewed."*

ProPublica produced a video short summarizing the issue: America's deeply flawed system of death investigation, explaining that in 1971 hospitals were no longer required to perform autopsies, once required in 50% of deaths. It seems cost was the main motivating factor. PBS Frontline produced actually produced a series[64] : *Post Mortem Death Investigation in America* to raise public awareness and action. But there were no changes.

In the latter part of 2021 I submitted a freedom of information request (FOIA) requesting data on autopsy reports associated with VAERS ID's and nearly a year later received this reply by email denying my request on the grounds that they are unable to complete it:

[63] https://www.propublica.org/article/without-autopsies-hospitals-bury-their-mistakes
[64] https://www.pbs.org/wgbh/pages/frontline/post-mortem/

Fri 9/23/2022 8:46 AM
Kotler, Sarah <Sarah.Kotler@fda.hhs.gov>
Request Number: 2021-7502
To [redacted]
Follow up Start by Friday, September 23, 2022. Due by Friday, September 23, 2022.

September 23, 2022

Request Number: 2021-7502

Sending via Email: [redacted]

Subject of Request: All COVID19 vaccine associated deaths reported in VAERS (specific VAERS ID's) that also completed an autopsy for cause of death and a copy of the (anonymized) autopsy report, if available. In other words the specific VAERS ID's and corresponding autopsy report.

Dear Requester:

The Food and Drug Administration (FDA) has completed processing your request for records under the Freedom of Information Act (FOIA).

We are unable to search VAERS to identify a list of VAERS IDs which had corresponding autopsy reports. To the extent you are seeking any autopsy reports for COVID-19 vaccines VAERS, we are denying your request.

The following exemptions of FOIA, 5 U.S.C. 552, are the authority for denying you access to the non-disclosable material: Exemption (b)(3) Prohibited from disclosure by other laws; Exemption (b)(6) Personal Privacy Interest. We have included citations to the FOIA and FDA's regulations for your information.

Section 5.31(c) and (f) of the implementing regulations of the Department of Health and Human Services (DHHS) are applicable to this denial. The regulations are contained in the Code of Federal Regulations (CFR), Title 45.

The following sections of the implementing regulations of FDA and reasons applicable to this denial contained in the Code of Federal Regulations (CFR), Title 21 are:

- 20.63 Personnel, medical and similar files the disclosure of which constitutes a clearly unwarranted invasion of personal privacy.

Other laws, in addition to FOIA, may prohibit disclosure of the information you requested. The following law applicable to this denial is 42 U.S.C. § 300aa-10, et seq. (National Childhood Vaccine Injury Act).

FDA's Regulations at CFR Part 20 are available at:
http://www.access.gpo.gov/nara/cfr/waisidx_04/21cfr20_04.html

You have the right to appeal this determination. By filing an appeal, you preserve your rights under FOIA and give the agency a chance to review and reconsider your request and the agency's decision. Your appeal must be made within 90 days from the date of this response, to: Director, Office of the Executive Secretariat, US Food & Drug Administration, 5630 Fishers Lane, Room 1050, Rockville, MD 20857, E-mail: FDAFOIA@fda.hhs.gov. Please clearly mark both the envelope and your letter "FOIA Freedom of Information Act Appeal."

If you would like to discuss our response before filing an appeal to attempt to resolve your dispute without going through the appeals process, please contact Sarah Kotler at 301-796-8976. You may also contact the FDA FOIA Public Liaison for assistance at: Office of the Executive Secretariat, US Food & Drug Administration, 5630 Fishers Lane, Room 1050, Rockville, MD 20857, E-mail: [redacted]

If you are unable to resolve your FOIA dispute through our FOIA Public Liaison, the Office of Government Information Services (OGIS), the Federal FOIA Ombudsman's office, offers mediation services to help resolve disputes between FOIA requesters and Federal agencies. The contact information for OGIS is as follows: Office of Government Information Services, National Archives and Records Administration, 8601 Adelphi Road–OGIS, College Park, MD 20740-6001; telephone at 202-741-5770; toll free at 1-877-684-6448; or facsimile at 202-741-5769; e-mail at [redacted]

Sincerely yours,

Sarah Kotler
Director
Division of Freedom of Information

Sarah B. Kotler, J.D.
Director, Division of Freedom of Information
US FDA
301-796-8976

At the time I submitted, and out of curiosity I searched the FDA FOIA submission data base to see if others had inquired regarding autopsy. At that time, no other requests. But on September 29 of this year Zachary Stieber of the Epoch times published an article[65] describing the Epoch Times had submitted a similar FOIA, and they were also denied[66]. But the reason the FDA gave was that they are "barred from releasing medical files". But the Epoch Times says they have a source in the drug industry who says that's bunk - the FDA can release a redacted copy. So it appears the FDA is just stonewalling. Indeed they do not want more incriminating information released.

Starting in 2021 thousands started receiving an experimental vaccine that, by all accounts outside of official regulatory agency reports, did not undergo sufficient testing. According to Our World in Data, almost 70% of the world's population received at least one dose of COVID-19 vaccines. That's almost 13 billion doses with about 4.5 million doses continuing to be administered each day. Mankind has changed the landscape of the human biosphere without adequate monitoring and introspective, skeptical prudence. It's about time to bring autopsies back. The San Diego Medical Examiner needs to bring this need to the policy makers for immediate action.

"Chance favors the prepared mind" -- Louis Pasteur

References

[1] Lii Jye Tan, Cai Ping Koh, Shau Kong Lai, Woon Cheng Poh, Mohammad Shafie Othman, Huzlinda

[65] https://www.theepochtimes.com/exclusive-fda-withholding-autopsy-results-from-people-who-died-after-getting-covid-19-vaccines_4763765.html
[66] https://thevaccinereaction.org/2022/10/fda-withholds-autopsy-results-of-those-who-died-after-covid-shots/

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https://www.sciencedirect.com/science/article/pii/S0379073822002997

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[3] Paddock CD, Reagan-Steiner S, Su JR, Oster ME, Martines RB, Bhatnagar J, Shimabukuro TT. **Autopsy Histopathologic Cardiac Findings in Two Adolescents Following the Second COVID-19 Vaccine Dose**. Arch Pathol Lab Med. 2022 Apr 8. doi: 10.5858/arpa.2022-0084-LE. Epub ahead of print. PMID: 35395076.
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[6] Hirschbühl, K., Schaller, T., Märkl, B. et al. **High viral loads: what drives fatal cases of COVID-19 in vaccinees? – an autopsy study**. Mod Pathol (2022). https://doi.org/10.1038/s41379-022-01069-9
https://www.nature.com/articles/s41379-022-01069-9

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[8] James R. Gill, Randy Tashjian, Emily Duncanson; **Autopsy Histopathologic Cardiac Findings in Two Adolescents Following the Second COVID-19 Vaccine Dose**. Arch Pathol Lab Med 2022; doi: https://doi.org/10.5858/arpa.2021-0435-SA

[9] Mörz M. **A Case Report: Multifocal Necrotizing Encephalitis and Myocarditis after BNT162b2 mRNA Vaccination against COVID-19. Vaccines** (Basel). 2022 Oct 1;10(10):1651. doi: 10.3390/vaccines10101651. PMID: 36298516; PMCID: PMC9611676. https://pubmed.ncbi.nlm.nih.gov/36298516/

Mörz conclusion:

"Numerous cases of encephalitis and encephalomyelitis have been reported in connection with the gene-based COVID-19 vaccines, with many being considered causally related to vaccination [31, 38, 39]. However, this is the first report to demonstrate the presence of the spike protein within the encephalitic lesions and to attribute it to vaccination rather than infection. These findings corroborate a causative role of the gene-based COVID-19 vaccines, and this diagnostic approach is relevant to potentially vaccine-induced damage to other organs as well."

[10] Tan LJ, Koh CP, Lai SK, Poh WC, Othman MS, Hussin H. **A systemic review and recommendation for an autopsy approach to death followed the COVID 19 vaccination.** Forensic Sci Int. 2022 Nov;340:111469. doi: 10.1016/j.forsciint.2022.111469. Epub 2022 Sep 20. PMID: 36162300; PMCID: PMC9487151. https://pubmed.ncbi.nlm.nih.gov/36162300/

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- See section 5.1 for other references on autopsies involving vaccine induced deaths

10 Timeline of Events & Discussion

After vaccine rollout, I publicly spoke at most if not all county board of supervisors meetings throughout 2021 and 2022 to protest their lack of mentioning vaccine harms and later on continuation of the emergency order in San Diego. My records indicate I started assembling vaccine injury 'reports' as early as October of 2021 which were at least communicated by my public comments monthly if not also filed with the county clerk in the public record.

The reports I've submitted document a progressive, upward trend of injury and death and substantiate recognition of the injuries and harms by numerous citations of peer reviewed publications and letters in scientific and medical journals, freely accessible to the public willing to research.

To give perspective of the progression of change having occurred in less than a year, here is the script from my public address to the San Diego County Board of Supervisors on August 17, 2021:

I'm reading to you statistics obtained from queries I ran on the CDC's VAERS WONDER database on August 13. These numbers have not been provided to vaccine recipients as part of informed consent, have not appeared anywhere in the mainstream media except on OAN, and when I tried to post the data on YouTube and Google powered comments, it was immediately censored.

Deaths associated with the three COVID-19 vaccines for all US locations is ***12,791*** *of which 36% of these deaths occurred within 2 days after injection.*

According to the Mayo Clinic there's been about 200 million people in the US that have received at least one dose of the covid-19 vaccine over the 9 months they've been administered.

By comparison, the 14 seasonal influenza vaccines, amount to about 3 billion doses administered over the last 30 years and these are associated with ONLY ***1950*** *deaths.*

Consider these additional statistics for the COVID-19 vaccines:

- ***13,139 Life threatening events,*** *44% of which occurred in the first two days after receiving injection*
- ***16,044 Permanent disabilities,*** *53% of which occurred within the first two days after receiving injection*
- ***51,242 Hospitalized,*** *40% of which occurred within the first two days after receiving the injection*
- ***70,610 Emergency room visits,*** *64% of which occurred within the first two days after receiving the injection*
- ***92,586 Office visits,*** *54% of which occurred within the first two days after receiving the injection*
- ***1,146 Miscarriages,*** *30% of which occurred within the first two days after receiving the injection*
- ***331 cases of myocarditis or pericarditis,*** *37% of which occurred within the first two days after receiving the injection and 50% of these cases were ages less than 40 years*

These same statistics for the seasonal influenza vaccine are also dwarfed by the numbers reported for the COVID-19 vaccine.

The simple comparison suggests the covid-19 vaccines have caused an unprecedented number of deaths, life threatening events and permanent disabilities never seen before in the history of medicine including the Thalidomide tragedy in the 1950's.

While the FDA has clearly ignored responsibility in either acting or at least explaining why they are not acting, it's on our local HHS to question the safety of these vaccines. And until that's sufficiently answered, you need to stop the rabid campaign to vaccinate in SDC.

Rather than investigate and respond with a factual based rebuttal of why their own systems (managed by the CDC) was reporting so many injuries and deaths, the San Diego County Board of Supervisors chose to discredit all public comments and concerns on COVID-19 vaccine harms by declaring any criticism as an *attack* on their authority. The Board's response at the end of August 2021 was to launch a campaign aligning with national and state rhetoric of *misinformation*:

COUNTY OF SAN DIEGO
2021 AUG 27 AM 8:33
CLERK OF THE BOARD OF SUPERVISORS

NATHAN FLETCHER

CHAIR

SUPERVISOR, FOURTH DISTRICT
SAN DIEGO COUNTY BOARD OF SUPERVISORS

AGENDA ITEM

DATE: August 31, 2021

19

TO: Board of Supervisors

SUBJECT
FRAMEWORK FOR OUR FUTURE: DECLARING HEALTH MISINFORMATION A PUBLIC HEALTH CRISIS (DISTRICTS: ALL)

OVERVIEW
The resurging pandemic has led to more infections and hospitalizations than the region has seen since the beginning of the year and ICU capacity is once again being tested. The U.S. Surgeon General has recently warned that health misinformation presents an urgent threat to public health. Therefore, urgent action is needed to curb the spread of the Delta variant by combatting misinformation, thereby supporting our health care system and, in turn, saving lives. There would be a substantial detrimental effect on the County and public if not acted upon immediately. For these reasons, this Board Letter requires immediate action at the next Board meeting.

This Board Letter declares health misinformation to be a public health crisis. At a pivotal time in our history, with an FDA-approved vaccine available to all San Diegans free of charge and booster shots recommended later this year, health misinformation now presents a greater threat to public health than a variant of COVID-19. In response, the Board of Supervisors of the County of San Diego recognizes the vaccine hesitancy, that stands in the way of the County moving beyond the COVID-19 pandemic, is being fueled by the spread of health misinformation, and commits to developing strategies to actively combat health misinformation.

Following the recommendations of the U.S. Surgeon General Vivek H. Murthy in his advisory entitled "Confronting Health Misinformation,"[1] this board letter acknowledges the role misinformation has had in the resurgence of COVID-19 infections, once again filling hospital capacity, and driving the deaths and hospitalizations of thousands, including San Diegans[2] and committing County resources to work with trusted stakeholders to aggressively counter misinformation in our community and engage in outreach based on best practices.

We strongly urge your support for the recommendations in this letter to recognize health misinformation as the threat to public health that it is, and take the necessary steps towards a stronger, healthier future.

What could possibly explain such actions by governing boards? An unwillingness to even consider public opinions? Many of these opinions at the time reflected a few doctors with enough courage to also publicly speak out. California's 'Misinformation' campaign, endorsed by the San Diego Board of Supervisors has progressed to Orwellian proportions with the passage of AB 2098 that literally silences medical opinions. There is at lease one lawsuit in action.

Philip Bagwell of the Mises Institute offers one possible explanation in an October of 2021 article titled *Vaccine Mandates and the Great Reset*[67].

Bagwell posed the question: Why is the vaccination campaign so important to governments that they are increasing pressure to such an extent? And who has an interest in the global vaccination campaign? He recognized the pharmaceutical industry, mass media, the state, and supranational organizations as main players.

Obviously the pharmaceutical Industry has a strong interest in realizing huge profits we know tens of billions of dollars.

But what about the state? – Although we shouldn't discount the possibility of corruption and grift, Bagwell believes their motivation is systematically amplifying fear & hysteria to maintain power. Bagwell references another paper by Bagus et. al. published in the International Journal of Environmental Research & Public Health titled *COVID-19 and the Political Economy of Mass Hysteria*[68].

Politics heavily depends on game theory: Self-interested politicians face what's called an asymmetric pay-off. Underestimating a threat and failing to act has great political cost, as politicians will be held responsible for the disaster caused by the threat they underestimated. By contrast, an exaggeration or even invention of a threat and bold state intervention are politically more attractive. If the existential threat claimed by politicians really turns out to be such a great danger, they can be celebrated as heroes if they enacted bold measures. In summary Bagus says politicians, enjoying a guaranteed income, and constrained by this asymmetric payoff have an incentive to exaggerate a danger and to impose exaggerated measures, conducive to the emergence and growth of mass hysteria.

I believe the fear politicians channel to society also penetrates organizations under their control. For example the County Board of Supervisors and Health and Human Services. The influence may not be intentional, but even good scientists and doctors, under duress of narrative and political goals can fail to report critical information when their jobs are at stake. This can lead to the unstable outcome we now have.

Regardless of actual reasons, on September I4, 2021 I delivered another public comment regarding my concerns:

> *The following data is from CDC's VAERS WONDER database, September 13.*
>
> *Deaths associated with the three COVID-19 vaccines for all locations is **14,506** of which 35% occurred within 2 days following injection.*

---

[67] https://mises.org/wire/vaccine-mandates-and-great-reset

[68] Bagus P, Peña-Ramos JA, Sánchez-Bayón A. **COVID-19 and the Political Economy of Mass Hysteria**. Int J Environ Res Public Health. 2021 Feb 3;18(4):1376. doi: 10.3390/ijerph18041376. PMID: 33546144; PMCID: PMC7913136.

*According to the Mayo Clinic there's been about 210 million people in the US that have received at least one dose of the covid-19 vaccine over the **10 months** they've been administered.*

*By comparison, the 14 seasonal influenza vaccines, amount to about **3 billion** doses administered over the last **30 years** and these are associated with ONLY **1950** deaths.*

Consider these additional statistics for the COVID-19 vaccines:

- ***14,593 Life threatening events**, 43% of which occurred in the first two days after receiving injection*
- ***18,439 Permanent disabilities**, 52% of which occurred within the first two days after receiving injection*
- ***58,440 Hospitalized**, 38% of which occurred within the first two days after receiving the injection*
- ***77,863 Emergency room visits**, 61% of which occurred within the first two days after receiving the injection*
- ***106,183 Office visits**, 53% of which occurred within the first two days after receiving the injection*
- ***1,358 Miscarriages**, 32% of which occurred within the first two days after receiving the injection*
- ***4,663 cases of myocarditis or pericarditis**, 32% of which occurred within the first two days after receiving the injection and 40% of these cases were ages less than 40 years*

The high percentage of events occurring within two days of injection and the simple comparison with seasonal flu vaccines strongly suggests the covid-19 vaccines are causing an unprecedented number of deaths, life threatening events and permanent disabilities never seen before in the history of medicine including the Thalidomide tragedy in the 1950's.

The vaccine harms I've mentioned and the recent resignations of the director and deputy director of the FDA's Office of Vaccines Research & Review, should give everyone pause, but the San Diego County HHS just ignores these facts continuing to promote vaccination despite the fact effective therapeutics exist that do not cause the harms the vaccines are causing. And the board further voted to silence these options by labeling them misinformation.

On January 11, 2022 I submitted further public comment, but by phone since the County shut down live meetings with the public with the excuse of 'safety':

*I would like to point out a letter published in the **The Lancet Regional Health** – Europe dated November 20, 2021 from Prof. Dr. Gunter Kampf, University Medicine Greifswald, Institute for Hygiene and Environmental Medicine, Greifswald, Germany*

High COVID-19 vaccination rates were expected to reduce transmission of SARS-CoV-2 in populations by reducing the number of possible sources for disease transmission. Kampf however points out recent epidemiological data suggests the relevance of COVID-19 vaccinated individuals is increasing.

The UK reported secondary attack rates among household contacts exposed to fully vaccinated index cases was similar to household contacts exposed to unvaccinated index cases (25% vaccinated vs 23% unvaccinated). 12 of 31 infections in fully vaccinated household contacts (39%) arose from fully vaccinated epidemiologically linked index cases.

Kampf emphasizes ***Peak viral load did not differ by vaccination status or variant type.***

In Germany, the rate of symptomatic COVID-19 cases among the fully vaccinated was reported weekly between July and October, 2021 increasing from 16.9% to 58.9% for ages 60 and older.

In the UK, between week 39 and 42, over 100,000 COVID-19 cases were reported among citizens of 60 years or older. 90,000 occurred among the fully vaccinated (that's 89.7%)

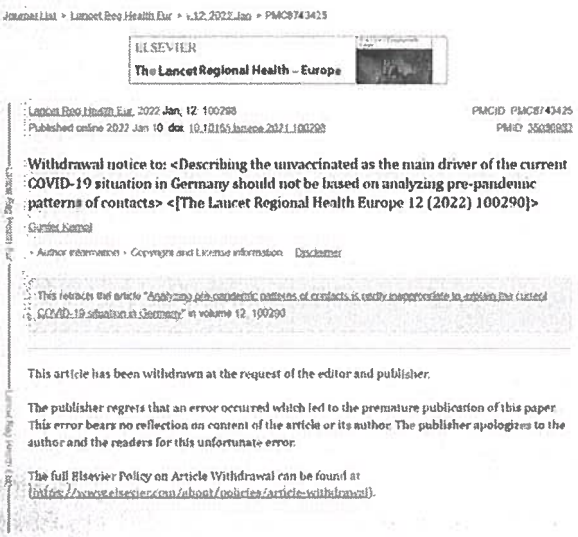
One week before, the COVID-19 case rate per 100,000 was higher among the subgroup of the vaccinated compared to the subgroup of the unvaccinated in all age groups of 30 years or more.

In Israel a nosocomial outbreak was reported involving 16 healthcare workers, 23 exposed patients and two family members. The source was a fully vaccinated COVID-19 patient. The vaccination rate was ***96.2%*** *among all exposed individuals (151 healthcare workers and 97 patients).* ***Fourteen fully vaccinated patients became severely ill or died****, the only two unvaccinated patients developed mild disease.*

The CDC identifies four of the top five counties with the highest percentage of fully vaccinated population (99.9 to 84.3%) as "high" transmission counties.

Many decision makers assume the vaccinated can be excluded as a source of transmission. It appears to be grossly negligent to ignore the vaccinated population as a possible and relevant source of transmission when deciding about public health control measures.

A disturbing fact, after revisiting the source of Kampf's letter just recently I learned it had subsequently been retracted (censored) by the publisher, ELSEVIER:



Journal List › Lancet Reg Health Eur › v.12; 2022 Jan › PMC8743425

ELSEVIER
The Lancet Regional Health – Europe

Lancet Reg Health Eur. 2022 Jan; 12: 100298 PMCID: PMC8743425
Published online 2022 Jan 10. doi: 10.1016/j.lanepe.2021.100298 PMID: 35036932

Withdrawal notice to: <Describing the unvaccinated as the main driver of the current COVID-19 situation in Germany should not be based on analyzing pre-pandemic patterns of contacts> <[The Lancet Regional Health Europe 12 (2022) 100290]>

Gunter Kampf

› Author information › Copyright and License information Disclaimer

This retracts the article "Analyzing pre-pandemic patterns of contacts is vastly inappropriate to explain the current COVID-19 situation in Germany" in volume 12, 100290

This article has been withdrawn at the request of the editor and publisher.

The publisher regrets that an error occurred which led to the premature publication of this paper. This error bears no reflection on content of the article or its author. The publisher apologizes to the author and the readers for this unfortunate error.

The full Elsevier Policy on Article Withdrawal can be found at (https://www.elsevier.com/about/policies/article-withdrawal).

But later in 2022 I did learn that other communications and papers had been censored by ELSEVIER. It was public knowledge. Consider what may have motivated the publisher to censor and put that into perspective with the recent admission by Pfizer's Executive that they never studied efficiency of their vaccine on reducing transmission – mentioned in section 3 of this report.

January 2022 marked the completion and submission of my first 'sizeable' COVID-19 Vaccine Injury Report. The County had also launched a series of YouTube broadcasts starring Dr. Eric McDonald, the San Diego County HHS Chief Medical Officer. The purpose, to 'combat' (as Nathan Fletcher put it) misinformation. As rebuttal I sent a letter (email & by post) to Dr. McDonald suggesting a possible remedy to our differences:

County of San Diego Health and Human Services Agency
1600 Pacific Highway, Room 206
San Diego, CA 92101

Attention: Dr. Eric McDonald, Chief Medical Officer

Date: 15 February, 2022

RE: "Public Health Misinformation Panel" of Feb 9, 2022

Dear Dr. McDonald,

You probably don't remember me, but we met briefly outside county chambers early last year after HHS presented one of their first COVID-19 reports at a BOS meeting. It was you and Gary Johnston, me and Audra Morgan. We were discussing CDC VAERS data and the number of deaths associated with COVID-19 vaccination which I believe, at that time, had reported about 2000. Your belief was that the vaccines had so far led to zero deaths. Since that time I've regularly produced VAERS reports, tracking numbers of categorical adverse events, but also specific events cited in published journal articles as potential harms associated with COVID-19 vaccine use. My summary report to date was delivered to Gary and the board of supervisors the day before the Feb 8 meeting.

After listening to your live panel on Feb 9 responding to public comment received at the Feb 8 County Board of Supervisors meeting, agenda item 16, the UPDATE ON THE COVID-19 RESPONSE, it seems we are still at loggerheads in resolving differences of opinion over death and injuries caused by the COVID-19 vaccines.

I admit I am not an expert in data analytics, and particularly analyzing data surrounding public health, but I am at least confident in my skills and ability as an engineer to perform simple analyses of the VAERS data that expose a definite <u>strong temporal correlation</u> on a large numbers of cases. This should concern <u>anyone</u> (I'm not just "adding numbers up"). There are typically 30 to 50% in the numbers of these categories that occur within 2 days of vaccine injection.

> Have you personally plotted or else tabulated VAERS numbers of deaths vs. onset of death?

I've also taken careful time to read through some of the details that reporters entered into the adverse event descriptions. If you were to do this yourself you'd see that most are entered not by individual consumers but rather physicians or nurses. These entries include information that one might copy and paste from the hospital information system in addition to other observations. My impression is the database is NOT being abused. Perhaps poorly managed, but I would not simply discount or dismiss VAERS as inaccurate or useless information.

Your panel only succeeded in disparaging and dismissing public comment rather than providing any convincing analyses or evidence to gain our confidence that the vaccines are safe. With all due respect, your rebuttal to public comments is just idiomatic "hand waving". I understand you do not want to get too technical and lose your audience. But the problem is the material is NOT simple. And we are not stupid! I've educated myself on the Bradford Hill method of inferring causation in signals, but since I do not have access to other required datasets and information I can't properly complete such an analysis. CDC administration does not grant 'unqualified' individuals access to VSD data.

> Have SD HHS data analysts completed their own Bradford Hill analysis of any VAERS data? Or do you just trust the CDC and FDA?

I have not found any reports on such analyses on either the CDC or FDA websites or anything suggesting they have or that any group of researchers have by searching the journals. If you have a reference please email me. If requirements are anything like the medical device industry, the FDA should impose that the manufacturer would have to perform and submit such analyses to the FDA for review. Do you have access to these records?

What I did find is that Rose & McCullough recently made a case for causation between COVID-19 vaccinations and myocarditis in a paper they attempted to publish in an Elsevier journal, Current Problems in Cardiology, Sept. 2021. Although the paper clearly passed peer review, Elsevier withdrew the paper without proper cause. So the authors have been forced to self-publish. One source is Rose's own webpage: https://jessicar.substack.com/p/a-report-on-myocarditis-adverse-events .

Besides the vaccines themselves causing harm, another of my concerns that is blatantly apparent to others I've spoken with at county meetings is that SDC HHS monthly reports focus only on (1) the number of covid cases and (2) the percent of population vaccinated. Jim Desmond acknowledged this concern and last year made a motion in the vote to approve, to expand considerations surrounding the emergency order. But HHS still falls short in providing a complete and comprehensive picture of collateral damages. As I see it you should at least be including:

> vaccine injuries, depression and suicides, psychological and health harms to children in schools, lost or compromised K-12 education, reluctance by many to seek regular checkups, screening and healthcare for other illnesses, loss of employment over vaccine 'non-compliance', an increase in crime now moving into the suburbs, and a weakening of countywide police and fire protection.

The virus hasn't caused these harms; HHS and County policies have. And an ACCURATE harms-benefit, age stratified assessment is critical to take ALL of these factors into account. Only by this manner can the county strategically architect an effective plan. There is no indication in any of your reports except on occasion that these are being considered in deciding persistence of the emergency order. This collateral damage, together with inflation and rise in taxes makes life untenable for many. People are sick of their dysfunctional, apparently corrupt government in the state, county and communities. I believe we are at a breaking point.

Before I suggest a remedy, I have to address a comment Dr. Sawyer made regarding long term effects of the vaccines. He said "There is no vaccine that has ever been used that has long term side effects". While I might agree with legacy technologies such as "killed virus" vaccines, the mRNA vaccine technology is worlds apart from anything ever released on large human populations. Barely has a year gone by; many years are required to affirm such a conclusion.

An in-vitro study of the COVID-19 vaccines published last November by a group in Sweden suggests that the vaccines are turning off the adaptive immunity mechanisms in cells. As Dr. Schooley mentioned in his public address on immunology, these mechanisms serve to preserve genetic integrity. The Swedish team's observed response to the vaccines showed suppression of the natural immune system which could make people more susceptible to other infection or cancer. In fact data from the UK is showing a proportional increase in infection relative to number of doses/booster. This observation likely prompted the UK to back off mandates.

> How can Dr. Sawyer possibly make such a blanket statement that includes the COVID-19 vaccines when we have only one year experience with the vaccines?

To me this sounds not like misinformation, but rather disinformation.

What can you do to help fix the matter? Like Dr. Sawyer said, it's healthy to be skeptical. Without skepticism, science cannot effectively advance. For the moment, setting aside the question of efficacy, there are literally thousands of scientists and doctors (once considered legitimate and now castigated) that disagree that the COVID-19 vaccines are safe. So far we've not had any qualified opponents engage in public comment at our county meetings, but even if that were possible it would not effectively conquer the divide. The manner of proceedings is just not an effective way to reach consensus. What we need is a public special discussion between opposing authorities on vaccine safety, or series of discussions and debate by experts on both sides of opinion.

Consider the historic scientific debates in Solvay, 1927 where Einstein and Bohr challenged one another on quantum theory. Einstein to Bohr on the uncertainty principle: "God does not play dice". While Solvay involved a revelation in reality, the stakes over COVID-19 vaccine safety is much higher. We all need to come to a common consensus on vaccine safety or at least for now a plan on how to get there.

San Diego is one of the greatest cities in the world, so why can't we lead in such an endeavor to find truth? That's all reasonable people want. That's all I'm looking for. If opposing sides on the issues are allowed to lay the facts on the table as they know them and be allowed and encouraged to offer critique, I believe we can finally settle the matter. Can San Diego lead the way?

It's OK to lose arguments if truth is revealed; either side should be willing to sacrifice loss for truth.

Sincerely,

Mike Borrello

Mike Borrello
maborrello@roadruner.com

Unvaccinated & Unemployed Engineer

PS: It may interest you in knowing that despite some labeling me an 'anti-vaxxer', in 2020 I volunteered on-line to participate in one of the Pfizer trials. They never contacted me. Then in early 2021 I was initially passed by according to age. But by the time I was qualified to get jabbed I had (1) learned that the COVID-19 vaccine was a very different technology that hijacks protein manufacturing functions in somatic cells and (2) that VAERS was reporting a significant number of

adverse reactions. So I decided to wait, gather data and see. But authorities have NEVER adequately explained, to my satisfaction, the COVID-19 vaccines are safe. Up to the COVID-19 vaccines I have been an annual recipient of the influenza vaccines and in 2020 received the shingles vaccine. So I'm not an 'anti-vaxxer'. I believe in choice, medical freedom. At this point I've lost all trust in government and corporations to properly manage healthcare, so I'm not in a hurry to get ANY injection. I believe the best solution for me now, personally, is to do nothing until information is unchained.

Dr. McDonald, nor any other HHS official bothered to respond to my letter.

That same month, February 2022, Council Chambers were still closed to the public, so I called in the following communication during Wilma Wooten's COVID-19 update:

This report is intended to supplement information regularly provided by San Diego HHS regarding Covid-19. I've submitted a full report with the clerk and supervisors. But here's a brief summary.

- **As reported by Professor Kampf's letter to the Lancet last month:**
- **The vaccines are NOT preventing people from getting covid**
- **The larger percentage of covid infections are occurring in the <u>vaccinated</u> rather than the <u>unvaccinated</u>**
- **There's little difference in viral load between infected people that are vaccinated and those not vaccinated**
- **Since the vaccinated can be infected, they can also <u>spread</u> the virus**
- **Covid is endemic, just like the cold virus, so vaccines are no longer an effective control measure**
- **Dr. Brown in Medicina exposed statistical deception by Pfizer and Moderna in their phase 3 trials**
- **Calculations show you <u>needed</u> to vaccinate 88 to 120 people to prevent one covid infection**
- **That was the alpha variant. The vaccine now has negative efficacy on delta and omicron.**
- **But everyone must get vaccinated!**
- **They're not vaccines, they are <u>experimental genetic agents</u>.**
- **The mRNA technology is not like any other legacy vaccine**
- **It's killing people, now our children.**
- **We can only speculate about the long term effects**

And now the numbers from VAERS

1. **23,000 Deaths**
2. **26,000 Life threatening events**
3. **41,000 Permanent disabilities**
4. **125,000 Hospitalized**
5. **117,000 Emergency room visits**
6. **3,000 cases of sudden cardiac death**
7. **1,800 cases of blindness;**
8. **3,000 Miscarriages or stillbirths**
9. **18,000 cases of myocarditis or pericarditis**

10. **41,000 cases of various cardiomyopathies**
11. **2,000 cases of ischemic stroke**
12. **3,000 cases of thrombocytopenic purpura**
13. **2,000 cases of renal system disorders**
14. **1,800 cases of paralysis or catatonia**
15. **29,000 cases of various neurogenic disorders**
16. **9,000 cases of anaphylaxis or shock**
17. **8,000 cases of convulsions or seizure**
18. **163,000 cases of various gastrointestinal disorders**
19. **5,000 cases of intracranial hemorrhage**
20. **11,000 cases of pulmonary embolism**
21. **6,000 cases of pneumonia, or pulmonary edema**
22. **7,000 Cases of Deep vein thrombosis or thrombophlebitis**
23. **18,000 cases of tinnitus or other hearing impairments**

On April 5, 2022 I delivered the following public comment:

> *Vaccines, by original design were never intended to 'wane', nor allow infections to 'break through'. If a 'booster' is required every few months, we can't really call it a vaccine. And we can't really call it a therapeutic if there are serious safety issues. Today I submitted a compendium vaccine injury report to the County Board of Supervisors and San Diego Health and Human Services containing a preponderance of evidence from reputable, authoritative sources. Collective evidence strongly infers the COVID-19 vaccines are causing irreparable injury, permanent disability, and even death, to many individuals.*
>
> *Given that factual basis, we should consider a key question: How can any official justify any measure, ordinance or decree that mandates, requires, encourages or endorses universal vaccination when one group of people is indiscriminately injured or killed to protect another group? If we know the vaccine is unsafe, and even a single individual is killed, there can be no claim of a greater good. There is no good in saving some to sacrifice a few. All for satisfying bureaucratic metrics. Killing vitiates any benefit-risk analysis. There's no math required. No Bayesian analysis. The answer is - It cannot be justified. Many others agree. But I welcome Dr. Eric McDonald in his monthly YouTube rebuke to mis-informationists to tell me why we are wrong.*
>
> *By this simple argument I indict this Council and County Health as having committed, and continuing to commit unethical and immoral, if not criminally deceptive acts against the people of San Diego County. This notice, now on public record, calls for a cease and desist in all further endorsements of COVID-19 vaccination and to end COVID-19 vaccinations in San Diego County now until full informed consent can be provided to the people that includes the risks detailed in the contents of my report.*

On May 23, 2022 I delivered the following public comment

Vaccines are supposed to provide recipients with immunity from infectious microorganisms by stimulating the immune system. They are supposed to be safe and effective. Safe meaning they do not kill, seriously injure or permanently disable people.

But somewhere along the way public health convinced many with the notion of "the greater good". As long as the "benefits outweighed the risks" the right thing to do is vaccinate everyone. Some people might die or be injured but that's OK. Benefits will outweigh the risks for the population as a whole. The vaccinated will presumably be spared death from infection; more than will die from vaccination. The number dying from vaccination, hidden, suppressed, ignored.

What many have failed to see in this reasoning is the loss of ethical ground. It's not ethical to kill even one individual with the vaccine that might otherwise survive infection so that many will be presumably saved. That's like throwing the virgin into the volcano to appease the gods. But with vaccines all appears more scientific, and its big pharma that's surreptitiously appeased by astronomical profits.

COVID-19 vaccines have clearly caused many deaths and very much pain and suffering under an unethical public health policy, but more so immoral. It's all well documented in the reports I've submitted to this council over many months. These reports, all derived from authoritative sources under the CDC and NIH, will serve as evidence you were informed.

In all these communications that span nearly two years after vaccine rollout, these concerns voiced by a resident of San Diego County were never answered. They never explained HOW they could ethically continue to encourage vaccination given the magnitude of risk and harm reported by CDC, nor any explanation WHY those numbers might not be legitimate.

11 Conclusions and Recommendations PLEASE READ!

This report consolidates extensive authoritative sources of data, analysis and published medical accounts that substantiate compelling evidence the COVID-19 vaccinations and policies are harmful to health and seriously demand an anwer to the question: do the benefits outweigh the risks? It summarily serves as a body of evidence and testimonial concluding, with little doubt, **the COVID-19 vaccines have led to unprecedented death and injury** across the nation if not the entire planet.

The magnitude of injury and death far exceeds anything that was previously considered acceptable by any government or regulatory agency. The FDA, CDC, NIH and national and local HHS were trusted with the responsibility for safeguarding the health and welfare of the American people. But either by intentional acts, reckless negligence or gross incompetence, they have all failed by allowing a dangerous pharmaceutical product to be widely distributed, and furthermore continue promoting its use using fear, bribery and coercion.

They have further failed the people they serve by recommending policies such as lockdowns, isolation and masking that have done irreparable physical and psychological harm, stunted the education of our

children, and caused loss of employment or business for many. All because these agencies failed to recognize or otherwise ignore information outside what their orthodoxy or narratives allowed.

The chance these agencies, as an entire body, accidentally failed to notice the deaths and injury are inconceivable and inexcusable. We can no longer trust their judgement or authority over deciding policies regarding the health of the American people. This report is a declaration of no confidence and a harbinger of a crisis continuing to unfold in America and in the county of San Diego. Excess deaths are NOT decreasing. They are increasing. Why?

Regardless of what investigations and determinations may unfold, immediate actions are required within the County of San Diego:

1. Immediate ban on the distribution and use of all COVID-19 vaccines.
2. Form a committee to determine the extent of injury and death caused by COVID-19 vaccines.
3. Establish an effective program, clinics to heal those injured by the vaccine.
4. Communicate to the public the harms the vaccines have caused.

I'll point out the county continues to waste ARPA funds for expenses unrelated to fallout from the pandemic. If anything, this funding should be directed to those injured by the vaccines.

12 About the Author

Please direct all questions or requests for a file copy of this report to: maborrello@roadrunner.com. File for easy access to hyperlinks to all cited references.

About the Author: Mike Borrello is a resident, registered voter and taxpayer in San Diego County. He is an Engineer & Scientist that specializes in feedback control systems and dynamic simulations. For decades he has provided control system designs for the defense, aerospace and medical device industries and, until more recently, was employed by Philips Respironics, however terminated by corporate policy requiring him to disclose his "vaccine status" which he refused to do out of principle besides health concerns.

Despite what the mainstream or social media or locals wish to label him, Mike Borrello was NOT an 'Anti-Vaxxer', at least before 2021. Up until covid he annually received influenza vaccines and during covid the shingles vaccine. He volunteered on-line to altruistically participate in the Pfizer Phase 3 trials for the covid vaccine, but Pfizer never contacted him. As he awaited authorization to vaccinate by age group in winter of 2021, he learned more about the mRNA technology and by curiosity ran queries on VAERS to confirm what he had seen and read in social media regarding vaccine harm. The numbers of deaths and other adverse events he saw reported in VAERS for the COVID-19 vaccines caused him concern to the point he decided to wait and see what the CDC or FDA might publicly offer as a valid excuse to dispel any concerns over what was happening on the CDC's own website. That explanation never happened, and to this day continues to be a void in the public space. Rather, media narratives that VAERS information is 'unreliable' pervade that space. Eventually Borrello uncovered evidence of injury, death, fraud and corruption and decided he would avoid vaccination at all costs and that in his good health he could better manage infection by the virus with early treatment with therapeutics than risking some of the potential harms he's seen reported in VAERS – however little the risk might be. Indeed that paid off when in the summer of 2022 he and his wife became sick with omicron. It was clear by the distinct symptom of anosmia. Treatment with Ivermectin rid Borrello and his wife of the disease within a week's time.

Borrello's experiences prompted him to become more involved in researching the data and publications that continue to examine the covid-19 vaccine injuries and to become active in communicating this information to others. Since June of 2021 he has publicly engaged the San Diego County Board of Supervisors, Wilma Wooten and the San Diego HHS each month by presenting the type of materials contained in his reports which now exist on the public record. Based on the evidence, he has asked officials stop all vaccinations, especially for younger people who potentially have so much to lose, and little or nothing to gain by being vaccinated. He is asking that the officials investigate these harms, the deception used by pharma over vaccine efficacy, and to end the persistent emergency orders to prevent further collateral damage caused by this unnecessary, destructive policy.