

Polio Awareness Day: Medical Myths Die Hard

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The heresy in challenging the Jonas Salk legend and suggesting that the cause of the mid-century epidemic—assuming it really was an epidemic—was not caused by a microbiological agent (poliovirus), may be comparable to observing that Islam is an intolerant religion and a belligerent political philosophy. Which perhaps was why House Resolution 526 (establishing Polio Awareness Day) passed by a voice vote on Sept. 19—albeit while the House floor was practically vacant of House members. In a body that has never been more contentious as this Congress, and during a period when many people and institutions have been stripped of sacred-cow stature, it's indeed a tribute to the public relations clout of allopathic medicine to have maintained the myth of vaccination's eradication of infectious and communicable disease.

That's not to say there were never instances of courage when it came to debates in the House regarding vaccination. Around 1990, during a Congressional hearing, I recall a young Rick Santorum (R-PA) seek to deny funds for a CDC program that would have promoted vaccination compliance, noting that the CDC had admitted that it had already achieved its goals for vaccination rates that year. He was the only legislator making this argument, because most politicians are too cowardly to speak their conscience, if there's the slightest risk of being perceived as antagonistic towards children or modern medicine.

But there were no instances of 'profiles in courage' in the House on Sept 19th. True to script, Rep. Nathan Deal introduced the Resolution by reminiscing the glory days when Jonas Salk rescued this nation from paralysis and the iron lung machine, and argued that every child today has the right to be vaccinated against poliomyelitis. Representatives Frank Pallone (R-NJ) and Steve Rothman (D-NJ) waxed on in similar fashion, noting that establishing October 1st as Polio Awareness Day will help further amplify modern medicine's triumph over polio 50 years ago, which in turn will help to increase polio vaccination rates and thereby prevent another polio epidemic in the U.S. (Apparently, legislators feel there's a deficiency of references in books, newspapers, documentaries, and the internet to Salk, Sabin and the supposed laudable role that vaccination has played in eradicating disease.)

What legislator could conceivably oppose this Resolution? None. Rep. Deal observed that 10 percent of children under 3 years of age are not vaccinated against polio. In trying to reconcile the reason for this, he parroted the medical establishment's line, saying that "medicine is a victim of it's own success": By having achieved victory over disease, parents no longer witness outbreaks and have become too placid with regards to the recommended childhood vaccines.

However, a growing number of parents would take issue with that. They still see outbreaks today among fully vaccinated children. They still see paralysis occur. (Many would be surprised to learn that rates of paralysis are about the same today as they were over the past 60 years.) Rather than being negligent, conscientious and responsible parents today are researching the issue and are actively resisting what they sense as a growing fanaticism taking hold of public health officials who seem to want to vaccinate everything that moves. Among the 36 medical physicians in my state coalition (www.CFIC.us)—who are themselves parents—the main concern pertains to the efficacy of administering particular types of vaccines, as well as the number of required doses—which has mushroomed to about 39 doses of 11 different vaccines by 6 years of age. By the time a child is finished primary school, he would have received roughly four times that many doses.

It is primarily the dose-dependent aspect that many believe is responsible for the rise in chronic diseases in children. Real autism rates—corrected for over-diagnosis error—have soared in recent years to epidemic proportions in the U.S. and developed nations. Many more journal articles have been associating vaccinations to the rise in autoimmune diseases like type-1 diabetes and asthma—which in children have more than doubled since 1980 in places where air pollution has sharply declined. Attention-deficit disorder has also doubled since that time; diabetes and learning disabilities have tripled, chronic arthritis now affects nearly one in five Americans.

Controversies swirl around particular mandated vaccines, like pertussis (in DPT) and measles (in MMR). The aggressive campaigns to mandate the risky hepatitis-b vaccine (for children with negligible risk for the disease) and the precipitous approval of the rotavirus vaccine (subsequently withdrawn from the market for its adverse effects) have led many to conclude that state health agencies appear far too eager to maximize vaccination rates at any cost—not just to maximize receipt of federal grants that are directly matched to state vaccination levels—but also as a reaction to bad publicity: High rates of vaccination makes it appear that there’s popular acceptance of it, as well as vindicate their medical paradigm—the standard infectious disease theory—which has become a cornerstone of their profession. In an ironic cycle, the Supreme Court’s perception in 1905 that there was a popular consensus behind smallpox vaccinations led it to affirm compulsory vaccination laws. (“Deliberation By Consensus” at <http://americandaily.com/article/1165>)

Smallpox in Brief

In other words, vaccine mandates force vaccination rates to rise, which supposedly demonstrates to the courts that there’s popular support for vaccination, which emboldens legislators to enact more mandates, which provides justification for health officials to clamor for more mandates and more money for the development of more vaccines, which leads to more vaccines administered, and back again. It’s government by legislative fiat, then by judicial fiat, followed by medical fiat. Proof of scientific effectiveness or safety—if it ever enters the process at all—always employs limited in-house rule sets which may sometimes yield objectively useful results for individual vaccines (depending on the nature of the test), but never poses questions to test the efficacy of the *theory and practice* of vaccination.

The converse situation plays an important role as well: If little or no outbreaks occur among populations with low vaccination rates, then the credibility of mainstream medical authorities would suffer. Before allopathy’s well-oiled public relations machine kicked into gear in earnest by 1914, that’s precisely what occurred with smallpox vaccination in the 18th and 19th centuries: Smallpox was among the so-called “filth” diseases. It occurred in the burgeoning cities of Europe and Russia where defecating upstream and drinking the water downstream was not always among the proscribed practices in city planning. Not only had poor sanitation and nutrition lay the foundation for these diseases, it was also compulsory smallpox vaccination campaigns in the late 19th and early 20th centuries that played a major role in decimating the populations of Japan (48,000 deaths), England & Wales (44,840 deaths, after 97 per cent of the population had been vaccinated), Scotland, Ireland, Sweden, Switzerland, Holland, Italy, India (3 million—all vaccinated), Australia, Germany (124,000 deaths), Prussia (69,000 deaths—all revaccinated), and the Philippines. Epidemics ended, or had never occurred, in cities where smallpox vaccinations were either discontinued or never begun, and also after sanitary reforms were instituted (Most notably in Munich-1880, Leicester-1878, Barcelona-1804, Alicante-1827, India-1906, etc.).

Before health agencies and schools of public health were completely taken over by allopathic medicine, the great legacy of the sanitary reformers—Max von Penttenkofer, James T. Briggs, Dr. John Snow, Edwin Chadwick, Florence Nightingale, Dr. Southwood Smith—was that they were able to eradicate cholera, yellow fever, tuberculosis, typhus, typhoid, scarlet fever, diphtheria, whooping cough, measles and the bubonic plague long before vaccinations were developed or routinely used. In many nations, mortalities from smallpox hadn’t begun to decline until the citizenry revolted against compulsory smallpox vaccination laws. For example, the town of

Leicester from 1878 to 1898 stood in stark contrast to the rest of England where thousands were dying from the aggressive half century-old government mandatory immunization campaigns.

By 1907 the Vaccination Acts of England were repealed, with the help of some of the world's preeminent scientists who had turned staunchly against vaccination: Alfred Russel Wallace (one of the founders of modern evolutionary biology and zoogeography, and co-discoverer with Charles Darwin of the Theory of Natural selection), Charles Creighton (Britain's most learned epidemiologist and medical historian), William Farr (epidemiologist and medical statistician, first to describe how seasonal epidemics rise and fall—known today as Farr's Law"), and the renowned Dr. Edgar M. Crookshank, Professor of Bacteriology and Comparative Pathology in King's College, London, and author of the scathing scientific critique of vaccination, *The History and Pathology of Vaccination* (1889). But before the law was amended in 1898 to include a conscientious exemption clause, an average of 2,000 parents per year were jailed and prosecuted—some repeatedly—for resisting vaccination. Large numbers went to prison in default of paying fines. Hundreds had their homes and possessions seized.

By 1919, England and Wales had become one of the least vaccinated countries, and had only 28 deaths from smallpox, out of a population of 37.8 million people. By contrast, during that same year, out of a population of 10 million—all triply vaccinated over the prior 6 years—the Philippine Islands registered 47,368 deaths from smallpox.

Compulsory Vaccination Negates the Spirit of Informed Consent

Before allopathic medicine could rewrite the history of smallpox, a century had to pass to ensure that prior generations—who had actually lived that history—had died off. Since the rebellion against the draconian 1907 Vaccination Acts and to date, Britain has not instituted any compulsory vaccination laws. But the U.S. has. They're known as the "no shots, no school" laws. The enforcement of these mandates vary from state to state. In New York, the medical exemption from the requirement is practically useless, as public health officials routinely veto the clinical judgments of private care pediatricians who certify that a child may be susceptible to adverse reactions to a vaccine.

The religious waiver is also difficult to obtain. The federal district court which found the prior NY statute unconstitutional in 1987 had warned that "defining 'religion' for legal purposes is an inherently tricky proposition", and that sincerity testing "must be undertaken with extreme caution". Yet local schools boards in NY are granted wide discretion in screening religious applicants for the waiver. Some school districts subject parents and extended family members to hours of depositions with attorneys for the school, and require every family member's medical records. So intrusive are some of these inquiries that the chairman of the Health Committee in the state assembly—a staunch advocate of both vaccination and the First Amendment, as well as the longest presiding chairperson of this committee in NY's history—became the prime sponsor of legislation to amend the exemption provisions to have these religious tribunals terminated.

Some school administrators extract information from parents that goes well beyond the parents' descriptions of their religious beliefs. Some parents are denied the waiver because they give their children aspirin, pain killers, foods with artificial ingredients, or take their children to the pediatrician or dentist (etc.). Indeed, some school systems employ screening regimes so restrictive as to require recipients of the religious waiver to reject the entire pharmacopoeia of modern medicine, as well as the medical advice and directives of their physicians, school nurses, or public health officials. In short, to qualify for the religious waiver in many school districts, parents must demonstrate a lifestyle akin to that of a 7th-century Tibetan monk.

In the best tradition of "heads I win, tails you lose", for parents to withhold some of these medical services—including vaccinations themselves—could lead to a finding of maltreatment and a petition to remove the children

from parental custody: A child's vaccination status is listed in the risk assessment instrument used by child welfare caseworkers, and an unvaccinated or undervaccinated child requires there be a full (and intrusive) investigation of the parents by the state's children's protective services agency.

Some parents are forced to hire attorneys to assist them, or to refute charges of truancy or medical negligence for withholding vaccinations from their children. (Schools often notify Child Welfare precipitously.) To avoid these and other hardships, many parents have either resorted to homeschooling, or moved into another school district. Some have even moved out of New York State. According to the Home School Legal Defense Association, the primary reason for the growth in homeschooling is due to the frustrations parents experience in pursuing their religious and medical choices—a good portion of that involves state vaccination mandates.

And to add insult to injury, we have legislators like Rep. Nathan Deal explaining that the reason children are not sufficiently vaccinated is not because their parents wish to make careful and prudent decisions about their children's health, but rather because they're too complacent today about what health authorities arrogantly term, "vaccine-preventable diseases". If this affront to individual liberties and informed consent continues, then future mainstream medical historians will have to fabricate yet another story, this time to coverup how this current generation of children became neurologically impaired.

The Salk Vaccine and the "Disappearance" of Paralytic Polio

With that brief introduction into the minor heresy of questioning the value of vaccination, I will now tackle the greater heresy, to wit, (1) Was there really a "polio" epidemic? and (2) Was paralysis a sequelae from viral infection? This is *not* a conspiracy rant. I don't dwell on motives of supposed evil doers. Instead, this is a sober scientific inquiry into medical fraud, which didn't require 100 years to pass before the public could be duped. It occurred in real time.

This essay challenges the two basic popular contentions about the polio epidemic of the 1950s. First, there's the claim that there was a genuine epidemic, in spite of, for example, the biased and grossly flawed epidemiology by public health officials, which included the manipulation of statistics, diagnostic criteria, and case definitions that artificially inflated cases **prior** to the Salk vaccine, and then artificially deflated them **after** the vaccine was administered. If there was indeed an epidemic (i.e. a genuine increase in paralysis), then the second consideration is to determine if it was caused by a microbial pathogen (poliovirus), or in my opinion, chemical and biological toxins with nutritional cofactors?

Subheadings That Follow:

- Introduction: Manufacturing Epidemics
- What is Polio?
- Determining Cause and Effect
- When Paralysis Follows Vaccination Campaigns
- The Polio Campaign: The Epidemic that Never Was
- Paralysis Increased Following the Salk Vaccine
- Was There Really an Epidemic?

Postscript #1: Excerpt From "Immunization: The Reality Behind The Myth", By Walene James

Postscript #2: Dr. Viera Scheibner, 1999 Commentary on Polio

Postscript #3: Neurological Complications of Vaccinations, By Charles M. Poser, M.D., FRCP

An reasonable question to ask is, why focus on a disease thought to have been conquered a half century ago? For those not old enough to know, the eradication of polio during the 1950s has been heralded ever since as the triumph of vaccination over disease—often supplanting the bluster that vaccination triumphed over smallpox.

In the State of New York, for example, the “success” of the Salk vaccine is specifically cited by the legislature as justification for the enactment of the vaccination requirements for school (Legislative Findings of L.1966, c.994, Section 1, effective 1/1/1967). The Historical Notes read:

“One of the truly great medical advances of this generation has been the development of proved methods of reducing the incidence of poliomyelitis, the once great crippler. Public health statistics show clearly that immunization is at least 90% effective in preventing paralysis. Immunization has been proven absolutely safe and there is no evidence or indication that anyone has contracted paralytic polio from an immunization dose.”

As the controversy over live virus polio vaccination has finally overtaken the vaccine promoters, I suspect not even the Department of Health would assert that last sentence today. Nevertheless, the purported effectiveness of the vaccine is still ‘lore’ today, and was the basis to enact the ‘law’ in NYS in the first instance.

The following is a lay article, to be sure. But the information presented about the 1950’s polio “epidemic” speaks for itself, and in a perfect world, it would be reason enough to rescind the above statute, not to mention make a mockery of Polio Awareness Day.

INTRODUCTION: MANUFACTURING EPIDEMICS

To appreciate how epidemics can be “created”, one has to understand the degree of control that public health officials have throughout the entire process.

Public health agencies have assumed wide discretion in announcing “public health alerts”. Such powers have been abused. The CDC loosely defines an “epidemic” as 5 or more confirmed cases clustered in a concentrated area. An “area” may be a few city blocks, or an entire country. An “outbreak” is defined as at least one case in one area. There’s also a loose standard by which if one person living in a household has a confirmed case of a “communicable” disease, then there’s no need to draw blood to test anyone else with similar symptoms living in that same household.

Also, there’s an over-reliance on incidence statistics rather than mortality, to demonstrate vaccination effectiveness. However, statisticians tell us that mortality statistics can be a better measure of incidence than the incidence figures themselves, for the simple reason that the quality of reporting and record-keeping is much higher on fatalities. [Darrell Huff, *How to Lie With Statistics*, p. 84] In 1982, Maryland state health officials blamed an epidemic on a television program, “DPT: Vaccine Roulette”, which warned of the risks from the DPT vaccine. However, when Dr. J. Anthony Morris, former chief virologist for the U.S. Division of Biological Standards, had analyzed the 41 cases, only 5 were confirmed cases of pertussis, and all 5 had been vaccinated against the disease. [Trevor Gunn, “Mass Immunization: A Point in Question”, p 15 (E.D. Hume, *Pasteur Exposed-The False Foundations of Modern Medicine*, Bookreal, Australia, 1989.)]

Historically, public health officials have routinely increased disease surveillance in areas of low vaccination acceptance as a retaliatory response (a) against people who reject Modern Medicine’s vaunted public health tool, and (b) to justify predictions that outbreaks will occur because of said rejection. Intensified surveillance for whooping cough in Britain, Japan, and Sweden, for example, had followed steep declines in pertussis vaccination rates in those countries.

Sometimes the increased disease surveillance is accompanied by a relaxation of the case definition of the disease, and lowered criteria required for its diagnosis. Subclinical and borderline cases are suddenly classified as “severe”. Suspected cases are permitted to be clinically diagnosed without laboratory confirmation. After 1955, for example, polio had “disappeared” following the Salk vaccine, only because thereafter clinicians hung new and different names on the same polio-like symptoms. In fact, it appears that it was the Salk vaccine itself that was the “great crippler”, and that paralysis would have disappeared sooner, had we done without the vaccine. This type of skewering of medical statistics has also occurred with common diseases such as flu, and with major pandemics like AIDS, a syndrome of 30 disparate diseases said to be infectious.

Finally, there are two primary means by which public health officials manufacture infectious or communicable diseases where there are none, or where the causes may be chemical or environmental toxins. First, because symptoms from chemical toxins or malnourishment (poor nutrition) closely mimic symptoms from infectious diseases (ie.: the catarrhal and zymotic diseases that allopaths deem to be caused by biological pathogens), the former can often be hidden under the latter. Many journal papers have been written supporting such theories for West Nile, Mad Cow, “Foot & Mouth” (U.K.), Legionnaires’, AIDS (self-induced drug toxemias), and dozens of others. Public health officials exacerbate this medical bias through their notorious inclination to shun investigations into possible non-infectious causes.

Secondly, the commonality of human symptoms across diseases of different names enables public health officials to artificially inflate one disease from a large available cache of disparate disease categories. Specifically, there’s a limited number possible combinations and sequences of fever, cough, sinus mucous, diarrhea, and skin lesions and rashes. Yet there are thousands of different names for infectious diseases which include these symptoms. Thus, hundreds of different diseases are symptomatically interchangeable. This enables health officials, for examples, to claim that there’s a West Nile virus epidemic despite the fact that the normal background incidence of encephalitic reactions for that given year, for that given locality, hadn’t risen at all. (The increase in bird mortalities caused by environmental pollution is a key factor not considered or investigated by officials in this example.)

Similarly, health officials may alert us to a flu epidemic, despite the fact that the normal background incidence of fever, muscle stiffness, and sinus release may have remained level, or even have dropped. Since so many other diseases share these same symptoms, it merely requires a clinician to report a cluster of “flu”. The deception (and self-deception) is facilitated and perpetuated through subsequent DoH bulletins ordering clinicians to increase disease surveillance for flu, and concomitantly, to relax the case-definition and requirements for lab confirmation.

The final result is an “epidemic” that was actually non-existent, or grossly inflated. Yet public health agencies are able to achieve what every publicly-funded entity requires to thrive: They remind the public of how much they are needed. The gullible media aids them in this endeavor by routinely dropping their usual objectivity and deferring to the medical experts. (What newspaper wants to be held responsible for risking lives by challenging the advice of medical authorities?)

Most people would be surprised to learn that there are more than one thousand outbreaks worldwide each year, including colds, seasonal flues, hepatitis, and numerous noninfectious syndromes, all running their course and disappearing, often despite remaining unexplained by scientists. Even the dreaded Ebola epidemic failed to materialize. The CDC claimed that 108 people may have been killed by the Ebola in Zaire in 1995. However, there had been no further deaths and not a single case has ever been reported in the U.S. or Europe. As historian Elizabeth Etheridge wrote, “the epidemic was virtually over before their work [CDC & WHO] began” (Sentinel for Health, 1992).

Considering the speed from exposure to death, the mortalities were more likely the result of a chemical toxicological agent. A couple of other indications point in that direction: Symptoms were rarely seen outside the localized area where it began. And 20 per cent of the 55 million Zairians are Ebola virus antibody-positive, having survived the virus without apparent disease (Dietrich J., 1995). One guess is that those who became sick had been exposed to the deadly cleaning solvents and oils that are often left at military base camps—possibly from groundwater contamination. Indeed, civil wars extending across 8 nations in central Africa killed about 2.5 million African civilians between 1998 and 2001 alone.

If it were not for the gullible media and fanatical virus hunters seeking fame and fortune, this virus would have joined the ranks of the thousands of known harmless passenger viruses. According to renowned molecular biologist Peter Duesberg, “these many outbreaks provide the CDC with its inexhaustible source of epidemics” (Inventing The AIDS Virus, 1996).

In conclusion, such deceptions skew the correct picture of disease prevalence. Too often, an apparent rise in cases of a disease is an artifact of epidemiological methodology—and bias. State legislatures cannot properly ascertain which vaccines to mandate based upon information provided solely from health officials. Dissenters outside, and from within the medical community must also be heard. Thus, given the traditional abuse of this responsibility by health officials, it is imprudent to continue to vest public health officials sole authority during states of “public health alerts”—particularly when they’re so poorly defined and entail such a low threshold to demonstrate.

WHAT IS POLIO?

Poliomyelitis is the inflammation of the gray matter of the spinal cord. Its clinical symptoms are varied, and in most cases, oddly enough, do not involve the spinal cord at all. Medical manuals report that most cases of polio are of a minor nature, the symptoms, if any, being fever, malaise, drowsiness, headache, nausea, vomiting, constipation, or sore throat in various combinations. The disease may last from 2 to 10 days, with recovery being rapid and complete. The more serious forms produce stiffness and pain in the back and neck and occasionally paralysis of some parts of the body, usually temporary. Death does occur, but infrequently.

What is the Cause of Polio?

Conventional medicine believes that polio is caused by a microbiological agent—poliovirus—for which a vaccine would be an appropriate preventative of the disease. Yet the viral mechanism to account for paralytic polio has yet to be established. (Similarly, the chemical mechanism for most viral diseases, including smallpox, have yet to be described.) While scientists can isolate the virus from tissue, and believe they know which part of the virus is responsible for attacking the nervous system, virologist Jonathan Weber, senior lecturer at the Royal Postgraduate Medical School in London—in an essay arguing that HIV is the cause of AIDS—wrote in the *New Scientist* (May 5th, 1988, page 32) that, “...the relationship between the virus and paralytic polio is still [merely] an epidemiological association; the majority of infections with polio virus do not lead to paralysis, the clinical manifestation of the illness.”

Indeed, that may be an understatement. Boyd’s *Textbook of Pathology* (8th Edition, 1984) states, “90-95% poliovirus infections are inapparent”—which means the virus doesn’t produce any symptoms of disease in almost all people who are infected with poliovirus. Among the 5-10% who do exhibit symptoms, the virus causes “a mild disease of headache, nausea, and fever. A few cases progress to aseptic meningitis, consisting of pains in the back and neck, ending in rapid and complete recovery. In less than 2% of total cases, poliovirus infection causes flaccid paralysis, frequently with...loss of muscle enervation, which may be prolonged and is often irreversible.” Nevertheless, according to Muir’s *Textbook of Pathology*, 9th Edition, 1972, polio cases WITHOUT paralysis are about 20 times as common as paralytic cases. And that, “such cases are difficult or impossible to recognize

on clinical grounds alone, since they simulate minor gastrointestinal or respiratory infections from other causes”—not unlike a severe cold. And prior to the Salk vaccine, there were no virus confirmation tests. Thus, one wonders today how polio could have struck terror in people a half century ago. As it turned out, a public relations campaign can take credit for that. (More on that later.)

Some believe that gene fragments (viruses) that have been associated with polio and all its clinical twins may be mere happenstance, or at best serological markers, possibly from the putrefaction of proteins in the blood, which is more likely responsible for the various forms of the disease. Other non-viral contributing factors that have been suggested range from vitamin and mineral deficiency, to toxicological, to factors that hinder our capacity to manage toxins and metabolic waste—such as tonsillectomies—as was suggested by Boyd’s Textbook. While there are currently “only” a couple of hundred thousand tonsillectomies performed annually, the operation had peaked in medical popularity to 2 million during the 1930s and 40s—the same years that paralytic polio began to develop in significant numbers.

Another cause of paralysis that displaces the poliovirus theory may be pesticides. A great deal of evidence for this is displayed on Jim West’s (harpub@hotmail.com) website, www.bcity.com/harpub. Insightful commentary regarding this polio site may be found at: www2.prestel.co.uk/littleton/index.htm

DETERMINING CAUSE AND EFFECT

The reader should be aware of a scientific axiom that is often forgotten or ignored by medical researchers: *correlation does not prove causality*. The mere presence of viruses, viroids or fragmented genes during disease may merely be coincidental, or a derivative of the underlying condition, and does not demonstrate causality.

For example, there was an abundance of different serological markers that correlated as highly to the various AIDS-defining diseases as HIV had. One or more of these indicators may have at least provided clues to the cause of the syndrome, though not necessarily represent the cause in and of itself. Yet not surprisingly, it was NCI researcher Robert Gallo, a specialist in retroviruses, who claimed that a retrovirus was the cause of AIDS. Soon after that claim, without a single study published that indicted HIV, HHS Secretary Margaret Heckler announced that HIV was the cause of AIDS, and that research grants would be available to those who wish to study that virus. Everything that happened since then was inevitable: Hence, a virus that has barely enough genes to enable it to reproduce itself, is now deemed to be the cause of over 30 exceedingly disparate and deadly AIDS-defining diseases.

Correlation and causality in the epidemiology of AIDS is just one of the subjects discussed in “Infectious AIDS: Have We Been Misled?” (©1995, North Atlantic Books), Renowned virologist Peter Duesberg mentions hundreds of diseases previously thought to be microbial were later shown to be toxicologically induced or nutritional deficiencies (p.330). The book is a compilation of Duesberg’s published articles (in the Proceedings of the National Academy of Sciences, for example) that disputes the HIV theory of AIDS. His other book, “AIDS: Inventing The AIDS Virus” (©1996, Regnery Publishing, Washington, D.C.) is an excellent companion book for the layperson, and provides fine analogs to the 1950’s polio “epidemic”, as both slap new labels to previously existing disease complexes.

What is the Cause of Paralytic Polio?

While conventional medicine has yet to suggest a direct viral mechanism for polio, there are plausible toxicological mechanisms. One such mechanism to account for paralytic diseases may be manifested by vaccination itself. In addition to highly antigenic (toxic) proteins and foreign viral particles, vaccines contain poisonous preservatives, adjuvants, neutralizers, carrying agents and extracting agents, such as thimerosal (a mercury derivative), benzethonium chloride, methyl paraben, phenol red, pyridene, ethanol, ethylene

chlorophyrin, aluminum hydroxide, aluminum hydrochloride, sodium hydroxide, aluminum sulfate, aluminum potassium sulfate, sorbitol, hydrolyzed gelatin, carbonic acid, thiosalicylic acid, and formaldehyde (in the form of formalin).

None of these chemicals are indigenous to the body, yet they're injected directly into the bloodstreams of two, four, and six month old infants—whose immune systems are not fully developed—bypassing important mucosal immune system barriers, as well as the liver, whose purpose it is to filter poisons before it gets into the blood. The medical literature and toxicology textbooks rank these chemicals as highly toxic poisons and potent carcinogens. The other component in vaccines—foreign proteins—can act as allergens, in which the most acute reaction may be anaphylactic shock, possibly leading to convulsions and death within minutes.

Injected proteins are also the likeliest suspects in causing paralytic symptoms. In the absence of digestive juices in the blood, these proteins decompose (putrefy) yielding extremely poisonous endotoxins, like ptomaines, creatins, xanthins, purines, indoles, skatols, phenols, leucomaines, uric acids, and indoxyl-sulphuric acids. These toxins are often eliminated (removed from the blood) vicariously through the mucous membranes or by diffusion into the spinal fluid. In the former, this irritating excretion causes an inflammation attended by mild fever, malaise, perhaps slight stiffness in the neck, with recovery in a few days for most children. In the latter case, if the child is already in a toxic state, with subnormal adrenal glands, the toxins build up in the mucous membranes of the sinuses. As the membranes of the brain are in close proximity, it is a simple matter for these fluids to penetrate brain tissue and the spinal cord. Stiffness and paralysis follows from that. The prognosis for recovery hinges on how quickly these toxins can be eliminated from the system, and may account for numerous reported clinical successes through fasting and detoxification supervised by chiropractors and naturopaths during the 1950s through to today.

Undigested Proteins From Diet

Whether it's from injected chemicals or protein toxins, if the cause of paralysis is indeed toxicological rather than microbial, we can expect to see examples of dose-dependent relationships that are characteristic of the former. And in fact there is a dietary link that conforms to this mechanism that may account for the generally milder forms of the disease (e.g. non-permanent weakness and stiffness of the muscles in the limbs). This diet may involve toxemia caused by the residue of "acid-type foods", compounded by foods containing refined sugar that adversely affects calcium and bone metabolism:

The end products of digestion are either acid or alkaline, depending upon the kind of food eaten. Meat, eggs, pasteurized milk and dairy products, breads, cereals, refined foods and most cooked foods are decidedly acid in reaction, producing great excesses of phosphorous, sulfur and chlorine. Raw fruits and vegetables provide the alkaline mineral salts (calcium, magnesium, iron, etc.). An alkaline blood and lymph is necessary to life and health, since the cells of the body are bathed in alkaline fluids. The body uses its alkaline mineral salts to neutralize acids, and if these acids are allowed to accumulate excessively, the alkaline minerals will be leached from the tissues to serve this function. Calcium, being the most abundant and readily available alkaline mineral (bones, teeth, etc.), is sacrificed in this way. Pasteurized milk, being extremely acid-forming in reaction (as opposed to raw milk, which is alkaline), necessitates the withdrawal of calcium from the body. In fact, all acid-forming foods require neutralizing, and thus cause a depletion of the body's alkaline reserve. In short, humans require an alkaline-forming diet for health. An acid-forming diet causes disease.

There is evidence to show that in all cases of polio, there is a deficiency in blood calcium. What lowers blood calcium? Acid-forming foods (practically everything except raw fruits and vegetables) and refined sugar in any form—ice cream, cola drinks, cakes and pies, ketchup, white flour, malteds, ices, etc., all steal calcium from the body. Refined sugar is converted (decomposes via fermentation) into alcohol almost immediately after it is taken into the body and does the same damage that alcohol does. It dehydrates the cells and leeches calcium from the

nerves, muscles, bones, teeth, and all other tissues that are supplied with calcium. Refined sugar is absorbed into the blood almost immediately, causing the blood sugar level to rise, thus producing more and more carbonic acid. Carbonic acid has a chemical affinity (attraction) for minerals, especially calcium, which it dissolves from the teeth and bony structures. The bloodstream, acidified by sugar consumption, has a corrosive action on the minerals of the teeth. It is calcium particularly, which is dissolved and a serious calcium deficiency is a forerunner to polio.

For example, consider ice cream consumption by children. Unlike meat, ice cream—containing huge amounts of protein and sugar—may be consumed in prodigious amounts. It is also cold, and therefore in a state that is difficult to digest. What does not digest will decompose, leading to the poisoning mechanism described earlier. The rise of polio (known as the “summertime disease”) and its symptomatic twins can be traced to the widespread introduction of refrigeration and the increased consumption of ice cream and other concentrated protein foods. In fact, the well-known piercing pain—known as “brain freeze”—that many people feel behind their nose, eyes, or temples right after eating ice cream may be explained by protein toxins building up in the mucous membranes of the sinuses, described earlier.

A campaign to restrict ice cream and sugar consumption—instituted in 1948 by Dr. Benjamin P. Sandler, a medical doctor and nutrition expert at the Oteen Veteran’s Hospital, N.C—had led to drastic declines in the incidence of polio. In just one year the number of polio cases dropped 90%. The North Carolina State Board of Health reported 2,498 cases of polio in the Tarheel Commonwealth during 1948. In 1949—after that campaign began—that figure dropped to 229 (with no polio vaccine available yet). Dr. Sandler’s researches showed specifically that the modern tendency to consume excessive amounts of cola and fountain drinks and frozen foods in hot weather, loaded with refined sugar, was responsible for the rise in polio cases. The phosphoric acid in soda absorbs the phosphorus and sulfates in the foods we eat before they metabolize. The nerves are thus deprived of the necessary phosphorus and sulfate, and certain nerve trunks cease to function. The victim loses the use of one of more limbs.

This non-viral mechanism seems to confirm the epidemiology of this disease—one which generally affected affluent societies during the summer months. (In “The Mysteries Within”, author Sherman B. Nuland accurately conveyed what was observed at the time—that polio was a middle-to-upper class disease.) First, more frozen deserts and sweetened beverages are consumed during the summer months. Second, the affluent could better afford to avail their children with the services of physicians, and being better educated as well, would be more inclined to make sure that their children were fully immunized with the recommended (by 1944) doses each of diphtheria and pertussis vaccines. The pertussis vaccine has been the most notoriously associated with adverse neurological injuries. (The combined DPT vaccine was introduced after 1947, with the pertussis component still inducing the most damages according to VAERS data.)

Contracting polio by swimming in dirty ponds was obviously a whimsical notion for the virus hunters—one whose only virtue was that it validated their chosen career path in microbiology, and financially sustained their research in virology.

WHEN PARALYSIS FOLLOWS VACCINATION CAMPAIGNS

Neurological effects are the most commonly known reactions that follow vaccinations. In nearly 20% of VAERS reports, the first of eight listed side effects suggests central nervous system involvement. Examining the first listed effects shows about 4,600 involving such symptoms as prolonged screaming, agitation, apnea, ataxia, visual disturbances, convulsions, tremors, twitches, an abnormal cry, hypotonia, hypertonia, abnormal sensations, stupor, somnolence, neck rigidity, paralysis, confusion, and oculogyric crisis. The last is a striking feature of post-encephalitic Parkinson’s disease, or it may occur as a dystonic reaction to certain drugs such as

phenothiazines. The CDC admits that the results of ongoing studies on a potential association of hepatitis B vaccine and demyelinating diseases such as multiple sclerosis are not yet available.

Epidemiological evidence suggests that a common cause of polio epidemics has often been vaccination itself. Paralytic disease has been recorded hundreds of years ago. But epidemic numbers hadn't appeared until the latter part of the 19th century when compulsory smallpox vaccination was instituted. A major outbreak of infantile paralysis followed a diphtheria toxin-antitoxin vaccination campaign in the United States in 1916. Worst hit was New York City, where 9023 cases were reported with 2448 deaths ("Breakthrough: The Saga of Jonas Salk", by P. Carter). Pertussis and typhoid vaccination campaigns had also been implicated in outbreaks: Polio cases began to soar in 1948-9 when pertussis vaccine began.

And by January 1977, Langmuir (1979) reported that out of 43 million who were vaccinated with the Swine Flu vaccine, 3905 vaccine injury claims were filed, with 500 cases of Guillain-Barré syndrome (GBS) medically established, and 25 deaths. The relative risk of acquiring GBS during the six weeks after vaccination was about ten (10) times the endemic expectation (i.e.: blood poisoning from other sources).

A report on Vaccination and Immunization, published by The Howey Foundation, Surrey, England (which takes an impartial look at all vaccination procedures) stated flatly:

"It is now accepted that paralytic poliomyelitis was precipitated by diphtheria vaccines and tonsillectomies, and other vaccines have also been implicated. This almost certainly accounts for the sudden upsurge between 1940 and 1950 of what had been a declining disease...Since the introduction of poliomyelitis vaccine there have been many cases of poliomyelitis in fully vaccinated persons and instances of the vaccine actually leading to the disease."

Finally, in April 2005, Harold E Buttram, M.D., wrote the following in his article, "Vaccines and Immune Suppression", at http://www.redflagsweekly.com/articles/2005_apr07.html:

In the text, The Hazards of Immunization (*), by Sir Graham Wilson, there is a chapter entitled "Indirect Effects (of Vaccines): Provocation Disease." Although Wilson was not in principle opposed to immunizations, the book was directed at a review of known or suspected adverse effects from vaccines. In this particular chapter, one of the examples was that of the typhoid vaccine given to members of the German Army during World War I; that is, if typhoid vaccine were given during the incubation phase of this disease, the vaccine sometimes provoked a sudden and severe attack of typhoid fever. The same applied for poliomyelitis, about which Wilson quoted a variety of published reports showing that children had many times greater incidence of poliomyelitis who had received an injection of DTP vaccine in preceding 4 to 6 weeks as compared with uninoculated groups, or those not recently immunized.

* The Hazards of Immunization, Sir Graham Wilson, Athlone Press, University of London, 1967, Pages 265-280.
(note: this out-of-print book is available free to activists and researchers from Coalition For Informed Choice.)

continued next page . . .

Sidebar information:

Irish Examiner Archives: 08/05/03
<http://www.irishexaminer.com>

Ryle Dwyer—journalist with the Irish Examiner (Irish Examiner, May 1)—writes on the horror of the 1918-20 pandemic which the propaganda says was caused by Spanish flu.

How did they know it was the virus of Spanish flu that killed millions of civilians and soldiers? This disaster occurred when viruses were unknown to medical science.

It took a British science team to identify the first virus in man in 1933.

As regards the origin of the outbreak, he relates that a senior US army officer suggested that the Germans might have been responsible for the bug as part of their war effort, by spreading it in theatres or where large numbers of people assembled. Did they also spread it among their own people, killing 400,000 as reported?

Ryle would have us believe that all those American soldiers who died from non-combatant causes may have died from Spanish flu. But US Army records show that seven men dropped dead after being vaccinated.

A report from US Secretary of War Henry L Stimson not only verified these deaths but also stated that there had been 63 deaths and 28,585 cases of hepatitis as a direct result of yellow fever vaccination during only six months of the war.

That was only one of the 14 to 25 shots given to recruits.

Army records also reveal that after vaccination became compulsory in the US Army in 1911, not only did typhoid increase rapidly but all other vaccinal diseases increased at an alarming rate. After America entered the war in 1917, the death rate from typhoid vaccination rose to the highest point in the history of the US Army.

The deaths occurred after the shots were given in sanitary American hospitals and well-supervised army camps in France, where sanitation had been practised for years. The report of the Surgeon-General of the US Army shows that during 1917 there were admitted into the army hospitals 19,608 men suffering from anti-typhoid inoculation and vaccinia.

This takes no account of those whose vaccine diseases were attributed to other causes. The army doctors knew all these cases of disease and death were due to vaccination and were honest enough to admit it in their medical reports.

When army doctors tried to suppress the symptoms of typhoid with a stronger vaccine, it caused a worse form of typhoid paratyphoid. But when they concocted an even stronger vaccine to suppress that one, they created an even worse disease Spanish flu.

After the war, this was one of the vaccines used to protect a panic-stricken world from the soldiers returning from WWI battlefronts infected with dangerous diseases.

The rest is history.

Source: http://www.examiner.ie/pport/web/opinion/Full_Story/did-sg0mhRGR66i1Msgdq-nXIDaYFE.asp

Chemicals vs. Microbes

We can test the non-viral mechanism further. As mentioned before, toxicological diseases are dose-dependent: The more toxins there are, the more disease. Polio is an “endemic” disease—habitually appearing in limited and consistent numbers in all parts of the world. But when epidemics have appeared, they were usually preceded by toxicological assaults that could account for them. One type of assault has been vaccination. Encephalitis and paralysis has been established clinical “side effects” of vaccination. And parents of children with these neurological injuries typically report that the more severe and permanent symptoms occurred after followup vaccinations and boosters—often after the physician assured the parent that the reactions from the initial vaccines were “harmless” and “normal”. Recent books about the autism epidemic, such as David Kirby’s “Evidence of Harm”, document how the chemical preservative, Thimerosal, seems to have a cumulative effect on children genetically predisposed to the biological mechanism hypothesized therein.

All in all, neurological injuries following vaccination seem to increase in severity and type following additional vaccinations. This is the hallmark of the dose-dependent relationship of chemical toxins. The bias in the medical establishment favoring microbial evidence of causation is not only a common scientific bias (searching in a familiar venue), but also an institutional bias (it validates the institutions and careers so heavily invested in the hunt for microbes and the diseases to blame on them).

Certainly many deem it heretical to suggest that the 1950s polio epidemic was not caused by polio virus. Equally so with the claim that the AIDS pandemic is not caused by HIV—despite the unprecedented branding of the name with the subtitle, “*the virus that causes AIDS*”. (I would venture that it was and is a desperate attempt to shut down further debate and challenges from the growing number of renowned scientists who have joined the Group for the Reappraisal of HIV-AIDS) It’s nevertheless instructional to realize that the medical establishment is capable and intent upon blaming microbial agents for non-microbial diseases: poisons from decomposing proteins, or pesticides or other substances in the case of polio, and long-term recreational drug abuse in the case of AIDS.

My First “Exposure”

This section on Legionnaires’ Disease illustrates how illnesses from chemical toxins are erroneously attributed to infectious microbiological agents. You’ll also read in the section that follows, several state public health officials during the 1950s declare the polio campaign a fraud. To allege that fabricating an epidemic is possible opens the door halfway into accepting these ‘heresies’. But actually *Believing* that the fraud occurs routinely opens the door completely. My first inclination to *believe* this occurred before I had any knowledge about the fallacious contentions regarding polio and smallpox. In 1979, I read a three-page article that started to change my perspective. The protagonist in “*What Dr. Runsdorf Knows (And the Government Doesn’t) About Legionnaires’ Disease*” (Phil Patton, New York magazine, January 29, 1979, p.30) was a Brooklyn surgeon whose independent investigation into the outbreaks of pneumonia revealed that they were not infections from a bacterium, as the CDC concluded, but rather a chemical toxin.

The first incident occurred in August 1976, when the disease struck an American Legion convention at the Bellevue Stratford Hotel in Philadelphia, eventually killing 29 of the 180 people in which *Legionella pneumophila* was later detected. I recall the news reports at the time, and had no reason to question the experts.

But Dr. Harold Runsdorf, a 70-year-old physician and inventor, was perhaps in the best position to realize that the CDC was wrong when it proclaimed *Legionella pneumophila*, “a previously unknown bacterium”, as the cause of Legionnaires’ Disease (LD). When he was an engineering student, he developed a turbine engine that ran on the fluorocarbon, Freon. But he learned in engineering school the problem with fluorocarbons as a fuel: At temperatures above 500 degrees Fahrenheit they “pyrolyze”, or break down, into dangerous gases.

For two years prior to the publication of Phil Patton’s article about him, Runsdorf had been pursuing the theory that Legionnaires’ Disease was actually caused by the pyrolyzed products of refrigerants leaking from air conditioners. The predominant byproduct is phosgene gas, which had been the most common poison gases used in World War I. He eventually learned that cases of poisoning occurred only where there was air conditioning and some heat source hot enough to convert the refrigerant to phosgene. When the cause of the disease still eluded public health officials, the air-conditioning maintenance crew in his hospital felt that phosgene gas could have been carried through the ventilation ducts.

Exposure to the gas may provoke slight irritation, or no symptoms at all until several hours or even several days later. The symptoms include headache, nausea, and a tightness in the throat and chest. These symptoms may progress to chills, shock, delirium, a dry cough, and high fever (102-105 deg.), as fluid builds up in the lungs.

These symptoms—including kidney failure that may develop 72 hours later—mimic pneumonia. Indeed, the delayed expression of symptoms following exposure made it easy for the microbiologists at CDC to believe they were dealing with a biological pathogen. The lack of contagion didn't dissuade them.

A piece of evidence that favored the phosgene gas theory was the finding of particles of nickel in the lungs of some of the dead Legionnaires. Runsdorf realized that the highly corrosive hydrogen fluoride from decomposed refrigerant had reacted with the CDC's stainless-steel containers holding the tissue samples, yielding the large quantities of nickel, whose presence the CDC couldn't account for any other way. Prior to this finding, Runsdorf was alert to this possibility and had warned against the use of stainless steel instruments and containers.

Patton wrote that neither the CDC nor public health officials knew about phosgene, nor were they interested in Runsdorf's ideas. Leonard Bachman, Philadelphia's secretary of health who was heading the investigation of the Bellevue Stratford Hotel outbreak was not interested. Runsdorf brought his case to medical officials in that city—Marvin Aronson and Lewis Polk—and the district attorney's office, and the NY Daily News, and the NY Times, and ABC News, and Philadelphia magazine, and CBS News. Only the last two did stories on his hypothesis. Runsdorf testified in hearings in Philadelphia in November 1976, held by the House Interstate and Foreign Commerce Committee. Ironically, the only affirmative response came from the manufacturer of the refrigerant used at the Bellevue Stratford Hotel. Refrigerant "F-11" was a trademark of DuPont, which threatened Runsdorf with legal action.

But mainly, Runsdorf tried to sell his theory to the CDC, which ultimately took over the investigation. He also begged them to test for fluorine. The CDC replied that no assay was performed because "*the relatively high background levels of tissue fluorine resulting from fluoridation of water would have made interpretation of the findings extremely difficult.*" But the concentrations in water was very low—1 part per million—and would have been lower still in tissue samples. Patton wrote that *quantitative* tests for fluorine could have been significant.

Dr. John Marr, director of the Bureau of Preventable Diseases, considered Runsdorf's theory. According to Patton, Marr felt that while the theory was hard to prove, it was also "very hard to disprove." It was hard to prove because cooling devices using Freon included air conditioners in buildings and cars, refrigerators, and heating pumps. Runsdorf had to demonstrate that there occurred some scenario of Freon leakage from such devices, *and* that a conversion to phosgene had taken place.

For the first case at the Bellevue Stratford Hotel, there appears to have been a Freon leak. The hotel manager testified before the House panel that the air-conditioning system was leaking F-11, the most easily pyrolyzed of all refrigerants. Experts thought the leak was coming from the compressor in the basement. After the leak was repaired, service technicians reported that large quantities of F-11 had to replace what had been lost from the leakage.

Burning cigarettes or the brushes of the compressor motors could have converted the Freon to phosgene. But Congressional testimony established the incinerator in the basement operated from 7am until 5pm. Congressional investigators thought that the incinerator may have been working overtime, due to the garbage strike that summer. Both the compressor and the incinerator—glowing white hot—were located in the same 60 by 40-foot room in that hotel basement. The CDC investigators failed to note these facts.

Congressional investigators also confirmed there was an exhaust fan in that basement which would have drew any gas escaping from the compressor over the hot incinerator, and into ducts ventilating the ballroom where the Legionnaires met. Patton wrote that "*it was also linked to an exhaust pipe Bellevue Alley, behind the hotel, where a large number of those suffering from the so-called Broad Street pneumonia, a less severe form of LD,*

remembered walking.” To Runsdorf, the varying intensities of the illness supported a chemical rather than a bacterial agent.

Runsdorf suggested that the conditions in the hotel basement could have been duplicated for purposes of testing. He also sought to test tissue samples taken from the lungs of dead Legionnaires for concentrations of fluorine. That request was repeatedly denied by the CDC. However, eventually he was able to surreptitiously obtain the lung specimens, through a Philadelphia health official. He sent those samples to the NYC medical examiner’s office for chemical testing. The tissue preserved by freezing confirmed high levels of fluorine compared to controls. But fluorine had leached out of the sample that was preserved in formalin. Runsdorf requested the formalin that was used in preserving the other samples. The CDC promised to furnish it, but never had.

Patton delineated close to a dozen other outbreaks in various cities that Runsdorf studied, ranging from 1965 to 1978. On that last one—August, 1978—two years after his investigations had begun, two fatal cases of LD had been confirmed, and 17 suspected cases were observed on Seventh Avenue in the garment district of New York City. LD bacterium was found in the cooling tower at Macy’s department store.

(Note: The CDC report on it failed to explain why there were only those 17 confirmed cases, even though its own sampling found that a quarter of the entire population of Manhattan showed positive blood tests for the LD bacterium. Regardless of Runsdorf’s theory, that alone should have demolished the CDC’s bacteria theory.)

Patton describes how Runsdorf, on September 1, 1978, used his GE Type H-10 halogen detector—which lights up in the presence of fluorocarbons—to pinpoint the actual location and likely cause of the Macy’s outbreak. The heavier-than air Freon likely fell from the roof or upper stories of the tall New York Telephone Company headquarters, onto the roof of a shorter building at 249 West 35th Street. On the street level in front of that address, his halogen detector flashed red, indicating the presence of fluorocarbons. This was the area in which one man died and his two brothers became ill with LD, while unloading garments from trucks and moving them into the Interstate Dress Carriers warehouse. Other cases in the same area included a shipping clerk and an elevator operator for Interstate, and a policeman who walked the beat on that block.

Runsdorf believed that the heat source that pyrolyzed the refrigerant were the engine manifolds of the delivery trucks idling along 35th Street. He was unable to confirm the leak, because the telephone company would not allow him access to their air-conditioning system. However, Patton found sources within the company who reported an unusually high number of telephone operators—as many as 3 dozen—became ill during the period of the outbreak. Perhaps some of the gas had penetrated the building through windows, vents, or doors.

The CDC’s final tally was 3 fatalities and 57 cases, including suspects. The CDC and the city’s health and buildings inspectors would not check the area for air-conditioning leaks. Patton noted that this was due mainly to their bias in favor of a bacterium. He wrote that the CDC never gave serious consideration to the phosgene gas theory, even though it cropped up in the press several times. He explained that *“the reason lies in the heart of the whole biological—and bacteriological—bias built into the disease-control agency, a bias all the more inappropriate as more and more toxic agents turn up in our environment.”* I’ve seen abundant evidence of this bias ever since I read Patton’s words.

Patton ended his article with a quote from Runsdorf: *“I’m 70 years old. I just want to prove this damn thing and die.”* I spoke to Runsdorf once, not long before he passed away around the mid 80s. He was far from a germ theory denialist, as I had hoped. He was able to gain allies for his phosgene theory, such as the American Society of Sanitary Engineers. And his questions persist after his passing, such as, “Why doesn’t the CDC test for fluorocarbons”; “Why are air conditioning systems always involved?”; etc.

Personally, I wonder how many cases of phosgene poisoning have since become diagnosed as the disease in fashion at the time? For example, given the similarities in symptoms, such cases might be diagnosed today as West Nile infections.

As a **postscript** to this subsection on LD, I'll just note the following: People exposed to chemical toxins can become ill, and in the process, their own bodies will generate abnormal strains of microbes to deal with the crisis. Researchers tend to select the microbe that most correlates to those who are ill, and attribute that as the cause of the illness. It's beyond the scope of this article to get into this process. Just suffice to say that the ability to isolate novel strains of bacteria or viral fragments in sick people exposed to the same environmental factors does not mean that those microbes had *caused* the illness. Whether the suspect microbe devolved endogenically within the host from exposure to those toxins, or was an exogenic viral or bacterial transmission, mere presence doesn't prove causation. At best, their detection are serological markers for exposure. Exposure to *what*, and whether or not it caused the disease, requires further proofs.

This is the distinction that many don't understand at first when introduced to Natural Hygiene: Pathogenic microbes are transmissible from person to person. But the the diseases they're alleged to produce are not. Pidoux expressed the theories of microbiologists Antoine Bechamp and Jules Tissot most succinctly when he wrote: "Diseases are born of us and in us."

Yet open any bacteriology textbook assigned to medical students today, and the cause of Legionnaires' Disease is ascribed to the bacterium, *Legionella pneumophila*. The same applies to poliovirus as the cause of paralytic polio.

THE POLIO CAMPAIGN: THE EPIDEMIC THAT NEVER WAS

Returning to the issue of vaccine-induced paralysis, the vaccine that had caused that greatest numbers of paralytic cases, ironically, was the vaccine intended to end paralysis forever. Publicity for polio received a boost in 1938 when President Franklin D. Roosevelt established the National Foundation for Infantile Paralysis (NFIP), and placed his friend, Basil O'Conner in charge of it. O'Conner was considered one of the greatest publicists of his time.

In the late 1940' and early 1950's, he inundated the world with reports of raging polio epidemics. The National Foundation mounted a continuous publicity campaign which reached the entire country with such reminders as the sight of paralyzed victims on crutches, or with names such as the "iron lung," the device used to help "bulbar" cases of polio (paralyzed chest muscles) to breathe. The word polio took on extraordinary emotional connotations, and the Foundation's annual March of Dimes became a fantastically successful fund-raising operation.

In 1952 Jonas Salk stepped into the spotlight. At that time, Salk was a research professor at the University of Pittsburgh and had been enlisted by Basil O'Connor into the National Foundation's polio research program. Salk did not offer a cure for polio. He sought a preventative—a vaccine which he tested on a small scale in 1952 and 1953.

1955: Salk Vaccination Begins

Salk vaccinations began in the U.S. in April 1955. Only two months into the Salk campaign, the U.S. Public Health Service, on June 23, 1955, announced that there had been 168 confirmed cases of poliomyelitis among the vaccinated with six deaths. The News Chronicle of May 6, 1955, reported:

“The interval between the inoculation and the first sign of paralysis ranged from 5 to 20 days and in a large proportion of cases it started in the limb on which the injection had been given. Another feature of the tragedy was that the numbers developing polio were far greater than would have been expected had no inoculations been given. In fact, in the state of Idaho, according to a statement by Dr. Carl Eklund, one of the government’s chief virus authorities, polio struck only vaccinated children in areas where there had been no cases of polio since the preceding autumn; in 9 out of 10 cases the paralysis occurred in the arms in which the vaccine had been injected.”

In June, 1955, James C. Spaulding, a staff writer for the Milwaukee Journal covered an American Medical Association convention. Here is what Spaulding learned and reported on June 19, 1955:

“A policy of secrecy and deception has been followed by the National Foundation for Infantile Paralysis and the U.S. Public Health Service in the polio vaccine programs. As a result the nation’s physicians were prevented from learning vital information about the trouble in making and testing Salk vaccine... The secrecy and deception started before the field trials.”

“One of the things the AMA was not told was that the USPHS had an advisory group made up almost entirely of scientists who were receiving money from the National Foundation for Infantile Paralysis, which body was exerting pressure to go ahead with the program, even after Salk vaccine was found to be dangerous.”

“In May, some state public health officers met in Atlanta, expecting to be told what had gone wrong with the vaccine program. Instead, the USPHS scientist said he was not permitted to disclose what had happened because it would jeopardize the investment of the pharmaceutical firms in the vaccine program.”

Suppressed reports condemning the Salk vaccine by technicians at the National Institutes of Health, was reported in, *The Drug Story* by Morris Bealle. Among the stories carried in this book is the one that James A. Shannon, M.D., of the National Institutes of Health in Washington, D.C., knew about the reports from the Institute’s technicians in 1955, that *“Salk vaccine was a killer and totally ineffective as a preventative.”* As a result of these reports of the Institutes Technicians, no official of the NIH would permit the vaccination of their own children with the Salk vaccine. Word of this leaked out when Robert S. Allen, Washington correspondent, reported in the *New York Post*, June 8, 1955, that *“Doctors and others on the staff of the National Institute of Health are not inoculating their own children with the Salk Vaccine.”* *“Nevertheless,”* says Mr. Bealle, *“on orders from higher-ups in the U.S. Public Health Service, they kept quiet and let hundreds of unfortunate children be killed and thousands maimed for life.”*

By contrast, the editor of *“The Lancet”* (June 11, 1955) wrote: *“In addition to the possibility of producing the very disease the vaccine is used to prevent, there is a risk, of unknown dimensions, that repeated injections of a vaccine prepared from monkey kidney may eventually sensitize the child in some harmful way.”*

In July, 1955, Dr. Graham S. Wilson, Director of the Public Laboratory Service of England and Wales (and also Honorary Lecturer in the Department of Bacteriology at the London School of Hygiene and Tropical Medicine), who knew about the secret field trials conducted by the NIH, announced, *“I do not see how any vaccine prepared by Salk’s method can be guaranteed safe.”* (*American Capsule News*, January 21, 1956). In 1967, Sir Graham S. Wilson, M.D., LL.D., F.R.C.P., D.P.H., published one of the most scathing indictments of vaccination: *“The Hazards of Immunizations”* (Univ. of London, The Athlone Press. 324 pages.)

PARALYSIS INCREASED FOLLOWING THE SALK VACCINE

An Associated Press Dispatch from Boston on August 30, 1955, reported 2,027 cases of polio in Massachusetts against 273 the same time the previous year—representing an increase of 743%. This followed the inoculation of

130,000 Massachusetts children, and the authorities banned the vaccine. Connecticut reported 276 cases in 1955, up from 144 in 1954; Vermont, 55 up from 15; Rhode Island, 122 up from 22, and Maine, 74 up from 43.

The Washington D.C. Star, September 20, 1955, reported 180 cases in Washington against 136 the same time in 1954; Maryland's Health Department reported 189 in 1955 to 134 in 1954; New York State, 764 to 469; Wisconsin, 1655 to 326. The Milwaukee Journal, on August 30, 1955, reported that the city's schools closed indefinitely because of the polio outbreak, following inoculation with the Salk vaccine.

Idaho stopped Salk inoculations completely on July 1, 1955, with this blast from State Health Director Peterson said, *"I hold Salk vaccine and its manufacturers responsible for a polio outbreak that has killed 7 Idahoans and hospitalized 79."* By September 14th 1955, that state had 190 cases compared with 132 for the entire year of 1954. Newark, N.J. stopped inoculations in June, 1955, while Utah took similar action on July 12.

An Associated Press dispatch on November 11, 1955, quoted Dr. Herbert Ratner, Health Commissioner of Oak Park, Illinois, who said that *"English authorities in July, 1955, canceled the Salk vaccine programs as 'too dangerous', and all European countries, with the exception of Denmark, have discontinued their programs."* Canada also postponed its Salk vaccine program on July 29, 1955.

The New York Times on May 11, 1956, reported on Supplement No. 15 of the Poliomyelitis Surveillance Report for the year which showed 12% more paralysis in 1956 than in 1955. By January 1, 1957, 17 states had rejected their supplies of Jonas Salk's "anti-paralytic" polio vaccine. During this year very nearly half the paralytic cases and three-quarters of the non-paralytic cases in children between the ages of 5 and 14 years occurred in "vaccinated" children.

The Expert Committee on Poliomyelitis of the World Health Organization stated in its Technical Report Series, No. 145 (Second Report, p. 34 Geneva, 1958) that:

"It was noted in the Union of South Africa and in the USA, especially in the course of severe outbreaks in Hawaii and Chicago, that vaccination in the face of an epidemic did not appear to shorten its course. Laboratory and field studies have shown that vaccination does not prevent infection or interfere with dissemination of virus in the community."

Hawaii had an outbreak of polio in 1958. The Honolulu Advertiser on July 15, 1958, carried a statement by Dr. Enright of the Territorial Dept. of Health which broke down the figures as follows: *"Of the 32 discovered paralytic polio cases so far this year, six had 3 Salk shots, six had 2 shots, four had one shot, the rest, none."* Percentage vaccinated: 50%.

The Chicago Daily News, May 28, 1959, printed the following UPI dispatch from Duluth, MN:

"One of the developers of the new oral (polio) vaccine said Wednesday the recent use of Salk vaccine in Israel had 'little if any effect.' Dr. Herald R. Cox of Lederle Laboratories, ...suggested the ineffectiveness of Salk inoculations during a round table discussion at the Minnesota State Medical Association convention. Cox said a confidential report on a polio epidemic showed 90% of children under six years old in Israel were given Salk shots. But the outbreak became epidemic. It is evident that the vaccine failed, Cox said."

Polio cases rose about 300 to 400% in these 5 places that made the Salk vaccine compulsory by law:

—North Carolina: 78 cases in 1958 before compulsory shots. 313 cases in 1959.

—Connecticut: 45 cases in 1958 before compulsory shots. 123 cases in 1959.

—Tennessee: 119 cases in 1958 before compulsory shots. 386 cases in 1959.

—Ohio: 17 cases in 1958 before compulsory shots. 52 cases in 1959.
—Los Angeles: 89 cases in 1958 before compulsory shots. 190 cases in 1959.

By 1960, the Salk vaccine had proven to be so hazardous and ineffective, that the Journal of the American Medical Association (February 25, 1961) carried an article admitting that, *“It is now generally recognized that much of the Salk vaccine used in the U.S. has been worthless.”*

In his statement submitted to the House of Representatives Sub-Committee on Health and Environment, 94th Congress, Dr. Thomas E. Baynes (Assistant Professor of Law at Nova University Law Center, Fort Lauderdale, FL, under a contract with HEW, CDC, No. 39204) reported to our elected officials that:

“... In 1949, a polio vaccine was only a dream...now that dream has turned into a nightmare... The extent of litigation from vaccine injuries in humans had been minimal until the advent of the Salk and Sabin vaccines...Resultant litigation from vaccine injuries will require a reevaluation of current efforts to immunize vast numbers of people from communicable diseases.”

WAS THERE REALLY AN EPIDEMIC?

Contrary to popular mythology, it's clear from these reports that the Salk vaccine had been a disaster. The next question is whether there had actually been a polio epidemic in the 1950s? To determine that question, several issues have to be examined.

First, was polio increasing or decreasing going into that decade? Perhaps because of the effectiveness of the PR campaign then—and the lingering mythology today—most people didn't know that paralytic polio was substantially declining before the vaccine had been used, with a drop of almost 20,000 cases between 1952 and 1954, for example. This was also true in England, where polio mortalities was at its height in 1950, but had declined 82 percent by 1956 before the Salk vaccinations began there.

But despite this actual decline of paralytic polio, the polio PR campaign cited for 1952, for example, that polio had peaked at 57,879 cases. This disparity was due to statistical “flim-flam”: they swelled the statistics by combining the larger numbers of non-paralytic, “unspecified” and “abortive” polio cases with the dwindling numbers of paralytic cases. Almost two-thirds of this total were among the former—“non-paralytic” polio—a mild expression of symptoms no more serious than a bad cold. In the minds of millions of people—then and now—polio had meant “paralysis”. But by combining paralytic cases with the various milder, non-paralytic forms, the public was misled into thinking that paralysis was sweeping the land.

Thus, before the Salk vaccine began in 1955, cases that described a wide spectrum of symptoms of the disease were combined under one name: polio. That made it look like there was an epidemic. But after the vaccine was introduced, the reverse procedure was required to *demonstrate* that there were fewer cases and that the vaccine was successful. That procedure was to fractionate all those cases into several smaller classifications.

This method of hiding paralytic cases under names other than “polio” was discussed in 1960, during a panel discussion on *The Present Status of Polio Vaccine* (reported in the Aug.&Sept./1960 issues of the Illinois Medical Journal). One of the speakers at this panel discussion was Dr. Bernard G. Greenberg, Ph.D., head of the Department of Biostatistics of the University of North Carolina School of Public Health, and former Chairman of the Commission of Evaluation and Standards of the American Public Health Association. Greenberg pointed out that after 1955, *“Coxsackie virus infection and septic meningitis [so-called ‘polio twins’] have been distinguished from paralytic poliomyelitis. Prior to 1954, large numbers of these cases undoubtedly were mislabeled as paralytic polio.”*

Dr. Greenberg mentioned only two polio twins. But Dr. Ralph R. Scobey, President of the Poliomyelitis Research Institute, Syracuse, N.Y., in the Archives of Pediatrics, January, 1950, listed 170 diseases of “polio-like” symptoms and effects but with different names such as *“spinal meningitis, inhibitory palsy, epidemic cholera, cholera morbus, ergotism, famine fever, billious remittent fever, spinal apoplexy, scurvy, berri-berri, pellagra, acidosis, etc.”* In fact, symptoms from nutritional and toxicological factors overlap much of the “various forms” of polio.

Ernest B. Zeisler, M.D., in his article, *The Great Salk Vaccine Fiasco*, (Herald of Health, December, 1960) pointed out that there are over a dozen illnesses that are identical to paralytic polio. In addition, he presents a clear picture of medical guesswork that renders all polio statistics wholly unworthy of confidence:

“No attempt was made to eliminate personal bias in making the diagnosis of poliomyelitis. There are more than a dozen illnesses due to viruses other than those of poliomyelitis, which may be ‘indistinguishable from paralytic polio’ except by special virus studies. A physician seeing a patient with such paralytic illness at once inquires whether or not the patient has been vaccinated with the Salk vaccine, and his diagnosis is very likely to be influenced by his reply. Inasmuch as physicians have been convinced that triple vaccination is highly effective, they will make a diagnosis of poliomyelitis if there is no history of vaccination and will make a diagnosis of one of the other diseases if there is a history of triple vaccination.”

“Paralytic polio” seemed well buried with the additional classifications. After 1955, non-paralytic polio also acquired a new name. It wasn’t until the mid-1950’s that new laboratory techniques of culturing viruses could distinguish polio from its clinical twins (i.e. aseptic meningitis, etc.). Since the Salk vaccine had begun to be used in 1955, the huge swing from the incidence of polio to aseptic meningitis following that year indicated that (1) prior to the vaccine, clinicians had been over-diagnosing poliomyelitis in most instances when they had really been cases of aseptic meningitis, or just cases involving a bad cold, and (2) the apparent decline in polio due to the Salk vaccine was merely an artifact of diagnostic methodology (more of which is described below). That was the conclusion of Michael B. Gregg, M.D., Deputy Director, Bureau of Epidemiology of the CDC, from personal correspondence to Barry Mesh, dated 11/23/77 (copy of signed letter available upon request).

Statistics bear out the above item (2): Non-paralytic polio diagnosis was based on subjective clinical observation, not laboratory confirmation. Doctors diagnosed 70,083 cases of non-paralytic polio between 1951 and 1960. They simply called it “polio” for the popular press. And during this time, not one case of “aseptic meningitis” was reported. After 1960, “aseptic meningitis” began to displace “non-paralytic polio”. Non-paralytic polio became so rare that the MMWR stopped reporting it in 1983. What had been a (non-paralytic) polio epidemic before, is now an aseptic meningitis epidemic. These numbers were compiled from national surveillance reports from the MMWR for the years indicated:

Date	Non-Paralytic Polio	Aseptic Meningitis
1951-1960	70,083	0
1961-1982	589	102,999
1983-1992	0	117,366

Thus, non-paralytic polio may have “disappeared”. But thousands of children still experience the same symptoms as non-paralytic polio every year. It just goes by another name now.

At the aforementioned panel discussion in 1960, Dr. Greenberg also blew the whistle on the modified diagnostic criteria for polio. Prior to 1954, the diagnosis of spinal paralytic poliomyelitis in most health departments followed the World Health Organization definition: *“Signs and symptoms of nonparalytic polio with the addition of partial or complete paralysis of one or more muscle groups, detected on two examinations at least 24 hours*

apart.” But beginning in 1955, the criteria changed to conform more closely to the definition used in the 1954 Salk field trials: *“Unless there is residual involvement (paralysis) at least 60 days after onset, a case of poliomyelitis is not considered paralytic.”*

Obviously, more cases of paralysis had a chance to recover within 60 days, than in 24 hours. During the panel discussion, Dr. Greenberg commented, *“This change in definition meant that in 1955 we started reporting a ‘new’ disease, namely, paralytic polio with a longer lasting paralysis [than what was required before 1955]. As a result of these changes in both diagnosis and diagnostic methods, the rates of polio plummeted from the early 1950’s to a low in 1957.”* (a decrease of 23,500 cases from 1955 to 57.)

However, Dr. Greenberg pointed out that not even this artifactual decline could continue, after the Salk vaccine had been in widespread use for 2 years. He showed that nationally, paralytic polio increased about 50% from 1957 to 1958, and about 80% from 1958 to 1959.

Finally, the PHS redefined a “polio epidemic”: Before the introduction of the Salk vaccine, only 20 cases per 100,000 population was an “epidemic”. Afterwards, it required 35 per 100,000 per year. Considering all these manipulations to endow efficacy upon the Salk vaccine, to say that public health officials had moved the goal posts would be an understatement. They moved the stadium! This was not epidemiology.

Thus, polio had indeed been wiped out. But in name only.

Perhaps a good note to end this essay on is one which is emblematic of the soft science of polio diagnosis. In an article published in the Journal of Medical Biography on October 31, 2003), Armond Goldman, an emeritus professor of pediatrics at the University of Texas Medical Branch in Galveston, and three other doctors and a biostatistician, argue that President Franklin D. Roosevelt was probably paralyzed by Guillain-Barré syndrome, and not polio, as has been widely assumed. Guillain-Barré is an immune system disease that was barely recognized at the time Roosevelt lost the use of his legs. It is polio's closest mimic.

This assessment was described by Washington Post Staff Writer David Brown [www.washingtonpost.com, in *Study Challenges Polio as Cause Of FDR's Illness: Researchers Blame Guillain-Barré*, October 31, 2003; Page A03] as follows:

“Using the “attack rate” in adults recorded in a polio outbreak in 1916, and the current estimate for the rate of Guillain-Barré in adults, the researchers calculated there was a 39 percent probability that Roosevelt’s paralysis was caused by polio and a 51 percent chance that it was caused by Guillain-Barré. They then applied that probability to the signs and symptoms reported by Roosevelt himself, by relatives taking care of him, and by the physicians they consulted. Some of those features—such as fever typical of polio, and paralysis that is symmetrical side-to-side in Guillain-Barré—differ greatly between the diseases, and the precise frequency of each is known. By multiplying the disease probability by the symptom probability, the Texas researchers calculated a net probability for each of the eight features of FDR’s illness. Six of the eight favor a diagnosis of Guillain-Barré, according to this analysis.”

Acknowledgment: The above article is dedicated to the late Barry Mesh, who inspired his generation of vaccine awareness activists. As early as 1975, researcher Barry Mesh was perhaps the first to assemble the complete polio story of the 1950’s. In the speeches he delivered before Natural Hygiene groups (CDs available from CFIC), he painted a starkly different picture from the popularized legend of the Salk vaccine. The sections in this article on the Salk vaccine and Dr. Sandler are based on his research, plus other sources.

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POSTSCRIPT #1:

Excerpt From, “Immunization: The Reality Behind The Myth”,
By Walene James, ©1988, page 26, under the section, “Polio”:

The case of poliomyelitis is particularly instructive since its apparent decrease cannot be explained by such developments as sanitation, public water supplies, ventilation, etc. In fact, it is a disease that occurs only among the most civilized peoples with the highest standards of sanitation, etc., being unknown among preliterate cultures that have been relatively untouched by civilization.

Jonas Salk, the discoverer of the Salk polio vaccine, has been called the “twentieth-century miracle-maker” and the savior of countless lives. (W6) We read glowing reports of the dramatic decrease in poliomyelitis in the United States as a result of the Salk vaccine. For instance, the Virginia State Department of Health distributes a folder which tells us that polio vaccines have reduced the incidence of polio in the United States from 18,000 cases of paralytic polio in 1954 to fewer than 20 in 1973-78. A recent article in *Modern Maturity* states that in 1953, there were 15,600 cases of paralytic polio in the United States; by 1957, due to the Salk vaccine, the number had dropped to 2,499. (W7)

During the 1962 Congressional Hearings on HR 10541, Dr. Bernard Greenberg, head of the Department of Biostatistics of the University of North Carolina School of Public Health, testified that not only did polio increase substantially (50 percent from 1957 to 1958 and 80 percent from 1958 to 1959) after the introduction of mass and frequently compulsory immunization programs, but statistics were manipulated and statements made by the Public Health Service to give the opposite impression. (W8)

For instance, in 1957 a spokesman for the North Carolina Health Department made glowing claims for the efficacy of the Salk vaccine, showing how polio steadily decreased from 1953 to 1957. His figures were challenged by Dr. Fred Klenner who pointed out that it wasn't until 1955 that a single person in the state received a polio vaccine injection. Even then injections were administered on a very limited basis because of the number of polio cases resulting from the vaccine. It wasn't until 1956 “that polio vaccinations assumed ‘inspiring’ proportions.” The 61 percent drop in polio cases in 1954 was credited to the Salk vaccine when it wasn't even in the state! By 1957 polio was on the increase. (W9)

Other ways polio statistics were manipulated to give the impression of the effectiveness of the Salk vaccine were: (1) Redefinition of an epidemic: More cases were required to refer to polio as epidemic after the introduction of the Salk vaccine (from 20 per 100,000 to 35 per 100,000 per year). (2) Redefinition of the disease: In order to qualify for classification as paralytic poliomyelitis, the patient had to exhibit paralytic symptoms for at least 60 days after the onset of the disease. Prior to 1954 the patient had to exhibit paralytic symptoms for only 24 hours! Laboratory confirmation and the presence of residual paralysis were not required. After 1954 residual paralysis was determined 10 to 20 days and again 50 to 70 days after the onset of the disease. Dr. Greenberg said that “this change in definition meant that in 1955 we started reporting a new disease, namely, paralytic poliomyelitis with a longer lasting paralysis.” (3) Mislabeled: After the introduction of the Salk Vaccine, “Cocksackie virus and aseptic meningitis have been distinguished from paralytic poliomyelitis,” explained Dr. Greenberg. “Prior to 1954 large numbers of these cases undoubtedly were mislabeled as paralytic polio.” (W10)

Another way of reducing the incidence of disease by way of semantics—or statistical artifact, as Dr. Greenberg calls it—is simply to reclassify the disease. From the Los Angeles County Health Index: Morbidity and Mortality, Reportable Diseases, we read the following:

Date	Viral Meningitis or Aseptic Meningitis	Polio
July 1955	50	273
July 1961	161	65
July 1963	151	31
Sept. 1966	256	5

The reason for this remarkable change is stated in this same publication: “Most cases reported prior to July 1, 1958, as non-paralytic poliomyelitis are now reported as viral or aseptic meningitis.” (W11) In Organic Consumer Report (March 11, 1975) we read, “In a California Report of Communicable Diseases, polio showed a zero count, while an accompanying asterisk explained, “All such cases now reported as meningitis.”

There have been at least three major polio epidemics in the United States, according to Dr. Christopher Kent. “One occurred in the teens, another in the late thirties, and the most recent in the fifties.” The first two epidemics simply went away like the old epidemics of plague. Around 1948, the incidence of polio began to soar. (Interestingly, this is when pertussis—whooping cough-vaccine appeared, Dr. Kent points out.) It reached a high in 1949, with 43,000 cases, but by 1951 had dropped to below 28,000. In 1952, when a government subsidized study of polio vaccine began, the rate soared to an all-time high of well over 55,000 cases. After the study, the number of cases dropped again and continued to decline as they had in the previous epidemics. “This time, however, the vaccine took the credit instead of nature.” (W12)

The cyclical nature of polio is again illustrated by the remarks of Dr. Alec Burton at the 1978 meeting of the Natural Hygiene Society in Milwaukee, Wisconsin. Some years ago at the University of New South Wales in Australia, statistics were compiled which showed that the polio vaccine in use at the time had no influence whatsoever on the polio epidemic. Polio comes in cycles anyway, Dr. Burton said, and when it has been “conquered” by vaccines, and a disease with identical symptoms continues to appear, doctors look for a new virus because they know the old one has been “wiped out.” “And the game goes on,” he added. (W13)

When Dr. Robert Mendelsohn was asked about the possibility of childhood diseases—particularly polio—returning if the vaccinations were stopped, he replied: “Doctors admit that forty percent of our population is not immunized against polio. So where is polio? Diseases are like fashions; they come and go, like the flu epidemic of 1918.” (W14)

On a 1983 Donahue Show (“Dangers of Childhood Immunizations,” Jan. 12), Dr. Mendelsohn pointed out that polio disappeared in Europe during the 1940s and 1950s without mass vaccination, and that polio does not occur in the Third World where only 10 percent of the people have been vaccinated against polio or anything else.

Returning to the congressional hearings referred to earlier (HR 10541), we read that in 1958 Israel had a major “type I” polio epidemic after mass vaccinations. There was no difference in protection between the vaccinated and the unvaccinated. In 1961, Massachusetts had a “type III” polio outbreak and “there were more paralytic cases in the triple vaccinates than in the unvaccinated.” (W15)

Testimony at these same hearings from Herbert Ratner, M.D., pointed out that because poliomyelitis is such a low-incidence disease, this complicates the evaluation of a vaccine for it. He also said that there is “a high degree of acquired immunity and many natural factors preventing the occurrence of the disease . . . in the Nation at large.” (W16)

Dr. Moskowitz adds that the virulence of the poliovirus was low to begin with. “Given the fact that the poliovirus was ubiquitous before the vaccine was introduced, and could be found routinely in samples of city

sewage whenever it was looked for, it is evident that effective, natural immunity to poliovirus was already as close to being universal as it can ever be, and “*a fortiori*” no artificial substitute could ever equal or even approximate that result.” (W17)

References:

W6. Joan S. Wixen, “Twentieth-century miracle-maker,” *Modern Maturity*, Dec. 1984-Jan. 1985, p.92.

W7. *Ibid.*

W8. Hearings before the Committee on Interstate and Foreign Commerce, House of Representatives, Eighty-Seventh Congress, Second Session on H.R. 10541, May 1962, p.94

W9. “The Disturbing Question of the Salk Vaccine,” *Prevention*, Sept. 1959, p.52

W10. Hearings on H.R. 10541, *op. cit.*, pp.94, 96, 112.

W11. Christopher Kent, D.C., Ph.D., “Drugs, Bugs, and Shots in the Dark,” *Health Freedom News*, Jan.1983, p.26.

W12. *Ibid.*

W13. Alec Burton, O.D., “The Fallacy of the Germ Theory of Disease,” talk given at the convention of the National Hygiene Society, Milwaukee, WI, 1978.

W14. Interview with Robert Mendelsohn, M.D., *The Herbalist New Health*, July 1981, p.61.

W15. Hearings on 10541, *op. cit.*, p.113.

W16. *Ibid.* pp.89, 94.

W17. Richard Moskowitz, M.D., *The Case Against Immunizations*, reprinted from the *Journal of the American Institute of Homeopathy*, vol.76, March 1983, p.21.

POSTSCRIPT #2:

Dr. Viera Scheibner, a Principal Research Scientist (Retired)
in Australia and noted critic of vaccination, wrote in 1999:

Polio has not been eradicated by vaccination, it is lurking behind a redefinition and new diagnostic names like viral or aseptic meningitis. When the first, injectable, polio vaccine was tested on some 1.8 million children in the United States in 1954, within 9 days there was huge epidemic of paralytic polio in the vaccinated and some of their parents and other contacts. The US Surgeon General discontinued the trial for 2 weeks. The vaccinators then put their heads together and came back with a new definition of poliomyelitis. The old, classical, definition: a disease with residual paralysis which resolves within 60 days has been changed to a disease with residual paralysis which persists for more than 60 days. Knowing the reality of polio disease, this nifty but dishonest administrative move excluded more than 90% of polio cases from the definition of polio. Ever since then, when a polio-vaccinated person gets polio, it will not be diagnosed as polio, it will be diagnosed as viral or aseptic meningitis. According to one of the 1997 issues of the *MMWR*, there are some 30,000 to 50,000 cases of viral meningitis per year in the United States alone. That’s where all those 30,000—50,000 cases of polio disappeared after the introduction of mass vaccination. One must also be aware that polio is a man-made disease since those well-publicized outbreaks are misrepresented that those huge outbreaks were causally linked to intensified diphtheria and other vaccinations at the relevant time. They even have a name for it: provocation poliomyelitis.

JAMA (1993) published that the fall in the incidence of Hib meningitis occurred in the age group below the age of one year at the time when none of the Hib vaccines were even licensed for that age group. The recent outbreaks of meningitis in the US College students can be clearly linked to the enforced MMR vaccination as a condition for enrolment to Colleges in the U.S.

Neurological Complications of Vaccinations By Charles M. Poser, M.D., FRCP

Neurological complications of immunizations have been recorded in the medical literature for many years, yet many physicians fail to recognize their clinical manifestations and identify their etiology. This is due in part to their rarity, and to the well-publicized, overriding public health benefits that make these complications easily overlooked. Yet they can be devastating despite the fact that early treatment is often successful.

A great deal of knowledge regarding their pathogenesis has accumulated over the years based on the existence of excellent animal models of the human disease, acute disseminated encephalomyelitis, the commonest neurological manifestation of an adverse immune response to vaccines. Experimental allergic encephalomyelitis and neuritis faithfully reproduce the pathologic alterations of the nervous system that may complicate immunizations.

Adverse reactions involving the nervous system from a wide variety of immunizations result from the same pathogenetic mechanism. They may affect any and all parts of the central and peripheral nervous systems. With rare exceptions, e.g. rubella immunization, the nature of the vaccine does not seem to influence the nature of the response.

Thus the nervous system ailments include many different clinical forms, ranging from the classic acute disseminated encephalomyelitis to aseptic meningoencephalitis. In rare instances, in the case of live viruses, e.g. polio and smallpox, an actual infection by the virus itself may ensue. Many different vaccinations involving many different sites in the nervous system have been reported. This is particularly true of vaccines commonly used in children against measles, varicella and rubella.

The pathogenetic mechanism is as follows: the primary effect of the hyperergic (immune) reaction is on the small blood vessels of the nervous system, usually capillaries, but occasionally involving arterioles and venules; in exceptional circumstances, even major arteries such as the carotid may be affected. The vasculopathy may cause vessel obstruction and ischemia, a stroke. Rupture of the vessel wall results in hemorrhage.

More commonly, however, there is alteration of the blood-brain barrier, exsudation of water and edema (swelling) of nervous tissue. Inflammation and disorganization of the myelin lamellae (layers) and destruction of myelin may ensue but are not obligatory. In some cases, there is sufficient red blood cell diapedesis (migration through the vessel wall) to produce what is known as acute hemorrhagic leukoencephalopathy, which despite its awesome appearance is usually responsive to vigorous treatment.

The extent of pathological involvement of nervous tissue also varies greatly, as seen in vaccination against measles, mumps and varicella. In infants, brain swelling, also known as congestive edematous encephalopathy, may be the only complication, a condition that often responds dramatically to treatment with corticosteroids. It occurs most commonly in vaccination against smallpox.

The diagnosis of acute disseminated encephalomyelitis, the commonest complication of vaccinations in both children and adult, has been aided by magnetic resonance imaging (MRI). The pictures are reasonably characteristic, yet, unfortunately, despite many published descriptions, these images are not always correctly interpreted, and are often misread as those of multiple sclerosis.

There is also some confusion in terminology: “encephalitis” and “meningoencephalitis” refer to actual invasion of the brain by a virus, while “encephalopathy” is a generic term that simply describes a pathological condition of the brain; “encephalomyelitis” refers to an “allergic” or immune reaction of the nervous system. It is the latter term that should be generally used for the nervous system complications of vaccinations.

The official publications that commented on the ill effects of the 1976 swine-flu (A-New Jersey 76) vaccination campaign illustrate the problems that arise when there is need to extrapolate scientific data to judicial considerations. The report stating that the Landry-Guillain-Barré syndrome (LGBS) was the only “real” complication of the swine-flu vaccine passed over published reports to the contrary. The statement that there had been underreporting of complications was simply ignored. The accepted view is that if an adverse reaction does not reach the magical figure of 5 percent, it does not exist.

The reverence accorded to statistical analyses overlooks the value of anecdotal reports in constructing valid medical hypotheses; this is despite the warnings by respected epidemiologists that such studies can never deny the existence of a cause-and-effect relationship. This is illustrated by the report of nervous system complications following vaccination against hepatitis B. Another problem arose from the decision to limit the “acceptable” time period of onset after immunization, which ignored a number of reports of well-documented delayed reactions.

In the last few years a new mantra has emerged to the effect that all published results such as proposed new treatments, must meet the test of being “evidence-based,” which means that they must be derived from statistically verified data. Thus calculations of probabilities, also known as educated guesses, will take precedence over clinical, pathological, radiological or experimental data. Close examination of some specific situations will reveal the flaws of this concept.

There is no way of predicting who will have an adverse reaction to vaccination. The individual’s susceptibility is determined by the genetic background and previous immunological history. We are constantly exposed to a wide variety of viral antigens that cause our immune system to develop antibodies against them. The phenomenon of molecular mimicry explains why some people’s immune system will mistakenly respond to the measles antigen, for instance, in the vaccine because some of its amino acid groupings, its epitopes, are the same as those in the protein of a previously encountered viral antigen.

This is why there was an unexpected preponderance of people in their 50s and 60s who developed LGBS after swine-flu vaccination, because they might have been exposed to the “Asian flu” caused by a somewhat similar virus in the 1920s. It is also germane to point out that vaccines contain a number of substances, many of them as antigenic as the one for which they were designed. Preservatives may also contribute to the adverse side effects. It is extremely difficult to distinguish the effects of the vaccines’ constituents.

Physicians often neglect to ask about previous vaccinations when confronted with puzzling neurological illness. Most of them appear to have been convinced that immunizations are completely harmless. Many also believe that such reactions must occur within one month from vaccination, and therefore do not inquire about immunizations in previous months.

Because of the expense of testing drugs, vaccines and other medical products, the pharmaceutical industry has assumed an increasingly important role in the conduct of therapeutic trials and post-marketing surveillance. This is both understandable and often beneficial. On the downside, however, is the appearance of conflict of interest when the analyses of the results are carried out by the pharmaceutical firm itself, or the government agency charged with guarding the safety of the product.

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