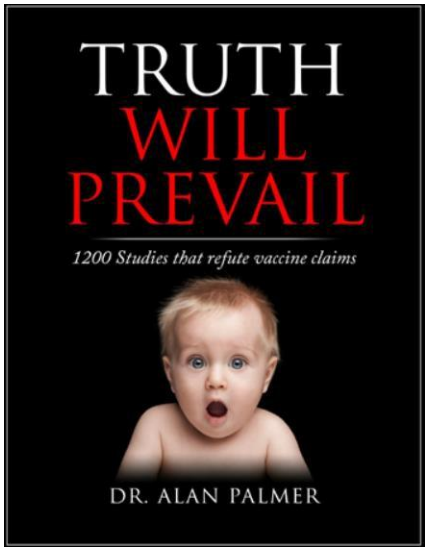
1200 Studies Update Newsletter April 1st, 2021



Welcome to *Issue 11* of the 1200 Studies Update Newsletter where the truth often flows against the mainstream narrative.

This month's issue contains updates on the stats, the data and the science of the many facets of the COVID-19 pandemic, including the direct and indirect consequences of the disease and the decisions that have been made along the way.

In addition to this vital information, I would encourage you to download and share my free COVID-19 Vaccine Critical Review. I have recently updated it to include the latest information. You can access the full paper and a 2-page overview here: https://www.wellnessdoc.com/covid-19-vaccine-review-2/

Links to major topics in this edition (titles are interactive links):

- What are the latest Infection Fatality Rates for different age groups in the U.S.?
- Latest VAERS COVID vaccine injury reports and the incredibly high real-world numbers
- The U.S. government funded a Harvard study that found that less than 1% of adverse reactions to vaccines are reported
- World renowned vaccine scientist warns of a global catastrophe from the vaccine program
- A brilliant evolutionary biologist and scientist lays out the most likely scenario for the COVID-19 vaccines to result in an epidemic of future illness in vaccinees and risk of autoimmune disease
- A new study showcases the advantage of natural infection over vaccine immunity with regard to SARS-CoV-2 variant strains
- Urgent letter from doctors and scientists to the European Medicines Agency over COVID-19 Vaccine concerns
- New research points to link between AstraZeneca Vaccine and blood clots
- A data breach reveals confidential emails showing that the spike protein RNA in the mRNA vaccines may not be as advertised
- Pfizer revises ultra-cold storage guidance for Covid-19 jab to refrigerator temperatures- This raises suspicions
- Is the death rate from the vaccines higher than from COVID-19?
- First lawsuit challenging mandatory vaccines
- Highly respected Stanford professor calls lockdowns the "biggest public health mistake we've ever made”
- CDC touts a 1+% “success” rate from masking and closing restaurants as significant
- More mask harms come to light
- Calling out Francis Collins Director of NIH, for stating people who have had COVID-19 still need the vaccine, while citing a study suggesting that they don’t
- Confusion still abounds amid CDC’s obvious worries that vaccinated people can still spread disease
- Bill Gates says a third shot may now be needed
- Dr. Fauci’s 2015 statements in this interview reveal his lack of knowledge, candor,

World-wide case and death numbers courtesy of Worldometer, April 1, 2021

Note the highlighted portion. Of all the active cases in the world, 99.6% are considered mild.

COVID-19 CORONAVIRUS PANDEMIC

Last updated: April 01, 2021, 15:12 GMT

Graphs - Countries - News

Coronavirus Cases:

129,670,924

view by country

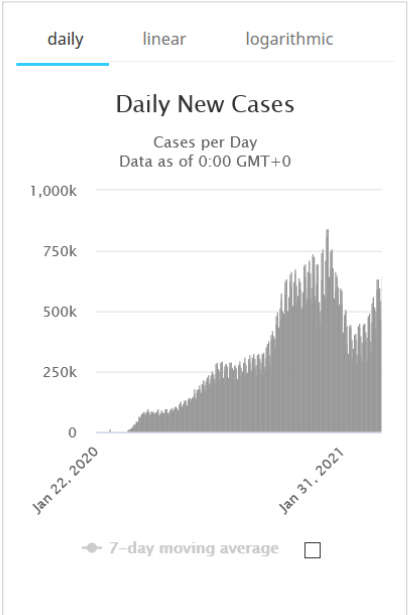
Deaths:

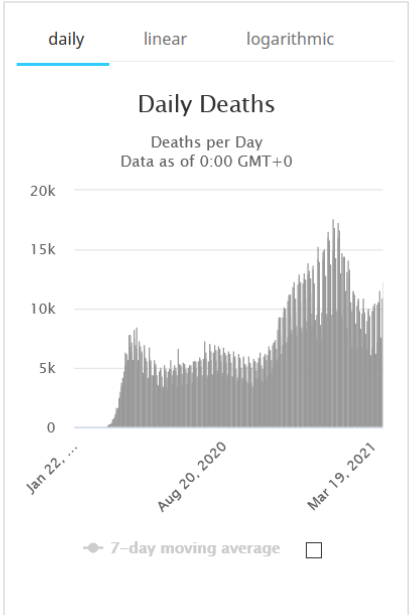
2,831,213

Recovered:

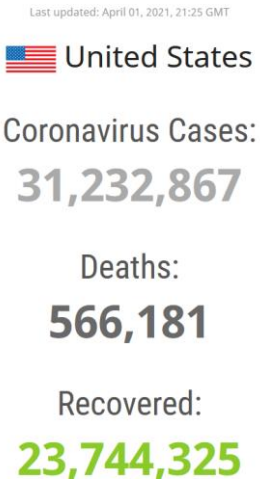
104,533,665

ACTIVE CASES	CLOSED CASES
22,306,046 Currently Infected Patients	**107,364,878** Cases which had an outcome:
22,209,469 (99.6%) in Mild Condition	104,533,665 (97%) Recovered / Discharged
96,577 (0.4%) Serious or Critical	2,831,213 (3%) Deaths
Show Graph	Show Graph





Overall case, death and recovery numbers in the U.S. as of April 1st



A footnote on deaths: We don't know what the actual number of deaths due to COVID-19 are, but all indicators are that it is GROSSLY inflated. Former Senator Dr. Scott Jensen a practicing physician from Minnesota has done an audit of deaths in Minnesota and found that they are 40% inflated due to incorrect assignment of cause of death on the death certificates. https://www.washingtonexaminer.com/news/coronavirus-death-certificates-minnesota-inflated

COVID-19 trends in the U.S. as of March 31st, 2021

Testing and cases-

Reminder on the nuances of testing:

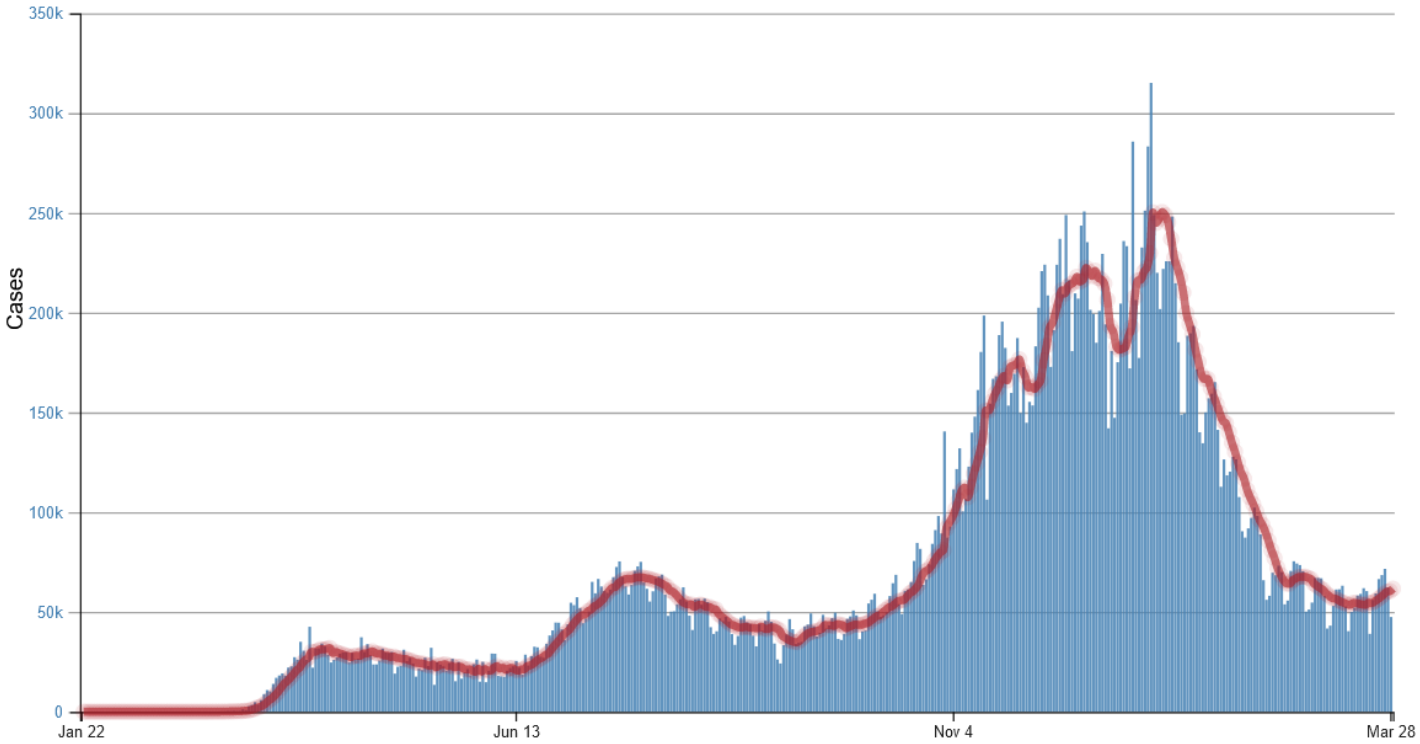
As you consider the case totals, bear in mind that cases are determined by PCR testing and not by combining PCR with a physician's clinical experience in properly evaluating a person based on history and examination. That is the way cases should be determined. The late Dr. Kary Mullis, the 1993 Nobel Prize in Chemistry Winner as the inventor of the Polymerase Chain Reaction (PCR) test was clear. The test is NOT appropriate for being used as a stand-alone diagnostic test for viral infection. He also made an interesting comment when talking about the AIDS epidemic. His comment mirrors many top scientist's feelings about the "case" numbers of COVID-19 that have and are being reported.

"Epidemic. The number of cases reported went up epidemically, exponentially because the number of tests that was done went up exponentially."

Therefore, more testing = more "cases". There is a major difference between infections and cases. If we stopped testing tomorrow and as a result "new cases" went to zero, would that mean that there are no more new people infected? Of course not. So, while it a metric that is driving public fear and policy decisions affecting all Americans, it is in no way the most important metric. This is not to mention that the reporting is fraught with inaccuracies, including some people being tested multiple times and each test being counted as a new test or new positive, as well as people that were never tested being called and informed that they tested positive! The PCR test also has significant rates of false positives (estimated at 30-50%) and false negatives (20% or so). And, despite the numbers that are discovered, the numbers of people that have been infected, been asymptomatic or had mild symptoms and never tested, are many multiples of the known positive case numbers (CDC says about 8X higher). Based on that estimation as of today it would mean that approximately 66% of all Americans have had the infection. Surely, we must be zeroing in on herd or population immunity and would expect the virus infection rate to decline.

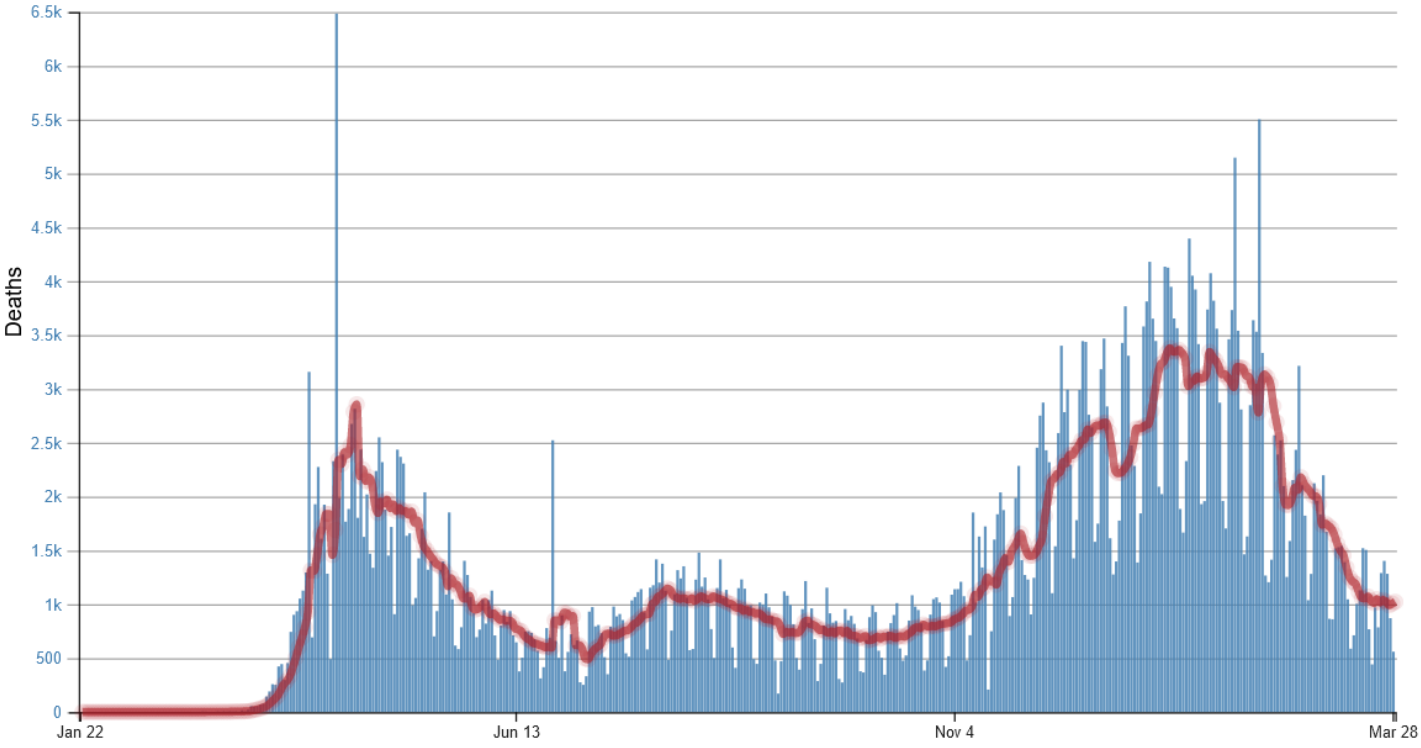
7-day average of U.S. New Cases and Deaths- as of March 28th

Daily Trends in Number of COVID-19 Cases in the United States Reported to CDC



https://covid.cdc.gov/covid-data-tracker/#trends_dailytrendscases

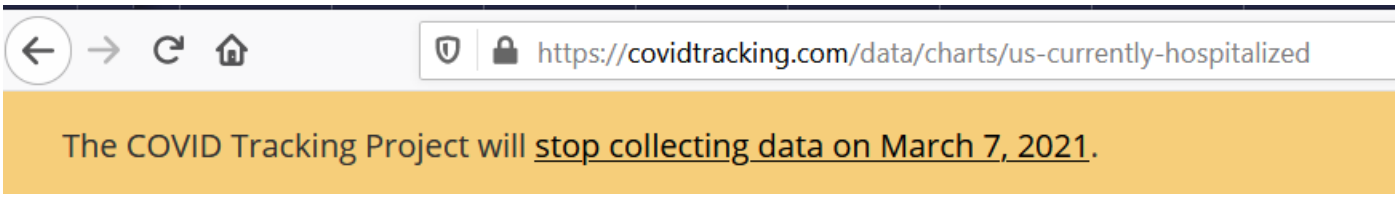
Daily Trends in Number of COVID-19 Deaths in the United States Reported to CDC



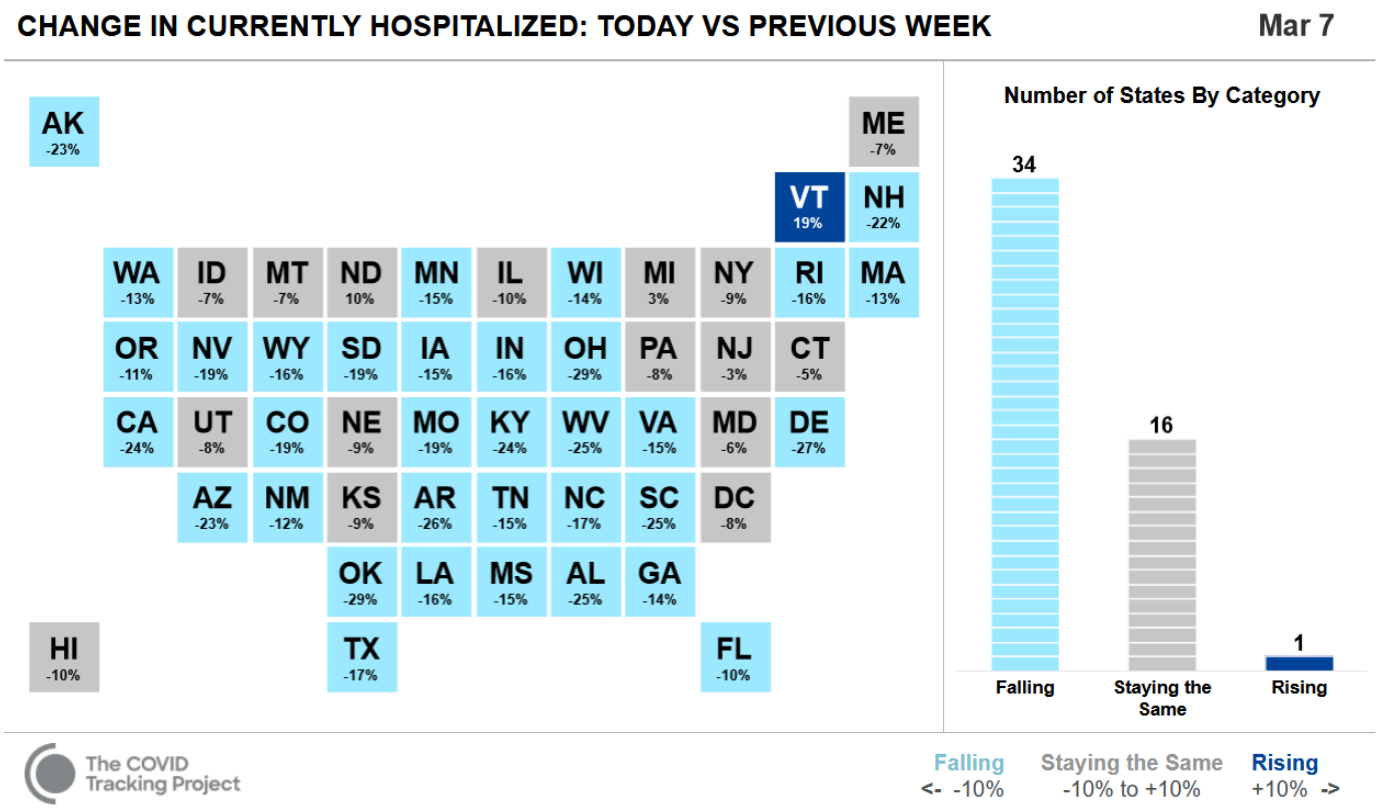
https://covid.cdc.gov/covid-data-tracker/#trends_dailytrendsdeaths

Interestingly, this banner is at the top of the covidtracking.com web site.

What do they know that we don't know? Is the pandemic coming to an end?



It's good to see that the rate of hospitalized patients is falling...

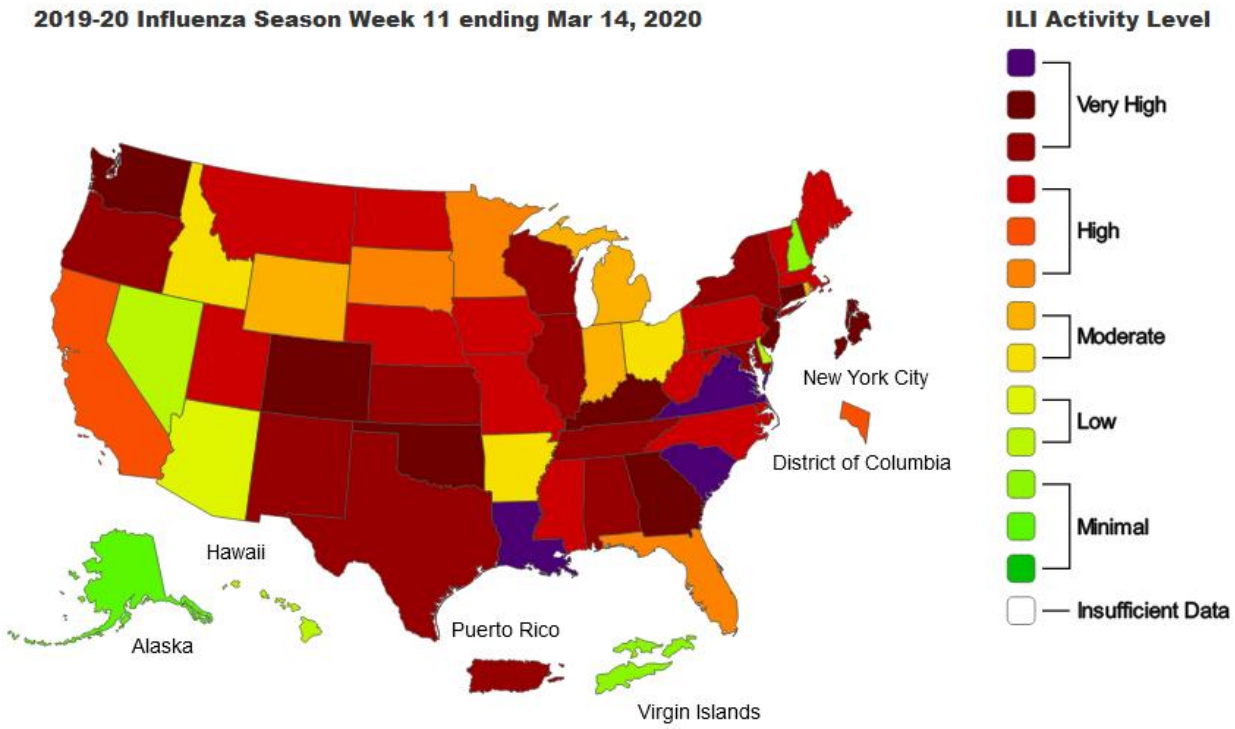


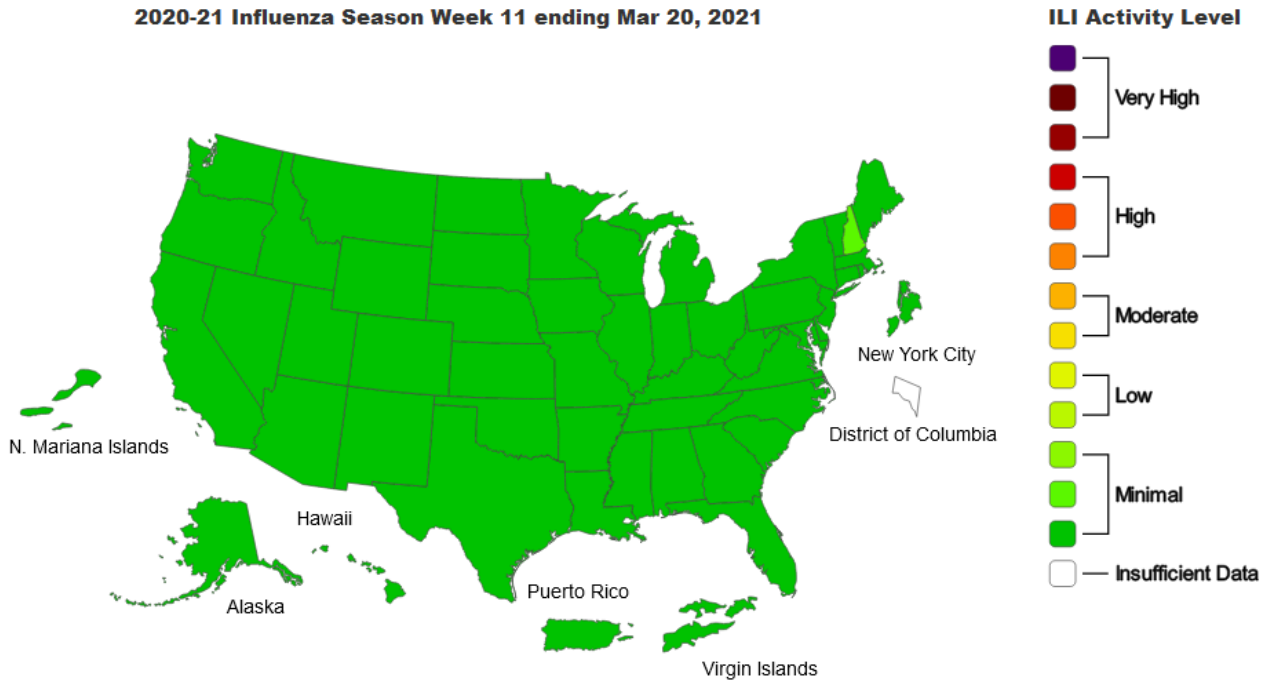
Where did all the flu and influenza like illness- ILI cases go?

As the number of COVID-19 cases have skyrocketed, are most of those replacing seasonal flu cases?

This is a comparison of the end of the week ending February 15, 2020 with the week ending February 20 this year. There are two explanations that come to mind. Either flu cases are being registered as COVID-19 cases, or the people that would have normally contracted the flu are getting COVID-19 instead as SARS-CoV-2 is the dominant circulating virus this year. https://www.cdc.gov/flu/weekly/usmap.htm

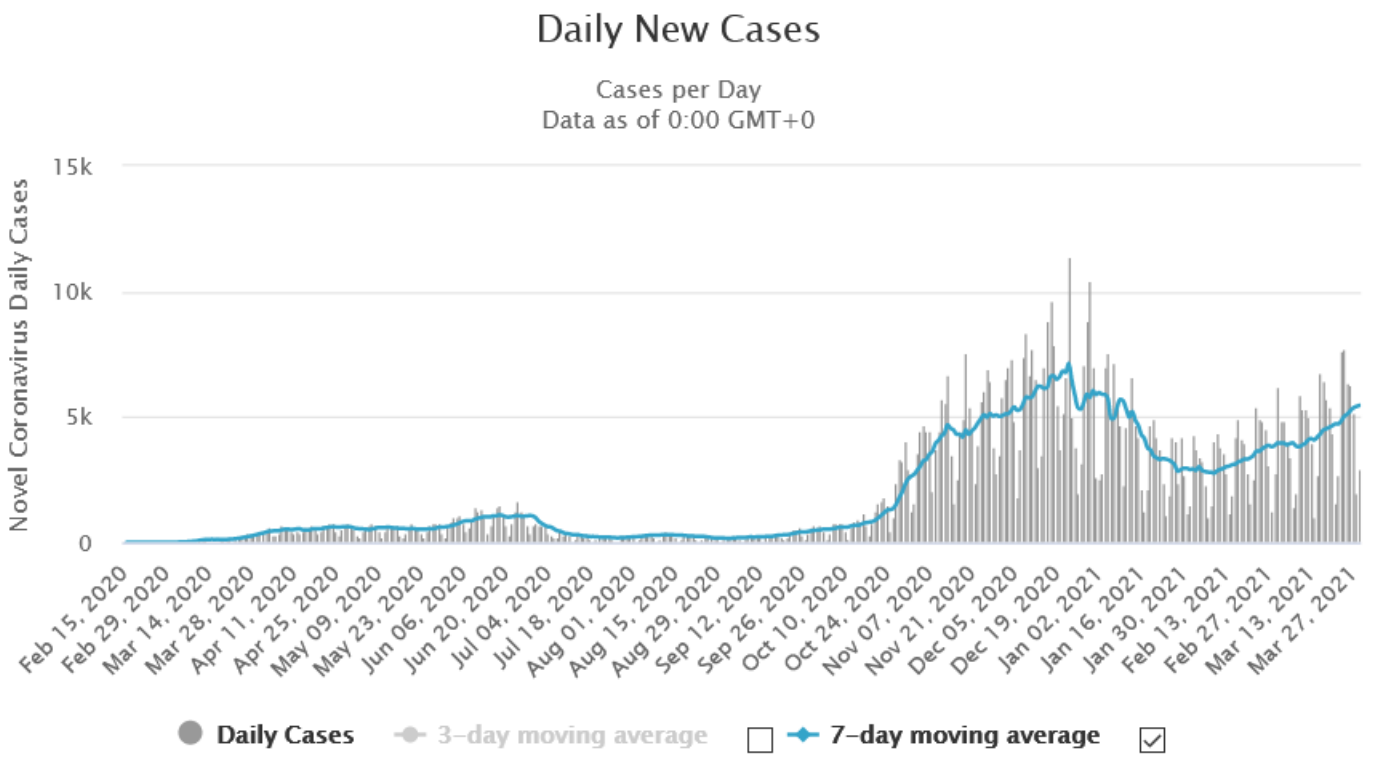
Two pictures are worth ten thousand words!

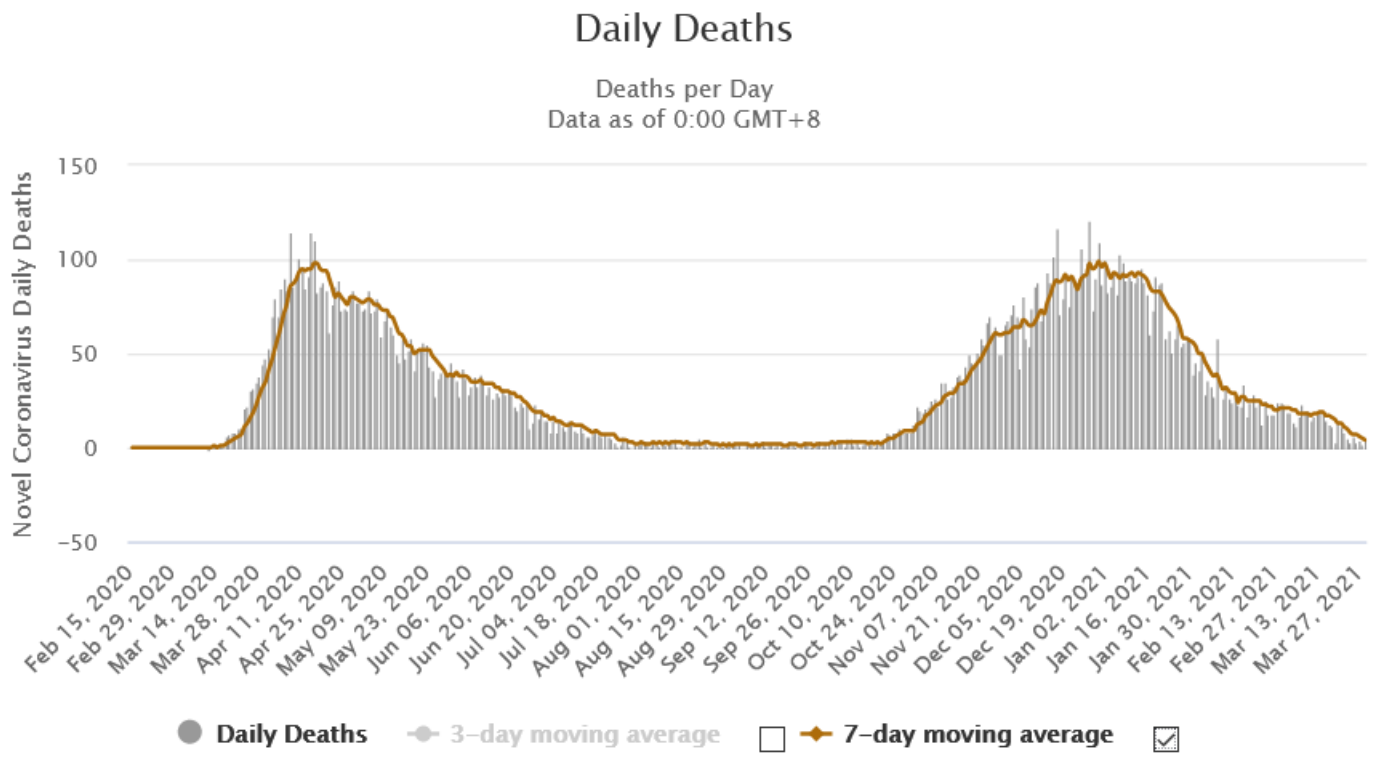




Sweden update as of March 29th

As you can see, even though the trend in cases is going up, the deaths continue to decline.





Some epidemiologists believe that a good portion of Sweden's mortality in April and May 2020, is due to the fact that they had a particularly mild flu and pneumonia season the year prior (2018-2019). This spared many elderly and frail people until to 2019-2020 SARS-CoV-2 pandemic, which then caught up with them.

Thank God for Sweden- The one country that did not conform

The world's control group for the COVID-19 pandemic. For those new to my newsletter and haven't been following it, Sweden is the one country in the world that did things differently. They never locked down. They never required or even suggested their citizens wear face masks. They never closed restaurants, bars, gyms, schools or other businesses. Their economy has flourished. Their people are not suffering from higher than usual percentages of mental health issues, alcohol and drug use, suicide, domestic violence and other collateral damage. They have avoided deaths of despair that countries using lockdowns and business closures are experiencing. They have essentially asked their citizens to social distance whenever possible and follow good hygiene practices. They have provided us with the much-needed contrast to compare to what virtually every other country did. If what they did continues to work as it has so far, it provides a template for the next "novel" outbreak, if God forbid there ever is a next time.

They made the same mistakes as virtually every other country by not doing enough to protect their elderly in nursing homes and long-term care facilities. That is where a large percentage of their deaths came from early on and you can see that represented by the peak in April deaths on the graph on the previous page. But other than that, it has pretty much been the textbook playbook that the authors of ***The Great Barrington Declaration*** are pushing for (more about that later). Obviously, they have and are continuing to do something right. This is exactly why I wish we would get the myopic focus off cases and look at hospitalizations, ICU capacity and deaths. Why should we really care how many cases there are if they aren't causing hospitalizations or deaths?

What are the latest Infection Fatality Rates for different age groups in the U.S.?

Updated on CDC site 03-19-21

Table 1. Parameter Values that vary among the five COVID-19 Pandemic Planning Scenarios. The scenarios are intended to advance public health preparedness and planning. They are **not** predictions or estimates of the expected impact of COVID-19.

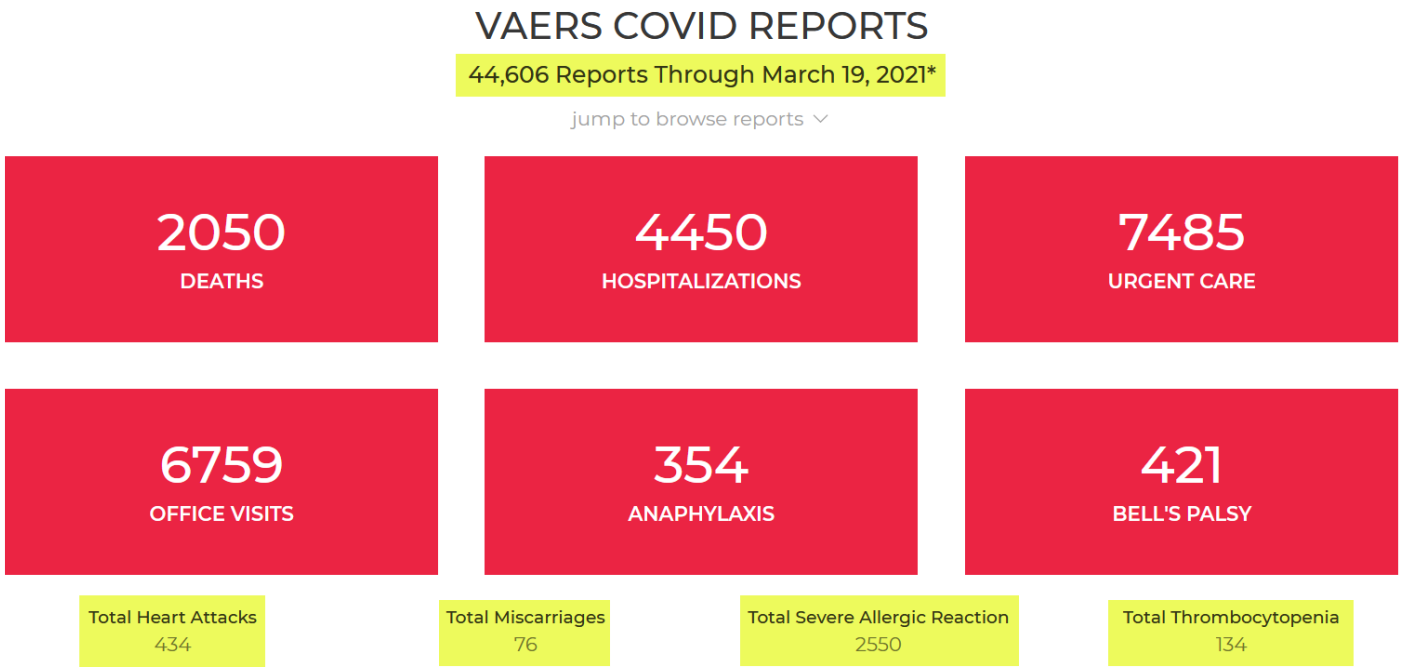
Parameter	Scenario 1	Scenario 2	Scenario 3	Scenario 4	Scenario 5: Current Best Estimate
R_0*	2.0		4.0		2.5
Infection fatality ratio (Estimated number of deaths per 1,000,000 infections)†	0–17 years old: 6 18–49 years old: 150 50–64 years old: 1,800 65+ years old: 26,000		0–17 years old: 80 18–49 years old: 1,700 50–64 years old: 20,000 65+ years old: 270,000		0–17 years old: 20 18–49 years old: 500 50–64 years old: 6,000 65+ years old: 90,000
Percent of infections that are asymptomatic§	15%	70%	15%	70%	30%
Infectiousness of asymptomatic individuals relative to symptomatic¶	25%	100%	25%	100%	75%
Percentage of transmission occurring prior to symptom onset**	30%	70%	30%	70%	50%

https://www.cdc.gov/coronavirus/2019-ncov/hcp/planning-scenarios.html

Later in this newsletter we will compare these death rates from COVID-19 to the reported and also the more likely death rates from the vaccines…Stay tuned!

Latest VAERS COVID vaccine injury reports and the incredibly high real-world numbers

VAERS, the ***Vaccine Adverse Event Reporting System*** is a voluntary (passive) reporting system. There are no requirements to report, and most people have no idea it even exists. Therefore, the number of adverse events from vaccines are grossly under-reported as you will see below.



The U.S. government funded a Harvard study that found that less than 1% of adverse reactions to vaccines are reported

More about that in a second. But imagine if this is true, you would ADD two zeros to each of the above numbers, i.e., 205,000 deaths! Some say that with serious reactions like deaths it may be higher reporting. If instead of <1%, what if only 10% were reported. You would then add one zero to the reported deaths and the actual number would be 20,500 thus far. The next logical question would have to be, “how many is too many?”

Here's the proof of the <1% reporting claim

Harvard Pilgrim Health Care performed the study between 12/01/2007 -09/30/2010. The report was titled, Electronic Support for Public Health–Vaccine Adverse Event Reporting System (ESP: VAERS) https://digital.ahrq.gov/sites/default/files/docs/publication/r18hs017045-lazarus-final-report-2011.pdf

The Purpose of the Study:

“This research project was funded to improve the quality of vaccination programs by improving the quality of

physician adverse vaccine event detection and reporting to the national Vaccine Adverse Event Reporting System (VAERS)...

"The CDC's Public Health Information Network Messaging System (PHIN-MS) software was installed within the facilities so that the approved reports could be securely transferred to VAERS as electronic messages in an interoperable health data exchange format using Health Level 7 (HL7)."

Results from the study:

"Preliminary data were collected from June 2006 through October 2009 on 715,000 patients, and 1.4 million doses (of 45 different vaccines) were given to 376,452 individuals. Of these doses, 35,570 possible reactions (2.6 percent of vaccinations) were identified. This is an average of 890 possible events, an average of 1.3 events per clinician, per month. These data were presented at the 2009 AMIA conference."

Dividing 1.4 million doses between 376,452 people is an average of 3.72 doses per person. And, if there were 35,570 reactions in 1.4 million doses given, that is one adverse reaction for every 39.4 doses. Perhaps what is most striking here is that if each person reacting experienced on adverse reaction only, of the 376,452 individuals vaccinated, nearly 10% experienced a possible reaction!

"Adverse events from drugs and vaccines are common, but underreported. Although 25% of ambulatory patients experience an adverse drug event, less than 0.3% of all adverse drug events and 1-13% of serious events are reported to the Food and Drug Administration (FDA). Likewise, fewer than 1% of vaccine adverse events are reported. Low reporting rates preclude or slow the identification of "problem" drugs and vaccines that endanger public health."

In addition, ESP: VAERS investigators participated on a panel to explore the perspective of clinicians, electronic health record (EHR) vendors, the pharmaceutical industry, and the FDA towards systems that use proactive, automated adverse event reporting." (Since in the end, this improved automated reporting system was stymied and went nowhere, one has to wonder what influence the pharma reps on the panel had on that).

Here's the kicker. After spending nearly 3 years and a million dollars, the CDC went dark on the program. Was it because the surveillance system would significantly increase the reporting of vaccine adverse reactions?

The last statement from the Results section of the article says it all…

"Unfortunately, there was never an opportunity to perform system performance assessments because the necessary CDC contacts were no longer available and the CDC consultants responsible for receiving data were no longer responsive to our multiple requests to proceed with testing and evaluation."

One has to wonder what is stopping the automation of the vaccine adverse reporting system from being implemented. This report suggested that its implementation would be easy to accomplish. That was in 2010. It is now 2018 and nothing has been done to accomplish this vital information system. And lives hang in the balance.

It is feared that the greatest number of deaths will not occur for some time to come

Many scientists and researchers warn that the potential for ***Antibody Dependent Enhancement*** AKA ***Pathogenic Priming*** as well as other autoimmune and immune dysregulation effects from the vaccines can lead to a large number of delayed deaths from the vaccines.

And here's an example of one of those raising a red flag!

World renowned vaccine scientist warns of a global catastrophe from the vaccine program

First, I would like to present this scientist/researcher's credentials

Geert Vanden Bossche, PhD, DVM

GSK biologicals:
- Senior Project Leader of Adolescent Vaccine Projects
- New Biotech Vaccine Development and QC-QA Manager
- Head of Adjuvant Technologies and Alternative Deliveries, R&D

Novartis vaccines and diagnostics:
- Director, Research Program Leader and Head of Adjuvants

Solvay Biologicals:
- Global Project Director Influenza Vaccines

Bill and Melinda Gates Foundation:
- Senior Program Officer, Global Health, Vaccine Discovery

Global Alliance for Vaccines and Immunization (GAVI)
- Program Manager

Univac
- Chief Innovation and Scientific Officer

German Center for Infection Research (DZIF)
- Head of the Vaccine Development Office

VARECO
- Managing Director

https://www.bitchute.com/video/BGtSE3OfO2wv/ Starts at 56:30

Here are the opening sections of his letter:

Geert Vanden Bossche, DMV, PhD, *independent virologist and vaccine expert, formerly employed at GAVI and The Bill & Melinda Gates Foundation.*

To all authorities, scientists and experts around the world, to whom this concerns: the entire world population.

I am all but an antivaxxer. As a scientist I do not usually appeal to any platform of this kind to make a stand on vaccine-related topics. As a dedicated virologist and vaccine expert I only make an exception when health authorities allow vaccines to be administered in ways that threaten public health, most certainly when scientific evidence is being ignored. The present extremely critical situation forces me to spread this emergency call. As the unprecedented extent of human intervention in the Covid-19-pandemic is now at risk of resulting in a global catastrophe without equal, this call cannot sound loudly and strongly enough.

As stated, I am not against vaccination. On the contrary, I can assure you that each of the current vaccines have been designed, developed and manufactured by brilliant and competent scientists. However, this type of prophylactic vaccines are completely inappropriate, and even highly dangerous, when used in mass vaccination campaigns during a viral pandemic. Vaccinologists, scientists and clinicians are blinded by the positive short-term effects in individual patents, but don't seem to bother about the disastrous consequences for global health. Unless I am scientifically proven wrong, it is difficult to understand how current human interventions will prevent circulating variants from turning into a wild monster.

Racing against the clock, I am completing my scientific manuscript, the publication of which is, unfortunately, likely to come too late given the ever increasing threat from rapidly spreading, highly infectious variants. This is why I decided to already post a summary of my findings as well as my keynote speech at the recent *Vaccine Summit* in Ohio on LinkedIn. Last Monday, I provided international health organizations, including the WHO, with my analysis of the current pandemic as based on scientifically informed insights in the immune biology of Covid-19. Given the level of emergency, I urged them to consider my concerns and to initiate a debate on the detrimental consequences of further 'viral immune escape'. For those who are no experts in this field, I am attaching below a more accessible and comprehensible version of the science behind this insidious phenomenon.

You can read the entire letter here:
https://mcusercontent.com/92561d6dedb66a43fe9a6548f/files/bead7203-0798-4ac8-abe2-076208015556/Public_health_emergency_of_international_concert_Geert_Vanden_Bossche.01.pdf

Typically, as viruses mutate, they may become more contagious, but less virulent (deadly). That may still hold true with SARS-CoV-2, at least to the non-vaccinated. But what about the vaccinated? Whether Dr. Vanden Bossche's predictions come true of not remain to be seen, but they do highlight one of the very possible risks that have been seen with other vaccination programs (measles and pertussis to name a couple) and one that is not beyond the realm of possibility with the rush vaccination efforts during this pandemic.

A brilliant evolutionary biologist and scientist lays out the most likely scenario for the COVID-19 vaccines to result in an epidemic of future illness in vaccinees and risk of autoimmune disease

James Lyons-Weiler PhD, CEO and Director of ***IPAK, the Institute for Pure and Applied Knowledge*** is a brilliant critical thinker. And his background makes him a perfect voice of reason that the scientific community had better listen to.

In an opinion piece March 17, 2021, he lays out the mechanisms for a likely autoimmune epidemic in COVID-19 vaccine recipients in the coming months and years. He also makes a case for natural immunity being superior to partial (vaccine derived) immunity. It can be a little technical, but for you science nerds like me (and you know who you are), you're going to love and appreciate it!

Here goes:

I've been doing a deep dive into the immunology of COVID19 scientific literature for weeks now, and it seems someone somewhere has proposed nearly every possible ill effect of the virus on the immune system. Few have bothered to transfer that concern over fully to vaccine effects.

We've all suspected **antigenic shift** and **antigenic drift** from all of the pediatric vaccines for quite some time.

Original antigenic sin has been known to be a problem with fixed vaccines - specifically w/influenza - since the 1950s. Andy (Wakefield) published a beautiful write-up on MMR vaccine failure; we know the mumps portion is failing because the vaccine lineage is older than anyone born after 1961.

The deal w/SARS-CoV-2, is that everything is happening on a massive scale at an accelerated pace: new variants are emerging due to RNA virus evolution - but they are increasing in frequency (proliferating) on an adaptive landscape specifically because of flattening, not truncating, the curve (in descending order of importance, i.e., size of selection coefficient, my guesstimate):

(1) **viremia** being allowed to increase in infected people (denial of early treatment) because new mutations occur in people

(2) **test escape** (increased survival and transmission of viruses due to non-isolation of people infected w/variants that escape the test)

(3) **immunological escape** (survival and transmission of viruses that can escape our immune responses

(4) **migration** (heterogeneity in public health response (maintenance of all variants at different frequencies somewhere in the globe))

(5) genetic drift

All of the above interact and are not competing.

In the meantime, allopathy has written itself another permission slip to skip Antibody Dependent Enhancement (ADE) in COVID19 - with highly questionable reliance on "authority" that absolutely misrepresents ADE (it's illness of infected immune cells, but allopathy does not want to make that part well known because the answer is antivirals, which compete w/vaccines.

https://www.medpagetoday.com/special-reports/exclusives/91648?xid=nl_mpt_DHE_2021-03-17

This completely ignores the pathogenic priming of people toward autoimmunity.

Definition of epitope: a molecular region on the surface of an antigen capable of eliciting an immune response and of combining with the specific antibody produced by such a response.

As an evolutionary biologist, my focus is on **pathoimmunogenic EPITOPES,** not vaccine, not virus. **EPITOPES**.

The pathoimmunogenic epitopes cause disease when introduced to the human body **via infection or vaccine**.

Real-world contemporary example

Let's call the spike protein in the current vaccines **spike2019.**

Due to original antigenic sin, a partial immune response to viral epitopes in the spike protein only will cause people to mount an ineffective immune response to the virus when it evolves new spike protein epitope

variants. These people will not have long-term adaptive immunity to the other pathoimmunogenic epitopes from the virus, and thus they will experience a new immune response - **as if they have not been vaccinated.**

So, we will see full-blown COVID-19 in some vaccinees regardless of their immunity to spike2019 epitopes (antigenic shifting).

Some of these people will have the same baseline rate of morbidity and mortality as anyone else... but will fail to seek care because they are vaccinated - they will not receive early treatment and thus morbidity and mortality will be higher.

Some **non-immune vaccinees** (who will not mount an adequate immune response to spike2020+ epitopes) will also have had occult infection (subclinical COVID19) before, during or after their vaccination.

Some of these non-immune vaccinees people are at full risk of ADE and autoimmunity from infection following secondary infection.

Why? Because we're keeping the virus around so long, because public health failed to truncate the curve. Failed early testing.

So, at this point, pathogenic priming is all-important (validated by Harvard scientists, very much recognized in the scientific literature) because autoimmunity from exposure to viral immunopathogenic epitopes is important and non-immune vaccinees are sitting ducks for it.

Natural immunity brings about a wide repertoire of responses to all of the immunogenic epitopes (diverse IgG, diverse memory B-cells, diverse T-cells).

People who have broad, lasting immunity can feel safer in a world w/COVID-19.

We need studies of the antibody responses to non-spike immunogenic epitopes... titres against spike2019 won't prove immunity for anyone for the reasons outlined above.

What about "Recurrent Infection"?

Some articles that show Spike proteins DID contribute to ADE and that "recurrent infection" can occur (likely due to new variants). I would not call it "recurrent infection"; I would call it "new infection by a non-vaccine-targeted lineage of SARS-CoV-2."

Also, here is some info on **immune escape.**

Their fabled, magical belief in "protection" from vaccines is going to be shattered by COVID-19, and it's going to be a wake-up call to those who wanted the vaccine so badly. They won't be able to keep up via updates to the vaccine, it's just not possible. Recall what's going on w/HPV vaccination - type replacement - it's the same thing.

https://www.sciencedirect.com/science/article/pii/S0163445321000438
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7749790/
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3187504/
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7115648/
https://www.sciencedirect.com/science/article/pii/S0163445321000104

https://www.sciencedirect.com/science/article/pii/S0163445321000438

They can try to deny ADE, but once chronic illness due to vaccination (as outlined below) is in full swing, there will be no denying it. THUS, they will require 100% vaccination to disallow any control group.

Risks vs "benefits" of the COVID-19 vaccines- JLW

(1) The vaccines can only be expected to provide protection against severe COVID19 and death for viruses that have the same spike protein epitopes against which people have been vaccinated. It's wishful thinking to expect cross-protection.

(2) The vaccines do not confer immunity from antibodies from any of the other viral epitopes; thus, when evolutionary pressure (antigenic shifting) makes the SARS-CoV-2 vaccines obsolete, those who believe they immune will be fully vulnerable to infection from SARS-CoV-20, 21, 22 etc. Only those who had prior COVID-19 INFECTION will be immune; the vaccine does not deserve ANY credit for immunity due to SARS-CoV-2 infection. To attribute immunity to SVCV2 vaccines is a form of "stolen valor". Objectivity dictates that we assay vaccinees and non-vaccinees for non-spike protein antibody immunity so proper scientific understanding of human immunity against SARS-CoV-2 can be procured.

(3) The total "benefit" of the SVCV2 vaccination program MUST include the full assessment, over one human lifetime, to the contribution of the vaccine-induced autoimmunity due to unsafe (immunopathological) epitopes - and a strategic misjudgment in vaccine formulation. The vaccines should have been multi-epitope with unsafe (autoimmunogenic) epitopes removed.

Given all of the above, and given that diseases of unknown origin have been on the increase since 1976 when the 1st national vaccination program against a respiratory virus was started (see https://jameslyonsweiler.com/2018/01/31/diseases-with-unknown-etiology-trace-back-to-mass-vaccination-against-influenza-in-1976/ for the compelling finding), I cannot in good faith promote the currently available vaccines.

The actual risk to benefit equation is undefined. Thus, choice. Thus, no mandate. Thus, more science on vaccinated vs. unvaccinated.

Here, for example, is an example of a SARS-CoV-1 autoimmunity induced in vaccinated animals.

Glycan arrays lead to the discovery of autoimmunogenic activity of SARS-CoV
https://journals.physiology.org/doi/pdf/10.1152/physiolgenomics.00102.2004

Which patients do worse from COVID-19 and thus potentially from the vaccines? JLW

We're not questioning basic principles of immunology. We're just taking in ALL of the information - the good and bad of it. As any science should.

My concern is reliance on unwarranted over-generalizations based on immunogenicity, ignoring pathimmunogenicity.

You're all about risk of vaccination given a certain condition (residual viral material).

But check this out, for example

"Patients that tested positive for auto-antibodies had a significantly more severe prognosis than other patients did: 6 of 15 patients (40%) with auto-antibodies died due to COVID-19 complications during hospitalization, whereas only 1 of 18 patients (5.5%) who did not have auto-antibodies died (P=0.03)."
https://pubmed.ncbi.nlm.nih.gov/32989903/

To me, this meant that those who have prior autoreactogenic immune systems do poorly.

We should focus on finding out what causes people to have Th2-skew and pro-autoreactogenic immune systems.

We see these features of poor immune health in highly vaccinated populations, esp. w/Aluminum.

Animal studies routinely use aluminum hydroxide to induce autoimmunity in animals. I've consumed all of that literature - the doses overlap per body weight up to year 2.

If so many people didn't have autoimmunity, would COVID-19 be much less of a threat?

Again, a determination of full cost/benefit of vaccine calculation requires full, unbiased accounting of the costs.

Denialism (by the public health oligarchy) in the name of "vaccine efficacy" has prevented objective analysis. Even IOM/NAS was rigged to prevent vaccine hesitancy. An utter waste of time, at great expense to our nation's health.

Here's more evidence that people w/autoreactogenic immune systems are at higher risk and are walking into a storm - unlike most people -

Latent rheumatic, thyroid and phospholipid autoimmunity in hospitalized patients with COVID-19 Juan-Manuel Anaya 1 , Diana M Monsalve 1 , Man
https://pubmed.ncbi.nlm.nih.gov/33681751/

Thank you Dr. Lyons-Weiler for a very insightful discussion and hopefully a wake-up call for the perpetrators of the mass vaccination program experiment before it's too late.

A new study showcases the advantage of natural infection over vaccine immunity with regard to SARS-CoV-2 variant strains

As a great follow up on the previous discussion on natural immunity, a new pre-print study titled **Memory B cell repertoire for recognition of evolving SARS-CoV-2 spike** highlights the effectiveness of long-term capabilities, diversity and flexibility of memory immune function.

From the abstract:

Memory B cell reserves can generate protective antibodies against repeated SARS-CoV-2 infections, but with an unknown reach from original infection to antigenically drifted variants.

The results furnish a global atlas of the S-specific memory B cell repertoire and illustrate properties conferring robustness against emerging SARS-CoV-2 variants.

More from the study:
(PC = Plasma Cells, GC = Lymphoid tissue Germinal Centers, ABs = Antibodies and SHM = gene Somatic Hyper-Mutation)

Both PC-derived secreted antibody and memory B cells supply immune memory to prevent repeat infection, but with non-redundant roles. Secreted antibodies can prophylactically thwart pathogen invasion with fixed recognition capability, while memory B cells harbor expanded pathogen recognition capacity and can differentiate quickly into PCs to contribute dynamically to the secreted antibody repertoire (*4*). Moreover, memory B cells retain plasticity to adapt to viral variants through GC re-entry and SHM-mediated evolution (*5*).

In a comprehensive competition analysis of 152 monoclonal antibodies (mAbs) from 19 subjects for binding with trimeric S ectodomain, we have identified 7 recurrently targeted competition groups -- three for antibodies with epitopes on the receptor-binding domain (RBD), two for epitopes on the N-terminal domain (NTD), and two for S2 epitopes. We show that these groups represent the major practical antibody footprints, with rare antibodies outside them.

Discussion:

Our results illustrate the landscape of memory B cell coverage of the SARS-CoV-2 S glycoprotein in convalescent donors. Unlike the terminally differentiated plasma cells that determine the profile of serum antibodies, memory B cells will clonally expand upon re-exposure to antigen, some differentiating into fresh antibody secreting cells and others re-entering germinal centers and undergoing further SHM-mediated diversification and affinity maturation. These outcomes offer a layer of flexibility for adaptation to drifted or related viral strains, if available secreted antibodies fail to prevent initial infection. Loss of protection against overt or severe disease is not an inevitable consequence of a waning serum antibody titer. This atlas of B cell memory therefore maps systematically a crucial component of the long-term immune response to SARS-CoV-2 infection.

Complementary recognition of non-overlapping viral targets by non-competing antibodies in the repertoire can reduce the likelihood of viral escape (*41*). Our data suggest an additional mechanism for preventing viral escape: competing antibodies may help retain recognition of a rapidly evolving antigen by their differential sensitivity to specific mutations. The potential dynamic reach of otherwise redundant mAb recognition, illustrated by selective retention of affinity for the UK variant by some antibodies within a cluster but not by others, may give selective advantage to immune mechanisms that yield multiple competing antibodies to critical epitopes, as those that retain adequate affinity can then re-activate, expand, and potentially undergo further affinity maturation. The emergence of strains that may have gained selective advantage by escape from neutralization emphasizes the importance of determining whether the level of retained affinity for the S protein by some antibodies in the immunodominant clusters influences protection from clinical disease.

https://europepmc.org/article/MED/33758863

Urgent letter from doctors and scientists to the European Medicines Agency over COVID-19 Vaccine concerns

An article titled, **Urgent Open Letter from Doctors and Scientists to the European Medicines Agency regarding COVID-19 Vaccine Safety Concerns**, was published on the ***Doctors for Covid Ethics*** site.

The letter in its entirety:

Emer Cooke, Executive Director, European Medicines Agency, Amsterdam, The Netherlands

28 February 2021

Dear Sirs/Mesdames,

FOR THE URGENT PERSONAL ATTENTION OF: EMER COOKE, EXECUTIVE DIRECTOR OF THE EUROPEAN MEDICINES AGENCY

As physicians and scientists, we are supportive in principle of the use of new medical interventions which are appropriately developed and deployed, having obtained informed consent from the patient. This stance encompasses vaccines in the same way as therapeutics.

We note that a wide range of side effects is being reported following vaccination of previously healthy younger individuals with the gene-based COVID-19 vaccines. Moreover, there have been numerous media reports from around the world of care homes being struck by COVID-19 within days of vaccination of residents. While we recognise that these occurrences might, every one of them, have been unfortunate coincidences, we are concerned that there has been and there continues to be inadequate scrutiny of the possible causes of illness or death under these circumstances, and especially so in the absence of post-mortems examinations.
In particular, we question whether cardinal issues regarding the safety of the vaccines were adequately addressed prior to their approval by the European Medicines Agency (EMA).

As a matter of great urgency, we herewith request that the EMA provide us with responses to the following issues:

1. Following intramuscular injection, it must be expected that the gene-based vaccines will reach the bloodstream and disseminate throughout the body [1]. We request evidence that this possibility was excluded in pre-clinical animal models with all three vaccines prior to their approval for use in humans by the EMA.

2. If such evidence is not available, it must be expected that the vaccines will remain entrapped in the circulation and be taken up by endothelial cells. There is reason to assume that this will happen particularly at sites of slow blood flow, i.e. in small vessels and capillaries [2]. We request evidence that this probability was excluded in pre-clinical animal models with all three vaccines prior to their approval for use in humans by the EMA.

3. If such evidence is not available, it must be expected that during expression of the vaccines' nucleic acids, peptides derived from the spike protein will be presented via the MHC I — pathway at the luminal surface of the cells. Many healthy individuals have CD8-lymphocytes that recognize such peptides, which may be due to prior COVID infection, but also to cross-reactions with other types of Coronavirus [3; 4] [5]. We must assume that these lymphocytes will mount an attack on the respective cells. We request evidence that this probability was excluded in pre-clinical animal models with all three vaccines prior to their approval for use in humans by the EMA.

4. If such evidence is not available, it must be expected that endothelial damage with subsequent triggering of blood coagulation via platelet activation will ensue at countless sites throughout the body. We request evidence that this probability was excluded in pre-clinical animal models with all three vaccines prior to their approval for use in humans by the EMA.

5. If such evidence is not available, it must be expected that this will lead to a drop in platelet counts, appearance of D-dimers in the blood, and to myriad ischaemic lesions throughout the body including in the brain, spinal cord and heart. Bleeding disorders might occur in the wake of this novel type of DIC-syndrome including, amongst other possibilities, profuse bleedings and haemorrhagic stroke. We request evidence that all these possibilities were excluded in pre-clinical animal models with all three vaccines prior to their approval for use in humans by the EMA.

6. The SARS-CoV-2 spike protein binds to the ACE2 receptor on platelets, which results in their activation [6]. Thrombocytopenia has been reported in severe cases of SARS-CoV-2 infection [7]. Thrombocytopenia has also been reported in vaccinated individuals [8]. We request evidence that the potential danger of platelet activation that would also lead to disseminated intravascular coagulation (DIC) was excluded with all three vaccines prior to their approval for use in humans by the EMA.

7. The sweeping across the globe of SARS-CoV-2 created a pandemic of illness associated with many deaths. However, by the time of consideration for approval of the vaccines, the health systems of most countries were no longer under imminent threat of being overwhelmed because a growing proportion of the world had already been infected and the worst of the pandemic had already abated. Consequently, we demand conclusive evidence that an actual emergency existed at the time of the EMA granting Conditional Marketing Authorisation to the manufacturers of all three vaccines, to justify their approval for use in humans by the EMA, purportedly because of such an emergency.

Should all such evidence not be available, we demand that approval for use of the gene-based vaccines be withdrawn until all the above issues have been properly addressed by the exercise of due diligence by the EMA.

There are serious concerns, including but not confined to those outlined above, that the approval of the COVID-19 vaccines by the EMA was premature and reckless, and that the administration of the vaccines constituted and still does constitute “human experimentation”, which was and still is in violation of the Nuremberg Code.

In view of the urgency of the situation, we request that you reply to this email within seven days and address all our concerns substantively. Should you choose not to comply with this reasonable request, we will make this letter public.

https://doctors4covidethics.medium.com/urgent-open-letter-from-doctors-and-scientists-to-the-european-medicines-agency-regarding-covid-19-f6e17c311595

The letter also provides a list of references to studies supporting their concerns and a list of the doctors and scientists that have generated the letter.

New research points to link between AstraZeneca Vaccine and blood clots

Researchers in Norway and Germany say they've identified antibodies that provoke immune reactions leading to the type of cerebral blood clots experienced by some people who received AstraZeneca's COVID vaccine.

A March 22nd article posted on ***Children's Health Defense*** by Megan Redshaw reveals the mechanisms of the suspected connection between the rash of fatalities and strokes and the AstraZeneca Vaccine.

Researchers at the Greifswald teaching hospital in northern Germany said Friday they've discovered how the AstraZeneca COVID vaccine could cause blood clots that could lead to rare thrombosis in the brain, public broadcaster Norddeutscher Rundfunk reported.

The researchers found that AstraZeneca's vaccine activates blood platelets, or thrombocytes, which typically only happens in the body when a wound is healing — when the blood coagulates as the wound closes. In some patients, the vaccination activated a mechanism that caused blood clots to form in the brain.

The German research team did not release detailed data but planned to submit their findings to The Lancet.

While researchers were studying cases in Germany, a team led by Pål Andre Holme, chief physician at Oslo University Hospital, was investigating three cases of post-vaccination blood clots in Norway that occurred in healthcare workers under the age of 50.

Holme told the Norwegian newspaper VG he's confident they've identified antibodies triggered by the vaccine that caused an overreaction of the immune system leading to blood clots.

"Our theory is that this is a strong immune response that most likely comes after the vaccine," Holme said. "There is no other thing than the vaccine that can explain this immune response," Holme said.

The European Medicines Agency (EMA) investigated the reports of blood clot-related injuries and deaths and concluded that AstraZeneca's vaccine was not associated with an overall risk of blood clots in those vaccinated.

My comment: Of course they didn't!

See the rest of the article with all the links here:
https://childrenshealthdefense.org/defender/link-astrazeneca-vaccine-blood-clots/?itm_term=home

***Late March 30th update: Germany halts distribution of AstraZeneca vaccine in people under 60 years of age due to blood clots in the brain known as sinus vein thrombosis. At least thirty-one people have now suffered these effects in Germany.**

A data breach reveals confidential emails showing that the spike protein RNA in the mRNA vaccines may not be as advertised

In an investigation published in the BMJ on March 10th, 2021 titled **The EMA covid-19 data leak, and what it tells us about mRNA instability**, reveals that between 55-78% of the mRNA in the Pfizer vaccine is not the DNA/protein sequences they are intended to be. This could have vast implications as it relates to the possibility of causing autoimmune disease in the people receiving the vaccine. If the degraded protein sequences are

similar to proteins in the host tissues of the people receiving the vaccine, the person's immune system may mount a persistent attack against those tissues.

From the article:

As it conducted its analysis of the Pfizer-BioNTech covid-19 vaccine in December, the European Medicines Agency (EMA) was the victim of a cyberattack.1 More than 40 megabytes of classified information from the agency's review were published on the dark web, and several journalists—including from *The BMJ*—and academics worldwide were sent copies of the leaks. They came from anonymous email accounts and most efforts to interact with the senders were unsuccessful. None of the senders revealed their identity, and the EMA says it is pursuing a criminal investigation.

The BMJ has reviewed the documents, which show that regulators had major concerns over unexpectedly low quantities of intact mRNA in batches of the vaccine developed for commercial production.

EMA scientists tasked with ensuring manufacturing quality—the chemistry, manufacturing, and control aspects of Pfizer's submission to the EMA—worried about "truncated and modified mRNA species present in the finished product." Among the many files leaked to *The BMJ*, an email dated 23 November by a high ranking EMA official outlined a raft of issues. In short, commercial manufacturing was not producing vaccines to the specifications expected, and regulators were unsure of the implications. EMA responded by filing two "major objections" with Pfizer, along with a host of other questions it wanted addressed.

The email identified "a significant difference in % RNA integrity/truncated species" between the clinical batches and proposed commercial batches—from around 78% to 55%. The root cause was unknown and the impact of this loss of RNA integrity on safety and efficacy of the vaccine was "yet to be defined," the email said. suffers from contain "a significant difference in % RNA integrity/truncated species".

RNA instability is one of the biggest hurdles for researchers developing nucleic acid based vaccines. It is the primary reason for the technology's stringent cold chain requirements and has been addressed by encapsulating the mRNA in lipid nanoparticles (box).

"The complete, intact mRNA molecule is essential to its potency as a vaccine," professor of biopharmaceutics Daan J.A. Crommelin and colleagues wrote in a review article in *The Journal of Pharmaceutical Sciences* late last year. "Even a minor degradation reaction, anywhere along a mRNA strand, can severely slow or stop proper translation performance of that strand and thus result in the incomplete expression of the target antigen."6

AN IMPORTANT SECTION AT THE END OF THE ARTICLE:

Lipid nanoparticles—where do they go and what do they do?
Conceived three decades ago, RNA based therapeutics11 have long inspired imaginations for their theoretical potential to transform cells of the body into "an on-demand drug factory."12 But despite heavy investment by the biotech industry, bench-to-bedside translation was constantly hindered by the fragility of mRNA.

Over the years, researchers attempted to resolve intrinsic instability by encapsulating mRNA in nanocarriers made of polymers, lipids, or inorganic materials. Lipid nanoparticles (LNPs) were chosen by Moderna, Pfizer-BioNTech, CureVac, and Imperial College London for their covid-19 vaccines. This has attracted the attention of specialists in the field of pharmaceutical biotechnology, some of whom have raised concerns about further unknowns.

In a rapid response posted on bmj.com, JW Ulm, a gene therapy specialist who has published on tissue

targeting of therapeutic vectors,13 raised concerns about the biodistribution of LNPs: “At present, relatively little has been reported on the tissue localisation of the LNPs used to encase the SARS-CoV-2 spike protein-encoding messenger RNA, and it is vital to have more specific information on precisely where the liposomal nanoparticles are going after injection.”14 It is an unknown that Ulm worries could have implications for vaccine safety.

End of excerpts

A concern about this revelation from a scientist that specializes in immunoreactivity.

“On a good day at the vaccine plant, as much as 30% of the mRNA in the vaccine can be "truncated and modified" due to instability. 45% on a bad day. That means instead of producing the target spike protein, this mRNA will direct the cell to produce RANDOMLY modified proteins with RANDOMLY modified peptides that can have high homology to ANY protein/peptide. These randomly modified proteins can have peptides that have high homology to self-proteins, food proteins, aeroallergen proteins, etc. The result is the immune system could be trained to attack self-proteins (autoimmunity), food proteins (food allergy), aeroallergen (asthma) etc.” Quote from Vinu Arumugham

Final thoughts

Not only does this article expose defects in the final product that raise concerns over host autoimmune reactions, but what how does that huge deficiency affect the efficacy of the vaccine, when the person’s cells make the wrong proteins to be displayed to the immune system? The only possible answer is that the effectiveness can’t be nearly as expected. And lastly, the unknowns over the Lipid Nanoparticles (LNPs). Is it prudent to test these “unknowns” on much of the world’s population? What could possibly go wrong!!!?

Pfizer revises ultra-cold storage guidance for Covid-19 jab to refrigerator temperatures- This raises suspicions

Considering the previous report, isn’t it ironic that Pfizer has now announced that its vaccine does not need to be stored at the ultra-cold temperatures previously recommended. The article is titled, **Pfizer revises ultra-cold storage guidance for Covid-19 jab, says vaccine is stable at refrigerator temperatures**, and was published on RT.com.

Given the original rationale for the ultra-cold storage as the fact that the mRNA is unstable at “warmer” temperatures. Based on the previous report, the mRNA appears to be very unstable even in the manufacturing process. So, if the final product is left with an unacceptably high level of degraded and incomplete mRNA already, does it make any sense that they are now promoting a storage temperature that they were convinced from the outset was necessary to maintain stability?

https://www.rt.com/news/516069-pfizer-covid19-vaccine-refrigerator-cold/

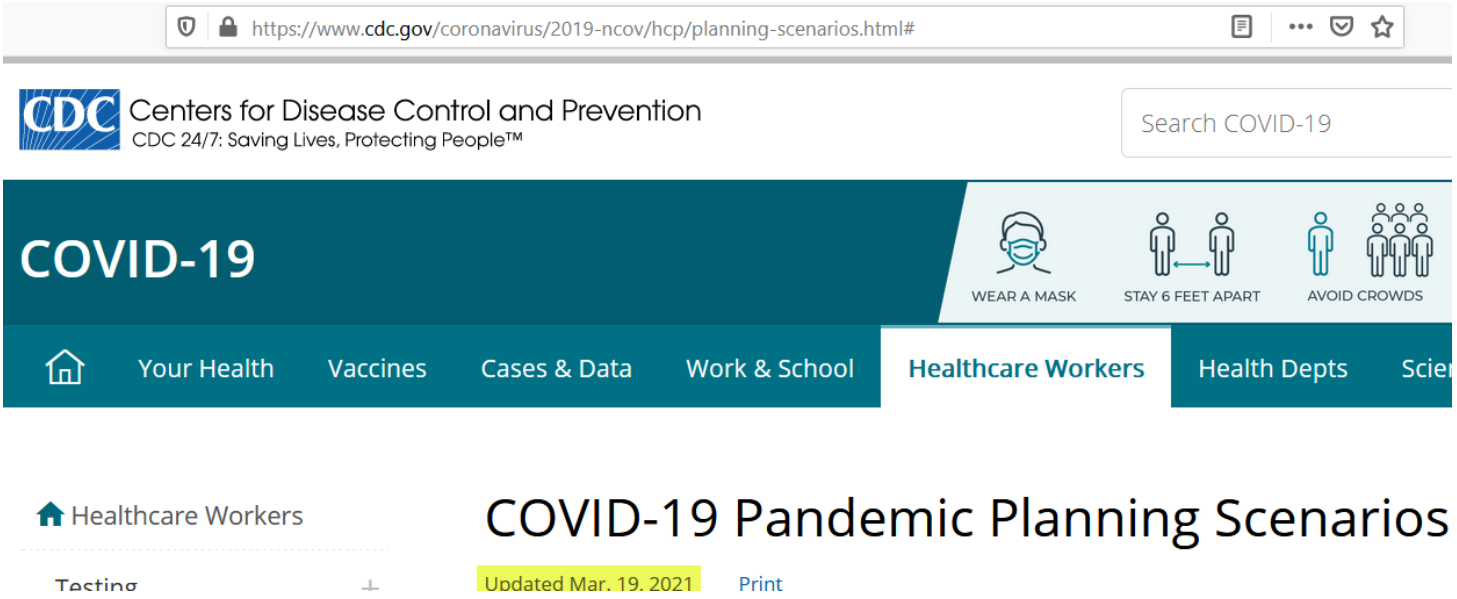
Is the death rate from the vaccines higher than from COVID-19?

On its face, that sounds like a ludicrous and highly improbable possibility but consider this.

According to a January 2021 article published in the ***Annals of Internal Medicine*** titled, **Infection Fatality Ratios for COVID-19 Among Non-institutionalized Persons 12 and Older: Results of a Random-Sample**

Prevalence Study, the infection Fatality Rate (IFR) for persons under age 40 is just 0.01% or 1 in 10,000. https://www.acpjournals.org/doi/10.7326/M20-5352

So, how does that compare to the IFR estimates in different age demographics according to the CDC's statistics as of March 19th 2021?



https://www.cdc.gov/coronavirus/2019-ncov/hcp/planning-scenarios.html#

The SUMMARY of most likely scenario according to the CDC:

- In the 0-17 year-old age group, the Infection Fatality Rate is 0.002% (20 deaths per million infections, or 1 death in every 50,000 infections)
- In the 18-49 year-old age group it is 0.05% (500 deaths per million infections, or 1 death in every 2,000 infections)
- In the 50-64 year-old age group it is 0.6% (6,000 deaths per million infections, or 1 death in every 167 infections)
- In the 65+ age group it is 9% (90,000 deaths per million infections, or 1 death in every 11 infections). The CDC previously reported in June 2020, that people 65 and over account for 80.73% of all COVID-19 deaths. https://www.cdc.gov/coronavirus/2019-ncov/hcp/planning-scenarios.html

Footnote: We have to keep in mind the significant over-reporting of what consists of a COVID-19 death. But let's set that aside for now and compare suspected vaccination deaths to what the CDC has been considering COVID-19 deaths.

So, what is the death rate for those getting the vaccine? We have no way to now for sure, but we can play out different scenarios based on what we know so far.

As seen in the screen capture below, as of March 26th, there have been 48,695,172 people FULLY vaccinated in the U.S.

COVID-19 Vaccinations in the United States

Overall US COVID-19 Vaccine | Deliveries and Administration; Maps, charts, and data provided by CDC, updated daily by 8 pm ET†

Represents all vaccine partners including jurisdictional partner clinics, retail pharmacies, long-term care facilities, Federal Emergency Management Agency and Health Resources and Services Administration partner sites, and federal entity facilities.

Total Vaccine Doses

Delivered	177,501,775
Administered	136,684,688

Learn more about the distribution of vaccines.

People Vaccinated	At Least One Dose	Fully Vaccinated
Total	89,559,225	48,695,172
% of Total Population	27%	14.7%
Population ≥ 18 Years of Age	89,288,998	48,622,958
% of Population ≥ 18 Years of Age	34.6%	18.8%
Population ≥ 65 Years of Age	38,890,325	25,098,831
% of Population ≥ 65 Years of Age	71.1%	45.9%

About these data

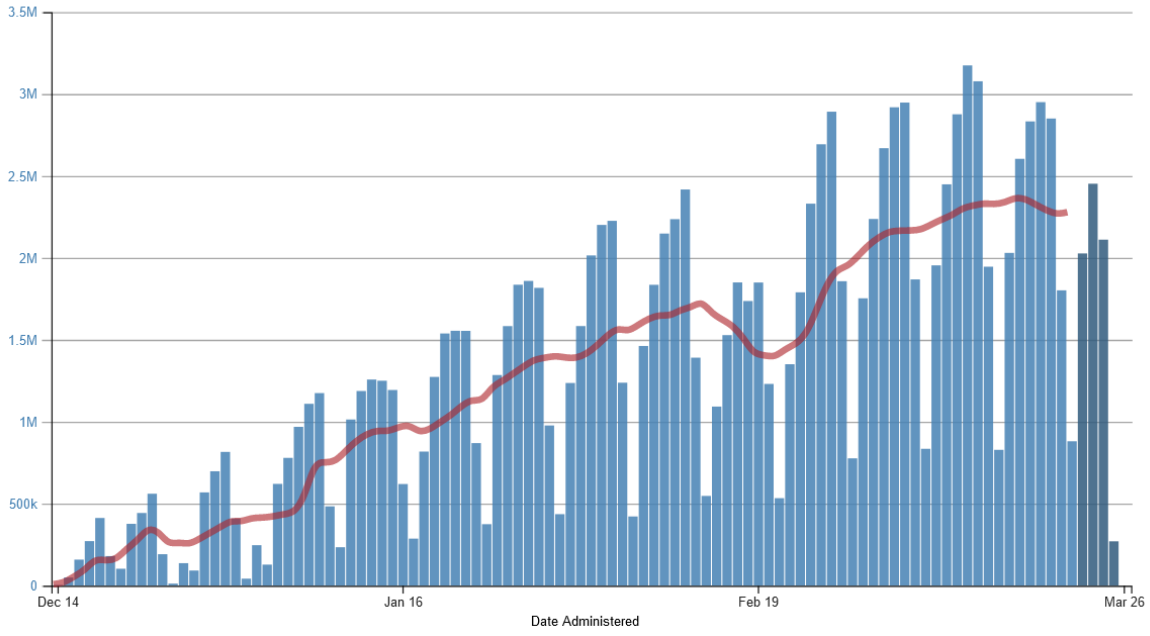
CDC |Data as of: Mar 26 2021 6:00am ET | Posted: Mar 26 2021 1:24PM ET

https://covid.cdc.gov/covid-data-tracker/#vaccinations

Since the latest reported VAERS death totals were as of March 19th, and this chart was through March 25th, I had to back out the doses given from March 19th through March 25th. This is how I did that. I used the data from the CDC's web site shown in the chart below. It is an interactive chart, so I could see how many doses were given each day. Since both the Pfizer and Moderna vaccines require 2-doses to be fully vaccinated I cut the number of doses to back out from the total in half.

https://covid.cdc.gov/covid-data-tracker/#vaccination-trends

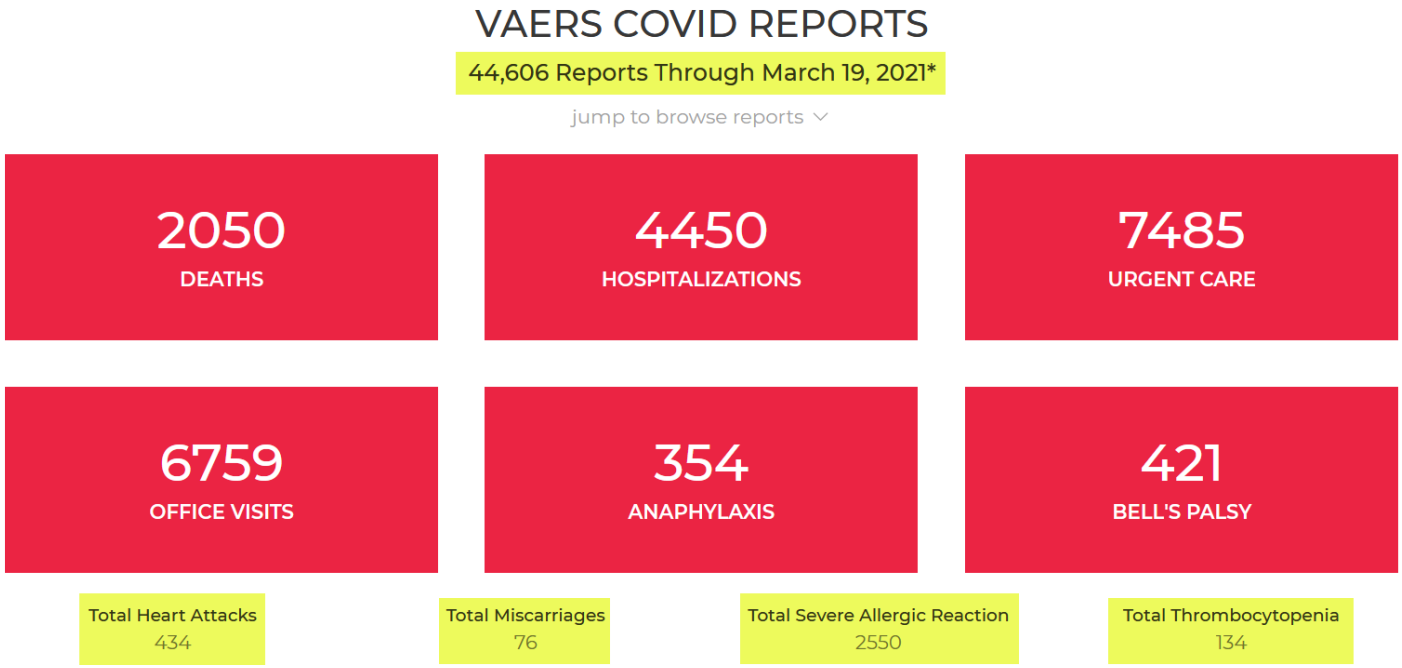
Daily Count of Total Doses Administered and Reported to the CDC by Date Administered, United States



My calculation resulted in 14,123,487 doses March 19th (last VAERS death total available) through the 25th, the last full day reported for vaccines doses administered. Since I am calculating the number of people fully vaccinated and Pfizer and Moderna require 2 doses, I will divide the 14,123,487 does by 2. That equals another 7,061,744 fewer people fully vaccinated by March 19th than the reported numbers for March 26th. That means approximately 41,633,428 people were fully vaccinated by March 19th.

Deaths reported to the Vaccine Adverse Event Reporting System (VAERS)

There have been 2,050 VAERS reported deaths as of March 19th, 2021.



Now the calculations

Dividing 2,050 (deaths) by 41,633,428 (fully vaccinated individuals) equals a 0.0049% mortality (death) rate from the vaccines.

It is critical to consider that there has been every attempt possible to deny that any deaths were related to the vaccine and people are afraid to even go there, because they will be ridiculed and accused of giving the "anti-vaxxers" ammunition to push back against the vaccines. Even the many cases of deaths in reportedly healthy people have been roundly denied without any investigative efforts. With all that going on, the reported deaths may actually be less than 1% of the actual deaths.

So, taking 1% reporting as has been shown to be accurate according to the ***CDC funded Harvard Pilgrim Health Study***, discussed previously in this newsletter, the actual death rate would be 100 times higher and calculates to 0.49% (take 0.0049% and move 2 decimal places to the right). That will calculate to 204,000 deaths. As strange and ironic as it sounds, that is one death in every 204 fully vaccinated people (204 X 204,000 = 41,616,000 or 41,616,000 / 204,000 = 204). Compare that number to the 50-64 year-old age group in the CDC table of 1 death in every 167 people infected with SARS-CoV-2.

It's doubtful, but let's consider that maybe as high as 10% of deaths are being reported to VAERS. That would mean that as of March 19th, there would have been 20,500 deaths from the vaccines rather than the 2,050 that

have been reported. **With 41,633,428 people fully vaccinated, that would be a death rate of 0.049% or one person in 2,041 fully vaccinated people.** So the notion that death as a consequence of the vaccines is a one-in-a-million as many like to parrot is ridiculous.

So once again. **If only 10% of the deaths from the vaccines are being reported to VAERS**, compare that death rate from the vaccines spread across all age groups at 0.049% to the CDC's data for the following age groups:

- **The 0-17 year-old age group-** The risk of death from the vaccines is approximately 25 times higher than from the infection itself! (0.002% to 0.49%). Now we don't know what the death rate in those under 17 will be from the vaccines, because thank God they haven't started vaccinating them YET, but they intend to. And it is unconscionable that they are even considering risking the short-term, the long-term and the potential risk of fatality in an age group with such low mortality from the disease. But that's the upside-down world we live in right now. And all driven by pharma's insatiable profit hungry motives.

- **The 18-49 year-old age group-** The risk of death from the vaccines is approximately 10 times higher from the vaccines than from the infection! (0.49% to 0.5%)

- **The 50-64 year-old age group-** The risk of death is nearly the same from the vaccines as compared to the infection. (.49% to .6%)

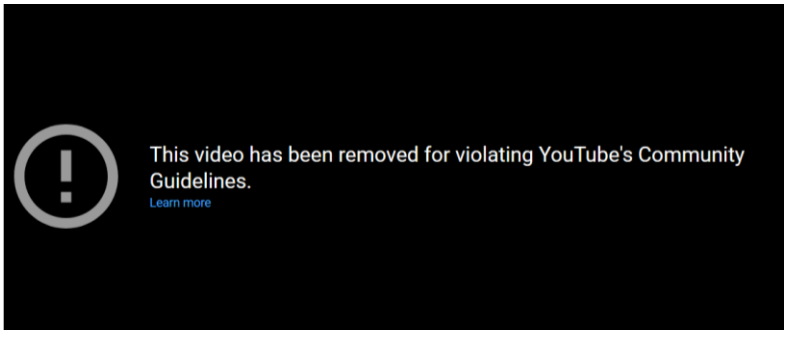
And remember, according to the ***Annals of Internal Medicine*** article above, the Infection Fatality Rate for the under 40 age group is only 0.01%. So according to their statistics the risk of death from the vaccines are nearly 5 times higher!

And to reiterate, one thing we have to keep in mind as we speculate as to the number of deaths and other serious adverse reaction reporting is that there is intense pressure from medical providers, the media and those in government that are highly invested in seeing that the vaccination program rolls on unencumbered by pesky reports like these. After all, if any causation is attributed to the vaccine for any of these reactions and deaths, it would "fuel the fires of vaccine hesitancy." And for heaven's sake, we wouldn't want truth and informed decision-making to get in the way!

Other interesting comparisons can be made looking at the number of adverse events reported through VAERS as of March 19th, 2021. As seen above, there were 44,606 reports registered. If that represents 1% of thew actual adverse reactions, the real number would be 4,460,600. With 41,633,428 people fully vaccinated, 4,460,600 AEs represents 11% of all vaccinated individuals. "One in a million" huh?

First lawsuit challenging mandatory vaccines

You could have seen the video here: https://www.youtube.com/watch?v=t3P9CYGq9M4 , but the arbiters of truth have taken it down.



Highly respected Stanford professor calls lockdowns the "biggest public health mistake we've ever made"

In a March 15th ***Newsweek*** article, Dr, Jay Bhattacharya one of the authors of ***the Great Barrington Declaration*** was candid about his feelings about the public health decisions that have been made not just here in the U.S., but across the globe.

This is the lead quote from the article:

Dr. Jay Bhattacharya, a professor at ***Stanford University Medical School***, recently said that COVID-19 lockdowns are the "biggest public health mistake we've ever made...The harm to people is catastrophic."

During the interview last month, Bhattacharya said that the declaration comes from "two basic facts." "One is that people who are older have a much higher risk from dying from COVID than people who are younger...and that's a really important fact because we know who his most vulnerable, it's people that are older. So the first plank of the Great Barrington Declaration: let's protect the vulnerable," Bhattacharya said. "The other idea is that the lockdowns themselves impose great harm on people. Lockdowns are not a natural normal way to live."

He continued, "it's also not very equal. People who are poor face much more hardship from the lockdowns than people who are rich."

In an email sent to ***Newsweek***, Bhattacharya wrote:

I stand behind my comment that the lockdowns are the single worst public health mistake in the last 100 years. We will be counting the catastrophic health and psychological harms, imposed on nearly every poor person on the face of the earth, for a generation.

At the same time, they have not served to control the epidemic in the places where they have been most vigorously imposed. In the US, they have – at best – protected the "non-essential" class from COVID, while exposing the essential working class to the disease. The lockdowns are trickle down epidemiology.

https://www.newsweek.com/stanford-doctor-calls-lockdowns-biggest-public-health-mistake-weve-ever-made-1574540

Another article interview of Dr. Bhattacharya cut against the public narratives

In another article published on Lockdown Skeptics and provocatively titled **Risk of Asymptomatic Spread Minimal. Variants Over-Hyped. Masks Pointless. An Interview With Professor Jay Bhattacharya**, Dr. Bhattacharya takes on some of the hottest topics related to lockdowns, masking and variants.

“There are tens of thousands of mutations of the SARS-CoV-2 virus. They mutate because the replication mechanisms they induce involve very little error checking. Most of the mutations either do not change the virulence of the virus, or weaken it. There are a few mutations that provide the virus with a selective advantage in infectivity and may increase its lethality very slightly, though the evidence on this latter point is not solid.”

"We should not be particularly concerned about the variants that have arisen to date. First, prior infection with the wild type virus and vaccination provide protection against severe outcomes arising from reinfection with the mutated virus. Second, though the mutants have taken over the few remaining cases, their rise has coincided with a sharp drop in cases and deaths, even in countries where they have come to dominate. Their selective infectivity advantage has not been enough to cause a resurgence in cases. Third, the age gradient in mortality is the same for the mutant and wild-type virus. Thus a focused protection policy is still warranted. If lockdowns could not stop the less infectious wild type virus, why would we expect them to stop the more infectious mutant virus?"

With regard to the hysteria and lockdowns in the U.K., Dr. Bhattacharya said the following:

"According to a meta-analysis by Dr John Ioannidis [Professor of Medicine at Stanford University] of every seroprevalence study conducted to date of publication with a supporting scientific paper (74 estimates from 61 studies and 51 different localities around the world), the median infection survival rate from COVID-19 infection is 99.77 per cent. For COVID-19 patients under 70, the meta-analysis finds an infection survival rate of 99.95 per cent."

"The CDC's [Centres for Disease Control] and Prevention] best estimate of infection fatality rate for people ages 70 plus years is 5.4 per cent, meaning seniors have a 94.6 per cent survivability rate. For children and people in their 20s/30s, it poses less risk of mortality than the flu. For people in their 60s and above, it is much more dangerous than the flu."

Regarding Asymptomatic cases, he said the following:

"The scientific evidence now strongly suggests that COVID-19 infected individuals who are asymptomatic are more than an order of magnitude less likely to spread the disease to even close contacts than symptomatic COVID-19 patients. A meta-analysis of 54 studies from around the world found that within households – where none of the safeguards that restaurants are required to apply are typically applied – symptomatic patients passed on the disease to household members in 18 per cent of instances, while asymptomatic patients passed on the disease to household members in 0.7 per cent of instances. A separate, smaller meta-analysis similarly found that asymptomatic patients are much less likely to infect others than symptomatic patients."

"Asymptomatic individuals are an order of magnitude less likely to infect others than symptomatic individuals, even in intimate settings such as people living in the same household where people are much less likely to follow social distancing and masking practices that they follow outside the household. Spread of the disease in less intimate settings by asymptomatic individuals – including religious services, in-person restaurant visits, gyms, and other public settings – are likely to be even less likely than in the household."

And about mask mandates:

"The evidence that mask mandates work to slow the spread of the disease is very weak. The only randomised evaluation of mask efficacy in preventing Covid infection found very small, statistically insignificant effects [Danish mask study]. And masks are deleterious to the social and educational development of children, especially young children. They are not needed to address the epidemic. In Sweden, for instance, children have been in school maskless almost the whole of the epidemic, with no child Covid deaths and teachers contracting Covid at rates that are lower than the average of other workers."

And vaccine passports:

"Vaccine passports are a terrible idea that will diminish trust in public health and do nothing to improve the health of the population. Vaccine certificates are not needed as a public health measure. The Government had

it right previously. The country should open up now that the older, vulnerable population has been vaccinated. The rest of the population is at much greater health risk from the lockdown than they are from the virus."

https://lockdownsceptics.org/risk-of-asymptomatic-spread-minimal-variants-over-hyped-masks-pointless-an-interview-with-professor-jay-bhattacharya/

Read more about and sign the *Great Barrington Declaration* here: https://gbdeclaration.org/

CDC touts a 1+% "success" rate from masking and closing restaurants as significant

It's hard not to laugh at the spin the CDC has put on its latest attempt to justify destroying tens of thousands of restaurants impacting not just the owners, but the employees, vendors, suppliers, and supply chain associated businesses as well. The trickle-down effect is enormous. And, touting the masking of our population including young children, something that 40 years of peer-reviewed science had found completely useless against viruses similar to SARS-CoV-2 as a "success", is also completely laughable. Success must always be gauged by comparing the benefits against the harms, especially when considering the largest science experiment ever conducted on the population of the world.

The study titled **Association of State-Issued Mask Mandates and Allowing On-Premises Restaurant Dining with County-Level COVID-19 Case and Death Growth Rates — United States, March 1–December 31, 2020,** was released on March 12th, 2021. It looked at data from 3,142 U.S. counties regarding mask mandates

The problem I have is with the categorical celebratory tone of the reporting. Here is a quote from the article:

From the first part of the report. This gives a rosy and even a positively definitive impression for those that don't dig into the meat of the study….Like the media for example.

"To examine the association of state-issued mask mandates and allowing on-premises restaurant dining with COVID-19 cases and deaths during March 1–December 31, 2020, county-level data on mask mandates and restaurant reopenings were compared with county-level changes in COVID-19 case and death growth rates relative to the mandate implementation and reopening dates. Mask mandates were associated with decreases in daily COVID-19 case and death growth rates 1–20, 21–40, 41–60, 61–80, and 81–100 days after implementation. Allowing any on-premises dining at restaurants was associated with increases in daily COVID-19 case growth rates 41–60, 61–80, and 81–100 days after reopening, and increases in daily COVID-19 death growth rates 61–80 and 81–100 days after reopening. Implementing mask mandates was associated with reduced SARS-CoV-2 transmission, whereas reopening restaurants for on-premises dining was associated with increased transmission. Policies that require universal mask use and restrict any on-premises restaurant dining are important components of a comprehensive strategy to reduce exposure to and transmission of SARS-CoV-2." Doesn't that sound pretty clear cut?

And from the Discussion…

Discussion

"Mask mandates were associated with statistically significant decreases in county-level daily COVID-19 case and death growth rates within 20 days of implementation. Allowing on-premises restaurant dining was associated with increases in county-level case and death growth rates within 41–80 days after reopening. State

mask mandates and prohibiting on-premises dining at restaurants help limit potential exposure to SARS-CoV-2, reducing community transmission of COVID-19."

Again, pretty confident that the findings were justified and are worthy of continuing under similar circumstances. Well, let's look a little closer…

On-premises dining- (emphases are mine)

"During the study period, states allowed restaurants to reopen for on-premises dining in 3,076 (97.9%) U.S. counties. **Changes in daily COVID-19 case and death growth rates were not statistically significant 1–20 and 21–40 days after restrictions were lifted. Allowing on-premises dining at restaurants was associated with 0.9** ($p = 0.02$), **1.2** ($p<0.01$), and **1.1** ($p = 0.04$) **percentage point increases in the case growth rate 41–60, 61–80, and 81–100 days, respectively**, **after restrictions were lifted (**Table 2) (Figure). Allowing on-premises dining at restaurants was associated with **2.2 and 3.0 percentage point increases in the death growth rate 61–80 and 81–100 days, respectively, after restrictions were lifted** ($p<0.01$ for both). **Daily death growth rates before restrictions were lifted were not statistically different from those during the reference period, whereas significant differences in daily case growth rates were observed 41–60 days before restrictions were lifted**."

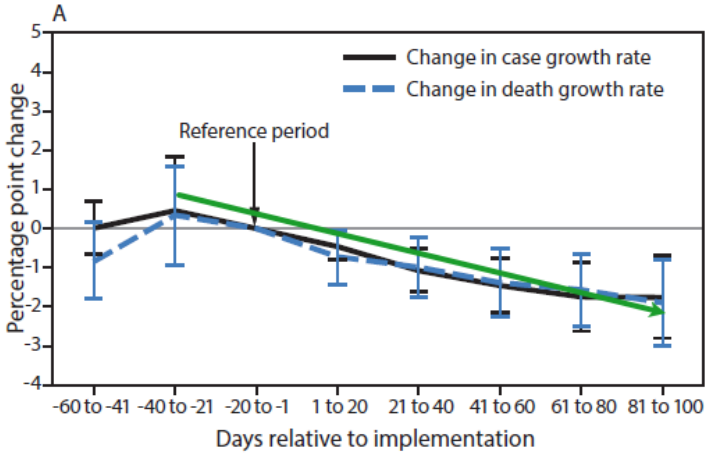
Reading that **second** sentence above is key...the rates did not change in the first 6 weeks after re-opening restaurants, something that certainly would have resulted in increased infections if people dining out were spreading infection, as the latency period is only 3-5 days from exposure to onset of symptoms. And beyond 6 weeks they cite approximately only a 1% increase in case rate. Keep that in mind as I discuss the next point.

Secondly, if the rates of infection went up only around 1% between 6 weeks and 14 weeks after opening restaurants, and more than 90% of infections are mild to moderate in severity, how can one implicate restaurant opening as the cause for a cited 2 to 3% increase in the death rate? That makes no sense. If only 10% of COVID-19 cases are severe and only a small percentage of those are fatal, the numbers don't add up. A 1% increase in cases will not produce a 2-3% increase in fatalities. You would need at least a 20-30% increase in cases to move the needle on death rates that much.

Masking-

Is it my imagination, or was the trajectory of the graph BEFORE the masking mandates (reference period) already in decline without a significant change in the trajectory of the line's drop?

Important and to that point! I have added the green arrow showing the degree of the decline in cases and deaths BEFORE mask mandates and continuing it throughout the reference time to compare to the study's change lines. As you can see, they are nearly parallel through most of the time period.



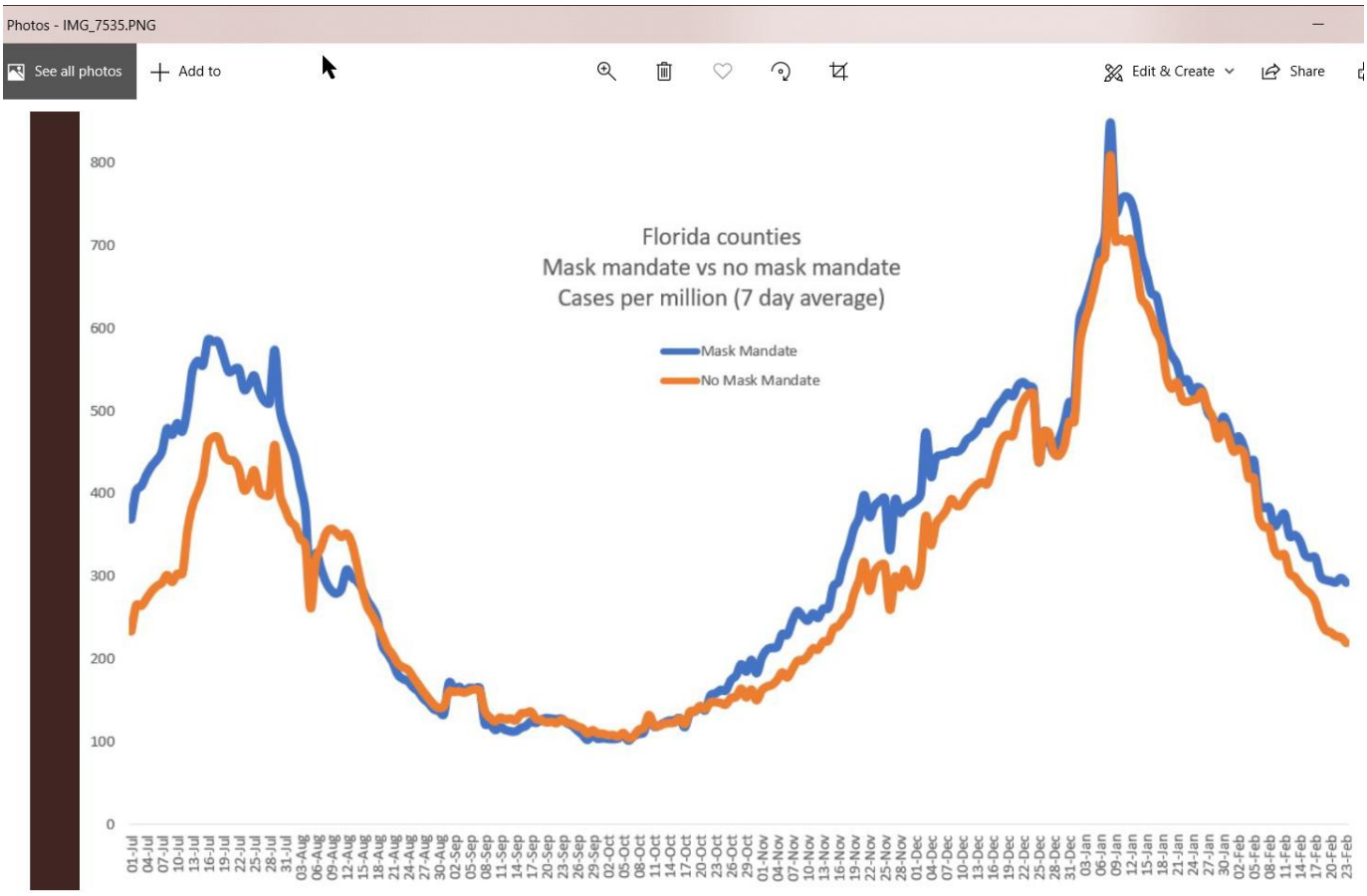
The cited limitations of the study are as follows:

"The findings in this report are subject to at least three limitations. **First**, although models controlled for mask mandates, restaurant and bar closures, stay-at-home orders, and gathering bans, the models did not control for other policies that might affect case and death rates, including other types of business closures, physical distancing recommendations, policies issued by localities, and variances granted by states to certain counties if variances were not made publicly available. **Second**, compliance with and enforcement of policies were not measured. **Finally**, the analysis did not differentiate between indoor and outdoor dining, adequacy of ventilation, and adherence to physical distancing and occupancy requirements."

In addition, I may add that Because of the seasonality of respiratory viruses and the hard lockdowns imposed in many locations in March and April which slowed transmission, most of those locations developed a spike in the middle of the summer. Because these statistics only use as the reference point the point in time which the counties imposed mask mandates and restaurant closures were lifted and no calendar date is referenced, the timing of restaurant re-opening could very well have coincided with the inevitable spikes that occurred outside of seasonal norms. That is because the virus will eventually make its way through the population without regard to measures taken. You can delay the inevitable, but you cannot avoid the inevitable.

One more criticism. If we were able to see the individual counties statistics and graphs, we would undoubtable see some that performed better with masks and some that performed better without masks. The point being that there may be geographic and socio-economic reasons for differences as well. That is why a one size fits all policy should never be implemented.

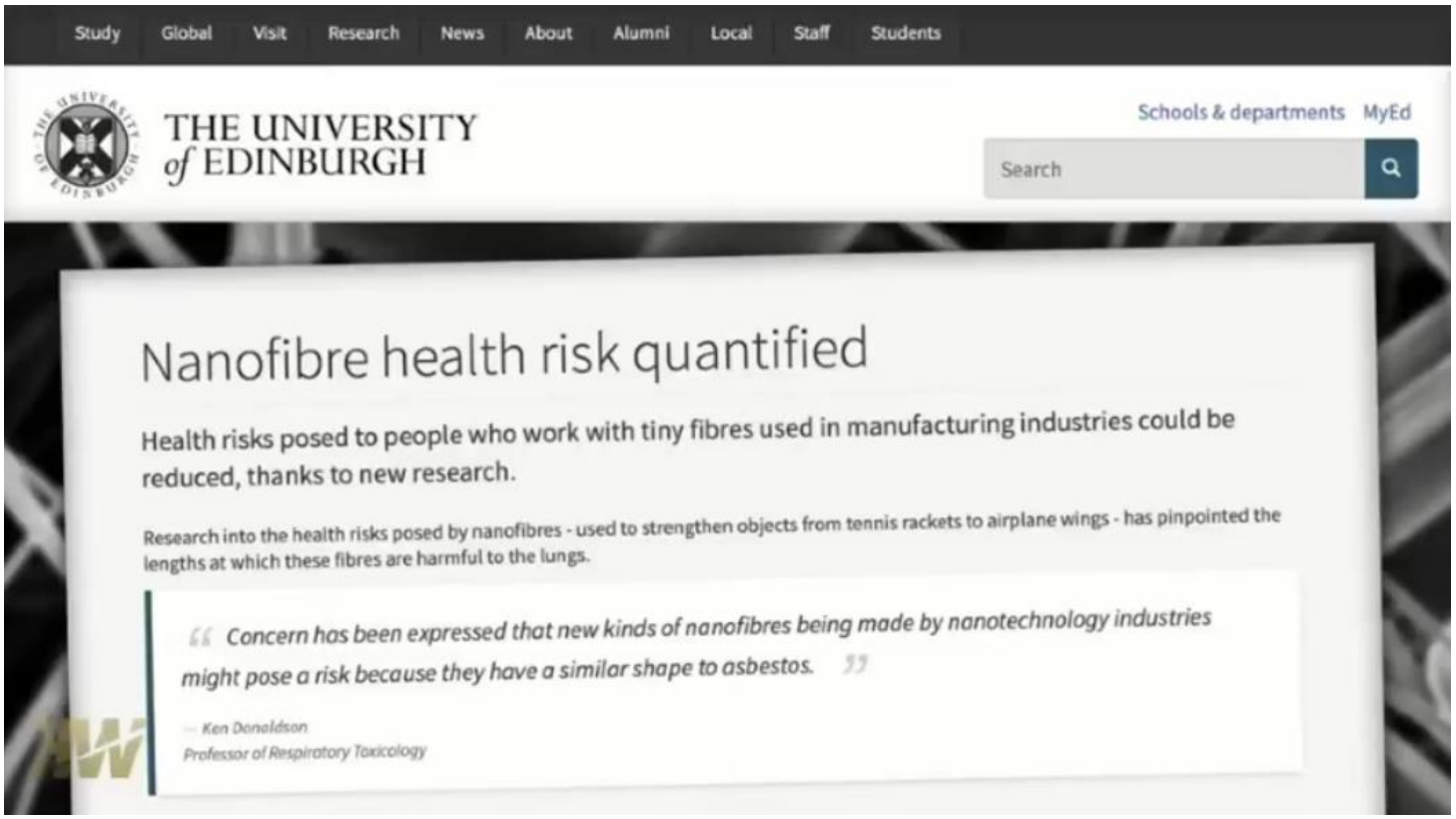
Take a look at this graph from Florida counties that did and didn't have mask mandates. They certainly look nearly parallel to me and in fact the no-mask-mandate counties actually seemed to do better.



More mask harms come to light

New concerns are being raised about the microscopic nanoparticles that people are breathing in from masks.

Del Bigtree aired a segment on his weekly Highwire show titled **Cancer Concern for Maskers**. This segment raises serious legitimate concerns for the future health of people from breathing through mask fabrics. https://www.bitchute.com/video/x3xhsPAVGrM8/



Here are quotes from the University of Edinburgh study.

“Nanofibers, which can be made from a range of materials including carbon, are about 1,000 times smaller than the width of a human hair and can reach the lung cavity when inhaled. This may lead to a cancer known as mesothelioma, which is known to be caused by breathing in asbestos fibers, which are similar to nanofibers.”

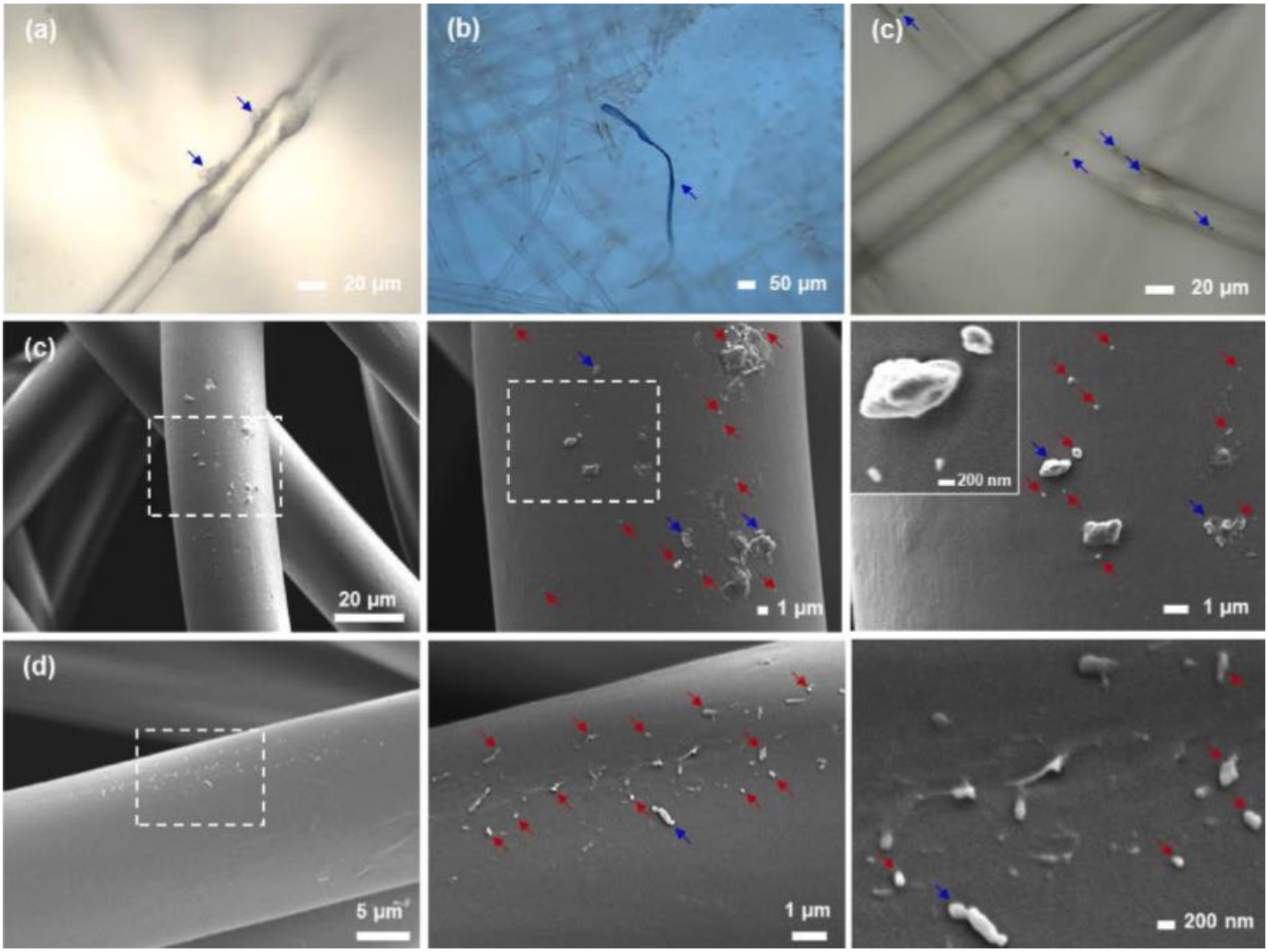
“Research into the health risks posed by nanofibres - used to strengthen objects from tennis rackets to airplane wings - has pinpointed the lengths at which these fibres are harmful to the lungs.”

“Concern has been expressed that new kinds of nanofibres being made by nanotechnology industries might pose a risk because they have a similar shape to asbestos.” Ken Donaldson, Professor of Respiratory Toxicology

https://www.ed.ac.uk/news/all-news/nanofibres-220812

Del and Jeffrey Jaxon also discussed an October 2020 study published in the journal ***Environmental Pollution*** titled, **Need for assessing the inhalation of micro(nano)plastic debris shed from masks, respirators, and home-made face coverings during theCOVID-19 pandemic**, troubling graphic visual evidence of nanoparticle fibers on facemasks are shown. These fibers many similar to asbestos, can lodge within the alveolae of the lungs.

Views under an electron microscope of mask fabrics



From the article:

"There seems to be, however, an important piece missing in the suite of standards and volumes of research on inhalable environmental contaminants. None of these standards, including the ASTM standards (F1862, F2100, F2101, F2299) and NIOSH regulation (42 CFR 84), which are adopted by the FDA in regulating medical face masks and surgical respirators in the U.S. (FDA, 2020a), regulate respirable debris such as micro(nano)plastics that may be present in these products. In fact, such neglect is not unique to US standards: a review of current ISO standards (ISO22609, 16900), EU standards (EN 140, 143, 149, 14683) and Chinese standards (GB 19083, 2626; GB/T 32610, 38880; YY 0469; YY/T0969) on masks and respirators found no information pertinent to this particular type of hazard. With these becoming a necessity for many in their daily life and work, questions must be raised over this apparent regulatory gap concerning their long-term use safety. This is especially important given that there is already a growing body of evidence on the inhalation of micro(nano)plastics and their adverse effects in humans and animals (Prata, 2018)."

"By putting several top-selling medical face masks and N95 respirators under microscopes, how-ever, we saw abundant loosely attached debris on their inner facings, some showing the morphology of fibers and others as particles, in the micron and sub-micron ranges (Fig.1). These could be either self-carried, or contaminants during their manufacturing process, or even from their plastic packaging most of the products were packed in plastic bags to maintain sterility. While more rigorous studies are undoubtedly needed, these images offer a

glimpse of the issue. With an ongoing shortage from the major suppliers and a myriad of products with countless brands currently offered in the market, it seems inevitable that some products would present similarly, if not more, abundant respirable debris, given that there is no such regulation in place."

"A special note must be given on home-made cloth face coverings. For fabrics repurposed as face masks, as per the current guidelines by the CDC (Centers for Disease Control and Prevention CDC, 2020), debris is likely to be generated from cutting and tearing. Some fabrics, such as velvets, fleeces and towels, are known to shed microfibers when disturbed (Prata, 2018). Detergent residues and lint generated from machine laundering and tumble drying may also be present as inhalable contaminants in washed garments (Leverette, 2019; Prata, 2018; Wright and Kelly, 2017)."

"…we call for collaborative efforts from scientists, manufacturers, and regulators to assess such risks and look for viable methods to reducing micro(nano)plastics and other respirable debris in face masks and respirators worn by a large population worldwide during the current pandemic.""

https://pubmed.ncbi.nlm.nih.gov/33065479

According to this article, "The textile would contain nanoparticles of silver and titanium dioxide. Inhaling this could have a negative effect on the respiratory tract. According to toxicologist Dominique Lison, carriers are at risk of developing pneumonia, especially if they already have underlying respiratory problems."

My question is, how might this play out during a "pandemic" of a respiratory virus like SARS-CoV-2? Wouldn't this be likely to contribute to progression of the disease into a more serious and complicated level in people that are exposed to the virus? This is one more thing to add to the list of ways that masking the general public has contributed to the serious physical and emotional illnesses and deaths from this pandemic. Certainly, this must just be the ignorance of our public health officials and nothing more sinister. Or is it? One

would certainly hope not.

Video shows that masking reduces blood flow to the brain

Transcranial Doppler has the ability to measure blood flow in the brain. Watch this demonstration and see why wearing masks can affect cerebral blood flow and heart rate variability and why it is such a terrible idea to make children wear them while exercising. https://www.youtube.com/watch?v=ul5E5BUrII4

Calling out Francis Collins Director of NIH, for stating people who have had COVID-19 still need the vaccine, while citing a study suggesting that they don't

In a February 23rd, 2021 article written by Francis Collins in ***The Director's Blog*** on the ***NIH*** website, Dr. Collins is saying that people that have had COVID-19 need the vaccines.
https://directorsblog.nih.gov/2021/02/23/is-one-dose-of-covid-19-vaccine-enough-after-covid-19-infection/

He cited that an NIH funded study in pre-print showed that people that had recovered from the wild infection showed a 10X or greater antibody response after their first vaccine dose than those who haven't had COVID-19 after their first shot (reference below). His point of the article is to say that they may only need the first dose of the vaccine, but what he probably doesn't even realize, is that he is essentially making the case that people who have had COVID-19 will have a robust antibody response when later exposed to the virus (in this case even just the spike protein from the vaccine). This basic virology. Antibodies may fall over time, but when presented with the virus (or vaccine), the Memory Cells are capable of kicking out high levels of antibodies once again.

Is this simply ignorance or an agenda? I'm guessing ignorance, because he also said people that have had the infection need the vaccine to prevent **"re-infection"**. An opinion paper in ***USA Today*** February 28th, 2021 titled, **COVID-19 cases are falling. This could be the beginning of the end of the pandemic**, by Robert M. Kaplan, a faculty member at ***Stanford Medical School Clinical Excellence Research Center***, a former associate director of the ***National Institutes of Health*** and a former chief science officer for the ***U.S. Agency for Health Care Research and Quality*** calls into question what Dr. Collins says. Dr. Kaplan stated that there have been only 57 documented cases of re-infection out of 113 million cases world-wide. I would hardly call this a reason to recommend all people that have infection with SARS-CoV-2 get an experimental vaccine with no long-term safety data. Many people claim that they know someone that has had it twice, but with the incredibly high false positive rates of the PCR test, the vast majority of those are just that…false alarms.

From Dr. Kaplan's article:

"Once infected with SARS-CoV-2, natural immunity offers powerful protection. Although there are some cases of reinfection, they are extremely rare. Among 113 million confirmed COVID-19 cases worldwide, there are only 57 documented reinfections. The placebo group in the Johnson & Johnson vaccine study includes 2,030 people who had previously been infected. These individuals were better protected against clinical infection than those who got the vaccine."

Once again back to Dr. Collins' article:

"People who've recovered from COVID-19 also should definitely get vaccinated to maximize protection against possible re-infection. But, because they already have some natural immunity, would just one shot do the trick? Or, do they still need two? A small, NIH-supported study, published as a pre-print on ***medRxiv***, offers some early data on this important question." https://www.medrxiv.org/content/10.1101/2021.01.29.21250653v1.full.pdf

(The study is titled: **Robust spike antibody responses and increased reactogenicity in seropositive individuals after a single dose of SARS-CoV-2 mRNA vaccine).**

"These findings come from a research team led by Florian Krammer and Viviana Simon, Icahn School of Medicine at Mount Sinai, New York. The researchers reasoned that for folks whose bodies have already produced antibodies following a COVID-19 infection, the first shot might act similarly to the second one in someone who hadn't had the virus before. In fact, there was some anecdotal evidence suggesting that previously infected people were experiencing stronger evidence of an active immune response (sore arm, fever, chills, fatigue) than never-infected individuals after getting their first shots."

"What did the antibodies show? To find out, the researchers enlisted the help of 109 people who'd received their first dose of mRNA vaccines made by either Pfizer or Moderna. They found that those who'd never been infected by SARS-CoV-2 developed antibodies at low levels within 9 to 12 days of receiving their first dose of vaccine."

"But in 41 people who tested positive for SARS-CoV-2 antibodies prior to getting the first shot, the immune response looked strikingly different. They generated high levels of antibodies within just a few days of getting the vaccine. **Compared across different time intervals, previously infected people had immune responses 10 to 20 times that observed in uninfected people.** Following their second vaccine dose, it was roughly the same story. **Antibody levels in those with a prior infection were about 10 times greater than the others**." (Emphasis mine). (**my comment:** Imagine how the immune system in a post-infection person would perform if it was faced with the wild SARS-CoV-2 virus or any of its variants later on. Being able to recognize all of the proteins from the wild virus instead of just the spike protein from the vaccines will certainly provide greater recognition and response. (see the graph at the end of this segment)

Now, that is exactly what the immune system should do Dr. Collins. And this phenomenon has been documented in numerous studies over the last many months. Even better, it is not just antibodies that remember the virus in those that have had COVID-19. It's also the T-Cells and other immune players that mount an effective attack upon re-exposure to the virus.

At any rate, thanks for referencing your NIH funded study Dr. Collins. It makes a makes a strong case against your unscientific positions. I know that wasn't your intention though.

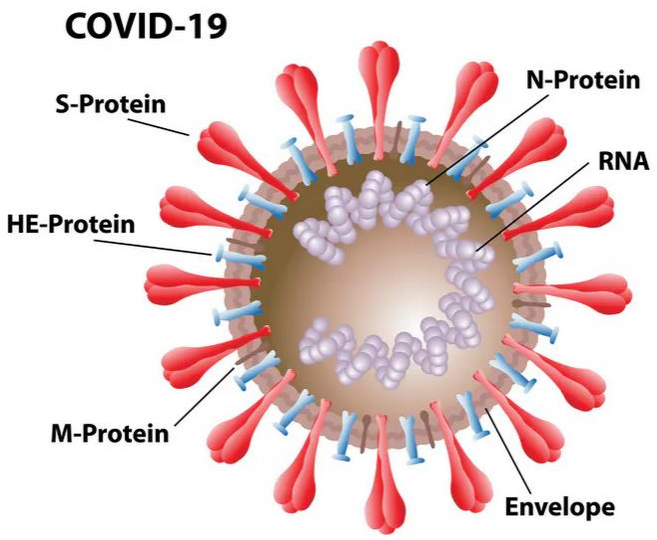
For those interested in reading the rest of Dr. Kaplan's opinion paper, he does a good job of discussing the estimated percentage of the population that have had the infection and relating it to being close to herd immunity even BEFORE the mass vaccine rollout.

IMPORTANTLY, and against the narrative we will hear about the vaccines being responsible for the decline of infections, he says the following:

"Vaccines will be essential for ending the pandemic, but they don't explain why cases are now quickly declining. Very few people had been inoculated when the decline started, and only more than 13% have received shots in the United States. Further, cases are dropping in countries that have initiated vaccination programs and those who have not started. **Japan, where vaccinations only launched last week, had a 85% decline in new cases since Jan. 11. In Colombia, where vaccines are unavailable, new cases have fallen 78% since Jan. 20."**

Here is the link to Dr. Kaplan's Opinion Paper:
https://www.usatoday.com/story/opinion/2021/02/26/covid-19-vaccines-herd-immunity-pandemic-could-be-ending-column/6810858002/

Picture showing the various protein categories of the SARS-CoV-2 virus



Confusion still abounds amid CDC's obvious worries that vaccinated people can still spread disease

From CDC's website 03-26-21

Fully vaccinated people can:

- Visit with other fully vaccinated people indoors without wearing masks or physical distancing
- Visit with unvaccinated people from a single household who are at low risk for severe COVID-19 disease indoors without wearing masks or physical distancing
- Refrain from quarantine and testing following a known exposure if asymptomatic

For now, fully vaccinated people should continue to:

- Take precautions in public like wearing a well-fitted mask and physical distancing
- Wear masks, practice physical distancing, and adhere to other prevention measures when visiting with unvaccinated people who are at increased risk for severe COVID-19 disease or who have an unvaccinated household member who is at increased risk for severe COVID-19 disease
- Wear masks, maintain physical distance, and practice other prevention measures when visiting with unvaccinated people from multiple households
- Avoid medium- and large-sized in-person gatherings
- Get tested if experiencing COVID-19 symptoms
- Follow guidance issued by individual employers
- Follow CDC and health department travel requirements and recommendations

https://www.cdc.gov/coronavirus/2019-ncov/vaccines/fully-vaccinated-guidance.html

This completely illuminates the double speak we hear from public health officials and the media on the vaccines. The talk of travel passports, passes to get into venues, etc. insinuating that those who are vaccinated are somehow less risk to others is ludicrous, because as the CDC knows, these "vaccines" which are really therapies for COVID-19 and can't prevent infection or transmission are useless to slow the spread of SARS-CoV-2. Somehow all of these very well-orchestrated messages always ends with some version of…"once enough people are vaccinated and we can stop the spread, then we can finally get back to normal." And based on public response, these P.R. machines have been effective at their misinformation campaigns.

Bill Gates says a third shot may now be needed

"Doctor" Gates is at it again. In a ***CBS News*** article, he says that the new variants may require his buddies in the vax industry to try to stay one step ahead of the virus. I guess he is setting us up for the eventual pitch that the public will "need" regular injections, maybe something similar to the low effectiveness "crap shoot" that is the annual flu shot campaign. And you can bet the shareholders for these companies are salivating at the idea.

The February 17th, 2021 article was titled, **Third shot may be needed to combat new coronavirus variants, Bill Gates says.**

And, in case you care what Gates had to say, here are some choice quotes:

"The discussion now is do we just need to get a super high coverage of the current vaccine, or do we need a third dose that's just the same, or do we need a modified vaccine?" Gates told "CBS Evening News" anchor and managing editor Norah O'Donnell.

"All five of the companies that have U.S. vaccines are looking at making that modification and adding that in so that people who've already had two shots might need to get a third shot," he said. "I think it's reasonably likely that we will have a tuned vaccine just to make absolutely sure that as these variants hit the U.S. that they're not escaping from vaccine protection."

If the coronavirus is not eradicated, he said, additional shots may be necessary in the future. "Probably not yearly, but as long as it's out there, we want as many Americans as possible not to be spreading it to each other," he said.

End of excerpts:
https://www.cbsnews.com/news/covid-vaccine-variants-third-shot-bill-gates/

Obviously, Bill is one of the few people that haven't heard that the vaccines have not been shown to prevent infection and transmission. His comment either shows his ignorance, or a pathological desire to deceive the public.

Dr. Fauci's 2015 statements in this interview reveal his lack of knowledge, candor, honesty and credibility

In a 2015 interview from an interview on ***PBS.org*** titled, **Dr. Anthony Fauci: Risks From Vaccines Are "Almost Nonmeasurable"**, the good doctor makes it obvious from the title quote that he is clueless about the rates and types of vaccine adverse reactions from vaccines. Or does he know and is lying? Either way it doesn't speak well for his credibility or character.

https://www.pbs.org/wgbh/frontline/article/anthony-fauci-risks-from-vaccines-are-almost-nonmeasurable/

A revealing moment:

Q: How many vaccines are we up to for children up to age 6?

A: "It is between 12 and 14 vaccinations that children get."

My comment: The CDC schedule from 2015 (that you can access from the link below) called for 48 doses (vaccines) in 33 shots, (due to some being combined i.e. MMR, DTaP) by age 6. Don't you think that Dr. Fauci, the director of the ***National Institute of Allergy and Infectious Diseases [NIAID]*** would have better knowledge about something so relevant to his role?

https://www.cdc.gov/vaccines/schedules/downloads/past/2015-child.pdf

Q: Some people think we have too many vaccines. Babies are given hepatitis B very soon after birth. What's the justification?

A: (My comment: This is a perfect example of a bureaucrat/politician's non-answer)… "Hepatitis is a serious disease, number one. You can get chronic hepatitis. Chronic hepatitis can lead to hepatic carcinoma — cancer of the liver. So the real question is, when is the best time to get someone vaccinated? The safety profile for hepatitis B vaccine is very, very clear. It's a highly effective vaccine, and the thought is that the best time to get people vaccinated is when you are a child, and you come in and you have a regimented situation where you go to see your physicians; you have a well-timed-out regimen of getting vaccinations."

Q: What about components and additives — aluminum, phenol, monkey cells?

A: "The monkey cells are not in the vaccine. The monkey cells grow some of the vaccines. If you look at some of the components that are in the vaccine, the safety record for those is enormous. There is no scientific evidence at all that there are any safety issues. …"

Q: A third group of parents argues that as the number of vaccines increases, it seems to correlate with the rise of chronic diseases like ADHD [Attention Deficit Hyperactivity Disorder] and autism.

A: "This issue has been looked into very carefully, about any scientific indication whatsoever that autism is caused — or any of the other chronic diseases — are caused by vaccine. And independent bodies have looked at this every which way and have come to the conclusion that there's no relationship at all between [them and] vaccination. Those diseases occur; they're tragic diseases, but they're not related to vaccinations."

Q: Why are vaccines proposed as the cause of disorders like autism?

A: "The one common denominator of childhood is that you get vaccinated. That's not cause and effect. So what you need to do is to see if there is any cause-effect relationship, and a lot of groups have looked very carefully at that, and there isn't. There's just no scientific data to indicate that that's the case."

Q: Some anti-vaccine groups say the only trial they'll accept is a randomized control study that compares vaccinated children with unvaccinated ones. What are the issues with a study like that?

A: "Methodologically, that is very difficult if not impossible to do, because there are real ethical concerns about withholding a potentially lifesaving intervention from a group of people where it would be a large enough group to have a statistically significant conclusion of unvaccinated cohort and vaccinated cohort. It's logistically difficult and ethically quite questionable."

Q: Then they say, why not just go to communities where people don't vaccinate and study them?

A: "Again, I think that those groups are probably so small, you're not going to get any kind of a meaningful information from small groups of people who are not vaccinated, because the incidence of the diseases you're looking for are so rare that you're going to have to have very large groups of people."

Q: Comment on the Redskins cheerleader [Desiree Jennings] who claimed she had a reaction to a seasonal flu shot. That was seen more than 2 million times. Does that alarm you?

A: "Well, you know, it's a fact of life. It certainly is alarming, because people who just turned it on and see it immediately believe it. That's just the way society is. That's the arena in which we are operating. So rather than run away from it and throw up your hands in frustration, what you've got to do is continue getting back to what I say all the time: Stick with the science. Science, by definition, is knowledge and truth."

Really doc? And obviously its only science if it aligns with your truth.

Q: Now a question about vaccine ethics. Why is it OK to mandate vaccination if it's not 100 percent safe?

A: "When you say mandate, it isn't absolute mandating. You're talking about getting into school. I mean, if a parent really feels strongly against that, that parent can get an exemption. So there's never a situation where someone is going to tie you down and vaccinate you or say you can't go to any schools at all if you're not vaccinated.
……."But nowhere should you force someone to do anything."

Oh, how times have changed.

Another quote from the interview:

"That's the reason why, when you have vaccine trials, it involves thousands and thousands of people."

In some cases, this is true. But in many cases, it is false. They way he states it, it sounds emphatic and absolute. To me that is deceptive.

In fact, Dr. Kary Mullis, the Nobel Prize Winner in Chemistry for his invention of the PCR test said the following about Dr. Fauci in an interview you can read and see here: https://dryburgh.com/kary-mullis-pcr-anthony-fauci/

Dr. Mullis didn't mince words about his feeling regarding Anthony Fauci. He said the following:

"Guys like Fauci get up there and start talking, and he doesn't know anything really about anything, and I'd say that to his face. Nothing."

"The man thinks you can take a blood sample and stick it in an electron microscope and if it's got a virus in there, you will know it. He doesn't understand electron microscopy and he doesn't understand medicine. He should not be in a position like he's in."

"Most of those guys up there on the top are just total administrative people and they don't know anything about what's going on with the bottom. You know, those guys have got an agenda, which is not what we would like them to have, being that we pay for them to take care of our health in some way."

"They've got a personal kind of agenda. They make up their own rules as they go. They change them when they want to and a smugly like Tony Fauci does not mind going on television in front of the people, face out, and lie directly into the camera."

Unfortunately, Dr. Mullis passed away in August of 2019.

Legal update-

ICAN DEMANDS THAT ALL ADVERSE EVENTS REPORTED THROUGH V-SAFE ARE ALSO REPORTED TO THE VAERS DATABASE

ICAN, through its attorneys, has written to HHS Acting Secretary Norris Cochran and Rochelle Walensky, the new Director of the Centers for Disease Control and Prevention, to demand that all adverse events following COVID-19 vaccination which are reported to the CDC's new V-safe tool also be automatically reported to the Vaccine Adverse Events Reporting System (VAERS).

As discussed in prior legal updates, the issue of underreporting to VAERS has been highlighted for over 30 years and is still an ongoing problem, making reliable statistics regarding vaccine adverse reactions hard to come by. The CDC has now created a new smartphone-based tool used to track adverse events following COVID-19 vaccines called V-safe. At first glance, V-safe may seem like a welcome development: a modern tool that should easily allow vaccine recipients to report, and CDC to track, any adverse events experienced following a vaccination. However, there are serious potential problems created by V-safe.

For all intents and purposes, V-safe intercepts reports that would have otherwise been made by vaccine recipients into VAERS. Only if the CDC deems an adverse event reported to V-safe worthy will it be added to the VAERS database. This leaves a large universe of data regarding adverse events outside of VAERS and outside the public's view.

When vaccinated for COVID-19, vaccine recipients are given a handout with information about what V-safe is, how it works, and how they can register for and use the program. V-safe is also explained in the FactSheets given out by both manufacturers at the time of vaccination. This "after vaccination health checker" uses text

messages and web surveys to gather data about vaccine recipients following vaccination. Once enrolled, individuals will receive one text message per day for the first week after vaccination inquiring about how they are feeling. For the next five weeks, users will be sent one text message per week. The user responds to questions and prompts and, depending on the answers, may receive a call from someone at CDC to follow-up. If the CDC reaches out to a user and if the CDC feels that person's adverse events rise to the level of "clinically important," then a report may be submitted to VAERS.

This is unacceptable and is why ICAN has reached out to the acting director of the HHS and the new CDC Director to demand that all adverse events reported through V-safe are added to the VAERS database. This is absolutely necessary for complete and consistent data as well as for transparency as the public does not have access to any information exchanged through V-safe.

Especially where clinical trials for COVID-19 vaccines are not capturing all adverse reactions and the companies selling these products have no liability for injuries, the American public must be confident that safety surveillance is the highest priority with these vaccines. For this and the other reasons above, ICAN has demanded that all adverse events be systematically collected and tracked in one database that the public can access: VAERS.

ICAN will continue to take additional legal steps to hold HHS, FDA, and CDC accountable for vaccine safety. ICAN will never stop fighting for true informed consent and for transparency.

As always, its critically important that you watch and share Del Bigtree's Highwire show on https://highwire.com or on BitChute or other platforms. New shows air each Thursday.

Nutrient of the month- Beta Glucans

Foods rich in Beta Glucan include:

- Oatmeal
- Barley
- Shiitake and reishi mushrooms
- Seaweed
- Algae

An interesting and surprising March 02nd, 2021 study in the ***Journal of Human Vaccines and Immunotherapeutics*** titled **β-glucans: wide-spectrum immune-balancing food-supplement-based enteric (β-WIFE) vaccine adjuvant approach to COVID-19**, suggests using a tried-and-true nutritional supplement in the battle against SARS-CoV-2. They actually hijack Beta Glucans and try to package by calling it a vaccine adjuvant. While the article does have a vaccine bent to it, the connection made with Beta Glucans is definitely worth the read.

Abstract

Conventional vaccines to combat COVID-19 through different approaches are at various stages of development. The complexity of COVID-19 such as the potential mutations of the virus leading to antigenic drift and the uncertainty on the duration of the immunity induced by the vaccine have hampered the efforts to control the COVID-19 pandemic. Thus, we suggest an alternative interim treatment strategy based on biological response modifier glucans such as the *Aureobasidium pullulans* AFO-202-derived β-glucan, which has

been reported to induce trained immunity, akin to that induced by the Bacille Calmette-Guérin vaccine, by epigenetic modifications at the central level in the bone marrow. These β-glucans act as pathogen-associated molecular patterns, activating mucosal immunity by binding with specific pathogen recognition receptors such as dectin-1 and inducing both the adaptive and innate immunity by reaching distant lymphoid organs. β-Glucans have also been used as immune adjuvants for vaccines such as the influenza vaccine. Therefore, until a conventional vaccine is widely available, an orally consumable vaccine adjuvant that acts like biosimilars, termed as the wide-spectrum immune-balancing food-supplement-based enteric (β-WIFE) vaccine adjuvant approach, with well-reported safety is worth in-depth investigation and can be considered for a clinical trial.

β-glucans and immunity

Trained immunity (TRIM) induction is a promising defense strategy against COVID-19.

β-Glucans are a heterogeneous group of polysaccharides abundant in the cell walls of yeasts, bacteria, and fungi that reportedly induce TRIM. β-Glucans induce epigenetic reprogramming in innate immune cells, leading to cellular activation, augmented cytokine production, and changes in metabolic function that shift cellular metabolism from oxidative phosphorylation to glucose fermentation mediated by the Akt/mammalian target of rapamycin (mTOR)/hypoxia-inducible factor 1α (HIF1α) pathway,12 thus effectively inducing TRIM.

Epigenetic alterations such as histone methylation and acetylation lead to the positive regulation of gene expression. When such epigenetically “trained” cells have contact with heterologous secondary stimuli, they are programmed to produce a more robust immune response. The cells are reportedly not peripherally trained, but β-glucans can impact the bone marrow (BM) and lead to a lasting TRIM phenotype.

β-glucan supplementation for COVID-19

Long-lasting immunity is currently a big challenge in COVID- 19-affected patients.17 β-Glucans can produce long-lasting TRIM against a wide range of pathogens.18 Furthermore, β-glucans are safe for consumption at all ages, and they fall under the FDA’s generally recognized as safe category.19 β-Glucans are stable and can be consumed continuously as a food supplement.9 Many types of β-glucans exist, but yeast- and mushroom-derived β- glucans exert stronger immunomodulatory effects than do other types of β-glucans.20 Oral β-glucans have been thoroughly described as prophylactic supplements to boost immune responses and to abrogate COVID-19 symptoms via their TRIM actions.10 Though SARS-CoV-2 is predominantly considered a virus that affects the respiratory system, the viral host receptor ACE2 appears in the cytoplasm of gastrointestinal epithelial cells, with the viral nucleocapsid protein appearing in the cytoplasm of rectal, duodenal, and gastric epithelial cells, suggesting that the intestine may be relevant in the pathogenesis of COVID-19 and maybe a possible route of infection.21 β- Glucans with immune effects on the intestine may therefore be an advantageous supplementation strategy for COVID-19 ther-apy. Gut-dysbiosis is also a key element in determining infection- related diseases. β-Glucans can also modulate the gut bacteria, improving immune response.22 β-Glucan supplements decrease the incidence of upper respiratory tract infections in randomized control trials.23–27 A β-glucan extract from the edible shiitake mushroom Lentinus edodes has recently been reported to show differential in vitro immunomodulatory and pulmonary cytoprotective effects and may be indicated for COVID-19 immunotherapy.27 The study compared two types of Lentinan extracts that differentially reduced cytokine-induced NF-κB acti-vation in human alveolar epithelial A549 cells and attenuated pro-inflammatory cytokine production (TNF-α, IL-8, IL-2, IL-6, and IL-26), as well as TGF-β and IL-10 secretion. The study suggested that β-glucans delivered as a tailored cocktail might fit future nutraceutical-based intervention for COVID-19.

https://pubmed.ncbi.nlm.nih.gov/33651967/

Beta-Glucan extracts from the same edible shiitake mushroom Lentinus edodes produce differential in-vitro immunomodulatory and pulmonary cytoprotective effects - Implications for coronavirus disease (COVID-19) immunotherapies. ***The Science of the Total Environment August 2020***

Abstract

Coronavirus pneumonia is accompanied by rapid virus replication, where a large number of inflammatory cell infiltration and cytokine storm may lead to acute lung injury, acute respiratory distress syndrome (ARDS) and death. The uncontrolled release of pro-inflammatory cytokines, including interleukin (IL)-1β and IL-6, is associated with ARDS. This constituted the first study to report on the variability in physicochemical properties of β-glucans extracts from the same edible mushroom Lentinus edodes on the reduction of these pro-inflammatory cytokines and oxidative stress. Specifically, the impact on the immunomodulatory and cytoprotective properties of our novel in 'house' (IH-Lentinan, IHL) and a commercial (Carbosynth-Lentinan, CL) Lentinan extract were investigated using in vitro models of lung injury and macrophage phagocytosis. CL comprised higher amounts of α-glucans and correspondingly less β-glucans. The two lentinan extracts demonstrated varying immunomodulatory activities. Both Lentinan extracts reduced cytokine-induced NF-κB activation in human alveolar epithelial A549 cells, with the IHL extract proving more effective at lower doses. In contrast, in activated THP-1 derived macrophages, the CL extract more effectively attenuated pro-inflammatory cytokine production (TNF-α, IL-8, IL-2, IL-6, IL-22) as well as TGF-β and IL-10. The CL extract attenuated oxidative stress-induced early apoptosis, while the IHL extract attenuated late apoptosis. Our findings demonstrate significant physicochemical differences between Lentinan extracts, which produce differential in vitro immunomodulatory and pulmonary cytoprotective effects that may also have positive relevance to candidate COVID-19 therapeutics targeting cytokine storm.

https://pubmed.ncbi.nlm.nih.gov/32413619/

β-glucans as wide-spectrum immune-balancing food- supplement-based enteric (β-WIFE) vaccine adjuvant approach to COVID-19

β-Glucans induce TRIM with epigenetic reprogramming in innate immune cells at the BM level, leading to a long-lasting central and peripheral TRIM.9–11 Since β-glucans are recog-nized as PAMPs, they are recognized by the ligation of specific PRRs, such as TLR and C-type lectin-like receptors, which stimulate both innate immunity by targeting cells, including macrophages and NK cells, as well as adaptive immunity by expanding and activating antigen-specific CD4 and CD8 T cells and enabling B lymphocytes to produce antibodies.15,16,28 β- Glucans also enhance mucosal immunity, employing the majority of the components of the reticuloendothelial system by inducing gut mucosal immunity, traveling to distant effector sites such as the spleen and lymph nodes.39,41 β-Glucans acti-vate all aspects of the immune system,9–13 resulting in a continuous, lasting immune response against various patho-gens that can elicit specific antiviral immunity.28 Above all, this β-glucan-based immune response is obtained through a simple oral food supplement administration, with a proven track record of safe consumption at all ages,28 besides having been employed as vaccine adjuvants.37,38,40 Thus, for COVID-19, we have termed this approach as a β-WIFE vaccine adjuvant approach.Our group has recently initiated a pilot study in healthy volunteers (men aged between 40 and 60) on evaluation of biomarkers relevant to thrombogenicity, apart from immune enhancement and immune modulation with AFO-202 β- glucan and the interim results are encouraging. Based on these encouraging preliminary results, we plan to undertake a controlled study in COVID-19 patients whose general health conditions permit oral consumption.

https://pubmed.ncbi.nlm.nih.gov/33651967/

Soluble and Insoluble Yeast *β*-Glucan Differentially Affect Upper Respiratory Tract Infection in Marathon Runners: A Double-Blind, Randomized Placebo-Controlled Trial. ***Journal of Medicinal Food*** April 2020.

Abstract

In a previous study, consumption of a dairy beverage incorporating insoluble *β*-glucan decreased upper respiratory tract infection (URTI) symptomatic days and severity in marathon runners. In this report, we extended our previous findings by presenting data on a dairy beverage containing soluble *β*-glucan and URTI in marathon runners. Healthy adults running in the 2017 Austin Marathon consumed dairy beverages (250 mL/day) containing 250 mg of insoluble (*n* = 69) or soluble (*n* = 76) baker's yeast *β*-glucan (Wellmune®) or placebo (*n* = 133) for the 45 days before, day of, and 45 days after the marathon (91 days total). Participants completed a daily online survey assessing compliance and URTI symptoms, which were evaluated using the Jackson Index and confirmed by the study physician. Total severity of URTI was significantly lower in the insoluble yeast *β*-glucan group compared to the placebo group, but was not different between the soluble yeast *β*-glucan group and placebo group. Severity ratings for nasal discharge were significantly lower in both the insoluble and soluble yeast *β*-glucan groups compared to the placebo group. Additionally, severity rating for sore throat was lower in the insoluble, but not the soluble yeast *β*-glucan group compared to the placebo group. The insoluble yeast *β*-glucan group, but not the soluble yeast *β*-glucan group also reported fewer URTI symptomatic days compared to the placebo group. The results suggest that soluble and insoluble yeast *β*-glucan, incorporated into a food matrix, differentially affected exercise-induced URTI in marathon runners.

https://pubmed.ncbi.nlm.nih.gov/31573387/

Effects of b-glucans on the immune system. Journal ***Medicina 2007***

Summary

b-Glucans are naturally occurring polysaccharides. These glucose polymers are constituents of the cell wall of certain pathogenic bacteria and fungi. The healing and immune-stimulating properties of mushrooms have been known for thousands of years in the Eastern countries. These mushrooms contain biologically active polysaccharides that mostly belong to group of b-glucans. These substances increase host immune defense by activating complement system, enhancing macrophages and natural killer cell function. The induction of cellular responses by mushroom and other b-glucansis likely to involve their specific interaction with several cell surface receptors, as complement receptor 3 (CR3; CD11b/CD18), lactosyl-ceramide, selected scavenger receptors, and dectin-1 (bGR). b-Glucans also show anti-carcinogenic activity. They can prevent oncogenesis due to the protective effect against potent genotoxic carcinogens. As immune-stimulating agent, which acts through the activation of macro-phages and NK cell cytotoxicity, b-glucan can inhibit tumor growth in promotion stage too. Anti-angiogenesis can be one of the pathways through which b-glucans can reduce tumor proliferation, prevent tumor metastasis. b-Glucan as adjuvant to cancer chemotherapy and radiotherapy demonstrated the positive role in the restoration of hematopiesis following by bone marrow injury. Immunotherapy using monoclonal antibodies is a novel strategy of cancer treatment. These antibodies activate complement system and opsonize tumor cells with iC3b fragment. In contrast to microorganisms, tumor cells, as well as other host cells, lack b-glucan as a surface component and cannot trigger complement receptor 3-dependent cellular cytotoxicity and initiate tumor-killing activity. This mechanism could be induced in the presence of b-glucans.

Conclusions

b-Glucan has been reported to act as immune system activator and cell response modifier. Binding of b-glucans to its specific receptors can elicit a serial cellular response through the modulating of activities of various factors including cytokines, chemokines, transcriptional factors, and growth factors. These effects are beneficial in by chemo- and radiotherapy induced immune suppression and depleted hematopiesis. b-Glucan shows anticarcinogenic activity, prevent oncogenesis and prevent metastasis. In addition, it demonstrates promised results as adjuvant to anti-tumor mAb by initiating additional tumor-killing mechanism.

https://pubmed.ncbi.nlm.nih.gov/17895634/

New PubMed articles of the month-

A meta-analysis of the efficiency of metal nanoparticles in vaccine delivery against infectious disease

Nanomedicine (Lond). 2021 Mar;16(6):481-495. PMID: **33683147** DOI: 10.2217/nnm-2020-0358

Abstract:

Background: Exploration of the efficiency of metal nanoparticles as adjuvants have reported varying results.

Objective: The efficacy of metal nanoparticles as adjuvants was investigated

Data sources: Database were searched using the terms 'metal nanoparticles' and 'vaccines'.

Study eligibility criteria: Studies in animal models utilizing any metal-based vaccines, where the survival rate was described.

Study appraisal: The quality of the studies was examined using aspects of the ARRIVE guidelines and assessment of the risk of bias of included studies.

Results: Metal nanoparticle-based adjuvants were more effective compared with control (unvaccinated groups) but have not been more successful in competing with common adjuvants or even antigens alone.

Limitation: More than 75% of articles have used only gold nanoparticles.

Conclusion: Nano-adjuvants do not have a significant effect on reducing mortality.

A March 2021 letter to the editor published in the ***Journal of Internal and Emergency Medicine*** titled, **Deep vein thrombosis (DVT) occurring shortly after the second dose of mRNA SARS-CoV-2 vaccine**, discusses a case of deep vein thrombosis in a 66 year old Italian woman after receiving the Pfizer mRNA vaccine.

The concluding paragraph:

“To our knowledge, this is the first reported case of DVT presenting as an adverse event post-SARS-CoV-2 vaccination. Arguably, the intense immunological response evoked by the second dose of vaccine could be a trigger for the thrombotic event described, a mechanism recognized in many clinical conditions. No DVT cases

have been reported on 21,720 persons receiving BNT162b2, suggesting that the DVT incidence may be lower than one case every 5889 (this figure representing the 95% upper boundary of confidence interval) [4]. No apparent correlation can be made with the presence of a mild thrombophilia mutation in this patient. In our district, the vaccination program started on January 2021 and involved only health workers, of whom 3010 received two doses on January 25th. This case not-withstanding, we may consider that DVT post-vaccination incidence may still be very low and within the expected incidence figure. A longer follow-up and a greater diffusion of SARS-CoV-2 vaccines in the population are needed to clarify the magnitude of this potential side effect—that, although extremely low, may not be negligible on a population-wide basis.

With that in mind, it is important that everyone that is considering receiving one of the COVID-19 vaccines, it is imperative that they go into the decision with eyes wide open. Therefore, they deserve to know about the possible risks, what many world-renowned scientists and doctors are saying expressing their concerns and warnings about the vaccines. This is called full informed consent. Every person deserves and in fact has the right to know the potential risks as well as the reported benefits of any medical procedure or in this case experimental biological intervention.

A June 2020 study published in the ***International Journal of Medical Sciences*** titled **Berberine Inhibits Pro-inflammatory Cytokine-induced IL-6 and CCL11 Production via Modulation of STAT6 Pathway in Human Bronchial Epithelial Cells**, may indicate promise of using Berberine to blunt the hyper-inflammatory response encountered in some cases of SARS-CoV-2.

Abstract:

Berberine is an isoquinoline alkaloid isolated from various Chinese herbs that has potential of anti-inflammatory, anti-lipidemic, anti-neoplastic, and anti-diabetic activity. In this study, we evaluated the anti-inflammatory efficacy of berberine on allergic airway inflammation by targeting epithelial cells.

Allergic airway inflammation driven by T helper 2 (Th2)-type immunity is characterized by airway hyperresponsiveness, elevated IgE production, and eosinophilic infiltration. For eosinophil recruitment, major chemoattractant CCL11 (eotaxin-1) was secreted by lung epithelial cells.

BEAS-2B cells, a human bronchial epithelial cell line, were pre-treated with berberine and then activated by IL-4 plus TNF-α. The viability of BEAS-2B cells was assessed. Expression levels of IL-6 and CCL11 were determined using ELISA and real-time PCR. The signaling pathways of MAP kinases, NF-κB, and STAT6 were analyzed by western blot.

- Berberine treatment (≤1 μM) didn't significantly affect the viability of BEAS-2B cells with or without IL-4 plus TNF-stimulation.

- Berberine significantly inhibited the secretion of IL-6 and CCL11 from pro-inflammatory cytokine-activated BEAS-2B cells.

- NF-κB and MAP kinase pathways were seemingly unaffected in BEAS-2B cells with berberine treatment.

- Significant reduction of nuclear STAT6 protein expression in activated BEAS-2B cells with berberine treatment was observed.

Current study reveals that berberine has inhibitory effect in pro-inflammatory cytokine-activated BEAS-2B cells through reducing IL-6 and CCL11 production, which is possibly modulated by suppressing STAT6 signaling pathway.

Remember to download my FREE COVID-19 Vaccines Critical Review and 2-page summary at https://www.wellnessdoc.com/covid-19-vaccine-review-2/

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