HB

277

file 2

MEMORANDUM State of Alaska

TO: John Katz, Special Counsel
Office of the Governor
Washington, D.C.

DATE: March 3, 1988

FILE NO: SD:3

TELEPHONE NO: 465-3030

THRU:

SUBJECT: Supplemental Funding for Vaccine Purchases

FROM: Myra M. Munson
Commissioner
Department of Health and Social Services

The federal Immunization Compensation Bill (ICB) recently signed into law by President Reagan imposes a federal excise tax on vaccines. As a result, vaccine manufacturers have announced substantial price increases for vaccines effective January 1, 1988. As the following table shows, these price increases have serious budget implications for Alaska's immunization program in FY 89.

Vaccine	Old Price Per Dose	New Price Per Dose	Difference		Doses Needed/Yr.		Extra Cost/Yr.
DPT	$7.6933	$9.623[1]	$1.9297	x	60,000	=	$115,782
MMR	$10.67	$17.78[2]	$7.11	x	15,000	=	106,650
OPV	$1.363	$1.363[3]	--	x	54,000	=	--
Ped DT	$.13	$.19[4]	$.06	x	2,500	=	150
Adult TD	$.096	$.156[4]	$.06	x	25,000	=	1,500
Mumps	$5.97	$11.90[2]	$5.93	x	500	=	2,965
						Total	$227,047

DPT = diphtheria, pertussis, tetanus; MMR = measles, mumps, rubella; OPV = oral polio vaccine; Ped DT = pediatric diphtheria/tetanus; Adult TD = adult tetanus/diphtheria

[1]Includes per dose federal excise tax of $4.56
[2]Includes per dose federal excise tax of $4.44
[3]Includes per dose federal excise tax of $ .29
[4]Includes per dose federal excise tax of $ .06

New prices are current as of January 27, 1988 (MMR and mumps are estimates based on manufacturer's announcement February 18, 1988).

The manufacturers of DPT and OPV have adjusted their base prices to reflect their reduced liability as a result of the ICB. The manufacturer of our MMR and mumps vaccines has just announced a possible 25% increase in price, effective February 25, 1988, in addition to the federal excise tax. This is reflected in the prices shown in the table.

Vaccine prices generally increase every year, and we anticipate this in our budget requests. Before the ICB was signed, we had already asked for an FY 89 budget increment of $125,000 for vaccine purchases. The $227,047 shown in the table as the total extra cost per year represents a projected FY 89 deficit beyond the $125,000 already anticipated and requested.

It is my understanding that the ICB contains language allowing for an appropriation of federal funds to help states pay the expected higher vaccine costs. This assistance is crucial to Alaska.

I request your assistance in encouraging the Alaska delegation, the sponsors of the bill, and the key members of the relevant finance and budget committee to appropriate sufficient funds in the coming federal budget to provide financial assistance for vaccine purchases to states requiring such assistance.

cc: Representative Mark Boyer
Representative Johnny Ellis
Representative Steve Frank
Representative Cliff Davidson

Dissatisfied Parents Together
Alaska Chapter
Box 1746
Soldotna, Alaska 99669
262-3825

Representative Johnny Ellis
Co-Chairman
House H.E.S.S. Committee
Juneau, Alaska 99811

March 17, 1988

Dear Representative Ellis;

Thank you and the H.E.S.S. committee for sponsoring the teleconference of March 10th to hear HB 277 again. I took part in the teleconference in Soldotna and became quite frustrated during Dr. Middaugh's testimony. For some reason that the legislative liason could not correct, we could not discern what Dr. Middaugh was saying about 95% of the time. So until I am able to review his testimony in writing, I can't comment on his testimony in this correspondence.

What I would like to address is the legislative process that HB 277 is involved in now. I understand that it has been referred to a H.E.S.S. subcommittee for possible reconstruction in order to avoid conflict with the impending enactment of the National Childhood Vaccine Injury Compensation Act.

I have compared both bills and after discussing the situation with other members of AK-DPT have prepared a written presentation that outlines what we feel must be retained in HB 277 to best serve the health interest of Alaskan children.

Ideally, we want some major improvements in the immunization program mandated before the legislature adjourns this spring. Since I am unsure of the legislative process and time allowances required to finalize this legislation, I would appreciate it if you would contact me as soon as possible to discuss what may or may not happen with HB 277 this year.

Thanks again,

Shannon Kohler

Shannon Kohler
President

cc; Pat Malone
Lisa McClaren

HB 277, AN ACT RELATING TO THE IMMUNIZATION OF MINORS

Alaska Dissatisfied Parents Together (AK-DPT) recommendations as to how bill could be reconstructed to comply with National Childhood Vaccine Injury Compensation Act (N.C.V.I.C.A.), to facilitate legislative progress, and to serve the health interests of Alaskan children.

Recommendations will be referred to according to page number and line number of HB 277.

Page 1. Section 1, lines 8-17; as refers to philosophical objection to vaccinations.

AK-DPT wishes to retain this portion of HB 277; however, it is open for discussion.

Page 1. Article 3A, Section 18.15.300 Immunization Information, lines 26-28 (2); as refers to manufacturer's product insert being required to be given to parents

AK-DPT stresses that this section must be retained for the simple reason that this is the only material that lists the ingredients of the vaccine it accompanies. Ingredients need to be known for a variety of reasons, the most important is to identify and avoid allergic reactions. The federal N.C.V.I.C.A. does not address ingredients as required parental information. Also, since manufacturers vary on occassion (as does accompanying data) parents should as a matter of course be presented whatever insert is applicable for vaccine being administered that day, week, or month, etc. Also, contraindications and adverse reaction listings can vary. Providing the manufacturer's insert will help parents to discern what the manufacturer recognizes as a contraindicating reaction to a vaccine and thus facilitate parental communication with health care providers so that health care providers will be able to effectively and accurately comply with page 12, Part C of the N.C.V.I.C.A: Assuring a Safer Childhood Vaccination Program in the U.S., "Recording and Reporting of Information", Section 2125(B)

Page 2, lines 7-9 (b); as refers to hospital provided parental information.

Since the State Health Department does already provide some material at birth, this section should remain to insure that the manufacturer's product insert also be presented.

Page 2, Section 18.15.310: Adverse Reaction Reports, lines 14-21

AK-DPT stresses that the wording of this section must remain as such. The N.C.V.I.C.A. does mandate that "health care providers" report serious adverse reaction, but only if they administer vaccines. See page 14 of federal bill, "Definitions", Section 2133 (1).

HB 277 requires that all health care providers comply, because more of them will see reaction than those that administer vaccines. i.e. physicians, emergency room personnel. It also mandates that a form be constructed so parents can also report a reaction. (See attachment of Maryland model parental form.)

Since HB 277 requires more specific reporting, its reconstruction needs to mandate that all reports (copies of federal reports) need to be sent to the Alaska Public Health Department, so that accurate Alaska statistics, follow-up, and legislative reporting may occur. Specifics to follow.

Page 2. lines 26-29 (c) Long Term Follow-up

The N.C.V.I.C.A. does not address long term follow-up of all adverse events. This must be done in at least our state to obtain an accurate benefit/risk ratio involving vaccinations. This also must be done to detail the effects of vaccination on individual children. Every statistic is a person and their developing problems must be chronicled.

Page 3. lines 1-5 (c) Long Term Follow-up (cont'd.)

An annual report prepared by the Health Department and presented to legislators is essential for the reasons stated in bill. This report would then be available to public. This is necessary for public awareness.

"TRIAL

"SEC. 2123. (a) GENERAL RULE.—A civil action against a vaccine manufacturer for damages for a vaccine-related injury or death associated with the administration of a vaccine after the effective date of this subtitle which is not barred by section 2111(a)(2) shall be tried in three stages.

"(b) LIABILITY.—The first stage of such a civil action shall be held to determine if a vaccine manufacturer is liable under section 2122.

"(c) GENERAL DAMAGES.—The second stage of such a civil action shall be held to determine the amount of damages (other than punitive damages) a vaccine manufacturer found to be liable under section 2122 shall be required to pay.

"(d) PUNITIVE DAMAGES.—

"(1) If sought by the plaintiff, the third stage of such an action shall be held to determine the amount of punitive damages a vaccine manufacturer found to be liable under section 2122 shall be required to pay.

and.

"(2) If in such an action the manufacturer shows that it complied, in all material respects, with all requirements under the Federal Food, Drug, and Cosmetic Act and the Public Health Service Act applicable to the vaccine and related to the vaccine injury or death with respect to which the action was brought, the manufacturer shall not be held liable for punitive damages unless the manufacturer engaged in—

21 USC 301 note.
42 USC 201 note.

"(A) fraud or intentional and wrongful withholding of information from the Secretary during any phase of a proceeding for approval of the vaccine under section 351,

42 USC 262.

"(B) intentional and wrongful withholding of information relating to the safety or efficacy of the vaccine after its approval, or

fety.

"(C) other criminal or illegal activity relating to the safety and effectiveness of vaccines,

which activity related to the vaccine-related injury or death for which the civil action was brought.

"(e) EVIDENCE.—In any stage of a civil action, the Vaccine Injury Table, any finding of a district court of the United States or a master appointed by such court in a proceeding on a petition filed under section 2111 and the final judgment of a district court of the United States on such a petition shall not be admissible.

"PART C—ASSURING A SAFER CHILDHOOD VACCINATION PROGRAM IN THE UNITED STATES

"RECORDING AND REPORTING OF INFORMATION

: USC
00aa-25.

"SEC. 2125. (a) GENERAL RULE.—Each health care provider who administers a vaccine set forth in the Vaccine Injury Table to any person shall record, or ensure that there is recorded, in such person's permanent medical record (or in a permanent office log or file to which a legal representative shall have access upon request) with respect to each such vaccine—

"(1) the date of administration of the vaccine,

"(2) the vaccine manufacturer and lot number of the vaccine,

"(3) the name and address and, if appropriate, the title of the health care provider administering the vaccine, and

"(4) any other identifying information on the vaccine required pursuant to regulations promulgated by the Secretary.

"(b) REPORTING.—

"(1) Each health care provider and vaccine manufacturer shall report to the Secretary—

"(A) the occurrence of any event set forth in the Vaccine Injury Table, including the events set forth in section 2114(b) which occur within 7 days of the administration of any vaccine set forth in the Table or within such longer period as is specified in the Table or section,

"(B) the occurrence of any contraindicating reaction to a vaccine which is specified in the manufacturer's package insert, and

"(C) such other matters as the Secretary may by regulation require.

Reports of the matters referred to in subparagraphs (A) and (B) shall be made beginning 90 days after the effective date of this subtitle. The Secretary shall publish in the Federal Register as soon as practicable after such date a notice of the reporting requirement.

"(2) A report under paragraph (1) respecting a vaccine shall include the time periods after the administration of such vaccine within which vaccine-related illnesses, disabilities, injuries, or conditions, the symptoms and manifestations of such illnesses, disabilities, injuries, or conditions, or deaths occur, and the manufacturer and lot number of the vaccine.

"(3) The Secretary shall issue the regulations referred to in paragraph (1)(C) within 180 days of the effective date of this subtitle.

"(c) RELEASE OF INFORMATION.—

"(1) Information which is in the possession of the Federal Government and State and local governments under this section and which may identify an individual shall not be made available under section 552 of title 5, United States Code, or otherwise, to any person except—

"(A) the person who received the vaccine, or

"(B) the legal representative of such person.

"(2) For purposes of paragraph (1), the term 'information which may identify an individual' shall be limited to the name, street address, and telephone number of the person who received the vaccine and of that person's legal representative and the medical records of such person relating to the administration of the vaccine, and shall not include the locality and State of vaccine administration, the name of the health care provider who administered the vaccine, the date of the vaccination, or information concerning any reported illness, disability, injury, or condition resulting from the administration of the vaccine, any symptom or manifestation of such illness, disability, injury, or condition, or death resulting from the administration of the vaccine.

"(3) Except as provided in paragraph (1), all information reported under this section shall be available to the public.

Alaska needs to have this exception

"VACCINE [illegible]ATION

"SEC. 2126. (a) GENERAL RULE.—Not later than 1 year after the effective date of this subtitle, the Secretary shall develop and

REPORT OF: SERIOUS ADVERSE REACTION FOLLOWING RECEIPT OF PERTUSSIS VACCINE.

Patient's Name and Address _____ Sex _____ Age _____ Phone _____

Describe Reaction (Include date vaccine was administered and type of vaccine)

_____

_____

_____

Hospitalized? _____ Name of hospital _____

CUT ALONG THIS LINE

If your child has a serious reaction following pertussis vaccine, this information must be reported to the health authorities. Normally, this will be done by your doctor or clinic once they have knowledge of the event. You also may file a report by completing the form above and submitting it to your respective local health department listed below.

NAMES, ADDRESSES AND PHONE NUMBERS OF MARYLAND'S LOCAL HEALTH DEPARTMENTS

Allegany, Box 1745, Willowbrook Road, Cumberland, 21502	777-5600
Anne Arundel, Health Services Bldg., 6 Harry S. Truman Pkwy., Annap., 21401	224-7095
Baltimore, New Courts Bldg., 401 Bosley Ave., Towson, 21204	494-2724
Calvert, P.O. Box 980, Prince Frederick, 20678	535-5400
Caroline, Box 10, 411 Franklin St., Denton, 21629	479-0556
Carroll, Box 845, 540 Washington Rd., Westminster, 21157	857-5000
Cecil, Court House Annex, 2nd Floor, Elkton, 21921	398-5100
Charles, Box 640, LaPlata, 20646	934-9577
Dorchester, Rt. 50 & Woods Rd., Box 519, Cambridge, 21613	228-3223
Frederick, 12 E. Church St., Frederick, 21701	694-1700
Garrett, Garrett Co. Medical Center, Oakland, 21550	334-8111
Harford, 119 Hays St., Box 191, Bel Air, 21014-0191	838-3047
Howard, 3450 Court House Dr., Box 476, Ellicott City, 21043	992-2333
Kent, College Ave., Ext., Box 359, Chestertown, 21620	778-1550
Montgomery, 100 Maryland Ave., Rockville, 20850	681-5000
Prince George's, Hospital Rd., Cheverly, 20785	386-0300
Queen Anne's, 206 N. Commerce St., Centreville, 21617	758-0720
St. Mary's, Tudor Hall Dr., P.O. Box 316, Leonardtown, 20650	475-8921
Somerset, Box 129, Dr. Robert Johnson Health Center, Westover, 21871	651-0822
Talbot, 100 S. Hanson St., Box 480, Easton, 21601	822-2292
Washington, 1302 Pennsylvania Ave., P.O. Box 2067, Hagerstown, 21740	791-3200
Wicomico, 300 W. Carroll St., Salisbury, 21801	749-1244
Worcester, P.O. Box 249, Snow Hill, 21863	632-1100
Baltimore City, 111 N. Calvert St., Baltimore, 21202	396-4187
State Health Dept., 201 W. Preston St., Baltimore, 21201	225-6677

Turn page for more→

IMPORTANT INFORMATION AVAILABLE TO YOU

Each time your child is given a DTP shot, the following information is recorded in a permanent record and is available to you from your doctor or clinic upon request.

- the date and time of day the vaccine was given,
- the DTP dose number,
- the name and title of the person who gave the shot,
- the vaccine manufacturer name, and
- the vaccine lot number.

You should keep information concerning the dates of any vaccine given to your child in a permanent immunization record plus the details of any reactions that may occur until your child enters school. The Maryland Department of Health and Mental Hygiene, Division of Immunization, 201 W. Preston Street, Baltimore, MD 21201, provides a personal Maryland Immunization Record for this purpose.

IMMUNIZATION REQUIREMENTS FOR ENTRY TO SCHOOL

There is a law in Maryland that requires children to have certain immunizations in order to enroll in a public or private school. Before a child is allowed to attend school, proof of immunization must be shown. Proof of immunization consists of a written record showing the month, day and year of each immunization, along with the signature of the person or clinic which administered each dose.

The following immunizations are currently required in Maryland.

- DTP — 4 doses for pupils less than 7 years of age,
- DT/Td — 3 doses for pupils 7 years of age and older,
- Polio — 3 doses for pupils less than 18 years of age.
- Measles — 1 dose of live virus vaccine on or after the first birthday, or a blood titer of at least 1:4, and
- Rubella — 1 dose of live virus vaccine on or after the first birthday, or a blood titer of at least 1:8.

As with pertussis, there are medical reasons that could exempt some children from mandated immunizations, the law allows a religious exemption, also.

SUMMARY

You have the right to receive and understand the information contained in this booklet. If you don't understand any part of it, ask to discuss it before your child receives pertussis vaccine.

Maryland law requires that most children receive, among other vaccines, pertussis vaccine in order to attend school. However, your child could be exempted temporarily or permanently from this mandate if he or she meets the appropriate conditions for such exemptions that are outlined in this booklet.

Under Maryland law, if your doctor decides that your child should not get the vaccine, his judgment is final. It cannot be reversed by the State or Local Health Department or by school officials. Except in an emergency, your child cannot be kept out of school because of the doctor's decision not to give your child the vaccine.

DHMH PPAAP
REV 01/90/87

IMPORTANT INFORMATION ABOUT PERTUSSIS AND PERTUSSIS VACCINE

Prepared for you by:

The Maryland Department of Health and Mental Hygiene
The Medical and Chirurgical Faculty of the State of Maryland
The Maryland Chapter of the American Academy of Pediatrics

INTRODUCTION

This booklet is intended to answer some of the questions you may have about pertussis (whooping cough) and pertussis vaccine. You should read this information before your child receives the DTP vaccine.

Pertussis or whooping cough can be a serious disease. In some persons, especially very young children, it can cause permanent brain damage or even death. In order to protect persons from whooping cough, Maryland law requires most children to get four DTP shots before they go to school.

However, not all children have to get pertussis vaccine. In some cases, the "P" part of the DTP vaccine can cause serious reactions, including permanent brain damage or even death. So some children should not get the "P" part of the DTP vaccine at all. Also, for some children the series of pertussis vaccine should be delayed.

So it is very important to read and to understand this information about the disease and the pertussis vaccine to protect your child's health. If there is something in this booklet you don't understand, ask the person who gave you the booklet to explain it.

WHAT IS PERTUSSIS (WHOOPING COUGH)?

Pertussis, also known as whooping cough, is a highly contagious disease caused by the bacteria, *Bordetella pertussis*, and is spread through the air to others. The disease starts with cold symptoms and progresses to repeated, violent coughing spells which can interfere with eating, drinking and breathing. The coughing spells may be accompanied at the end by a "whooping" sound while the victim struggles to inhale. The disease will normally last for one-to-two months.

WHAT ARE THE RISKS OF GETTING WHOOPING COUGH?

According to the Centers for Disease Control (CDC), in the past ten years an average of 1,800 cases of pertussis have been reported each year in the U.S. Since many cases go unrecognized or unreported, the real numbers could be much higher.

Over half of the reported cases occur in children under 1 year of age. Most reported cases of whooping cough involve children under 5 years of age. This is why vaccination in early life is so important. Older children and adults.. even those who have been vaccinated can also contract the disease and are believed in many cases to be the source of infection in the younger children.

Although there is some disagreement about how effective the vaccine is, most children who receive the series of pertussis vaccine are protected from whooping cough. The disease is often milder in vaccinated children who do become ill with the disease.

WHAT ARE THE POSSIBLE DANGERS OF WHOOPING COUGH?

In the U.S. over the last ten years, an annual average of 8 deaths has occurred following the disease. While fatality is low, almost all deaths are among children under 1 year of age, most in those under 6 months.

While there is no specific treatment for pertussis, prompt medical attention and supportive care can be successful in reducing the severity and complications of the disease.

WHAT ARE THE POSSIBLE DANGERS OF THE PERTUSSIS PART OF DTP VACCINE?

Most U S doctors and public health officials believe that the benefits of pertussis vaccine outweigh the risk of reactions to the vaccine for most children. Most children have only a low fever, some crying and/or soreness after a DTP shot. Some have no reaction at all.

Some children, however, have serious reactions to the "P" part of the DTP vaccine. These reactions may include convulsions, seizures, shock-collapse (turning blue or pale, limp, non-responsive), a fever of 105 degrees F. or more, high-pitched unusual cries, unusually long sleeping with great difficulty waking the child, or crying which lasts more than 3 hours and cannot be stopped. Any of these signs should be reported to your doctor or clinic at once.

In some cases serious reactions to the vaccine can involve long-term uncontrolled seizure disorders, brain damage, and even death.

There is a great deal of disagreement over how often these serious reactions happen. The pertussis vaccine is known to cause serious reactions more often than other vaccines. An effective test to screen the pertussis vaccine for its potential to cause reactions is not available. It is not known how many children die or get long lasting disabilities after the DTP shot is given, yet clearly children who get DTP shots are at somewhat greater risk of serious reactions than those who get DT shots, without the "P".

This is why parents, doctors, and clinics need to give careful consideration before giving this vaccine and need to be alert to possible serious reactions which may occur.

DOES THE LAW REQUIRE ME TO GET PERTUSSIS VACCINE FOR MY CHILD?

Maryland law requires most children to receive several different immunizations before they can enter school – pertussis vaccine is one of them. In order to enter school, a minimum of 4 doses of DTP is required, 5 are recommended.

Not all children are required to get DTP shots. Maryland law allows some children not to have the "P" part of these shots if:

- the child has any condition listed in the following section ("Which Children Should Not Receive Pertussis Vaccine?").
- the parents object due to their good faith religious beliefs and practices (in which case the objections must be universal and not for pertussis vaccine alone), or
- the doctor decides that because of your child's particular situation, the risks of the vaccine outweigh the benefits to the child and the public. For instance, if a parent, brother, or sister of the child to be given the vaccine has epilepsy, seizures, or other diseases of the central nervous system, or has had a severe reaction to a DTP shot, the doctor may choose not to give the vaccine.

WHEN SHOULD A CHILD'S DTP SHOTS BE DELAYED?

A child's DTP shots should be delayed if he or she:

- has a fever or ear or chest infection or is sick at the proposed time for vaccination, or has not completely recovered from a past illness,
- has had a previous convulsion, seizure, or nervous system illness, until it can be determined that no more seizures are happening and the condition is stable and under control, or
- is receiving chemotherapy or radiation treatments which may reduce the immune response of the child to vaccines.

A child's shots can be continued after he or she is well.

WHICH CHILDREN SHOULD NOT RECEIVE PERTUSSIS VACCINE?

It is generally agreed that some children should not get the "P" part of the DTP vaccine. The pertussis vaccine should not be given to your child if:

- he or she has an underlying neurologic or seizure disorder which is getting worse or is uncontrolled;
- he or she is seven years of age or older, or
- he or she has already had an earlier DTP shot and had any of the following reactions after the shot:
  - a measured fever of 105 degrees F. or greater (some manufacturers believe a temperature of 103 degrees F. or greater is a contraindication, therefore, this also should be reported to your doctor),
  - a severe allergic reaction,
  - collapse or shock-like state,
  - persisting, inconsolable crying lasting 3 hours or more, or an unusual high-pitched cry,
  - convulsion(s) with or without fever occurring within 7 days, or
  - other severe problems of the brain occurring within 7 days, this includes prolonged sleeping and inability to wake child, unusual twitching of the body or unusual staring.

Some vaccine manufacturers state that a family history of central nervous system disorders is an absolute reason not to get whooping cough vaccine (the P part of the DTP vaccine). However, the Centers for Disease Control and the American Academy of Pediatrics disagree with the manufacturers on this issue. Therefore, any family history of central nervous system problems should be considered carefully with your doctor before vaccination.

Your child should not need further pertussis shots if he or she has had laboratory confirmed whooping cough. This also should be considered with your doctor.

If a child should not receive pertussis vaccine, he or she can still be protected against diphtheria and tetanus by receiving DT vaccine rather than DTP.

ARE CERTAIN CHILDREN MORE LIKELY TO HAVE A SERIOUS REACTION TO DTP VACCINE THAN OTHERS?

The medical experts do not agree on the reasons why reactions following vaccination happen, nor can they predict in which children serious reactions will occur. But there are some factors which may make children more likely to have serious reactions.

A child may be at higher risk of a serious reaction to the "P" part of the DTP vaccine if he or she:

- has had a serious reaction to a previous DTP shot;
- has a neurologic illness, including seizures or convulsions, the severity of which is changing or uncontrolled, or
- has a fever or infection or is sick when the shot is given.

HOW TO REDUCE THE RISK OF A SERIOUS REACTION TO PERTUSSIS VACCINE

It is important that a child's medical history be provided to the doctor or clinic before he or she receives the pertussis vaccine. Such a history should include, but not necessarily be limited to, the following information:

- major birth problems,
- your child's and family's history of convulsion (seizure) or neurological illness,
- any allergy,

- recent or present illness;
- medicines or treatment currently taking; and
- your child's and family's history of previous vaccine reactions.

Besides providing your doctor with your child's medical history, there are other things which can be done to reduce the risk of a serious vaccine reaction. One thing you can do is take your child's temperature before he or she is vaccinated to make sure he or she has no fever. Another is to make sure your child has no obvious signs of infection at the time vaccine is given. If your child's throat is red or the child has been pulling his or her ears, this may be a sign of infection and should be discussed with your doctor.

WHAT SIGNS TO LOOK FOR IN A SERIOUS REACTION TO VACCINE

It is important to observe your child carefully at periodic intervals after vaccination, particularly during the first 72 hours. If your child has any of the following symptoms after a DTP shot, write down the details on this form to help you report the correct information to your doctor or clinic:

SYMPTOM	DATE	TIME	DURATION	DESCRIPTION
Measured fever nearing 105 degrees F				
High-pitched, unusual crying				
Persistent, inconsolable crying (3 or more hours)				
Inability to wake child, unusually prolonged sleeping				
Shock or collapse, loss of muscle control, turning white, blue or gray, limpness				
Convulsion, seizure, unusual repeated twitching, jerking, startling, or staring spells				
Loss of sensory or muscle control, paralysis, limping, loss of speech, hearing or sight				
Difficulty or stoppage of breathing				
Severe local reaction, large red, blue or purple coloring with extended swelling near where the shot was given				

If any of these events happen after your child gets a DTP shot, call your doctor or clinic at once. Tell them about the shot, when it was given, and about your child's reaction. *Arrange for a prompt examination at the doctor's office, clinic, or emergency room.* When things settle down, write down in detail exactly what happened.

MEMORANDUM State of Alaska

TO: Elizabeth Ward
Director, Division of Public Health

DATE: March 4, 1988

FILE NO:

TELEPHONE NO: 561-4406

FROM: Michael E. Jones
Medical Epidemiologist

SUBJECT: Review of MSAEFI Reports and Philosophical Exemptions to Immunization

I have reviewed all MSAEFI (Monitoring System for Adverse Events Following Immunization) reports submitted to the Section of Epidemiology during the three years from 1985 through 1987. During this period, there were eighty-one reports of adverse events occurring in persons vaccinated within the preceding 28 days. Of these events, twenty-seven (33%) were classified either as anaphylaxis or as one of the illnesses listed in subsections 7-15 of the MSAEFI form (attached); reports of such events require review by the Immunization Project physician to verify the clinical information.

The vaccines associated with these reported adverse events and the number of instances in which they were associated with such reactions were as follows: diphtheria-pertussis-tetanus (DPT) vaccine, 22 instances; oral polio vaccine (OPV), 7; measles-mumps-rubella (MMR) vaccine, 4; hepatitis B vaccine (Heptavax), 1; and Hemophilus influenzae type b (Hib) vaccine, 1. (Numbers total more than 27 because some individuals received two or more vaccines concurrently.) The disproportionate number of DPT-associated adverse events may be related in part to the fact that DPT is the most frequently administered vaccine in Alaska: a total of 5 doses of DPT vaccine are recommended for adequate immunization, compared with 4 doses of OPV and one dose of MMR vaccine.

The serious reactions reported, and the number of times they were associated with individual vaccines or with vaccine combinations, are listed in the table which follows:

1988 RECEIVED Division of Public Health

TABLE 1

VACCINE(S) ADMINISTERED PRIOR TO ADVERSE EVENT

Adverse Event	DPT	DPT/OPV	DPT/OPV/Hib	MMR	Heptavax	Total
Convulsions/Seizures	7	-	-	4	-	11
Screaming Episodes	3	4	1	-	-	8
Hypotonic/Hyporesponsive Episodes ("Collapse")	3	-	-	-	-	3
Encephalitis (without residual defect)	-	1	-	-	-	1
Weakness of Extremities	-	1	-	-	-	1
Anaphylaxis	1	-	-	-	-	1
Infantile Spasms	1	-	-	-	-	1
Neonatal Apnea	-	-	-	-	1	1
All Adverse Events	15	6	1	4	1	27

None of these reactions was fatal. Except for one child who had persistent, mild weakness of his extremities one year following onset of the adverse event, all patients recovered fully.

It is important to remember that these adverse events are defined as being temporally related to vaccination (that is, they have occurred within 28 days following vaccine administration). It is not possible, in any individual case, to establish a cause-effect relationship between immunization and an adverse event, nor is it possible always to exclude such a relationship. Of the eleven individuals who had seizures, four (36%) had had histories of seizures prior to vaccine administration. The child with encephalitis was clinically diagnosed as having "viral meningoencephalitis" (an inflammatory brain condition caused by a virus). The child with persistent weakness of his extremities was examined by a neurologist who did not believe that his impairment was related to immunization. However, since the possibility that such adverse events are related to vaccination cannot be discounted, it is important that they be included in Alaska's MSAEFI reports and be analyzed with nation-wide data by the Centers for Disease Control.

Table 2 illustrates the frequency with which certain adverse events were reported to follow DPT vaccination in Alaska during the 3-year period, 1985-1987. Based on the number of doses (33,073) of DPT vaccine known to have been administered during 1987, it is estimated that a minimum of 99,000 doses of the vaccine were administered during that 3-year period. Thus, on average, seizure activity occurred following one of every 14,143 doses of DPT vaccine; a hypotonic/hyporesponsive episode (transient "collapse") after one in every 33,000 doses; and encephalitis following one of the 99,000 doses. It is evident from the data in table 2 that the reported frequency of these events in Alaska is less than, or approximately equal to, the published frequency with which such events can be expected to occur within very large populations. Of course, these frequency estimates depend upon the completeness of reporting of vaccine-associated adverse events by health care providers; and reporting of "severe reactions to any vaccination" has been required (7 AAC 27.005) in Alaska since at least 1975. It is not possible, from existing data, to estimate completeness of reporting.

The National Childhood Vaccine Injury Act of 1986 requires that each health care provider who administers a vaccine containing tetanus toxoid or diphtheria, pertussis, measles, mumps, rubella, or polio components shall record in a permanent record the date of administration of the vaccine, the vaccine manufacturer and lot number of the vaccine, the name and address of the health care provider administering the vaccine, and any other identifying information on the vaccine required pursuant to regulations promulgated by the Secretary of the Department of Health and Human Services. In addition, each health care provider and vaccine manufacturer are to report certain adverse events or reactions, set forth in a vaccine injury table, which occur within specified time intervals following vaccine administration. These adverse events, which

vary according to the vaccine(s) specified, include anaphylaxis or anaphylactic shock, encephalopathy (or encephalitis), shock-collapse or hypotonic-hyporesponsive collapse, residual seizure disorder, paralytic polio, or any acute complication or sequela (including death) of these illnesses, disabilities, injuries, or conditions. As of October, 1988, federal law, as well as existing state statutes, will require Alaska's health care providers to record information about the vaccines they administer and to report any adverse events following administration of vaccines.

Finally, there are no published reports which document the effects of philosophical exemptions from immunization in states which have such an exemption nor is any organized information about this issue available from the Centers for Disease Control's Immunization Division. The American Medical Association's recommendation (American Medical News, August 14, 1987) that both philosophical and religious exemptions be removed from statutes requiring mandatory immunizations was prompted, in part, by reports of two large outbreaks of measles which originated in, and were facilitated by, infection of persons with religious exemptions to immunization. These outbreaks resulted in three fatalities and affected individuals without such exemptions. Thus, the concern that vaccine-preventable diseases occurring in persons with exemptions from immunization might have deleterious effects on the general population is clearly more than a theoretical consideration. However, no body of data exists that would allow a reliable assessment of the public health impact of philosophical or religious exemptions.

MJ/jh
Attachment

TABLE 2

ANALYSIS OF SELECTED ADVERSE EVENTS ASSOCIATED
WITH DPT VACCINE, 1985-1987, ALASKA

Adverse Event	Number of Adverse Events Reported	Estimated Number of Doses of Vaccine Administered 1985-1987	Observed Incidence of Adverse Event	Expected Incidence of Adverse Event *
Seizure/Convulsion	7	99,000	1 in 14,143 Doses	1 in 1,750 Doses
Hypotonic/Hypore-sponsive Episode	3	"	1 in 33,000 Doses	1 in 1,750 Doses
Encephalitis				
- Total	1	"	1 in 99,000 Doses	1 in 110,000 Doses
- With Residual Neurologic Defect	0	"	0	1 in 310,000 Doses

* Hinman and Koplan, JAMA 1984, 251:3109-3133

REPORT OF ADVERSE EVENT FOLLOWING IMMUNIZATION

FORM APPROVED OMB NO. 0920-0039 EXP DATE 9-87

PERSONAL IDENTIFIERS

Patient:	Form Completed By:	Vaccine Administered By:	Physician or Health Facility Visited for Treatment of Adverse Event:
Name	Name	Name	Name
Address	Address	Address	Address
Telephone No.	Telephone No.	Telephone No.	Telephone No.

REPORT OF ADVERSE EVENT FOLLOWING IMMUNIZATION
DEPARTMENT OF HEALTH & HUMAN SERVICES, PUBLIC HEALTH SERVICE, Centers for Disease Control, Atlanta, Georgia 30333

PATIENT ID

Immunization Project Area | State Code | Seq. No. | County Where Administered: | County Code | MSAEFI REPORT NO. | FOR CDC USE ONLY

Date of Birth (Mo. Day Yr.) | Sex M F | Date of Initial Report (Mo. Day Yr.) | Source of Information: MD/DO Nurse Family Other

VACCINE HISTORY

Date of Immunization (Mo. Day Yr.)

Vaccine Administered By: Pub. Pvt. Mil. Other

Vaccine Purchased By: Pub. Pvt. Mil. Other

Enter Below All Vaccines Given on the Date of Immunization:

	Vaccine Type	Mfgr.	Lot Number	Route	Site	No. Prior Doses
A						
B						
C						
D						

CLINICAL DESCRIPTION OF PRESENT ILLNESS

SIGNS AND SYMPTOMS OF PRESENT ILLNESS

Onset of 1st Sign or Symptom: (Mo. Day Yr.)

	Yes	No	Unk
1. Fever: Temp ≥(100°F (37.8°C) (7806)			
Felt Hot, But Temperature Not Measured: (7806)			
Highest Measured Temperature ____ F/C			
2. Local Reaction: Site ____			
Pain, Swelling, Increased Warmth, Induration or Lump Without Abscess (9993)			
Abscess Formation — Required Drainage or Drained Spontaneously (6629)+(9993)			
Results of Culture ____			
3. Rash: Other Than at Injection Site (7821)			
4. Adenopathy:			
Local (Injection Site Area) (7856)			
Generalized (7856)			
5. Allergic Event: (9995)			
Hives (7060)			
Angioneurotic Edema (9951)			
Wheezing/Asthma (4939)			
Anaphylaxis (9994)			
If "Yes," Interval from Vaccination to Onset: <30 min 30 min-6 hrs >6 hrs			
Was Blood Pressure Measured?			
If "Yes," Lowest B.P. ___/___			
6. Arthralgia/Arthritis:			
Pain in Joints (7194)			
Inflammation of Joints (Redness, Swelling, Tenderness) (7169)			
7. Convulsions: (7803)			
If "Yes," How many Episodes Following Immunization			
8. Encephalitis and/or Encephalopathy: (3483)			
Abnormal Lumbar Puncture (Enter Results in Laboratory subsection) (7920)			
Signs of Increased Intracranial Pressure (3482)			
Focal Neurologic Signs (3499)			
Coma or Marked Alteration in Level of Consciousness (7800)			

	Yes	No	Unk
9. Guillain-Barré Syndrome: (3570)			
10. Reye's Syndrome: (3318)			
11. Polio: (0459)			
12. Paralysis other than GBS, Reye's Syndrome or Polio: (3449)			
13. Other Neurologic Symptoms and Diagnoses:			
Aseptic Meningitis (0479)			
Infantile Spasms (Hypsarrhythmia, drop seizures) (3456)			
Bell's Palsy (3510)			
Hearing Loss (3899)			
Neuritis, Neuralgia (7292)			
Paresthesias (7820)			
Screaming Episode (High-Pitched Abnormal Cry or Screaming Lasting ≥3 Hours) (7998)			
Neurologic Symptoms not cited above (specify) ____			
14. Miscellaneous:			
Hypotonic, Hyporesponsive Episode (7859)			
Idiopathic Thrombocytopenic Purpura			
If "Yes," Lowest Platelet count (2873)			
Pancreatitis (5770)			
Parotitis (5272)			
15. Death:			
Sudden Infant Death Syndrome (SIDS) (7980)			
Non-SIDS Death (7981)			
If "Yes," Cause(s): ____			

LABORATORY:

	Performed Yes	No	Unk	Results Normal	Abnormal
EEG (7940)					
BRAIN SCAN (7940)					
LUMBAR PUNCTURE (7920)					

Results if Abnormal:

WBC's ____ Opening Pressure ____

Lymphs (%) ____ Culture Results ____

Glucose ____ Other ____

Total Protein ____

Other Pertinent Information:

Signature of MSAEFI Coordinator:

Seen by Health Care Provider: Yes No Unk Number of Visits | Hospitalized Yes No Unk Number of Days

PAST HISTORY

Previous Illness Following Immunization: Yes No If "Yes," Date: (Mo. Day Yr.)

Vaccine ____

Describe Illness ____

Previous Convulsions in Patient: Yes No Unk.

If "Yes," With Fever Without Fever

History of Convulsions in Siblings or Parents: Yes No Unk.

If "Yes," With Fever Without Fever

FOLLOWUP

SEVEN DAY FOLLOWUP: (Mo. Day Yr.) If recovered, send to State Office

30 DAY FOLLOWUP: If not recovered at 7 days, carry out 30 Day Followup and send to State Office

	Duration of Illness	Recovered	Partially Recovered*	Not Recovered*	Not Located	Dead
SEVEN DAY FOLLOWUP	Days					
30 DAY FOLLOWUP	Days					

* Comments ____

Reviewed By Immunization Project Physician (Items 7 - 15 and Anaphylaxis): Yes No Unk Signature of Reviewing M.D.

FOR CDC USE

Results of One-Year Followup: Recovered Partially Recovered* Not Recovered* Dead Not Located *Comments ____

POSITION PAPER/Department of Health & Social Services

Position Paper

HB 277

For an Act entitled: "An Act relating to the immunization of minors."

HB 277 proposes the following changes in statutes pertaining to the immunization of minors in Alaska:

1. Section 1 amends AS 14.30.125 by removing the requirements for immunization against specific diseases as a condition for admission to schools, preschools, nurseries, or day care or child care when a parent or legal guardian states that immunization is contrary to the parent's or guardian's philosophical beliefs. (The Alaska Administrative Code currently exempts children whose parents object to immunizations because of religious beliefs.)

2. Section 2 requires that an individual or facility administering vaccine must provide the following information to the parent or guardian prior to the immunization: (a) a written explanation of the risks and benefits associated with the immunization; (b) a copy of the product insert required by the Food and Drug Administration; (c) a list of symptoms of adverse reactions to the immunization; and (d) a copy of the pertinent legislation and regulations. Moreover, the person who administers the immunization must ascertain that the parent or guardian has received and understands the materials provided.

3. Proposed Section AS 18.15.310 requires that health care providers submit and the Department of Health and Social Services investigate any reports of adverse reactions to immunizations and requires the department to report annually to the legislature on the incidence of infectious disease and the incidence of serious reactions and permanent or long-term damage to minors that results from immunization.

4. Proposed Section AS 18.15.320 requires that records of lot numbers and vaccine manufacturers be maintained for three years after immunization.

The first three of these provisions are discussed below.

1. <u>Exemption from mandatory immunization requirements based on philosophical beliefs of parent or guardian</u>

AS 14.30.125 authorizes the Department of Health and Social Services to require that children entering school be immunized against diseases

specified by the commissioner. Currently, regulations (7 AAC 50.255) require immunizations against diphtheria, tetanus, polio, measles, rubella, and if the child is under seven years of age, pertussis. Regulations allow a child to be exempted from immunization requirements if receiving the immunization is contrary to the religious beliefs of the parent or guardian or if there are medical reasons to exempt the child. 7 AAC 50.255, adopted under the authority of AS 47.35.030, requires that a child receive immunizations "appropriate to his age as prescribed in the Alaska Division of Public Health's schedule for active immunization" as a condition of admission to day care.

Although "childhood diseases" are commonly thought to be benign, complications do occur and can be severe. For example, inflammation of the heart muscle can complicate diphtheria; pneumonia is one of the chief complications of both measles and pertussis; and neurological damage can occur with diphtheria, measles, mumps, and pertussis. Rubella can cause a wide spectrum of congenital disorders when acquired by the mother during pregnancy. The goal of rubella immunization programs is to assure immunity of all females before they reach childbearing age and to limit the accidental exposure of pregnant women to the virus.

Vigorous immunization efforts aimed particularly at very young children have virtually eliminated most of the vaccine-preventable diseases, as seen in the following table:

	Diphtheria	Measles	Mumps	Pertussis	Rubella
1976	8	14	39	0	2
1977	2	60	35	5	1
1978	3	1	15	18	8
1979	0	17	15	10	4
1980	0	6	15	5	12
1981	1	0	20	1	1
1982	0	1	6	0	1
1983	0	1	10	0	0
1984	0	0	8	3	1
1985	0	0	10	30	1
1986	0	0	8	5	0

Unfortunately, vaccines are not perfect. Vaccines are not 100 per cent effective, and therefore some people who are immunized may not be protected. Also, vaccines are not perfectly safe, and some people who receive them may be damaged by them. The question is one of balancing the benefits to the individual receiving the vaccine and the benefits to society in general against the risk of damage.

In recent years, debate on benefit v. risk has centered on the pertussis vaccine. (Pertussis is a component of the DPT vaccine, one of the "baby shots.") Reactions to the vaccine are relatively common since about 40 per cent of vaccinated children develop minor redness, swelling, and pain at the site of injection. Fever, vomiting, and drowsiness occur in about 20 per cent of vaccines. Convulsions or collapse with complete recovery occur at a rate of about one episode per 1,750 vaccine doses given. Encephalitis occurs at a rate of one case per 110,000 doses

given, and encephalitis with residual defect at a rate of one case per 310,000 doses administered. Sudden infant death syndrome is not related to pertussis vaccine use.

Given the relatively low incidence of pertussis, the adverse effects associated with the vaccine seem prominent. However, for perspective, the effects of the disease itself should be considered. The death rate from pertussis for previously unvaccinated patients who develop the disease is one in 1,000; among affected children less than one year of age, the death rate is one per cent. Permanent brain damage from whooping cough afflicts one child in 10,000 cases. Consensus among health authorities is that the benefit from immunization outweighs the risk. This view has been expressed by the American Medical Association, the Public Health Service, the American Academy of Pediatrics, and the American Public Health Association.

The department believes that because the proposed exemption includes individuals with philosophical objections to immunization, a serious health threat for many Alaskan children will be created. There will be increased risk for those whose parents or guardians elect to exclude them from immunization. There will be increased risk to very young children in other families who have not had a chance to complete the entire series of injections. There will be increased risk to the 10 to 20 per cent of completely immunized children who are incompletely protected because the vaccine is not 100 per cent effective. The decision not to immunize has effects that extend beyond the individual.

Since the decision not to immunize is likely to be unevenly distributed across the population, it is thought that there will be geographic areas in which significant numbers of children will be unimmunized and where the likelihood of disease occurrence will be great.

The recent upswing in reported cases of pertussis in Alaska is directly attributable to the nonimmunized or inadequately immunized status of the cases.

2. Immunization Information

Much of the intent of this portion of the proposed bill is already required by the department as a part of its agreement with the federal Centers for Disease Control, through whom the state's vaccine supply is purchased. The department provides the major portion of vaccines used in the state, with the exception of vaccines used by the military. A written explanation of risks and benefits called the Important Information Statement is used in the public sector. By signing the statement, the parent or guardian states that he or she has read the statement and has had an opportunity to ask questions of the person administering the vaccine. The manufacturer's name and vaccine lot number are recorded and retained. Private physicians who receive vaccine from the state can use the Important Information Statement system or exercise their professional judgement in informing parents or guardians of the risks and benefits of immunization. Written descriptions of potential adverse reactions are also provided. Copies of applicable statutes and regulations are not distributed or discussed.

POSITION PAPER/Department of Health & Social Services

3. Reporting of adverse reactions

7 AAC 27.005 currently requires health care providers to report "severe reactions to any vaccine" to the department. These reports are investigated according to strict protocol required by the national Centers for Disease Control. The investigation and reporting of adverse reactions to vaccinations are required as a condition of the immunization grant awards the department receives from the Centers for Disease Control. The department believes that the current regulatory language is sufficiently directive with regard to the reporting of adverse reactions and the statutory changes proposed in HB 277 are unnecessary.

In addition, Congress has recently adopted a federal vaccine liability law, and the federal government is currently writing regulations for its implementation. This law states: "The Secretary shall establish in the Department of Health and Human Services a National Vaccine Program to achieve optimal prevention of human infectious diseases through immunization and to achieve optimal prevention against adverse reactions to vaccines."

This new law does not allow states to use any discretion regarding the reporting and investigation of reactions to vaccinations. This law also requires that each health care provider who administers a vaccine shall provide to any legal representative of any child to whom such provider intends to administer a vaccine a copy of written information about the vaccine.

Departmental Position

The department opposes this bill for three reasons: (1) Extending exemption from immunization requirements to individuals with philosophical opposition to such requirements will create a serious public health threat to Alaskan children. (2) HB 277's requirement to inform the parent or guardian of an immunization's risks and benefits is unnecessary, as this is already required by the department and by recently enacted federal law. (3) The department will be required to conform with the stringent new federal law governing reporting of adverse reactions. The statutory changes proposed in HB 277 are thus unnecessary and, if adopted, may have to be changed to meet the new federal requirements.

Recommended by: Elizabeth A. Ward
Elizabeth Ward, Director
Division of Public Health

Date: January 26 1988

Approved by: Myra M. Munson
Myra M. Munson, Commissioner
Department of Health and
Social Services

Date: Feb 10, 1988

STATE OF ALASKA
1988 LEGISLATIVE SESSION

BILL VERSION: HB 277
PUBLISH DATE: _____

FISCAL NOTE

REQUEST:

Revision Date: 4/29/87
Title: An Act relating to the immunization of minors.
Sponsor: _____
Requestor: Navarre

Agency Affected: Health & Social Services
BRU: State Health Services
Components: Section of Epidemiology

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 88	FY 89	FY 90	FY 91	FY 92	FY 93
PERSONAL SERVICES		45.2	46.9	48.7	50.5	52.4
TRAVEL		6.0	6.0	6.0	6.0	6.0
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING		51.2	52.9	54.7	56.5	58.4
CAPITAL						
REVENUE						

FUNDING: (Thousands of Dollars)

GENERAL FUND		51.2	52.9	54.7	56.5	58.4
FEDERAL FUNDS						
OTHER						
TOTAL		51.2	52.9	54.7	56.5	58.4

POSITIONS:

FULL-TIME		1.0	1.0	1.0	1.0	1.0
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary)

Personal services and travel costs are for one PFT Public Health Representative, range 16, to assure public information and reporting requirements are met. See attached.

Prepared by: Elizabeth Ward, Director — Phone: 465-3090
Division: Public Health — Date: 2-09-88

Approved by Commissioner: Myra M Munson — Date: 2-10-88
Agency: Department of Health & Social Services

Distribution (by preparer):
Legislative Finance
Legislative Sponsor
Requestor
Office of Management and Budget
Impacted Agency(ies)

HB 277 Fiscal Note Analysis

To meet the requirements of Section 2 of HB 277, which requires individuals or facilities administering immunizations to provide detailed immunization information, a PFT Public Health Representative, range 16, will be needed. This person will be responsible for monitoring the individuals and agencies providing immunizations to assure compliance with the public information requirements of this bill. This person will educate providers on public information and reporting requirements, and will develop and maintain a centralized data bank regarding compliance.

The incumbent will also serve as the intial investigator for the proposed AS 18.15.310 and will develop the annual report for submission to the legislature.

This legislation will cause a reduction in immunization levels in Alaska. Increased disease outbreaks will follow, requiring additional staff time to perform follow-up investigations and outreach information services.

Position Title	No. of Positions	Range/Step	Barg. Unit
Public Health Representative	1	16B	GGU

Time Status	Staff Months	Location	Election District
PFT	12	Anchorage	HD 10/SD F

Type of Expenditure		Amount
1	2	3
Salary	33.6	
Benefits	11.6	
Premium Pay	0	
Other	0	
Total Personal Services		45.2
Travel		6.0
Contractual		
Commodities		
Equipment		
Other		
Total Cost		51.2

Funding Source for Total Cost		
Federal Receipts	1002	
G. F. Match	1003	
General Fund	1004	51.2
GF Program Receipts	1005	
Other		

Justification

A Public Health Representative, range 16, in Anchorage is necessary to assure compliance with the public information requirements of this legislation. This position will monitor the individuals and agencies providing immunizations and will educate them on public information and reporting requirements. The position will develop and maintain a centralized data bank on compliance. The incumbent will also be the initial investigator for the proposed AS 18.15.310 and will develop the annual report to the legislature.

Request For New Position

Agency: Health & Social Services

BRU: State Health Services

Component: Epidemiology

Revised Date

FY 89

Children's Diseases Increase As Vaccinations Decline

Officials are worried about minor problems becoming major

By Michael Specter
Washington Post Staff Writer

Cases of measles, mumps and whooping cough have risen steadily over the past several years while the percentage of young children receiving vaccines has dropped, according to a recent report by the Children's Defense Fund.

Public health officials have become worried that if the trend continues, childhood diseases that are now considered minor problems in the United States could return in force.

"Anytime you have a disease that can be prevented by a vaccine, the effort of the nation should be to eliminate it," says Surgeon General C. Everett Koop. "Compare the cost of the vaccine—in pain as well as money—to the cost of the disease. We need to reach the children we are missing."

Health experts say that diminished federal funds have been responsible for at least part of the problem. As funds have been cut during the past five years, it has become increasingly difficult for poorer children to gain access to vaccines, according to the report.

The surgeon general has set as a health objective for 1990 that at least 90 percent of the nation's children have vaccines before they are 2 years old. But general levels of immunization for preschool children declined between 1980 and 1985, according to federal statistics.

Progress toward the surgeon general's vaccination goals slowed or fell off for most major childhood diseases in the past five years, the Children's Defense Fund report says. For polio, measles, rubella, mumps and DPT (diphtheria, pertussis and tetanus), the percentage of children under 2 who received full immunization declined between 1980 and 1985.

During those years, the last for which there are complete statistics, the proportion of 1- to 4-year-olds receiving no doses of polio vaccine rose by 40 percent for children of all races and 80 percent for nonwhite children, according to the report. In addition, cases of mumps rose in 1986 after a 15-year decline, and in 1985 there were 3,589 reported cases of whooping cough, or pertussis, the highest number since 1970.

"This is becoming a very serious problem," says Dr. Richard Narkewicz, president of the American Academy of Pediatrics. "The immunization program in this country is a bulwark for the future health of our children. It has been built over years and it is beginning to erode."

Narkewicz cites several reasons for the drop in the percentage of children seeking immunization. The liability risks have driven the costs of vaccines up and pushed many drug companies out of the business. Also, because vaccines pose an inherent—but incredibly small—risk to children under 2, some parents decide to avoid them.

"Many American pediatricians have never even seen whooping cough," Narkewicz says. "Because the disease is so rare a certain complacency begins to settle in. But as long as the disease is still out there, it cannot be ignored."

Many health officials believe that parental fears about bad reactions to vaccines have been blown out of proportion. Nearly 11 million children are immunized in America each year and about 30 to 50—at most one out of 220,000—have reactions that cause permanent damage.

But health officials agree that benefits of vaccines far outweigh possible risks. The Children's Defense Fund report, which used figures compiled by the federal Centers for Disease Control, says the number of measles cases reported has risen dramatically since 1983 and that more than 80 percent could have been prevented through adequate immunization.

The development of successful vaccines for most major childhood diseases has been regarded as a hallmark of modern medicine. Vaccines routinely protect children against seven diseases: polio, measles, mumps, rubella, diphtheria, tetanus and pertussis.

Statistics suggest that the decline in vaccinations can be attributed at least partially to access problems rather than parental decisions to avoid the shots. Poor and minority children consistently had the biggest drop in vaccination rates.

Vaccines against DPT give some illustration of the small but growing problem. The percentage of children from 1 to 4 years old with no reported dosages rose only slightly from 0.7 to 0.8 percent between 1980 and 1985, according to the report.

Complete protection requires a series of shots. The number of children younger than 1 only partially immunized against DPT climbed by 10 percent, from 15.8 to 17.3, while the percentage of nonwhite infants not fully immunized climbed 68 percent from 21.0 to 35.2 percent.

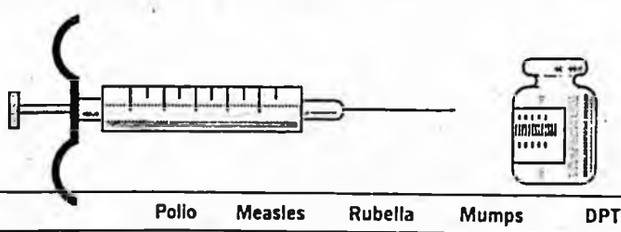
The final appropriation for the program in fiscal 1988 has been set at $86 million, $8 million below the full authorization level. That figure is slightly higher than current levels, but the price per dose of vaccine for measles, mumps and rubella has risen sharply over the past decade from $2.42 in 1975 to $8.47 last year, according to the report.

"By 1986 it took three times as many federal immunization grant dollars to purchase the same number of vaccine doses that were purchased in 1981," the report says.

The number of children younger than 6 has also increased over the past several years, from 18.8 million in 1979 to 21.7 million in 1986, and the number of poor and uninsured children rose dramatically. Between 1982 and 1985 the number of uninsured children increased by more than 16 percent. "It all boils down to dollars," Narkewicz says. "But this makes sense economically as well as medically." ■

HOW MANY CHILDREN ARE IMMUNIZED?

PERCENTAGE OF CHILDREN AGE TWO AND YOUNGER



Year	Polio	Measles	Rubella	Mumps	DPT*
1980	80.7%	83.0%	83.2%	80.2%	87.0%
1981	80.9	81.5	83.9	79.1	87.6
1982	78.6	84.3	81.1	79.0	88.4
1983	78.6	83.9	81.9	78.1	88.4
1984	74.2	81.7	76.7	78.4	85.8
1985	76.7	81.7	77.3	78.9	85.8
1990 Objective	90.0	90.0	90.0	90.0	90.0

*Diphtheria, pertussis and tetanus
NOTE: Full immunization for DPT and polio at this age is defined as three or more vaccinations.
SOURCE: Centers for Disease Control

THE WASHINGTON POST



Daniel S. Strickler

Vaccinations And Immune Malfunction

Harold E. Buttram, M.D. and John Chriss Hoffman

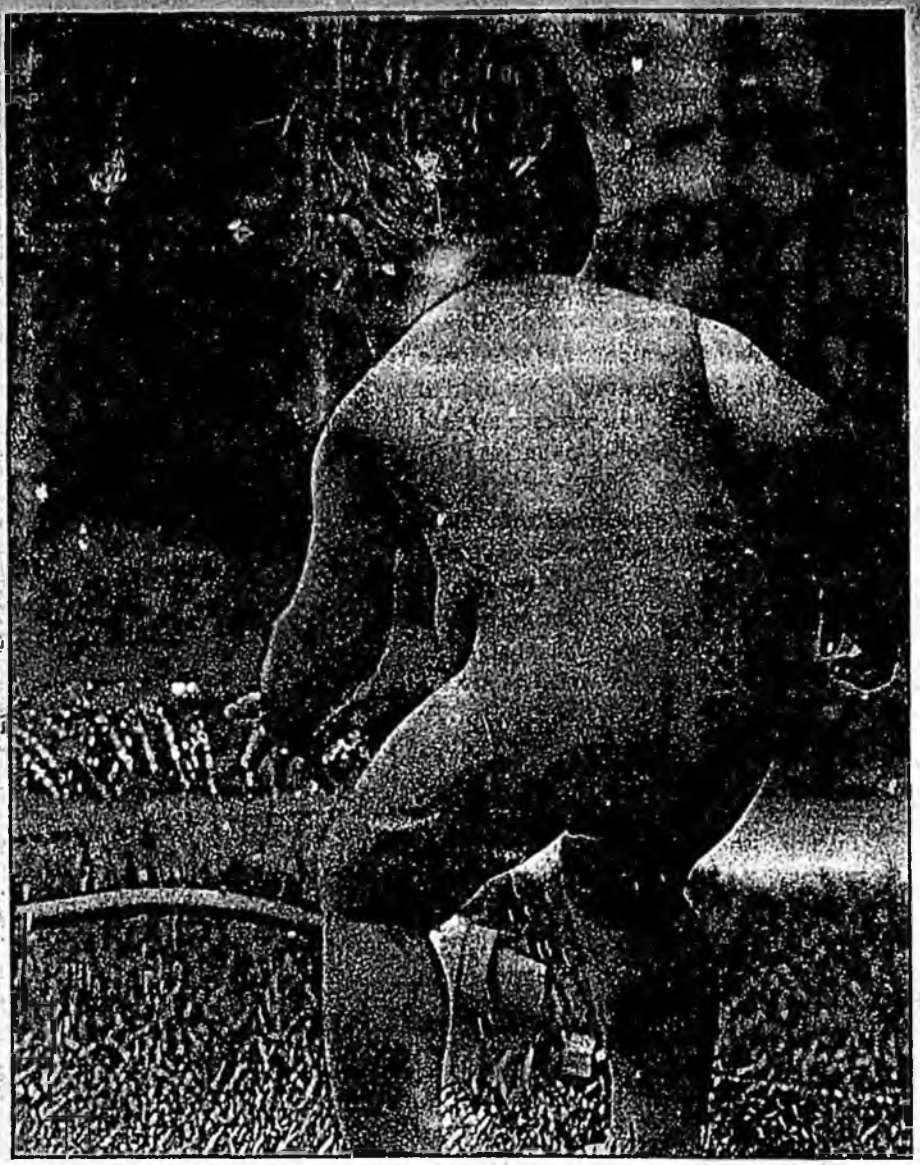
One of the fundamental issues concerning current vaccination programs can be summarized in the following question: **Is there a significant difference between the immunity acquired in the natural course of a disease, such as mumps or measles, and the immunity gained from vaccines?** There do appear to be fundamental differences.

Natural immunity in a healthy person is based on a series of body defenses, much as the defense of a medieval fortified castle. Vaccinations, on the other hand, inject massive amounts of vaccine preparations directly into the body, thus by-passing the outer defenses.

By way of illustration, let us assume that a child is born with a total immune capacity of 100 units. According to the one cell/one antibody rule, once an immune body (plasma cell or lymphocyte) becomes committed to a given antigen, it becomes incapable of responding to other antigens or challenges. Again, let us assume that a hypothetical child twenty or more years ago passed through the usual childhood diseases of former decades (measles, mumps, chicken pox, and so on) with relatively minor and uncomplicated illnesses. Consider-

ing the extreme efficiency of "natural immunity" we may make an educated guess that permanent immunity was gained to these diseases by utilizing only 3 to 7 percent of the total immune capacity. In the case of the routine childhood vaccines, in contrast, it is likely that a higher percentage of the total immune capacity becomes committed, perhaps something on the order of 30 to 70 percent. It should be emphasized that, once an immune body becomes committed to a specific antigen, it becomes inert and incapable of responding to other challenges.

If the reserve capacity of children is being reduced by current vaccinations in this manner, what will be the consequences? No one knows for certain at this time, but it is possible that these consequences could be seen as an increased susceptibility to viruses, to other infections, and to various forms of allergies. The consequences may be seen as immunologic disorders in the form of autoimmune diseases, which are increasingly recognized in modern times. Finally, there is indisputable evidence that many instances of mental and nervous disorders are caused by immunologic aberrations.[2-6] The relationship of these disorders to vaccinations remains speculative at this time, but there is a substantial and growing body of evidence that modern vaccines can result in immune malfunction.



Susan Peace

THE EVIDENCE

For many years immunologists have been aware of a state of *anergy* (immunological unresponsiveness) folowing vaccinations. For example, live-virus vaccines have been shown to transiently suppress tuberculin sensitivity.[7,8]

One of the most extensively documented studies of the indirect effects of vaccines is to be found in the book, *The Hazards of Immunization,*[9] by Sir Graham Wilson, formerly of the Public Health Laboratory Service, England and Wales. In his chapter entitled, "Indirect Effects: Provocation Disease," Dr. Wilson provides a number of documented historical examples in which vaccination against one disease seemed to provoke another. As one example, a physician in London first drew attention to the relation between inoculation against diptheria or pertussis and attacks of poliomyelitis when he de ed fifteen cases he had seen between 1944 and 1949. Paralysis came on, as a rule, seven to twenty-one days after injection and affected the left arm, into which injections were usually given, four times as often as the right. In describing this type of occurrence, Wilson stated:

> *"When a vaccine is injected into the tissues during the incubation period of a disease or during the course of a latent infection, it may bring on an acute attack of the disease. That is to say, the incubation period is shortened, or a latent infection that might have given rise to no manifest illness is converted into a clinical attack. The two diseases in which this so-called provocation effect has been most studied are typhoid fever and poliomyelitis, but evidence exists to show that it may be operative in other diseases . . ."*

An important investigation into the role of malnutrition and vaccination as causative factors in immune dysfunction has been in progress among the Australian aborigines since the early 1970's by Archie Kalokerinos, M.D. of New South Wales, Australia (later aided by Glenn Dettman, Ph.D., Orthomolecular Medisearch, of Mentone, Australia).

One of the first published reports of large-scale immune malfunction following the conventional childhood vaccines is to be found in the book, *Every Second Child,*[10] by Archie Kalokerinos. In this book, Dr. Kalokerinos describes his work as a physician in the 1960's and 1970's among Australian aborigines. In

early work with these peoples, he was appalled by the high infant mortality rate — death rates in some areas having soared to 50 percent.

The Australian aborigines were a unique population: They lacked the natural resistance to many infectious diseases to which the Caucasian race has been exposed through the centuries. Also the aborigines lived in relative poverty on a diet consisting mostly of highly refined and denatured food products, a diet deficient in many vital nutrients.

Dr. Kalokerinos determined that many of the aboriginal infants suffered from acute ascorbic acid (vitamin C) deficiency. He postulated that a compromised immune resistance due both to a diet lacking in essential nutrients, especially vitamin C, and to the presence of infectious illness placed many infants in a dangerous state of health. In many children the injection of vaccine, further challenging an already crippled immune system, was enough to bring on death.

Working on the assumption that these deaths were the result of an interaction of the vaccinations with malnutrition, he instituted an improved nutrition program with regular ascorbic acid supplementation. In addition, he screened infants to avoid giving vaccines during minor illnesses. As a result, infant mortality was virtually abolished. For two years, not one infant under his care died.

Besides diseases of an acute nature, chronic degenerative diseases have also been reported to follow vaccination. Numerous German authors have described the occurrence of multiple sclerosis following administration of vaccines against small pox, typhoid fever, paratyphoid fever, tetanus, poliomyelitis, tuberculosis, influenza, and rabies.[11] Systemic lupus erythematosis has been reported to occur following vaccination.[18]

Burton Waisbren posed the following question concerning the apparent immune system-mediated diseases of multiple sclerosis and Guillain-Barre syndrome — notorious due to its tragic occurrence after the ill-fated swine flu vaccine program:

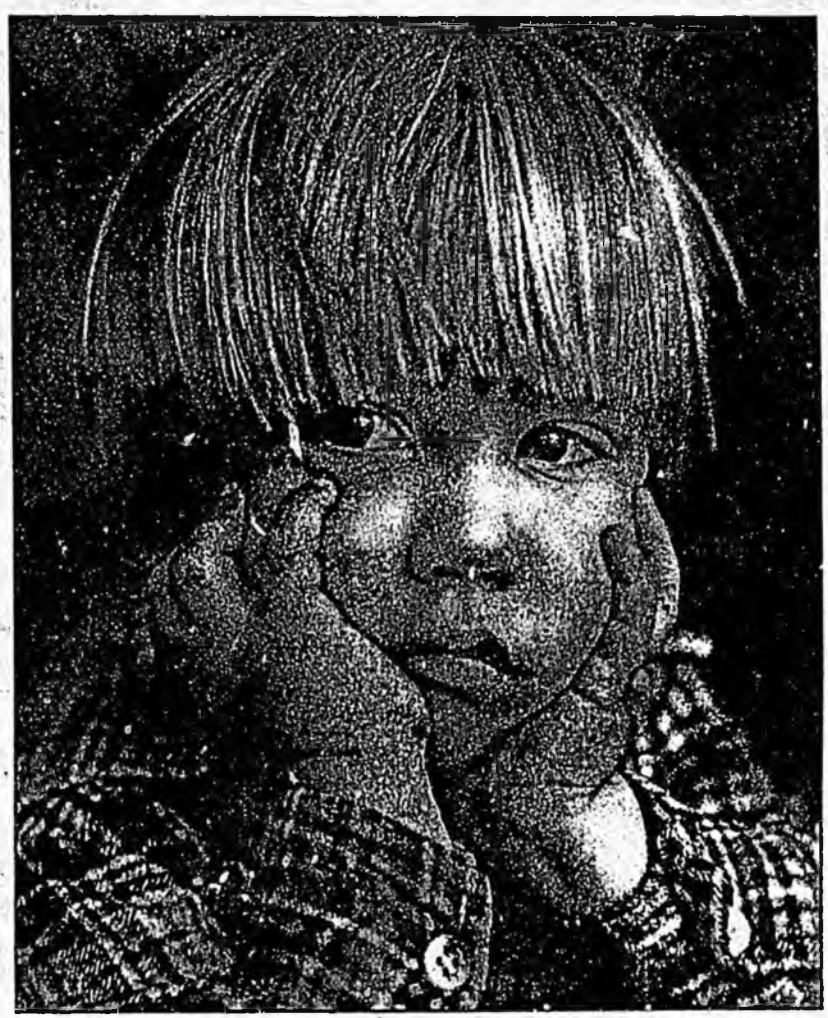
> *"Is it possible that an antigen in the swine-influenza vaccine evokes in some patients an immune response to myelin basic proteins; those that surround the peripheral nerves in patients who developed Guillain-Barre syndrome, and those around the central nerves in patients who developed a disorder similar to multiple sclerosis?"*[12]

Dr. Robert Couch, Baylor University, Houston, Texas, testified before the U.S. Public Health Service Immunization Practices Advisory Committee in January, 1982, that after flu vaccination of elderly persons who had history of chronic disorders, six of seven persons with allergies reported their allergies to worsen; one of twenty with hypertension noted increased blood pressure; one of nine with diabetes and two with gout developed a cold, a gout attack, and increased blood sugar; one on therapy for Parkinson's Disease noted increased clumsiness.[13]

In a study of the diptheria-pertussis-tetanus (DPT) vaccine, only 7% of those receiving the vaccine had no untoward reactions; 54% had fevers and 32% exhibited behavioral changes.[19]

SUMMARY AND CONCLUSIONS

At the present time an overwhelming majority of the members of the American medical community accept and approve current vaccination programs for children. It should be obvious that this period of early infancy with an immature immune system is one of extreme vulnerability and susceptibility to



Lucia Jenkins

Current research . . . is arrested by the system of compulsory vaccination for school children. If vaccinations are made optional . . . medical research can move ahead in search of other workable solutions . . .

vaccinations, especially in the earliest months following birth. Only a handful of physicians and lay-persons throughout the decades have objected to these vaccination programs because of suspected adverse side effects. In some instances their arguments have lacked substance due to the fact that they have sought to demonstrate direct toxicities from the vaccines.

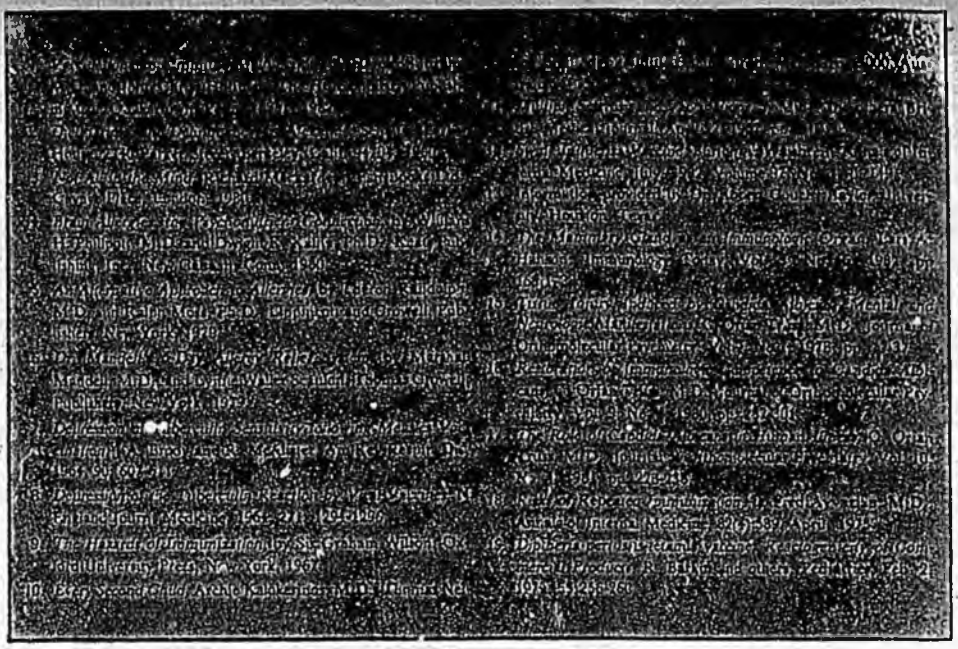
Direct toxicities do occur, but they appear to be relatively uncommon. Most authorities today consider these occasional incidents as an acceptable risk. They believe that the benefits from the vaccines, in terms of control gained over infectious diseases, far outweigh the danger of toxicities.

The real danger appears to be an indirect effect with impairment and malfunction of the immune system. Since this effect is often delayed, indirect, and masked, its true nature is seldom recognized.

Within the United States few persons have braved the wrath of orthodoxy by pointing out the probability of widespread and unrecognized immune system malfunctions, which are vaccine-induced, and the need for scientific investigation of these effects. In our opinion there is now sufficient evidence of immune malfunction following current vaccination programs to anticipate a growing public demand for research investigation into alternative methods for prevention of infectious diseases.

The one change that could bring immediate and far-reaching results is to allow absolute freedom-of-choice in accepting or rejecting vaccines for every individual and every parent. Like the Mississippi River steamboat that is grounded on a sand-bar, current research in the prevention of infectious diseases is arrested by the current system of compulsory, mandated vaccination for school children. If vaccinations are made optional, the situation will become unfrozen. Medical research can then move ahead in search of other workable solutions.

In an enlightened free society such as America, there are inherent checks and balances in a system which allows free choice to the individual in matters which concern his or her personal welfare. Nothing else works quite so well.





Harry Camp

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VACCINATIONS AND INDIVIDUAL FREEDOM

Vicki Giles

The Center for Disease Control (CDC) in Atlanta, Georgia has recently made recommendations concerning Wyoming immunization laws in an attempt to *increase* the number of school children who are "properly immunized." This number is currently 98.1 percent of Wyoming public school children, according to the CDC.

There can be no doubt that any medicine that is potent enough to do good has at least some potential for toxicity as well. Parents should be aware of the following precautionary steps when dealing with routine vaccinations:

- **Do not allow your child to be immunized if he or she has been ill or has had a cold or runny nose within the last 48 hours.** Vaccinations provide immunity by going directly into the bloodstream, and an immune system that is already taxed is more likely to react badly to immunization. Vaccinations also affect the lymphatic system which may already be stressed by a cold or runny nose.

- **If you wish to have your child vaccinated, consider beginning at six months rather than six weeks. If your child was small for gestational age or was born prematurely, consider waiting even longer.**

Although most physicians would recommend that immunizations be started at six weeks because the risk of pertussis, for example, is greater in infancy, there have never been any controlled studies done to determine whether or not an infant under six months of age can actually build immunity when immunized. Booster shots became popular to protect against the possibility that early immunity may not develop through immunization.

In Great Britain, vaccinations are started at six months of age. Why do we start them so much sooner in the United States? The major reasoning for beginning vaccinations so early comes from a study conducted by Parke-Davis in 1962, which concluded that it is more likely that children will receive the entire series of vaccinations if they are begun early in infancy. And, since most babies visit the doctor at four to six weeks for a check-up, it is more convenient for the health practitioner to start the series of immunizations at this time.

- **If you have a family history of central nervous system disease, deafness, blindness, convulsions, or life-threatening allergies, the pertussis vaccine may be contraindicated for your child.** The pertussis, or "P" part of the DPT vaccine is considered quite crude. The "whole-cell" pertussis vaccine which American children are given has not been separated; the child receives the part of the pertussis cell which generates immunity to the disease along with the part which causes toxic reactions. Current research may be able to isolate the toxic element.

- **If one child in your family has had a serious reaction to the pertussis vaccine, the child's siblings should probably not receive the vaccine.** Children in the same family tend to react similarly to the pertussis vaccine. The reason for this is not clear.

- **If your child has exhibited a severe reaction to the pertussis vaccine, immediately find a physician who will verify the reaction and write in your child's permanent medical record that he or she should never again receive a pertussis shot.**

Once a particular child has reacted seriously, additional doses will frequently cause more serious reactions. A serious reaction to vaccination may include any of the following: excessive, high-pitched screaming (the high-pitched scream is suggestive of central nervous system irritation); severe swelling or redness at the site of the injection; fever lasting several days; collapse or extreme lethargy; grayish skin color and cool extremities; or convulsions.

If your child exhibits any of these symptoms, be sure to report this to your health professionals and urge

Photo: James Ewing

them to report the reaction to the CDC along with the lot and batch number of the vaccination given. Some physicians might not consider local swelling and fever for several days to be severe reactions; but there have been cases of children who have exhibited swelling and fever reactions to a first immunization and more severe reactions to a second one, so even swelling and fever should not be minimized.

Some practitioners suggest a half dose followed by another half dose for children who have exhibited a toxic reaction to the vaccine. All available evidence indicates that giving the child a half dose of DPT, followed one week later by another half dose, does *not* lessen the potential for toxic reaction.

• **Always write down the batch and lot number of any vaccine that your child is given.** Be sure to look carefully at the vial whenever your child is given a vaccination. It is possible for a person to make a mistake and give your child the wrong vaccine.

If for any reason your child becomes ill enough to be hospitalized within two weeks following a vaccination, fully describe the course of illness to the health center where the child was given the vaccination. Urge the healthcare professionals to report the reaction and the batch and lot number to the CDC. This will help the CDC statistically analyze whether the batch is particularly reactive or whether your child is overly sensitive to vaccination.

Many, perhaps most, doctors do not consistently report adverse reactions to vaccines. Consequently, the CDC lacks clinical figures for how often a particular vaccine is reactive.

• **For about two weeks after receiving the "live" polio vaccine, keep your child away from anyone who is not fully immunized against polio, anyone who has an immune deficiency (for example, Acquired Immune Deficiency Syndrome or a deficiency due to chemotherapy)—for their own protection.**

The "live" polio vaccine, a live virus, is contagious. Because the disease is carried in the bodily excretions, it is especially important to refuse to allow people who have an immune deficiency to change your baby's diapers.

Be aware that most doctors recommend not giving your child aspirin following the live polio vaccine, because aspirin use has been associated with Reye's syndrome when a child is ill with a virus. A "killed" polio vaccine is also available, but it is not thought to be as effective as the live vaccine.

"Herd immunity" is based on the belief that if *most* people in a community are immune to a disease, an epidemic can be prevented. Those in favor of 100 percent vaccination do not seem to recognize the fact that not *everyone* who receives a vaccine for a particular disease will be totally immune to this disease. The belief that "allowing one person to be free from immunity will endanger everyone" is without validity.

Medical care is an individual question in a free country. Medical practice has a tendency to follow traditions long after they are useful. Vaccinations should be a question for each *individual* to answer. Only then will we be free to be healthy.

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IN THIS ISSUE: **AIDS: LINKAGE TO SMALLPOX VACCINE**
Condoms Aren't Foolproof . . . Blaming the Victim . . .
Tests Aren't Reliable

AIDS linked to smallpox vaccine

Have you read anything in your newspaper which links the AIDS epidemic with vaccinations? Have you seen or heard any television or radio reports on the subject? I haven't, and as you know, I've been following the AIDS epidemic very carefully.

Have you heard Dr. Robert Gallo, the U.S. expert who first identified the AIDS virus, talk about AIDS and vaccines? I haven't. But, Dr. Gallo did tell the London Times (May 11, 1987), "The link between the WHO programme [the World Health Organization effort to eradicate smallpox in Third World countries] and the [AIDS] epidemic in Africa is an interesting and important hypothesis. I cannot say that it actually happened, but I have been saying for some years that the use of live vaccine such as that used for smallpox can activate a dormant infection such as HIV."

Has Dr. Gallo been making these speculations "for some years" to only the British press? Or, if he and Surgeon General Koop and the experts from the Centers for Disease Control have mentioned this to U.S. reporters, have their words been drowned in the cacophony of statements telling people that it's their own fault if they get AIDS?

Government scientists have been quick to point the finger at peoples' lifestyles--"You don't have the right sexual partners," "You don't wear enough condoms," etc. But nowhere on the front pages of U.S. newspapers has there been a hint that the doctors may have played at least as important a role in spreading AIDS as have the people.

Look how quick government doctors are to blame drug addicts for spreading AIDS by sharing needles. But have they told you that, in the recent WHO smallpox vaccination campaign, needles were re-used 40 to 60 times? The main method of "sterilization" was waving the needle across a flame. Doctors are quick to play the game of "blame the victim," but what if it turns out that doctors themselves are responsible for the victims' plight?

WHO information indicates that the AIDS table of Central Africa matches the concentration of smallpox vaccinations, i.e., the greatest spread of HIV infection coincides with the most intense immunization programs. Thus, Zaire, at the top of the AIDS list, had 36,000,000 people immunized with the smallpox vaccine. Next is Zambia, with 19 million, followed by Tanzania with 15 million, Uganda with 11 million, Malawai with 8 million, Ruanda with 3.3 million and Burundi with 3.2 million. Brazil, the only South American country covered by the smallpox eradication campaign, has the highest incidence of AIDS in that part of the world.

This theory--that the AIDS epidemic in Africa may have been triggered by the smallpox immunization program--has sparked intense debate among scientists. You may not have heard about this debate, but an urgent call for evidence to support the idea has been demanded by the World Health Organization. This theory was discussed by WHO officials last autumn. No follow-up data are available from the smallpox eradication campaign because no systematic studies of the complications produced by the mass immunization have been done(!).

According to Professor Oswald Jarrett, an AIDS researcher at the University of Glasgow (Scotland): "We need to know whether the virus was spread from a small to a large group of people through the immunization programme." And Dr. Laurence Gerlis, a clinical AIDS researcher, states, "Previous circumstantial evidence looks more persuasive alongside the latest research that shows AIDS can be stimulated by smallpox vaccination."

Here's what the unnamed WHO advisor who disclosed the problem to the Times had to say: "I thought it was just a coincidence until we studied the latest findings about the reactions which can be caused by vaccinia. Now I believe the smallpox vaccine theory is the explanation to the explosion of AIDS."

This theory also provides an explanation of how AIDS infection is spread more evenly between males and females in Africa than in the West.

Further evidence of the link between AIDS and the smallpox vaccine comes from the Walter Reed Army Medical Center in Washington, D.C., where routine smallpox vaccination of a 19-year-old army recruit was the trigger for the stimulation of dormant HIV virus into full-blown AIDS. This discovery was made by a medical team working with Dr. Robert Redfield at Walter Reed. The recruit developed AIDS two-and-a-half weeks after being immunized against smallpox, and he died shortly thereafter.

While in no way diminishing the role certain lifestyles play in AIDS causation, isn't it high time that we turn the spotlight on the possibility that modern medical miracles--immunizations included--can help cause modern medical plagues?

AIDS and hepatitis B vaccine

The safety of the hepatitis B vaccine (a human blood product) has been questioned in the Journal of the American Medical Association (January 16, 1987). Albert L. Meric of Metairie, Louisiana, disagrees with other researchers who insist that the AIDS virus has been physically removed from the hapatitis vaccine. He points out that just because hepatitis vaccine recipients did not develop antibodies to the AIDS virus does not mean the AIDS virus is not present in the hepatitis vaccine. Or, to use his own words, "It does not rule out the physical presence of AIDS virus antigen in the vaccine." Meric concludes that the presence of AIDS virus in Heptavax-B remains an open question.

If your doctor recommends this vaccine, ask him if he has read this important article.

Q

As a result of your work and that of others, I have decided not to immunize our 18-month-old son against most childhood diseases. My only concern is with the tetanus vaccine. Although I hesitate to give it because of the various immune and chronic disease risks which seem to accompany it, it does seem to be important: If my son receives a deep tissue injury and has not been previously immunized, the treatment includes an injection of tetanus immune globulin, a pooled blood product which carries with it the risk of AIDS and other contagion.

What is your advice? Are such globulin injections really necessary and, if so, in what sorts of injuries?--S.F.

QualityCare Insights

Vol 2 No. 1 | *For Today's Healthcare Decision-Maker* | Spring 1988

Candidates' Representatives Talk About Health Issues

Representatives of seven presidential candidates met at a Washington, D.C. forum January 29 to explain each candidate's view on health issues in this election year to an audience of health policy planners, analysts, managers and practitioners.

The setting was the fourth annual health agenda conference cosponsored by the Washington Business Group on Health and the National Association of Manufacturers.

Present were representatives of Vice President George Bush and Sen. Robert Dole (KS) on the Republican side and Massachusetts Gov. Michael Dukakis, Sen. Paul Simon (IL), Rep. Richard Gephardt (MO), Rev. Jesse Jackson and Sen. Albert Gore, Jr. (TN) on the Democratic side.

Speaking for the Bush campaign, Deborah Steelman, a Washington lawyer, said the Vice President supports more money for AIDS research, education and demonstration treatment programs. He opposes mandatory blood testing and special benefits for AIDS patients. He does favor, however, routine blood testing for AIDS with ensured confidentiality.

On other issues, Steelman said Bush opposes any new federal programs for long-term care that would be funded by additional payroll taxes. She said he sees long-term care as a family responsibility. Steelman also noted the Vice President feels the Medicaid program is in need of change.

Lynn Drake, a health policy fellow in Dole's Senate office, cited Dole's work on the catastrophic health insurance bill, calling it a "giant step" toward addressing the acute care needs of the elderly. She said Dole favors educating employers and consumers so people understand what the bill covers and what it does not.

Drake said Dole encourages a better dialogue between employees and employers to help solve the uninsured and underinsured problem. He also wants more information on

(See "*Candidates*," page 6)

27 New Drugs Approved In 1987, Research Funds Up Even More

The U.S. Food and Drug Administration (FDA) approved 21 new drugs and six important new biological products in 1987, the same year the pharmaceutical industry reported spending a record $5.4 billion on research and development.

Among the most significant new drugs approved in 1987 were:

- zidovudine or AZT (sold under the trade name Retrovir). Previously known as azidothymidine, AZT is the first drug approved for treating patients with AIDS and AIDS-related complex.
- lovostatin (Mevacor), which lowers blood cholesterol levels and thus reduces the risk of a heart attack;
- ciprofloxacin (Cipro), an oral antibiotic that patients can take at

(See "*Drug Approvals*", page 3)

WHAT'S INSIDE

Speaking Out by Gerald L. Ubach 2
From the Editor's Desk 2
Focus: Robert Rubin 4
Early Discharges Disrupt Services 5
Biomedical Research Conference 6
Hospital Mortality Data 7
Government Roundup 8
Sources 8

SpeakingOut

The pharmaceutical industry is achieving breakthroughs in drug discovery that were barely imaginable a few years ago. This progress is possible because of powerful new tools of research and insights into human physiology. For example, scientists can use molecular modeling by computer and other means to conduct more targeted, rational research. New understanding of biology at the molecular level is leading to the discovery of superior new therapies in areas like heart disease.

At the same time, these scientific advances have made drug discovery an increasingly complex and resource-intensive process. An enormous investment of time and money is necessary to bring the promise of these new technologies to fruition. It takes some 10 years to bring a new drug from clinical trials to regulatory approval, while the cost of R&D per new drug marketed is now estimated at $125 million, more than twice the cost for a drug approved a decade ago.

But the investment is worth it in terms of results. Drug therapy is the least invasive way to treat diseases. It is also highly cost-effective. There are many examples. The new anti-ulcer drugs that act on the histamine-H_2 receptor site replace or reduce the need for more expensive treatments, like surgery. Another example: studies have found that using beta blockers to prevent second heart attack can save up to $3 billion per year.



Gerald D. Laubach, Ph.D.
President, Pfizer, Inc.

The advances of recent years are ultimately a response to an undiminished public demand for medical progress against disease. As far as we have come against diseases like heart disease, cancer, and diabetes, for example, much remains to be done—and the public clearly wants it to be done. According to polls cited by the *New England Journal of Medicine*, the public gives medical research the highest priority on the national research agenda. The threat of AIDS is now placing enormous additional pressure on biomedical research, and it is clear that our best hope for containing this epidemic will come from vaccines and drugs.

Almost equally important are the quality of life advances offered by new drug therapy. There is a growing demand for drugs that can improve the quality of life by increasing mobility and convenience and by lessening sexual dysfunction and pain.

The resources are clearly available to make further progress against disease, and public demand for such progress is strong. The major uncertainty concerns the diffusion of new drug products. Will these drugs be accessible to patients who need them? Will they be paid for at a level that reflects ever increasing costs of research?

These questions will be answered by the myriad of drug access and reimbursement decisions that are going to be made by those beyond the physician now involved in drug product selection: pharmacists, third-party payers, health plan administrators, and formulary committees—all of whose importance has rapidly increased. Their role in holding down costs is well known.

What is less appreciated is the equally important role they will necessarily play in pharmaceutical innovation—and thus in medical progress. Questions of access and payment will inevitably affect the resources available for research. A statesmanlike approach is called for to see that short-term cost savings do not obscure the long-term public interest in new and better therapies. All the relevant parties will have to work together to make certain that patient needs continue to be met—both now and in the future.

QualityCare Insights

Quality Care Insights is a quarterly newsletter provided by the Pharmaceutical Manufacturers Association, 1100 Fifteenth Street, N.W., Washington, D.C. 20005.

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From The Editor's Desk

With this issue ***Quality Care Insights*** starts its second year. From the beginning we have sought to keep you informed about developments in health policy, planning and practice affecting the quality of care.

This issue reports on two significant developments. One concerns a conference on biomedical research that examined the partnership between government, academia, private industry and voluntary organizations. The second involves findings that, at least for now, early hospital discharges under Medicare's DRG system is disrupting community health services for the elderly.

Many readers have written to say how much they value ***Quality Care Insights*** and we appreciate that. In addition, we want to hear how you are dealing with quality of care issues in your community, company, agency or care setting. Information of that kind will be of value to all our readers.

("*Drug Approvals*," from page 1)

home to treat conditions that formerly required intravenous antibiotics; and

- lisinopril (Prinivil or Zestril), a once-a-day hypertensive drug.

The most visible new biological product is alteplase (Activase) or tissue plasminogen activator (TPA). When given to a heart attack victim within hours after the attack, alteplase can dissolve clots blocking coronary arteries.

In 1987, FDA approved eight orphan drugs—drugs for diseases that afflict relatively few people and thus are often unprofitable to develop without FDA aid. Eight is the most the agency has approved in a single year since Congress passed the Orphan Drug Act in 1983.

"These new drug approvals will save lives, enhance the quality of life and save money, thereby helping the health care system in general," said Gerald J. Mossinghoff, president of the Pharmaceutical Manufacturers Association, the trade group representing research-based drug companies.

The record $5.4 billion U.S. drug makers spent to find and develop more new pharmaceuticals in 1987 represents a 15 percent increase in R&D investments over the $4.7 billion in 1986. It also roughly equals what the National Institutes of Health (NIH) spend on all biomedical research.

"The country no longer needs to depend solely on taxpayers and the government to carry on medical research," Mossinghoff noted. "It is highly significant that the private sector continues to shoulder a substantial and growing share of the nation's medical research."

"We have seen at FDA in recent years a concerted effort to upgrade performance of the agency and the (drug-approval) system," Mossinghoff said.

Before approving new drugs for consumer use, FDA requires the pioneering manufacturer to submit massive research data showing the drug is safe and effective, and may ask for additional tests if unanswered questions remain. PMA estimates it takes about 10 years to bring a new drug from concept to FDA approval. Studies have shown the average cost of bringing a new drug to market is $125 million.

New Drugs & Biologicals Approved By FDA In 1987

NAME	MANUFACTURER	CATEGORY
Drugs		
Bactroban *(mupirocin)*	Beecham Laboratories	Antibiotic
Cefmax *(cefmenoxime HCl)*	Tap Pharmaceuticals	Antibiotic
Choletec *(technetium Tc-99m mebrofenin)*	Squibb Diagnostics	Imaging Agent
Cipro *(ciprofloxacin HCl)*	Miles Inc.	Antibiotic
Deursil *(ursodiol)*	Gipharmex S.P.A./CIBA-GEIGY Corporation	Gallstones
Elocon *(mometasone furoate)*	Schering-Plough Corporation	Dermatologic
Hytrin *(terazosin HCl)*	Abbott Laboratories	Cardiovascular
Iopidine *(apionidine HCl)*	Alcon Laboratories, Inc.	Ophthalmologic
Levatol *(penbutolol sulfate)*	Eli Lilly and Company	Cardiovascular
Mevacor *(lovastatin)*	Merck Sharp & Dohme	Cardiovascular
Novantrone *(mitoxantrone)*	Lederle Laboratories	Cancer
Parathar *(teriparatide acetate)*	Rorer Group Inc.	Diagnostic
Primacor *(milrinone lactate)*	Sterling Drug Inc.	Cardiovascular
Prinivil* *(lisinopril)*	Merck Sharp & Dohme	Cardiovascular
Prozac *(fluoxetine HCl)*	Eli Lilly and Company	Anti-depressant
Retrovir *(zidovudine)*	Burroughs Wellcome Company	Anti-viral
Rimadyl *(carprofen)*	Hoffmann-La Roche Inc.	Anti-arthritic
Rowasa *(mesalamine)*	Reid-Rowell	Gastrointestinal
Spectamine *(iofetamine HCl)*	Medi-Physics, Inc.	Imaging Agent
Terazol 7 *(terconazole)*	Ortho Pharmaceutical Corp.	Gynecologic
Ucephan *(sodium benzoate/sodium phenylacetate)*	Kendall McGaw Laboratories	Hyperammonemia
Biologicals		
Activase *(alteplase, recombinant)*	Genentech, Inc.	Cardiovascular
HIV Western Blot Test Kit	Biotech Research Laboratories/Dupont	Diagnostic for AIDS
Poliovirus Vaccine Inactivated	Connaught Laboratories, Inc.	Polio Vaccine
Monoclate *(factor VIII: C)*	Armour Pharmaceutical Co.	Anti-hemophilic
Prohibit *(haemophilus b conjugate vaccine)*	Connaught Laboratories, Inc.	Bacterial Meningitis Vaccine
Prolastin *(alpha$_1$-proteinase inhibitor)*	Cutter Biological of Miles Inc.	Emphysema

*Also being marketed by Stuart Pharmaceuticals under the brand name of Zestril.

Focus

HSR's Robert Rubin

Dr. Robert Rubin, M.D., is president of Health and Sciences Research Inc. (HSR), a Washington, D.C. consulting firm. He was assistant secretary for planning and evaluation at the Department of Health and Human Services from 1981 to 1984. HSR recently delivered a report on the quality of health care to the National Committee for Quality Health Care. The following excerpts were taken from a longer interview with ***Quality Care Insights.***

QCI: What is the state of health care in the United States today?

Rubin: Overall, good. There is neither a national nor a regional quality crisis today. But there is a potential for both if certain trends we identified in the report are not averted. Those trends are signposts signifying problems on the horizon. In some cases, the problems are here today.

QCI: What are the problems you see?

Rubin: There are a series of red flags concerning potential problems. One is a clearly growing nursing shortage. There are not enough nurses to care properly for all patients in many hospitals. Some Maryland hospitals have a 20 percent nursing shortage. At the same time, nursing school enrollments are down. We either have to train someone else to do that work or make nurses' salaries competitive with other fields young women can choose to go into.

There is also a malpractice crisis that is making it too expensive for some physicians to practice medicine. Twenty percent of obstetricians in Massachusetts are no longer delivering babies. That is creating access problems. In fact, access in general is becoming more difficult for the most vulnerable people in our society—the poor, pregnant women and those living in rural or inner city areas where hospitals have closed.

QCI: Have changes in health care brought about by cost-saving pressures affected quality?

Rubin: My concern with cutting health care costs is that many people suppose you can cut indefinitely without affecting quality. That is not the case. There is certainly waste, but there is not an infinite pool of fraud, abuse or inefficiency. The problem is no one today is really talking about preserving quality in any meaningful way.

QCI: Where should our first priority be?

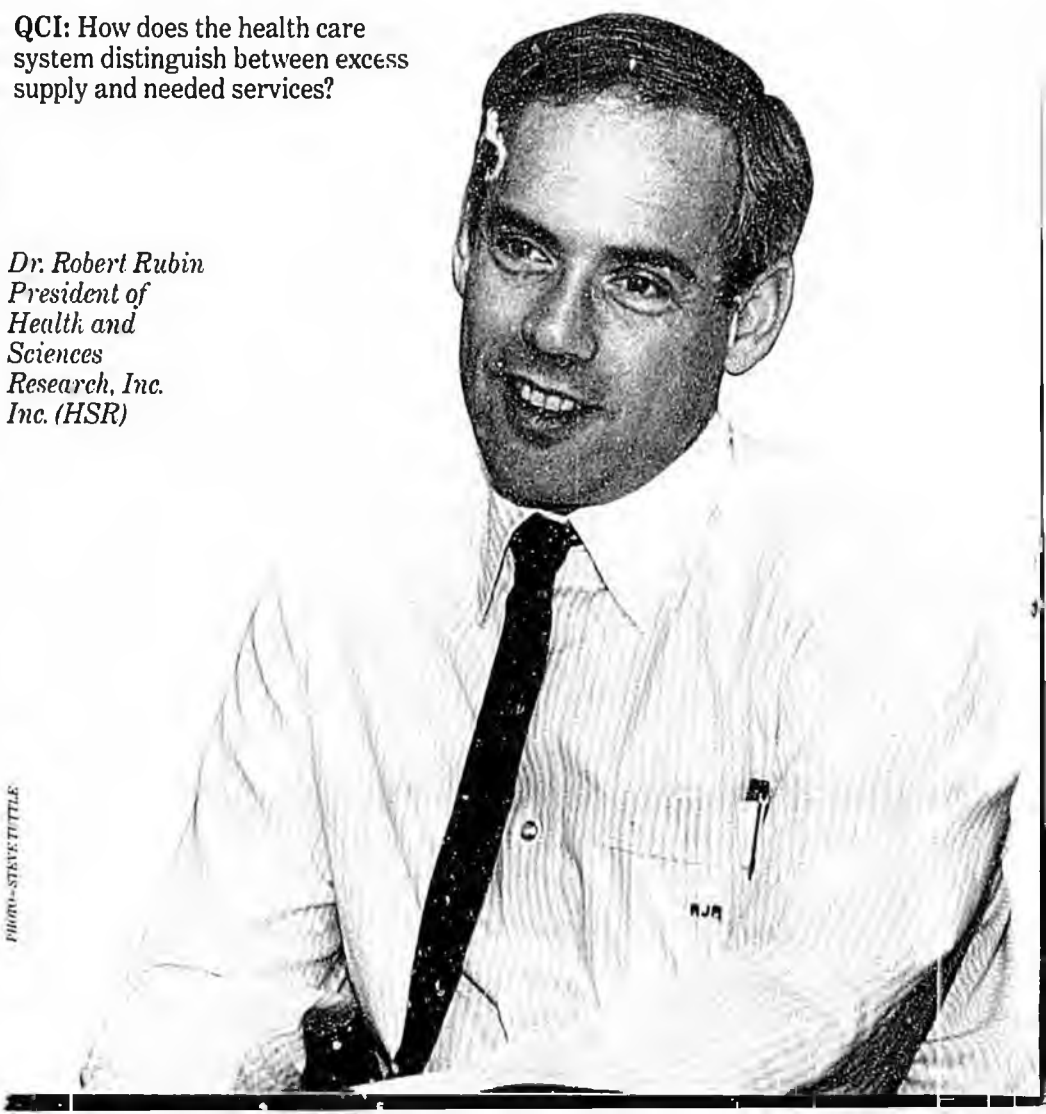
Rubin: The first priority ought to be access to quality health care. To come back to cost-cutting or savings, we should really be talking about cost-effectiveness. That is a better term for the kind of health care system I would like to see in place. The dilemma is whether we are willing to spend the money to develop new cost-effective health technologies that will improve quality care.

QCI: How does the health care system distinguish between excess supply and needed services?

Rubin: Badly. That is the most difficult question in the health care arena. Nobody doubts there is an oversupply of hospital beds, but figuring out which ones to eliminate is very difficult. When the extra bed is in your community it is no longer an extra bed. The local hospital, especially in rural communities, is a symbol as well as a provider of care.

QCI: How do we as a society balance the often-conflicting goals of access, quality and cost?

Rubin: There needs to be an acceptable level of access to high quality care at a reasonable price. The problem is some people want almost instantaneous access to the highest quality care at the lowest possible price. That's where we get into questions of how many tests to order or



Dr. Robert Rubin President of Health and Sciences Research, Inc. Inc. (HSR)

PHOTO—STEVE TUTTLE

what procedures to perform on whom or the role of government. We are willing to pay any price to treat ourselves or our families, yet collectively we may not be willing to pay for the same level of care for everyone in society.

QCI: Is there a role for pharmaceuticals and pharmaceutical companies in ensuring access to quality care at reasonable prices?

Rubin: Yes. Pharmaceutical companies are beginning to hold down costs as a major marketing tool. They are looking for more cost-effective ways of delivering drugs. They achieve this by making the drugs longer acting or administering them in more cost-effective ways. This is just one example of how pharmaceutical companies are providing better drugs at lower prices through research.

QCI: Has Medicare's prospective payment system, as some critics allege, contributed to a decline in quality?

Rubin: The DRG (diagnosis related group) system has not adversely affected quality. It did what we set out for it to do. Whatever the problems, they are not widespread or directly related to quality. The problem is that Medicare has been used as a vehicle for balancing the budget rather than caring for people who need medical services.

QCI: Beyond addressing such problems as a nursing shortage or malpractice crisis, how do we ensure quality care?

Rubin: First, we need to educate private and government payers as to what constitutes quality care. Next, we have to balance concerns for quality with those for cost-cutting. In doing so, we have to reconsider what level of health care we want, remembering that we will have to pay for that level of quality either directly or indirectly. That is why this Administration and I favor a marketplace approach with an eye to preserving access.

DRG-Linked Hospital Discharges... Problems For Community Services

A new survey of 191 randomly selected home health agencies shows that the early discharge of Medicare patients from hospitals is causing major problems for and changes in community health services for the elderly.

"The DRG (diagnosis related groups) system has placed lots of new demands on relatively few resources," said Linda Bergthold, assistant professor of social and behavioral sciences and project director at the Institute for Health and Aging, University of California, San Francisco. "Things are very chaotic right now," she added.

Bergthold told the American Public Health Association that DRGs are causing a shift of patients from hospitals to outside programs, thereby straining the latter's ability to provide quality care and threatening the elderly's access to it.

In particular, Bergthold said, 91 percent of the home health agencies surveyed reported DRGs affecting their patients. Further, 95 percent of the agencies said their newly-discharged patients from hospitals were sicker than before DRGs were adopted by the federal government in 1984.

Of eight home health agencies that shifted status in the past three years, all have changed from public or non-profit agencies to for-profit ones, she reported. "That is a large change," Bergthold observed.

Bergthold also said that more than two-thirds of community mental health centers surveyed reported being affected by DRGs. The finding was surprising, she said, because most hospital psychiatric care is exempt from Medicare's early discharge policies and because the elderly usually do not use community mental health centers. More than half the centers said their patients were arriving older, sicker and in need of more care than before.

Similarly, nursing homes surveyed said they have more elderly patients requesting care than before DRGs. They also reported patients were waiting longer to get care. More than two-thirds of 198 nursing homes surveyed had a waiting list and more than half said the list had grown in the past two years.

One of the most significant changes found, Bergthold said, was in the hospital discharge planning function. Previously, most hospital staffs did not need to know much about the community programs and services available for the elderly.

Now, hospitals are finding they have to help their elderly patients find post-hospital care.

Bergthold said for-profit hospitals were more likely to use registered nurses as discharge planners and that nonprofits were more likely to spend more and have larger discharge planning staffs.

For health policy analyst Bergthold, the changes brought to light by the survey are disturbing. "We may be creating again a two-tiered health care system where those who can afford it get care at home and those who cannot afford it must go into a hospital or nursing home" she said. "The elderly poor and those without insurance will be affected most. We may wind up paying more for them if they cannot be cared for at home."

The survey showed that planners should think more about the whole health care system rather than just part of it, Bergthold added. "We found that major changes in the acute-care setting have had major ramifications for out-patient services," she said. "You cannot cut costs in one sector because those costs merely shift to another."

Research Partnership Praised At NHC-PMA Conference

An unprecedented partnership among government, academia, private industry and voluntary organizations has helped spark major biomedical research advances since World War II, but has shown signs of strain in recent years, participants at a November conference on America's medical research were told.

The conference, which was cosponsored by the National Health Council and the Pharmaceutical Manufacturers Association, also examined the contribution of pharmaceuticals to the litany of medical advances as well as the outlook for new and more effective therapeutic agents.

"The private sector wants to produce new drugs," said prizewinning scientist Paul Janssen, president of Janssen Research Foundation Worldwide. "There is more money and manpower being devoted to the search for new drugs by the private sector than ever before. But policy makers are devoting more energy to cost containment than to biomedical research."

That theme was also touched on by Sen. Lowell Weicker (R-Conn.), the conference's keynote speaker. Weicker warned that continuing cuts for science and education in the name of reducing budget deficits "won't keep the United States on top" in a competitive world.

"Government's task is to provide a consistency of funding for basic biomedical research and to encourage young people to go into research," Weicker said. "This nation can and should speak out on the priority of life. The business of life has to be translated into the national budget and national policy."

Seconding Weicker's words was Robert Bolan, vice president of the National Health Council and executive vice president of the American Diabetes Association. Bolan warned that an inadequate supply of new researchers, a growing obsolescence of equipment and facilities, a heightened uncertainty over public funding and a rising competition from foreign research centers are threatening U.S. leadership in health and medicine.

"We need to heighten public and congressional concern for the cause of medical research," he said. "We need to convince them that nothing can increase our nation's gross national product more and contribute to our everyday lives than to encourage medical research."

On the subject of research itself, all basic biomedical studies today begin with deoxyribonucleic acid or DNA, said George Poste, vice president for worldwide research at SmithKline & French Laboratories.

"Our ability to move genes around gives us an ability to control their expression," Poste added. "That will lead to new molecular weight pharmaceuticals in amounts impossible by traditional means. That, in turn, will allow us to target cellular molecules for drug action rather than just cell surface receptors."

(See "*Conference*", page 8)

("*Candidates*," from page 1)

home health care services for AIDS patients and block grants to states so they have flexibility in dealing with the disease, she said. In the long run, Drake said, Dole favors prevention as the way to reduce health care costs.

The most important health issue today is that of equity, said Karen Smith, assistant director of health policy in Massachusetts' Office of Human Services. Speaking for Gov. Dukakis, Smith cited his work with the business community to develop a plan to provide health care to the uninsured. She said Dukakis favors a more creative approach so that small and marginal businesses can afford to buy health insurance for their employees. Dukakis also wants an approach to long-term care that lets elderly people who can, stay at home with their families, she said.

Jack Bresch, Sen. Simon's campaign manager in Montgomery County, Maryland, said a national health policy is needed to resolve where this country wants to go in providing health services to its people. Bresch said Simon wants the government to ensure health care coverage for everyone as a right.

On specific issues, Bresch said Simon favors an emphasis on children's health, more money for biomedical research and voluntary testing, education and a caring and compassionate approach to AIDS victims and blood testing.

Speaking for Gephardt, Joanne Symons, a campaign consultant on loan from the American Nurses Association, called the health care system a "crazy quilt" of little programs that are out of control. She said Gephardt favors affordable, accessible health care. He sees prevention, education and more home care as ways to cut costs and make more care more accessible to more people.

Symons also said Gephardt favors programs that encourage competition in the health care arena so people and companies can choose among plans, providers and physicians. One problem Gephardt is most concerned with, she said, was our "hideous" infant mortality rate, an issue the candidate wants to address.

Returning to the uninsured and underinsured issue, Dr. Vincent Navarro, a professor of health policy at Johns Hopkins University, said Jackson is outraged that 38 million Americans lack health insurance and 25 million more are underinsured. Jackson favors a comprehensive, universal national health service, with coverage for everyone ensured by the federal government. Navarro said Jackson sees this as a moral rather than just a health issue.

Navarro said universal health insurance can be paid for "if we want to do it." He said Jackson would increase taxes for the wealthy and cut defense spending to reduce federal budget deficits and pay for health care. He also said the government can manage health care programs better than private industry.

Health care costs concern Gore, said Jerry Mande, the Senator's legislative assistant. Mande said Gore thinks money can be saved by investigating FDA practices, creating a national data base for malpractice cases, and promoting prevention and screening programs nationwide. He also said Gore favors cutting out "unnecessary and inappropriate" treatments as a way to cut costs and finance other services, such as organ transplants.

Hospital Data Release Produces Comment, Controversy and Action

The release of mortality data for Medicare patients in hospitals nationwide by the Department of Health and Human Services in December generated a storm of controversy as well as an opportunity for the public to take a first good look at one measure of hospital quality.

The information is contained in a seven-volume report weighing some 30 pounds. It includes data on 735,000 deaths of Medicare patients either in, or within 30 days after discharge from, 5,971 hospitals in 1986. The data, which is accompanied by comments from individual hospitals, is adjusted by age, sex, medical condition upon admission or transfer, and prior hospitalizations.

The result is a range of expected death rates for each of 16 diagnostic categories plus an overall range of expected deaths for each hospital. The report showed some 585 hospitals or 10 percent had death rates at the top of the spectrum and another 146 hospitals or 2.5 percent had rates above their expected range.

The meaning of such findings raised considerable comment and controversy. "The information is potentially misleading," said James Marriman, director of federal agency affairs at the American Hospital Association. "People will assume that mortality data relates to hospital quality, but you can't make that assumption."

Similarly, the American Medical Association warned that use of the information could be harmful. "Distributing this data provides no meaningful value to patients," said Dr. James Sammons, AMA executive vice president. "It will cause irreparable damage to physician-patient relationships."

On the other hand, consumer groups welcomed the data's release. "We have long encouraged government agencies to get hospital mortality data into the hands of consumers," said Craig Tanio of the Public Citizen Health Research Group. "We want to see more data become publicly available."

Agreeing was Vita Ostrander, immediate past president of the American Association of Retired Persons. The data, she said, "will build the patient's overall understanding of medical treatment, including an understanding of the difficulty of measuring and predicting quality."

To better measure and predict quality, the AHA's Marriman said, mortality rates should be adjusted for severity of illness. He said AHA is looking at existing severity indices to see how they might be used to interpret the data better. Marriman also said pilot studies are needed to examine the relationship between mortality data and hospital quality.

The Health Care Financing Administration, which runs the Medicare program, is likewise working to develop severity indices. Stephen Jencks, a senior physician in HCFA's office of research, said the agency is collecting and analyzing data on deaths from stroke, pneumonia, heart attack and congestive heart failure from five states.

The data will be used to give a likelihood of death for any individual or group of patients that can then be compared with what actually happened to those patients. Severity will be adjusted for, Jencks said, on the basis of some 30 physical and medical history measurements taken at admission. HCFA's severity index should be available by fall so hospitals and consumers can use it to analyze the agency's 1988 hospital mortality data release, he added.

Public Citizen advises the 1987 mortality data be used to ask questions of physicians and hospital administrators. The questions include what, if any, changes a hospital made regarding individual physicians and departments as a result of the data. "If there are no reasonable explanations, then you might consider going to a different hospital with a lower mortality rate," the consumer advocacy group said in its newsletter.

But, individual consumers might find HHS's seven-volume report difficult to obtain, costly ($69) to buy and hard to plow through. Help is on the way, however, said Robert Krughoff, president of Consumers' Checkbook, a Washington, D.C.-and San Francisco-based group. Consumers' Checkbook will publish a one-volume, 200-page condensed version in April.

The Consumer's Checkbook report will explain how to use the hospital mortality data, show whether each hospital is affiliated to a university medical school and/or has a residency program, and its type (nonprofit, community, for-profit) of ownership. It will also show the group's own surveys of patients, nurses and physicians of hospital quality in Washington,D.C. and San Francisco.

The condensed report will be available for $10 from Consumer's Checkbook, Suite 925, 806 15th Street, N.W., Washington. D.C., 20005.



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Government Roundup

Statehouse Report . . . **Delaware** has decided to drop its Medicaid incentive fee program to encourage generic drug substitution. The state Department of Health and Social Services said it could not show cost savings were achieved by the program. Any savings that were achieved might have been achieved without paying the incentive fee, it added. The program was a one-year pilot study begun in October 1985. A report on the program found generic substitutions increased only 12.7 percent during the incentive fee year. Meanwhile, a bill to create a similar incentive fee program for generic substitution under Medicaid has been dropped in **South Carolina**. The South Carolina bill was introduced in 1987, but has now been withdrawn. It cannot be reconsidered for two years . . . A new bill to provide "universal" health care in **Massachusetts** is being drafted. A bill passed the state Senate in 1987, but failed to pass the House before it adjourned. The 1987 bill would have required all businesses to provide health insurance benefits to employees or pay $1,680 per employee to a state health insurance fund. The Massachusetts bill also provided tax incentives for businesses to offer health care coverage to employees . . . Massachusetts is not the only state considering or actually adopting some form of universal health insurance. **Oregon** enacted a voluntary, employer-provided health care insurance program in 1987 that offers businesses with 25 or fewer employees a tax credit equal to 50 percent of their contributions to health insurance for their workers. In **Michigan**, the Robert Wood Johnson Foundation is sponsoring a demonstration project in which the state, employers and employees share equally in paying for insurance coverage. A similar Johnson Foundation-sponsored plan was adopted in **Arizona**. **Washington** state passed a bill in 1987 to provide health care coverage to 30,000 low-income people in five pilot project locations. And **Hawaii** has for 10 years required employers to provide health insurance to employees . . . Davidson County (Nashville), **Tennessee**, has proposed to tax six nonprofit hospitals in the Nashville area. The county assessor says the hospitals' charges are similar to those of local proprietary ones, even though the former do not provide appreciably more charity care. A similar proposal to tax nonprofit hospitals is being considered in Chattanooga.

. . . The **New York** State Department of Social Services issued a final regulation regarding reimbursement for brand name drugs under the Medicaid program. The regulations, scheduled to be effective on March 1, would deny full reimbursement for a brand name product even if the physician indicates on the prescription form that a particular brand name product should be dispensed. In promulgating this regulation, the state in effect has allowed a physician override for brand name products but will not provide full reimbursement . . . In January, Delegates White and Wells introduced **West Virginia** House Bill 4242, a bill which would assess hospitals, long-term care facilities, home health agencies, pharmacies, durable medical equipment companies and certain group homes in order to raise revenue to repay the state's consolidated investment fund. This fund is used to pay for the state's Medicaid program. The bill has now been dropped in Conference Committee, and $30 million from the State's Black Lung Fund will be used to fund the Medicaid program . . . **Utah** state Senate bill 75, a bill that prohibits the use of a restricted drug list for the Medicaid program in that state, has passed both the House and Senate and is waiting the Governor's signature.

Sources

• Project Hope has issued a pamphlet on "Buying Quality Health Care." The pamphlet is designed to help health care purchasers, whether individuals or companies, better understand the many new options available. It lists questions to ask and points to consider in selecting a health care plan, physician or hospital. *Copies can be obtained by writing the Center for Health Affairs, Project Hope, Suite 500, Two Wisconsin Circle, Chevy Chase, Maryland 20815.*

• Lewin and Associates has prepared a report for Pfizer Inc. summarizing the objectives, methodology and status of major research and other projects in progress relating to quality of care issues. The report discusses projects on measurements of quality and outcomes research, employer and consumer information, managed care and the Medicare prospective payment system. *Copies can be obtained by writing Paul Meyer, Ph.D., Pfizer, Inc., 235 East 42nd Street, New York, New York 10017.*

• The Food and Drug Administration has published a special report entitled "New Drug Development in the United States." It includes articles from the agency's magazine on how drugs are developed, tested and approved, on FDA's attempts to improve the process and on drugs for the desperately ill or rare diseases, among others. *Copies can be obtained by writing the Office of Public Affairs, HFI-1, Food and Drug Administration, 5600 Fishers Lane, Rockville, Maryland 20857.*

("*Conference.*" from page 6)

Where is research going? Marvin Jaffe, senior vice president at Merck Sharp & Dohme Research Laboratories, noted the graying of America's population and said new drugs are needed to control such body functions as heart rate, breathing and metabolism, all of which change with age. Jaffe also urged studies of how drugs work in different life stages and in different combinations.

Another look at the future was offered by Humphrey Taylor, president of Louis Harris and Associates. Using his firm's opinion surveys of health researchers and professionals, Taylor predicted a growing emphasis on preventive medicine, less invasive surgical and treatment methods, new drugs to treat neurological and viral disorders, and better nutrition to prevent and/or treat diseases such as osteoporosis.

Alaska State Legislature

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State Senate

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February 12, 1988

Honorable Ted Stevens
United States Senate
522 Hart Building
Washington D.C. 20510

Dear Senator Stevens,

Please consider this letter recommendation for the appointment of Shannon Kohler to the Advisory Commission on Childhood Vaccines.

Shannon has been active in Alaska Dissatisfied Parents Together (DPT) for a number of years. During this time she has completed extensive research with regard to vaccine safety and efficacy. She has been instrumental in the introduction of HB 277, a copy of which is enclosed, and the improvement of the vaccination program within the State of Alaska. Many of these concerns need to be addressed at the Federal level especially in regard to National Childhood Vaccine Injury Act of 1986.

Shannon has expressed a willingness to serve on the Commission. Taking into consideration her background, dedication, and motivation she would be an asset to the Commission.

Thank you for your time and consideration.

Cordially,

Paul

Senator Paul A. Fischer

PAF/ssw

Alaska State Legislature
House of Representatives
COMMITTEE ON HEALTH, EDUCATION
AND SOCIAL SERVICES

OFFICIAL BUSINESS

POUCH V
JUNEAU, AK 99811
465-3759

March 8, 1988

Honorable Ted Stevens
United State Senate
522 Hart Building
Washington, D.C. 20510

Dear Senator Stevens:

As the Co-Chairs of the Alaska House Health, Education, and Social Services Committee, we would like to recommend Shannon Kohler be appointed to the federal Commission being created in conjunction with the National Childhood Vaccine Injury Compensation Act.

Ms Kohler has a strong viewpoint on the subject of mandatory immunization and has put considerable effort into researching and organizing around it. We believe the federal Commission to be an appropriate place for someone with her concerns to serve. She would undoubtedly make a hard working member of such a commission.

It is our understanding that Shannon is also being recommended by the Alaska Department of Health and Social Services, by the Senate HESS Chair, Senator Paul Fischer, and by Representative Mike Navarre.

Thank you for your attention to this matter. We will continue to monitor discussions around the subjects of immunization and public health.

Sincerely,

Rep. Niilo Koponen, Co-Chair

Rep. Johnny Ellis, Co-Chair

CC: Shannon Kohler
NK/JE/ljm

Alaska State Legislature

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CHAIR, RULES COMMITTEE



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DISTRICT 5

Representative Mike Navarre

March 1, 1988

Honorable Ted Stevens
United States Senate
522 Hart Building
Washington, D.C. 20510

Dear Senator Stevens:

As I am sure you are aware, the National Childhood Vaccine Injury Act of 1986 deals with compensation for adverse vaccine reactions. In addition, the legislation calls for the creation of the Advisory Commission on Childhood Vaccines.

Three members of the nine member commission are to be from the general public, two of whom will be legal representatives of children who have suffered vaccine-related injury or death.

I strongly feel that one of the public members should be from Alaska, and would like to suggest Mrs. Shannon Kohler of Soldotna.

Shannon Kohler is the president of the Alaska Chapter of Dissatisfied Parents Together (DPT), a national organization dedicated to vaccine safety. I have worked closely with Shannon on vaccine legislation in Alaska, and she has testified before the House Committee on Health, Education and Social Services.

Because of Mrs. Kohler's intense dedication to elimination of vaccine-related injuries, she has become extremely knowledgeable about vaccines - as knowledgeable as many health care professionals are. In addition to this impressive knowledge, she demonstrates a real concern that the issue of vaccine-related injuries be addressed in a logical and fair manner.

In summary, I feel Shannon Kohler is highly qualified, and would prove to be a very valuable addition to the commission. I recommend her without reservation.

If you have further questions, feel free to contact me, or Mrs. Kohler directly at Box 1746, Soldotna, AK 99669. Her phone number is (907) 262-3825.

Thank you for your consideration.

Sincerely,

Mike Navarre
State Representative

cc: Shannon Kohler

ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

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January 28, 1988

MEMORANDUM

TO: Representative Mike Navarre

FROM: Patricia Brawley
Legislative Analyst

RE: **Personal Exemption from Mandatory Immunization**
Research Request 88.075 (Supplemental Information)

You requested that we provide information about personal exemptions from mandatory immunization laws in Colorado, Wisconsin and Utah. Specifically, you wanted to know the following:

1. Historically, how did this personal exemption come about in those states, and what was the reason for the change in existing law?

2. What happened to the vaccination compliance rate as a result of these waivers? What is the current compliance rate?

3. What is the before and after frequency of the "serious seven" diseases in those states, and in what percentage of cases, if any, were the persons vaccinated?

4. Do parents have the opportunity to "pick and choose" which vaccinations their children will receive, or is it an "all or nothing" proposition?

The Center for Disease Control in Atlanta indicates that all states have mandatory immunization laws. The following exemptions have been incorporated into law: every state allows a medical exemption; every state, except Mississippi and West Virginia, allows a religious exemption; and 22 states allow a philosophical (personal) exemption. Responses to your specific questions concerning Colorado, Wisconsin and Utah follow.

COLORADO

According to Judy Canner, Immunization Program Director, Colorado Department of Health, the state's mandatory immunization law was in place by 1975. The original version covered only kindergartners, transfer students through grade 6, and child care facility enrollees. An amendment in 1978 extended coverage to all students in public schools and added the personal exemption. The push for inclusion of a personal exemption was based on the argument that the law was an infringement of personal rights. Colorado officials believe that the amendment would not have passed without the addition of the personal exemption.

The Colorado Department of Health does not consider the personal exemption to have significantly affected compliance rates. Statistics showing percentage of compliance and percentage of personal exemptions suggest, however, that the compliance rate is in a slight downward trend while the personal exemption rate is climbing.

School Year	Compliance Rate (%)	Personal Exemption Rate (%)
78-79	90	0.3
79-80	97.7	0.5
80-81	unavailable	unavailable
81-82	97.4	0.6
82-83	97.8	0.7
83-84	97.4	0.8
84-85	97.2	0.8
85-86	97.4	0.8
86-87	97.1	0.9

There is little correlation between the personal exemption and the frequency of disease outbreak. Frequency has continued to decline during the last decade, except in the case of pertussis (whooping cough), which has been on the increase. This is a reflection of the law rather than the exemption, however, because Colorado does not require immunization against pertussis. Colorado currently has a an outbreak of measles in a college community; most of the involved individuals had been vaccinated. While this year's incidence far exceeds the frequency typical of the last decade, it is still considered to be "well within the five percent failure rate common in vaccines, and is typical of measle transmission."

Parents are allowed to choose which vaccines their children will be exempt from taking. In practice, parents generally object to all vaccines if they object to any.

WISCONSIN

Craig Leutzinger, Immunization Program Director, Wisconsin Department of Public Health, indicated that Wisconsin's mandatory immunization law included medical and religious exemptions when it was instituted in 1975. It was ineffective in that it covered only kindergartners, and the wording did not require parents to have children vaccinated. Amendments in 1980 expanded coverage to grades K - 12 (to be implemented gradually), changed the wording to require vaccinations, and added the personal exemption. In spite of Department of Health opposition, the exemption was included through lobbying efforts of a group known as Dissatisfied Parents Together (DPT), which was led by a woman whose son had been severely injured by the DPT vaccine.

Immunization is a widely accepted practice in Wisconsin as reflected by a 99 percent compliance rate. Since 1977, the total percentage of exemptions has remained constant at 0.8 percent to one percent. Prior to 1980, the one percent reflected equal numbers of religious and medical exemptions; since 1980, religious and medical exemptions have dropped to 0.1 percent each while personal exemptions have remained steady at 0.6 percent. It appears that individuals who might previously have claimed religious exemptions now call their objections philosophical rather than religious.

In spite of the high compliance rate, Wisconsin had the highest state rate of mumps in 1987. The incidence of measles in Wisconsin was also high (284 in Wisconsin compared to 12 in Colorado). This does not necessarily correlate to the personal exemption, however, because Wisconsin's mandatory immunization law was set up to be implemented in stages. For example, vaccination for mumps was required beginning in 1982, and only grades K - 4 are currently covered; if an unvaccinated fifth-grader from another state enters a Wisconsin school, there is no requirement that the child be vaccinated against mumps. Another important factor in the high incidence of disease in Wisconsin is that until 1987 there was a strong reluctance on the part of schools to exclude unvaccinated individuals from school during disease outbreaks, even though the law allowed for it. In 1987, during an outbreak of measles, the need to protect unvaccinated children and to interrupt the transmission cycle overcame that reluctance. Since then, exclusion from school has become widely accepted. Outbreaks have "certainly included uncovered children," but no statistics are available on the percentages.

As in Colorado, parents have the right to select which vaccinations their children will be exempt from taking; however, generally there is an all or nothing attitude.

UTAH

According to Rick Crankshaw, Immunization Program Coordinator, Utah Department of Health, Utah's mandatory immunization law included only entering kindergartners when it was enacted in 1976. An amendment in 1982 expanded the coverage to grades K - 12, included all licenced child care facilities, and incorporated the personal exemption. The inclusion of the personal exemption was based on other states' experience with the DPT controversy over vaccinations for pertussis--which sometimes causes extremely serious adverse reactions.

The compliance rate in Utah is very high; exemptions during the last several years have been approximately one percent. Of that, 0.8 percent are personal exemptions and the other 0.2 percent are medical exemptions. No statistics directly comparing compliance rates before and after incorporation of the personal exemption are available.

No statistics are available on the frequency of disease before and after incorporation of the personal exemption. Because of the law, Utah schools now have an accurate tracking system so that each school can make an immunization assessment. During an outbreak of disease, the Department of Health orders that any unprotected children be excluded from school until the outbreak is over.

As in Colorado and Wisconsin, parents can choose individual vaccinations to which they are philosophically opposed. In practice, however, parents generally object to all vaccinations or to none.

According to the results of this sample, and the Center for Disease Control, the availability of the personal exemption appears to have had relatively little significance. Feared problems have not materialized; the philosophical exemption does, however, weaken the force of immunization laws inasmuch as it provides some potential for sustaining transmission of disease.

I have requested a copy of the Center for Disease Control's most recent update of State Immunization Requirements, which I will forward to you.

I hope you find this information useful. Please contact me if you have any questions.

From the Governor's Interim Commission on Children and Youth Report

1. Quality: *Health*

BACKGROUND RECOMMENDATION

Child Care Revolving Loan Fund: 31

Centers and homes that provide child care and education must be healthy for our children. But many programs are located in inadequate, makeshift spaces, sometimes poorly heated and often with minimal outdoor play space and equipment. When children spend so much of their time indoors, the space must be adequate for the number of children as well as well-lit, heated and maintained.

Child care is labor intensive and capital poor. Alaska used to have a Child Care Revolving Loan Fund for capital improvement. The maximum loan per facility was $50,000. By banking standards the loans were small. Loans were only available to property owners who often did not run the programs. These factors make it extremely difficult for child care programs to find needed capital to improve existing buildings and make them healthy places for children.

Alaska should reinstate the low interest Child Care Revolving Loan Fund, increase its previous level of funding and simplify the required paperwork. This loan program provides funding support so child care facilities can meet all codes and ensure a healthy environment for our children.

Child care is labor intensive and capital poor.

Comprehensive Health Screening: 32

Comprehensive health screenings assure parents and practitioners that the care for young children is appropriate to their needs. Screenings that check height and weight, blood pressure, teeth and include a random check for scoliosis promote normal growth and development. Regular attention to each child's physical health is essential to all children's well-being. The only funding presently available for comprehensive health screening of children in the Department of Health and Social Services is for children who have already been identified as developmentally disabled.

Required immunizations, adequate nutrition and access to medical, dental and mental health services are the right of all of Alaska's children and part of any quality early childhood system.

Comprehensive health screenings should be guaranteed to all Alaska's infants, toddlers, preschoolers and students, to identify problems as soon as possible to prevent more expensive treatment later.

Regular attention to each child's physical health is essential to all children's well-being.

HB 277
REFERENCE MATERIALS
FROM
ALASKA DISSATISFIED PARENTS TOGETHER

(1)

TURNING POINT
Family Wellness Center

Edward H. Chapman, M.D.
Dolores Heeb, Reg. Ac.
Richard P. Ingrasci, M.D., M.P.H.
Richard Moskowitz, M.D.
Geri Schumacher, R.N.

November 25, 1987

Alaska State Legislature
Health Education and Social Affairs Committee
c/o Glenda Landua, Alaska DPT
39918 Dawn Avenue
Kenai, Alaska 99611

Dear Sir:

I am writing in support of House Bill No. 277, "An Act Relating to the Immunization of Minors."

I am a family physician and have been practising medicine for the past twenty years. During that time I have been impressed with the number and variety of chronic diseases that can be provoked or exacerbated by the various childhood vaccines in general use. My thoughts and observations on this subject are summarized in the articles enclosed herewith.

I am especially troubled by the fact that investigations of vaccine-related illness have generally been limited to acute complications occurring within thirty (30) days of the administration of the vaccine, thus excluding any condition occurring more gradually or not evident until months or years later.

Requiring all children to be vaccinated with foreign proteins or live viruses clearly presupposes the moral and legal obligation to prove both that the corresponding natural diseases constitute a serious public health hazard, and that the vaccines themselves are in no way detrimental to health. Furthermore, it implies full legal and financial liability for any illness or injury sustained by those vaccinated against their will.

Adequate investigation of chronic vaccine-related illness will necessarily be prolonged and difficult. It will require following large numbers of both vaccinated and unvaccinated children for at least a decade or more, to determine any differences in their overall health patterns, and in the incidence and severity of various chronic diseases (recurrent otitis media, asthma, epilepsy, behavior disorders, etc.).

173 Mt. Auburn Street, Watertown, Massachusetts 02172 (617) 923-4601

Until these studies are completed, it would be reckless indeed to continue routine childhood vaccination on a compulsory or statutory basis. I personally favor making all vaccines completely optional, i.e., freely available to all who want them, and allowing parents to make the choice with and for their children, as is now being done in West Germany and many other countries. This practice will effectively reduce the liability of the state, if and when complications do occur. Furthermore, it will create a sizeable control group of unvaccinated children for the long-term studies that urgently need to be done.

For all of these reasons, I urge you to support H. B. 277, and to make it as simple as possible for parents not to vaccinate their children. I would suggest, for example, amending the opening section so as to allow parents to accept some vaccines, and to reject others, without having to give a reason, and without any discrimination or penalty. The term "religious or philosophical beliefs" implies a principled, across-the-board repudiation, while many parents actually prefer to obtain the tetanus and oral polio vaccines, for example, but not the others. The right to make such choices should perhaps be stated explicitly.

But, even in its present form, the proposed law is an important step forward, bringing Alaska abreast of the other states that have been most progressive in this respect. It deserves your full support.

Thank you.

Truly yours,

Richard Moskowitz

Richard Moskowitz, M.D.

(3)

The Nevada Clinic
6105 W. Tropicana Ave., Las Vegas, NV 89103
(702) 871-2700

January 13, 1988

Shannon Kohler, President
Alaska Dissatisfied Parents Together
Box 1746
Soldotna, Alaska 99669

Dear Shannon:

I have received your letter and am in complete sympathy with your efforts to modify the immunization laws as they exist in your state. Thank you very much for sending me a copy of the House Bill No. 277. I wish you all the success in the world in getting it passed.

I am enclosing a photocopy of a fairly recent article from the April, 1987 issue of the British Homeopathic Journal that deals with the use of pertussin as a prophylactic treatment to prevent whooping cough. As you can see from the articles enclosed, the battle goes on in other countries, as well as in various states in the United States.

I believe that homeopathy offers tremendous advantages over the standard and routine immunization programs, which have been pushed by allopathic medicine since the beginning of time (Pasteur's time, that is).

Our clinic has seen several infants and children who have not had a good response as a result of D.P.T. immunizations. I can recall three small children who developed "infantile spasms" and seizures as a result of the pertussin part of the D.P.T. immunization. Of course, none of the physicians who administered the injections, nor the company that made the serum, would in any way admit any kind of a connection between the immunization and the child's problems. Nevertheless, when treated homeopathically to remove the pertussin from the brains and nervous systems of these infants, they all have totally recovered without any further seizures or spasms.

There has not been a great deal of research done that I am aware of in this country with regards to an immunization program based on the treatments utilized by homeopathic physicians for the past 150 years. Nevertheless, these programs have proven very effective. In fact, during the 1917 flu epidemic in this country, the only patients who survived were those who were fortunate enough to find a homeopathic physician and be treated homeopathically.

I hope this information is of some help to you. There are obviously other journals and articles that could be sent, but I don't have them in hand at the present time.

Sincerely,

F. Fuller Royal, M.D.

FFR/erm

IMMUNIZATION COMPLIANCE RATES OF SCHOOL AGE CHILDREN (K-1ST GRADE) AND INCIDENCE OF VACCINE PREVENTABLE DISEASES (1986)

ALL STATES INCLUDED IN SURVEY HAVE PHILOSOPHICAL OBJECTION TO STATE MANDATED IMMUNIZATIONS IN STATUTES

	compliance rate:	reported cases of: measles	rubella	mumps	pertussis	tetanus	diptheria	polio
Michigan	91%	185	24	467	36	1	INA	INA
1971 (approx.) - mandatory law implemented 1971 (approx.) - philosophical objection allowed								
Utah	93%	13 [38.5%] {61.5%}	15	16	44 [65.9%] {34.1%}	0	0	0
1975 - mandatory law implemented **1982 (approx.) - philosophical exemption allowed**								
Washington	95.7%	176 [65%] {35%}	15	30	163 [56%] {44%}	0	0	0
Missouri	98.3%	32	1	23*	32*	2(2)*	0	0
California	93.4%	497 [50%] {50%}	242	336	310 [40%] {60%}	3	0	1
1961-mandatory law implemented 1961-philosophical exemption allowed								
Pennsylvania	99.2%	28	1	63	52	1	0	0
Oklahoma	97.6%	39	0	INA	134	1	0	0
1976-mandatory law implemented 1976-philosophical exemption allowed								
Nebraska	96.5%	1	0	2	10	INA	INA	INA
1973-mandatory law implemented 1973-philosophical exemption allowed								
Indiana	97%	39	0	339	39	2	0	0
1976-mandatory law implemented 1976-philosophical exemption allowed								
Delaware	98%	35	INA	INA	INA	INA	INA	INA
1982-mandatory law implemented 1982-philosophical exemption allowed								

(6)

COMPLIANCE RATES CONT'D.

	compliance rate:	reported cases of: measles	rubella	mumps	pertussis	tetanus	diptheria	polio
Ohio	95%	10 [80%] {20%}	0	150	170	0	0	2
1959-mandatory law implemented **1970 (approx.)-philosophical exemption allowed**								
Arizona	95.1%	252	2	209	78	1	0	0
1976-mandatory law implemented **1981-philosophical exemption allowed**								
Minnesota	99%	50 [89%] {21%}	1	86 [88.8%] {11.2%}	50	0	0	0
1967-mandatory law implemented **1978-philosophical exemption allowed**								
Colorado	96.3%	11	1	17	84(2)	0	0	0
1974-mandatory law implemented **1979-philosophical exemption allowed**								
Maine	INFORMATION NOT AVAILABLE							
1977-mandatory law implemented 1977-philosophical exemption allowed								
Wisconsin	96.5%	287	1	325	111	0	0	0
1975-mandatory law implemented **1980-philosophical exemption allowed**								
Vermont	98%	0	1	6	5	0	0	0
1979-mandatory law implemented 1979-philosophical exemption allowed								

INA: information not available
*: immunization not mandatory in state
(n): fatalities
[n]: percent of ill fully immunized
{n}: percent of ill unimmunized

Data received from State Health Departments of states listed
22 states contacted - 17 states responded to date - January 20, 1988

All states implement exclusion of unimmunized children from school during vaccine preventable disease occurances.

13 of 17 states have mandatory disease reporting laws; 7 of those have penalties for non-reporting of contagious diseases

Data compiled by the Alaska Chapter of Dissatisfied Parents Together

(7)

P.O. Box 118
Columbus, Ohio 43266-0118

Telephone (614) 466-3543

RICHARD F. CELESTE
Governor

November 4, 1987

Shannon Kohler
Alaska Chapter-DPT
Box 1746
Soldotna, Alaska 99669

Dear Ms. Kohler:

I am responding to your July 27 letter regarding immunization exemptions. I am sorry for the delay, but the mail had apparently been misrouted.

While immunization exemptions are a concern, immunization-exempt children have not contributed to disease initiation or propagation in Ohio.

In Ohio immunization levels exceed 95 percent in schools; in fact, in kindergarten they are 97 percent or greater. Immunization exemptions have not exceeded Ø.3 percent - Ø.5 percent among children new to Ohio schools. (The table enclosed gives you information regarding immunization levels, exemptions and reported cases of the vaccine-preventable diseases you requested.)

The measles cases in Ohio (1Ø last year) can virtually all be attributed to importations and spread from importations among persons either inadequately vaccinated or vaccine failures, but not persons who are immunization exempt. In 1986, only two of the 1Ø cases were not previously vaccinated. Because of their small number, exemptions have not played a major part in outbreaks.

In 1986 Ohio reported 17Ø cases of pertussis. Of these we were able to determine the age and vaccine status of 115. Most of these cases were just too young to have completed a full series of DTP immunizations. While an analysis of immunization exemptions was not made, only two of the cases were of school age.

Mumps cases have been declining in Ohio since the inclusion of mumps in the school immunization law beginning in 1984. The 15Ø cases reported in 1986 can not be attributed to immunization exemptions.

I hope this answers most of your questions, please let me know if I can provide any further information.

Sincerely,

Thomas J. Halpin, M.D., M.P.H.
Chief
Bureau of Preventive Medicine

KOHLERLE.PRN
Enclosure:

(9)

November 12, 1987

SUMMARY OF SEVERE ADVERSE REACTIONS TO STATE MANDATED IMMUNIZATIONS

Data collected by: Dissatisfied Parents Together, Alaska Chapter

Dates of survey: October 1986-October 1987

Method used: Alaska "DPT" vaccine adverse reaction questionnaire

Number of subjects (reactions) - 25: 24 DPT
1 MMR

Range of survey: State of Alaska

1- College, AK.	1- Anchorage, AK.
1- Gustavis, AK.	1- Anchor Point, AK.
1- Sterling, AK.	1- Homer, AK.
4- Kenai, AK.	3- Fairbanks, AK.
2- Juneau, AK.	7- Soldotna, AK.
1- Palmer, AK.	2- Kasilof, AK.

Ages of subjects at date of response:

2- 4 months	1- 4 years
1- 6 months	2- 5 years
1-10 months	3- 6 years
1- 14 months	1- 8 years
1- 18 months	1- 17 years
5- 2 years	1- 20 years
4- 3 years	1- 23 years

Return to: Dissatisfied Parents Together (11)
Box 1746
Soldotna, AK 99669
Shannon Kohler 262-3825

DPT SHOT REACTION QUESTIONNAIRE

Directions: Please place an "X" before the answer(s) you select or fill in the spaces when appropriate.

1. Before your child received his DPT shot(s), did a health professional inform you of the possible serious reactions to the shot?

5 Yes (1) 19 No (2) 1 Don't Know (3)

2. Did the health professional who gave your child the DPT shot(s) tell you to look for and report severe reactions such as a high temperature, excessive crying or high pitched screaming, excessive sleepiness, etc.?

6 Yes (1) 15 No (2) 1 Don't Know (3)

3. Before giving your child the DPT shot(s) did a health professional tell you when the shot should not be given (i.e. if the child has an active infection or a fever, if the child reacted severely to a previous DPT shot, etc.)?

6 Yes (1) 16 No (2) 3 Don't Know (3)

4. Did you sign a consent form containing information about the DPT shot and its possible reactions before your child received his DPT shot?

2 Yes (1) 15 No (2) 8 Don't Know (3)

5. Before your child received his DPT shot(s), did a health professional question you about your family's and your child's medical history?

___ Yes (1) 23 No (2) 2 Don't Know (3)

6. Do you believe your child reacted severely to any of his DPT shots? (Answer yes only if the reaction was more serious than a low fever, mild crying, or slight redness or puffiness around the site of the shot)

25 Yes (1) ___ No (2) ___ Don't Know (3)

If you answered yes to question #6, please answer the rest of the questionnaire. If you answered no to question #6, skip the rest of the questions and fill in your name, address and telephone number at the end of the questionnaire.

7. After the DPT shot that caused your child to react severely, did he have:

most children had more than one symptom of reaction

4 convulsions (1)

16 fever of more than 103 degrees (2)

13 excessive crying or high pitched screaming for long periods (3)

6 extreme sleepiness (4)

___ collapse or shock (5)

5 loss of muscle control (temporary or pemanent paralysis) (6)

___ death (7) 1-nerve damage deafness 1-severe allergies & eczema
2-permanent partial paralysis 1-chronic cold sores

___ other (please explain) 1-severe congestion 1-whooping-like cough (8)
1-limping 1-severe swelling of arm 1-severe leg swelling
1-severe swelling of glands in head

(12)

8. How long after the shot did the reaction begin to occur?

24 Within 24 hours after the shot (1)
1 24-48 hours after the shot (2)
___ 2 days - 7 days after the shot (3)
___ 1 week - 2 weeks after the shot (4)
___ more than 2 weeks after the shot (5)

9. After which DPT shot did your child react severely? Some children reacted to more than 1 shot

15 First shot (1)
4 Second shot (2)
3 Third shot (3)
2 Fourth shot (4)
___ Fifth shot (5)
1 all shots

10. How old was your child when he was given the DPT shot that caused the severe reaction?

8 2-3 months old (1)
6 4-5 months old (2)
4 6-7 months old (3)
3 8-12 months old (4)
1 13-18 months old (5)
1 19-24 months old (6)
___ 25 months - 3 years old (7)
___ over 3 years old (8)
1 all
1 Dont Know

11. How old is your child now?

See 1st page attachment

12. Did you report your child's severe reaction to the DPT shot to a health professional?

21 Yes (1) 4 No (2) ___ Don't Know (3)

13. If you did not report your child's severe reaction to the DPT shot, was it because you were not aware that the reaction was serious and should have been reported?

4 Yes (1) No ___ (2) ___ Don't Know (3)

* 14. If you did report your child's severe reaction to the DPT shot to a health professional, did that person report your child's severe reaction orally or in writing to: NO: 10

___ drug manufacturer (1)
___ federal government (2)
3 state health department (3)
___ any local health agency (4)
8 Don't Know (5) none of these parents had an official MSAEFI form completed

15. Was your child's severe reaction to the DPT shot written on his medical record?

6 Yes (1) 8 No (2) 11 Don't Know (3)

16. After your child reacted severely to a DPT shot, was he given another shot that contained the pertussis vaccine?

6 Yes (1) 17 No (2) 1 Don't Know (3) 1 n/a MMR Shot

17. Was your child mentally and physically normal before he received the DPT shot to which he reacted severely?

25 Yes (1) ___ No (2) ___ Don't Know (3)

18. Prior to the DPT shot to which your child reacted severely, did your child have a history of convulsions or neurologic disease?

____ Yes (1) 24 No (2) 1 Don't know

19. Does your family have a history of convulsions or neurologic disease?

1 Yes (1) 23 No (2) 1 Don't Know (3)

20. Did you or your husband ever have whooping cough?

1 Yes (1) 22 No (2) 2 Don't Know (3)

21. Is there a significant history of allergies in your family or has your child ever been diagnosed as having allergies?

9 Yes (1) 12 No (2) 4 Don't Know (3)

22. If your child has allergies, were the allergies apparent before or after the DPT shot to which he reacted severely?

3 Before (1) 5 After (2) N/A 17

23. At the time your child had a severe reaction to the DPT shot, was he primarily bottle-fed?

9 Yes (1) 11 No (2) 5 Both

24. Has your child had a continuing physical or mental health problem since the DPT shot that caused the severe reaction?

12 Yes (1) 12 No (2) 1 dont know yet

If you answered yes to question #24, please answer the rest of the questions.

25. Is your child now:

1 experiencing motor delay
____ mentally retarded (1)
4 physicially handicapped (2)
3 experiencing convulsions (3)
4 exhibiting learning difficulties (4)
____ in an institution (5)
____ other (please explain) 1-nerve damage deafness 2-permanent partial paralysis's 2-Cerebral palsy 1-epilepsy 1-speech problem 1-severe allergies (6)

26. Has a physician confirmed your belief that your child's present health problems were caused by the DPT shot?

7 Yes (1) 7 No (2)

27. Has your child required special medical treatment, medicine, hospitalization, or therapy since the DPT shot that caused the severe reaction?

11 Yes (1) 14 No (2)

28. The cost of your child's special medical treatment is estimated to have been:

1 Under $2,000
10 $2,000 - $7,000
____ $7,000 - $12,000
____ $12,000 - $20,000 (4)
____ $20,000 - $40,000 (5)
____ Over $40,000 (6)

29. Please feel free to use the back of this page to tell us your story of what happened to your child as a result of his severe reaction to a DPT shot. Try to be as specific as possible, giving names, dates, and places.

Name: See next page for Emergency Treatment Information

Address: _____

Telepone Numbers: _____ (home) _____ (work)

Date:

(14)

4 visits to emergency room
2 telephone consultation only

a) 1st parent
b) 2nd parent
c) 3rd parent
d) 4th parent
e) 5th parent
f) 6th parent

30. Emergency room treatment of adverse reaction, if applicable

a) What hospital did you go to?
a) Central Pen Gen. Hospital
b) Kenai Emergency medical Clinic
c) Central Peninsula Gen Hospital
D) Tanana Alaska
e) Central Pen. Gen. Hospital
f) Homer South Peninsula [illegible]

b) Did you call the emergency room?
5 yes a) B) C) D) e) 1 no f)

c) Did you go to the emergency room?
4 yes a) B) D) f) 2 no c) e)

d) How were you treated? (if more room needed, use back of sheet)
a) told not to worry; give cold bath & tylenol
B) O.K.
C) Told not to worry; give cold bath & tylenol
D) hospital did not even record visit
e) Give cold bath & tylenol
f) good

e) Were you advised to tell your doctor of reaction?
___yes 6 no a) B) c) D) e) f)

f) Were you advised to tell Health Dept. of reaction?
___yes 6 no a) B) c) D) e) f)

31. Was your child hospitalized?
1 yes f) 5 no a) B) C) D) e)

a) Where? Homer South Peninsula General Hospital

b) For how long? 3 days

c) How was reaction treated? not treated as vaccine reaction

Attachment 2

COMPREHENSIVE CHILD CARE COMMITTEE

Public Comment
July 10, 1987

loyd Richmond, Executive Director of Women in Safe Homes, (WISH). ox 6552, Ketchikan, AK, 99901, 225-9474. Richmond expressed that the overnment has a role in providing freedom of choice to work outside the ome or in the home. This can only be achieved through a system of ffordable, quality child care. Note: Written testimony from Richmond s available by contacting the office.

hannon Kohler, President of the Alaska chapter of Dissatisfied Parents ogether (DPT), Box 1746, Soldotna, AK 99669, 262-3825. Kohler poke on behalf of AK-DPT. This organization is actively working for he passage of HB 277, sponsored by Rep. Navarre. This legislation ould 1) require all public health officials to report all adverse eactions to immunizations, 2) require that prior to vaccination that ll parents are given accurate benefit/risk information with regard to accine safety, and 3) amend Alaska statues to allow a parent to enroll child in public schools with out vaccinating the child. Note: Written estimony and supporting documents presented by Kohler are available in he office.

Margeret Green, Tom Thumb Montessori Schools, 1901 Spenard Road, nchorage, AK 99503, 272-5033
Green has b
een involved with this private school since 1956. Their rogram works with children from three years old through sixth grade. She attributes their success to emphasizing developmentally appropriate curriculum. Green shared that she is apprehensive about creating new statutes and regulations that would impact their successful program.

leather Heames, DPT, Box 73, Clam Gulch, AK 99568, 262-6287
Heames is the mother of a child that suffered a severe reation to a DPT vaccine. She urged the Committee to do what it could from subjecting others to the problems that her child has faced.

Mary Wilson, Tom Thumb Montessori Schools, 1823 Beaver Pl., Anchorage, AK, 338-1669. Wilson is a teacher/supervisor at the Montessori school and is a certified elementary and montessori teacher. This school is self supporting. In response to questions it was calculated that the typical cost per child per month, for the full day program is $295.

Cheryl Rykaczewski, DPT, Box 311, Kasilof, AK. She is a parent concerned about vaccine safety. She urge the Committee to support the passage of HB 277- The Alaska Vaccine Reform Act.

Terry Victor, DPT, Box 1752, Fairbanks, AK 99708, 488-9531. Victor is the parent of a 15 month old child that suffered a severe reaction to a vaccine. She urged the Committee to support passage of HB 277, which ld require health care providers to report adverse reactions.

Mary Jo Hotchkiss, Instructor at Anchorage Community College, 2533 Providence Dr., 99508. She explained that in 1980 the University deleted their degree program in Early Childhood Education. This was a

(16)

result of there being few graduates in the program, which she attributed to the lack of incentives with in the field for pursuing a degree. She urged the Committee to support changes in the University that would establish training and possibly degrees in Early Childhood Education.

Regina Olszewski, 4003 Garfield , Anchorage, AK. She has a niece that suffered a stroke following a DPT vaccination. She urge the Committee to support the passage of HB 277.

Cecelia Bumanglage, Box 2708, Palmer, AK, 745-2528. She is the parent of a child that suffered a stroke following a DPT vaccination. Since there is no pediatric neurologist in Alaska, they have had to make medical trips to Seattle. The process of treating her now handicapped child is financially difficult. She urges the Committee to support the passage of HB 277, and possibly save one family this pain as the result of mandatory vaccination.

Susan Adams, Illilgaat Tupqaat, Inc., Box 1130, Kotzebue, AK, 442-3157. Adams is the Director of Illilgaat Tupqaat, a day care center. She agreed with the statements shared by Floyd Richmond of Ketchikan with regard to the State's responsibility in assisting in providing affordable, quality child care. She shared the story of a mother of four children, ages 4 months to 6 years, who wants to work outside the home, but can not afford a babysitter and does not qualify for day care assistance. Adams urged the Committee to assist the government in taking a leadership role in establishing quality day care in Alaska.

Carolyn Barnes, 5131 Hatcher, Anchorage, AK, 333-6028.
She is the parent of a child that became deaf after a DPT vaccine. She urged the Committee to support the passage of HB 277.

Dianne Gerber, DPT, St. Rt. 2, Box 560-Z, Kasiloff, AK 99610, 262-1714. She is the parent of a child that had severe reactions to the DPT vaccine and to the MMR vaccine. The child suffered fours days of high fever following the MMR vaccine. She urged the Committee to support the passage of HB 277.

Sharon Wells, 9340 Stratamore, Anchorage, AK, 243-4148. She is a medical foster parent for infants and premature babies. She is very concerned that many infants stay in foster care too long. Because of problems in the Indian Child Welfare Act, many infants that are adoptable stay in foster care past the point of being easily adoptable.

Kathy Boucha-Roberts, Director of Child Development at Providence Hospital, 3200 Providence Dr., Anchorage, AK, 99510, 261-3075. Roberts directs the corporate sponsored child care facility at Providence Hospital. The program cares for approximately 500 children and has a staff of 65. The fee for a child is based on age and the type of care, (i.e. daytime, night time, full time, drop in). They provide services 18 hours a day, 7 days a week, 365 days a year. This program also provides parenting education through classes taught at the hospital that provide interaction between parents and teachers.

Dee Ann Mueller, DPT, 501 Cole Dr., Kenai, AK 99611, 283-7459. She expressed her strong concern that parents should have a choice in deciding to vaccinate a child. Her child had adverse reactions to two DPT vaccines. She was not given any precautionary information, nor was the reaction reported. As a result of the vaccine her child now suffers with mild cerebral palsy.

Pertussis Whooping Cough

definition: an infectious disease typically of children marked by paroxysms of violent coughing followed by a shrill, whooping drawing in of breath. from: Nelson's Medical Dictionary

the following from: Vaccine Preventable Diseases - manual publisned by CDC

diagnosis: It has fastidious growth requirements that make it difficult to isolate with multiple serotypes. There are other causes of paroxysmal coughing that may also be confused with pertussis. These include bronchiolitis, bronchopneumonia, Bordetella parapertussis, B. bronchiseptica infections, adenovirus infections, chlymydia trachomatis, and others. Difficult to diagnose. Some success with swabs taken from posterior nasopharynx or immunofluorescent antibody testing.

treatment: erythromycin antibiotic of choice to decrease communicability and treat bacteriological secondary infections such as bronchopneumonia (most common and most severe secondary infection). Intensive nursing care essential. Pertussis immune globula may help shorten illness.

complications: 10% of all pertussis cases may be hospitalized. 1982-1983 encephalopathy occurred in 371,000 cases, 2.5% of cases in children less than 1 year may have convulsion. Average of 6 deaths per year in United States due to pertussis.

Diptheria

definition: highly contagious bacterial disease spread by coughing and sneezing. Patches can be observed in throat that cause swelling, may obstruct breathing in severe cases and cause victim to choke to death.

diagnosis: usually made based on clinical presentation; swab of pharangeal area. variety of types: nasal, tonsillar, pharyngeal, laryngeal, etc.

treatment: antibiotics and antitoxin. respitory support and airway maintenance if needed

complications: respiratory diseases. 9% respiratory diptheria fatal. approx. 1 death per year in U.S. 1983; 5 cases, 0 deaths

Tetanus

definition: an acute infectious disease characterized by spasms of the muscles especially of the jaw caused by a baccillic toxin introduced through a wound. not contagious.

diagnosis: many medical conditions simulate tetanus. no laboratory findings characteristic of tetanus. Diagnosis is entirely clinical.

complications: spasms, coma, aspiration pneumonia. 20% of tetanus deaths attributed to tetanus toxoid. average 91 cases, 30 deaths per year in U.S. (no information as to vaccination rate of inflicted)

NOTES ABOUT TETANUS:
1) "....the mortality in reported cases of tetanus is higher in the U.S. than in developing countries." (Am J. Dis. Child. Vol 135, June 1981, pg. 571)
2) "nosocomial" (hospital acquired pneumonia) pneumonia is a major cause of death in these patients that come to autopsy." (J. Arkansas Med. Soc., Vol 80, No. 3, Aug. 1983, pg. 136)

(18)

GENERAL DPT (DIPTHERIA, PERTUSSIS, AND TETANUS) VACCINE INFORMATION

All vaccines come combined unless specifically requested separate via medical prescription. The following is from Lederle and Connaught manufacturer's inserts.

Ingredients: Lederle Co.: FORMALDEHYDE, potassium phosphate monobasic, sodium phosphate dibasis, glycine, THIMEROSAL (mercury derivative), sodium chloride, ALUMINUM, inactivated diptheria and tetanus toxoids, inactivated pertussis bacteria. Connought Co: basically the same out no mention of formaldehyde.

Minor-Moderate Adverse Reactions: (See manufacturer's product insert for complete list)
1) local reactions, adscess formation at sight of injection, fretfulness, drowsiness, vomiting, anorexia

Severe Adverse Reactions: (See manufacturer's product insert insert for those recognized by manufacturer. Read large print under ADVERSE REACTIONS.)

ADVERSE REACTIONS

Local reactions manifested by erythema and induration with or without tenderness are common after administration of DTP. Such local reactions are usually self-limited and require no therapy. A nodule may be palpable at the injection site for a few weeks.

Abscess formation at the site of injection has been reported [16,18]. Cervical lymphadenopathy has been reported following DTP injections into the arm [18].

Mild to moderate temperature elevations frequently follow DTP administration and are often accompanied by fretfulness, drowsiness, vomiting, and anorexia [16,18,19]. Approximately 50% of DTP recipients will develop temperature elevations > 38° C (100.4° F) after one or more doses of the series, approximately 6% > 39° C (102.2° F), and approximately 1.5% > 40° C (104° F). Some data suggest that febrile reactions are more likely to occur in those who have experienced such responses after prior doses [18].

SIGNIFICANT REACTIONS ATTRIBUTED TO THE PERTUSSIS VACCINE COMPONENT HAVE BEEN: HIGH FEVER OF 40.5° C (105° F), A TRANSIENT SHOCK-LIKE EPISODE, EXCESSIVE SCREAMING (PERSISTENT CRYING OR SCREAMING FOR THREE OR MORE HOURS DURATION), SOMNOLENCE, CONVULSIONS, AND ENCEPHALOPATHY. THESE REACTIONS HAVE BEEN REPORTED TO OCCUR RARELY FOLLOWING THE INJECTION OF THIS PRODUCT AND THEY MAY BE FATAL OR RESULT IN PERMANENT DAMAGE TO THE CENTRAL NERVOUS SYSTEM. PERTUSSIS VACCINE HAS BEEN ASSOCIATED WITH A GREATER PROPORTION OF ADVERSE REACTIONS THAN MANY OTHER CHILDHOOD IMMUNIZATIONS [16,17]. SHOULD SYMPTOMATOLOGY REFERABLE TO THE CENTRAL NERVOUS SYSTEM DEVELOP FOLLOWING ADMINISTRATION, FURTHER IMMUNIZATION WITH THIS PRODUCT IS CONTRAINDICATED (SEE CONTRAINDICATIONS). SUCH REACTIONS ALMOST ALWAYS APPEAR WITHIN 24 TO 48 HOURS AFTER INJECTION, BUT HAVE BEEN THOUGHT TO OCCUR AFTER AN INTERVAL AS LONG AS SEVEN DAYS.

NEUROLOGICAL COMPLICATIONS FOLLOWING TETANUS TOXOID ADMINISTRATION, SUCH AS PARALYSIS OF THE RADIAL NERVE [1], RECURRENT PHARYNGEAL NERVE [2], COCHLEAR LESION [3], BRACHIAL PLEXUS NEUROPATHY [4-6], AND A CASE OF DIFFICULTY IN SWALLOWING, ACCOMMODATION PARESIS, AND EEG DISTURBANCES [7], HAVE BEEN REPORTED. IN THE DIFFERENTIAL DIAGNOSIS OF POLYRADICULONEUROPATHIES FOLLOWING ADMINISTRATION OF TETANUS TOXOID, TETANUS TOXOID SHOULD BE CONSIDERED AS A POSSIBLE ETIOLOGY [8].

CONTRAINDICATIONS

IMMUNIZATION SHOULD BE DEFERRED DURING THE COURSE OF ANY ACUTE ILLNESS. THE OCCURRENCE OF ANY TYPE OF NEUROLOGICAL SYMPTOMS OR SIGNS, INCLUDING ONE OR MORE CONVULSIONS (SEIZURES) FOLLOWING ADMINISTRATION OF THIS PRODUCT IS A CONTRAINDICATION TO FURTHER USE. USE OF THIS PRODUCT IS ALSO CONTRAINDICATED IF THE CHILD HAS A PERSONAL OR FAMILY HISTORY OF CENTRAL NERVOUS SYSTEM DISORDERS.

THE PRESENCE OF ANY EVOLVING OR CHANGING DISORDER AFFECTING THE CENTRAL NERVOUS SYSTEM IS A CONTRAINDICATION TO ADMINISTRATION OF DTP REGARDLESS OF WHETHER THE SUSPECTED NEUROLOGICAL DISORDER IS ASSOCIATED WITH OCCURRENCE OF SEIZURE ACTIVITY OF ANY TYPE.

The Committee on Infectious Diseases of the American Academy of Pediatrics recommends that pertussis vaccine should be withheld when a previous dose has been followed by convulsion, encephalitis, focal neurological signs or collapse. Nor should infants who experience excessive somnolence, excessive screaming (persistent crying or screaming for three or more hours duration) or temperature more than 105° F (40.5° C) receive additional doses of the vaccine [9].

The Immunization Practices Advisory Committee (ACIP) of the U.S. Public Health Service recommends that hypersensitivity to vaccine components, presence of an evolving neurologic disorder, or a history of a severe reaction (usually within 48 hours) following a previous dose all remain definitive contraindications to the receipt of pertussis vaccine. Severe reactions include collapse or shock, persistent screaming episode, temperature 40.5° C (105° F) or greater, convulsion(s) with or without accompanying fever, severe alterations of consciousness, generalized and/or local neurologic signs, or systemic allergic reactions [9].

Immunosuppressive therapy, including irradiation, corticosteroids, antimetabolites, alkylating agents, and cytotoxic agents may result in aberrant responses to active immunization procedures. Administration should be deferred in individuals receiving such therapy.

The clinical judgement of the attending physician should prevail at all times.

Elective immunization of patients over the age of 6 months should be deferred during an outbreak of poliomyelitis.

PARTIAL LIST OF POSSIBLE SEVERE LONG-TERM ADVERSE REACTIONS TO DPT VACCINE (USUALLY PERTUSSIS COMPONENT IMPLICATED)

* article available from Alaska Dissatisfied Parents Together

*1) **Cervical lymphadenopathy** . Omokoku, B: "Post DPT inoculation caused lymphadenitis in children." N.Y. State Journal Medicine 81:1667, 1981

2) **Thrombocytopenia** (blood disease). Connaught manufacturer's insert*. Pertussis. Report of Committee on Infectious Diseases. AAP, Evanston, Illinois, p. 205. 1977

*3) **hemolytic anemia** (blood disease). Haneberg B.; "Acute hemolytic anemia related to DPT vaccination": ACTA Pae diatr. Scand. 67:347-350, 1978

*4) **death, encephalopathy, Reyes syndrome, tracheo bronchitis, convulsions with and without residual brain damage** . Griffith A.H: "Reactions after Pertussis vaccine; a manufacturer's experiences and difficulties since 1964", British Medical Journal: April 1, 1978, pg. 809-814

*5) **destructive encephalopathys, convulsions, hypsarrhythmia, shock, serious meningitis** . Incidence of neurological reactions 1:3,600 children. Strom, Justus M.D., "Further Experience of Reactions, Especially of a Cerebral Nature, in Conjunction w/Triple Vaccine: Swedish Study, 1959-1965", British Medical Journal, 1967, 320-323

*6) **recurrent seizures, severe developmental delays** . Murphy, Jerome. "Recurrent Seizures after DPT Vaccine Immunization", AJDC, Vol 138, Oct. 1984

*7) **blindness, cerebral palsy, death, mental retardation, chronic convulsions** Byers, Randolph. "Encephalopathies Following Prophylactic Pertussis Vaccine", Pediatrics, Vol. 1, #4, April 1948.

*8) **recurring convulsions, paralysis, mental retardation, allergies** Berg, J.M "Neurological Complications of Pertussis Immunization", British Medical Journal, July 5, 1958

*9) **death, sudden death, convulsions, paresis, rhinopharyngitis, rapid mental deterioration, coma, cerebral palsy, deafness, epilepsy** Neurological reactions after vaccination-1 in 6,000 children; death or permanent defect-1 in 17,000. "Is Universal Vaccination Against Pertussis Always Justified?" Justus Strom, M.D., British Medical Journal, Oct. 22, 1960.

*10) **allergic form of encephalopathy, death** . "Encephalopathy Following Pertussis Vaccine Prophylaxis", Joseph H. Globus, M.D., J.A.M.A., October 22, 1949

*11) **cerebral degeneration, blindness** . "Neurological Complications of Pertussis Inoculation", M. Kulenkanpff, Archives of Disease in Children, 1974, pg. 46, 49

*12) **sudden death, seizures, convulsions, respiratory infection** . John A. Toomey, "Reactions to Pertussis Vaccine", J.A.M.A., February

13) **"Post vaccinal lymphadenitis developing into Hodgkins Disease"**. Bichel, J. ACTA Med. Scand., 199:523, 1976

*14) **anaphylaxis** (extreme, sometimes fatal allergic reaction). Howard Orens, M.D. "Anaphylaxis due to vaccination in the Office". Can. Med. Assoc. Journal

*15) **paroxysmal supra ventricular tachycardia** . Joon M. Park, M.D. "Paroxysmal Supra ventricular tachycerdia precipitated by pertussis vaccine". Journal of Pediatrics, June 1983

SIDS AND DPT VACCINATION

STUDIES THAT SHOW CORRELATION BETWEEN SIDS/DPT

*1) BARAFF GRAPH "Possible Temporal Association between DPT Vaccination and Sudden Infant Death" Pediatric Infectious Disease, 1983, 2,7-11

*2) TORCH STUDY summary ... graph ... DPT ...mmunization, a Potential Cause of the Sudden Infant Death Syndrome. Neurology, 1982, 32 A [illegible]

(20)

*3) BERNIER STUDY GRAPH. "DTP Vaccination and SIDS in Tennessee." Journal of Pediatrics, 1982, 101:419-421
*4) "DTP Immunization and Sudden Infant Death Syndrome." Alexander M. Walker, et. al., AJPH, August 1987, Vol. 77, #8

TETANUS VACCINE REACTIONS (PARTIAL LIST)

1) "Abnormal T-Lymphocyte Subpopulations in Healthy Subjects After Tetanus Booster Immunization." Martha Eibe, New England Journal of Medicine, 310(3) 1307-1313, November 26, 1981. Report pointed out that similar drops in helper/suppressor ratio of T-lymphcytes are characteristic of AIDS.
2) neuralgic amyotophy . J Neurology, Neurosurgy & Psych, Vol. 47; 320, March 1984
3) transverse myelitis. Br. Med Journal 1977; 1: 1430-1431
4) demyelinating neuropathy . J Neur. Sci. 1978; 37: 113-125
5) peripheral neuropathy . Arch Phys Med Rehab Vol 63, July 1982, 332-334. (detailing many cases)
6) calcifying dermatomyositis . Arch Int Med Vol 143, July 1983, 1457-8
7) mono and polyneuritis (22 cases). Int. Sympos. on Imm. Dev. Biol Stands, Vol. 43, pg. 25-32, 1979
8) Guillain Barre Syndrome . N.Z. Med J., Nov 11, 1981 , Akt Neurol 1980: 7;195-200
9) hemolytic anemia . Acta Pediatric Scand, May 1978
10) anaphylactic shock . Harefuah, Nov 1975 - Dtsch Med Wochenschr, Jan 1973 - Annals of Allergy, Vol 49, August 1982, pg 107
11) nerve damage, inner ear. Munch Med. Wochen Schr, Nov 1965
12) foreign body granuloma . Rocky Mountain Medical Journal, Jan, 1966
13) seizure activity . Neurol Neurochir Pol, Sept 1981
14) recurrent abscess formatio n. Pediatric, May 1985
15) brachial plexus neuropathy . Archives of Neurology, 1972
(which can lead to paralysis of the arm)

DIPTHERIA VACCINE REACTIONS

(all from Center of Disease Control Manual: "Vaccine Preventable Diseases; Epedemiology, Prevention and Control", pg 38-39.)

1) local reactions, abscess at the site of injection
2) arthus-type hypersensitivity reactions, characterized by severe local reactions
3) severe systemic reactions such as generalized urticaria (allergic rash and hives), anaphylaxis, neurological complications

DPT VACCINE INGREDIENTS

*data available from Alaska Dissatisfied Parents Together

FORMALDEHYDE

"Formaldehyde (ingredient in Lederle DPT vaccine) is also mutagenic in bacteria, viruses, fungi, insects and mouse lymphoma cells with or without metabolic activation. It induces chromosomal recombination in yeast, insects, and cultured mammalian cells, as well as cellular transformation in mouse Balb/C 3T3 cells (Griesemer, et al., 1980). These results indicate that formaldehyde is capable of binding to, and altering, genetic material."
Formaldehyde: Review of Scientific Basis of EPA's Carcinogenic Risk Assessment Peter W. Preuss Ph. D. May 26, 1983 page 21

"Immunologic. (physiological effect). The characteristics of an allergic mechanism are that the response can be evoked in sensitized individuals with very small amounts of formaldehyde. Symptoms usually develop some time after the initial exposure rather than on initial contact. Usually only a proportion of the exposed will be affected. In the documented cases there is typically a delayed response, although there may be a brief immediate reaction as well (dual response), and the late reaction may be prolonged." Formaldehyde Toxicity, James E. Gibson, 1983*

"Carcinogenic Effect: Of additional concern is the carcinogenic potential of formaldehyde in humans. This concern is based on metabolism, mutagenicity, and carcinogenicity studies which were reviewed in the Report of the Federal Panel on Formaldehyde, Griesemer, et. al., 1980. In brief, the panel reported that these studies showed that formaldehyde reacts readily with biological chemical, including proteins and nucleic acids." page 395, Formaldehyde: Review of Scientific Basis of EPA's Carcinogenic Risk Assessment, May 20, 1982*

Aluminum

(another ingredient in all DPT vaccines)

"...In Canada (researchers) found that after a latent period of 10 to 20 days, animals receiving a single intracerebral injection of aluminum incurred a progressive decline in learning and memory." Physiol Behav, Crapper DR, Dalton AJ, 1973

"Crapper also found that aluminum accumulates preferentially on the chromatin of various cell nuclei, including brain cell nuclei from patients with SDAT... (Senile Dementia of the Alzheimer's Type)." Frontiers in Neurology and Neuroscience Research, "Dementia: Recent observations on Alzheimer's disease and experimental aluminum encephalopathy." Crapper, Dr., 1974

Thimerosal (mercury derivative)

definition: prepared by reacting ethylmercuric chloride (or ethymercuric hydroxide) with thiosalicylic acid. The Merck Index, 1983*

ethylmercuric chloride: caution: Highly toxic. causes skin burns, is absorbed through the skin, chronic exposure has caused permanent injury to brain, applied at 2% strength as a fungicide for treating seeds. The Merck Index, 1983*

the following from: "Epidemiology & Toxicology of Mercury" The Environmental Mercury Problem*

"Furthermore, the vast majority of the organomercurial poisonings are due to alkylmercurials such as methyl or ethylmercury."

"Therefore while it is important to recognize that all forms of mercury are powerful poisons, the akylmercurials are many times more effective poisons than either the inorganic or arylmercurials."

"...the organic mercury compounds, especially the alkymercurials (ethymercury) are more toxic than the other kinds of mercury compounds because the human body absorbs more and excretes less of them."

"Several alkylmercury poisoning epidemics have been recorded." Guatamala, Pakistan, Iraq: "In 1960 many farmers were poisoned and 221 patients were admitted to hospital in Baghdad, Iraq. Other patients were known to have been stricken by ETHYLMERCURIC CHLORIDE

POLIO

definition : a viral disease marked by inflammation of the nerve cells of the spinal cord, deformity, and paralysis. 95% of all polio infections are inapparent or subclinical, but may still be able to transmit infection to others (CDC Manual)

diagnosis : A) 4%-8% nonspecific illness of influenza-like illness B) 1%-2% of polio infections result in major illness w/complete recovery C) 0.1%-0.2% of all polio infections result in flaccid paralysis. Many persons w/paralytic polio recover completely. Deathrate: 2-5% in children 15-30% in adults

treatment : 1) early ambulation 2) muscular relaxation 3) controlled and prolonged medical observation 4) special nutrition program Virginia Medical Monthly, June 1956, Nutrition; "Nutrition as Treatment for Polio Victims", Prevention, November 1960

complications: See diagnosis

POLIOVIRUS VACCINE

all information from manufacturer's product insert unless specified

Ingredients: mixture of 3 types of attenuated poliviruses propagated in cercopithecus MONKEY KIDNEY CELLS, amino acids, antibiotics, CALF SERUM, sorbitol, streptomycin, NEOMYCIN

CONTRAINDICATION MUST NOT BE ADMINISTERED TO PATIENTS WITH IMMUNE DEFICIENCY

Question: Since no mechanisms are employed by health care providers to determine immune deficiency (especially public health providers who have never seen 2 month old infants before vaccine clinics), how is this to be determined?

ALL PERSONS WITH ALTERED IMMUNE STATUS SHOULD AVOID CLOSE HOUSEHOLD-TYPE CONTACT WITH RECIPIENTS FOR AT LEAST 6-8 WEEKS.

Question: Most people aren't aware of the health status of everyone their child comes in contact with (especially other infants in day care), so how is this to be accomplished and what are the other health implications?

Adverse Reactions: 1) paralytic disease, vaccine associated paralysis in healthy vaccines, susceptible family members, and other close personal contacts 2) transverse myletis (inflammation of spinal cord or bone marrow) "Transverse myletis after diptheria, tetanus, and polio immunization." case history British Medical Journal, June 4, 1977

NOTES:

1) "Many physicians and health workers will be surprised to learn that the Sabin vaccine is now the chief cause of polio in the world today and that it was introduced without any controlled field trials." J. and D. Salk, Science 4/4/77

2) Current Trends: Average of 10 cases per year reported 1980-1985, no wild virus cases since 1979, one imported case per year REMAINING CASES IN VACCINE RECIPIENTS OR CONTACTS. page 88, CDC manual Note: speaker at seminar Neil Livengood stated that no "natural cases" of polio have occurred in U.S. since 1979

(2-4)

3) "A defect either in the humoral (B-cell) mediated (T-cell) system appears to increase the risk of vaccine associated polio myelitis. T-cell dysjunction from any cause must therefore be assumed to confer greater risk for vaccine related poliomyelitis." Elena Nightengale, Ph. D, et al, Committee for the Study of Poliomyelitis Vaccines, Institute of Medicine. Correspondence New England Journal of Medicine, Dec. 8, 1977

4) "The poliovirus isolated from a patient with paralytic disease may not always be the virus causing the patients disease." Lancet, Dec. 8, 1984, pg 1315

*5) "The DBS (Division of Biological Sciences) requires monkey kidney cells used in growing polio vaccine be held for only 28 days in order to ensure that they contain no SV 40 virus According to A. Girandi of the Wistar Institute SV 40 may remain latent for up to 35 days. Nor does the DBS require monkey kidney cells to be screened for chromosomal abnormalities - a possible indicator of cancerous tendencies - a test they would probably fail in large numbers." "The Boat That Never Rocked", Science, March 17, 1977

CONTRAINDICATIONS

Under no circumstances should this vaccine be administered parenterally

Administration of the vaccine should be postponed or avoided in those experiencing an acute illness and in those with any advanced debilitated condition or persistent vomiting or diarrhea

ORIMUNE *must not* be administered to patients with immune deficiency diseases such as combined immunodeficiency, hypogammaglobulinemia and agammaglobulinemia. It would also be prudent to withhold ORIMUNE from siblings of a child known to have an immunodeficiency syndrome. Further, ORIMUNE *must not* be administered to patients with altered immune states such as those occurring in thymic abnormalities, leukemia, lymphoma or generalized malignancy or by lowered resistance from therapy with corticosteroids, alkylating drugs, antimetabolites or radiation. All persons with altered immune status should avoid close household-type contact with recipients of the vaccine for at least 6-8 weeks. IPV is preferred for immunizing all persons in this setting.[2,3,4,6,7]

PRECAUTIONS

Other viruses including poliovirus and other enterovirus may interfere with the desired response to this vaccine since their presence in the intestinal tract may interfere with the replication of the attenuated strains of poliovirus in the vaccine

It would seem prudent not to administer TOPV shortly after Immune Serum Globulin (ISG) unless such a procedure is unavoidable, for example, with unexpected travel to or contact with epidemic areas or endemic areas. If TOPV is given with or shortly after ISG, the dose probably should be repeated after three months, if immunization is still indicated.[4] However, ISG may not interfere with immunization with TOPV.[8]

The vaccine is not effective in modifying or preventing cases of existing and/or incubating poliomyelitis

ADVERSE REACTIONS

Paralytic disease following the ingestion of live poliovirus vaccines has been, on rare occasion, reported in individuals receiving the vaccine, (see for example CONTRAINDICATIONS) and in persons who were in close contact with vaccinees.[2,3,4,10,11,12,13] The vaccine viruses are shed in the vaccinee's stools for at least 6 to 8 weeks as well as via the pharyngeal route. Most reports of paralytic disease following ingestion of the vaccine or contact with a recent vaccinee are based on epidemiological analysis and temporal association between vaccination or contact and the onset of symptoms. Most authorities believe that a causal relationship exists.[2,10,13,15]

The risk of vaccine-associated paralysis is extremely small for vaccinees, susceptible family members and other close personal contacts.[2] However, prior to administration of the vaccine, the attending physician should warn or specifically direct personnel acting under his authority to convey the warnings to the vaccinee, parent, guardian or other responsible person of the possibility of vaccine-associated paralysis. The Centers for Disease Control report that during the years 1969 through 1980 approximately 290 million doses of TOPV were distributed in the United States. In the same 12 years, 25 "vaccine-associated" and 55 "contact vaccine-associated" paralytic cases were reported. Twelve other "vaccine-associated" cases have been reported in persons (recipients or contacts) with immune deficiency conditions.[2] These statistics do not provide a satisfactory basis for estimating these risks on a per person basis."[4]

When the attenuated vaccine strains are to be introduced into a household with adults who have not been adequately vaccinated or whose immune status cannot be determined, the risk of vaccine-associated paralysis can be minimized by giving these adults three doses of IPV a month apart before the children receive ORIMUNE.[2] The CDC reports that no paralytic reactions to IPV are known to have occurred since the 1955 cluster of poliomyelitis cases caused by vaccine that contained live polioviruses that had escaped inactivation.[2]

The Immunization Practices Advisory Committee of the U.S. Public Health Service states:

"Because of the overriding importance of ensuring prompt and complete immunization of the child and the extreme rarity of OPV-associated disease in contacts, the Committee recommends the administration of OPV to a child regardless of the poliovirus-vaccine status of adult household contacts. This is the usual practice in the United States. The responsible adult should be informed of the small risk involved. An acceptable alternative, if there is strong assurance that ultimate, full immunization of the child will not be jeopardized or unduly delayed, is to immunize adults according to the schedule outlined above before giving OPV to the child."[2]

The Immunization Practices Advisory Committee has concluded that "Oral polio vaccine remains the vaccine of choice for primary immunization of Children.

from: How to Raise a Healthy Child in Spite of Your Doctor, Dr. Robert Mendelsohn

MUMPS

definition and diagnosis: relatively innocous viral disease, usually experienced in childhood, causes swelling of one or both of the salivary glands. Symptoms; temp of 100-104 degrees, appetite loss, headache, back pain. Infection confers lifetime immunity.

treatment: does not require medical treatment - bed rest, lots of fluids, ice packs to reduce swelling.

complications: very rarely in adult males with mumps infection, orchitis (mumps condition that affects testicles) may occur. Orchitis rarely causes sterility and when it does usually only one testicle is affected

In 1981, 1,491 cases in U.S..; 1 death (MMWR 1983 summary)

MEASLES

definition and diagnosis: rubeola, contagious viral disease that can be contracted by touching an object used by infected person, slight fever at first to high (103-104 degrees) in few days-sometimes small white spots occur inside mouth - rash occurs below hairline and spreads downward to cover body in about 36 hours

treatment: bedrest, fluids, Calamine lotion or cornstarch to relieve itching, may be light sensitive (darken room), Vitamin A supplements in malnourished. "Vitamin A Supplements and Mortality Related to Measles: A Randemised Clinical Trial", Andrew J.G. Barclay, British Medical Journal, Jan. 31, 1987, Volume 294

RUBELLA

definition and diagnosis: non-threatening disease in children that does not require medical treatment- fever, slight cold w/sore throat - rash appears on face and spreads to body, spot do not run together (as in measles), confers lifetime immunity

treatment: rest and fluids

complications: none to child. Threat posed by rubella is the possibility it may cause damage to fetus if a women contracts disease during first three months of pregnancy

In 1981, 2,077 cases of rubella in U.S.; 5 deaths (MMWR 1983 Summary)

(26)

MEASLES, MUMPS, RUBELLA (MMR) VACCINE INFORMATION AND ADVERSE REACTIONS

NOTE: Since all three vaccines in combined shot, it's difficult to ascertain what vaccine causes what reaction. Any live virus vaccine is capable of producing the same syptoms, reactions, etc. as the virus.

Ingredients: CELL CULTURES OF CHICK EMBRYO (measles and mumps), HUMAN DIPLOID CELL culture (rubella), neomycin, sorbitol, hydorlized gelatin.
Adverse Reactions: (from Manufacturer's insert)

CONTRAINDICATIONS

Do not give M·M·R II to pregnant females; the possible effects of the vaccine on fatal development are unknown at this time. If vaccination of postpubertal females is undertaken, pregnancy must be avoided for three months following vaccination.

Hypersensitivity to neomycin (each dose of reconstituted vaccine contains approximately 25 mcg of neomycin).

Any febrile respiratory illness or other active febrile infection.

Active untreated tuberculosis.

Patients receiving therapy with ACTH, corticosteroids, irradiation, alkylating agents or antimetabolites. This contraindication does not apply to patients who are receiving corticosteroids as replacement therapy, e.g., for Addison's disease.

Individuals with blood dyscrasias, leukemia, lymphomas of any type, or other malignant neoplasms affecting the bone marrow or lymphatic systems.

Primary immuno-deficiency states, including cellular immune deficiencies, hypogammaglobulinemic and dysgammaglobulinemic states.

HYPERSENSITIVITY TO EGGS, CHICKEN, OR CHICKEN FEATHERS

This vaccine is essentially devoid of potentially allergenic substances derived from host tissues (chick embryos).* However, because the attenuated measles and mumps viruses in this vaccine are propagated in cell cultures of chick embryo, there is a potential risk of hypersensitivity reactions in patients allergic to eggs, chicken or chicken feathers. Widespread use of the vaccine for more than a decade has resulted in only rare, isolated reports of minor allergic reactions attributed to allergens of this kind, possibly related to the vaccine. Significantly, when children with known allergies to eggs, chicken and chicken feathers were given a similarly prepared vaccine in a clinical study,[20] none experienced reactions other than those reactions previously observed in non-allergic children.

PRECAUTIONS

Administer M·M·R II subcutaneously; *do not give intravenously.*

Epinephrine should be available for immediate use in case an anaphylactoid reaction occurs.

M·M·R II may be given simultaneously with monovalent or trivalent poliovirus vaccine, live, oral. M·M·R II should not be given less than one month before or after administration of other live virus vaccines.

Due caution should be employed in administration of M·M·R II to children with a history of febrile convulsions, cerebral injury or any other condition in which stress due to fever should be avoided. The physician should be alert to the temperature elevation which may occur 5 to 12 days following vaccination.

Vaccination should be deferred for at least 3 months following blood or plasma transfusions, or administration of human immune serum globulin.

Excretion of small amounts of the live attenuated rubella virus from the nose or throat has occurred in the majority of susceptible individuals 7-28 days after vaccination. There is no confirmed evidence to indicate that such virus is transmitted to susceptible persons who are in contact with the vaccinated individuals. Consequently, transmission, while accepted as a theoretical possibility, is not regarded as a significant risk.**

There are no reports of transmission of live attenuated measles or mumps viruses from vaccinees to susceptible contacts.

It has been reported that live attenuated measles, mumps and rubella virus vaccines given individually may result in a temporary depression of tuberculin skin sensitivity. Therefore, if a tuberculin test is to be done, it should be administered either before or simultaneously with M·M·R II.

As for any vaccine, vaccination with M·M·R II may not result in seroconversion in 100% of susceptible subjects given the vaccine.

ADVERSE REACTIONS

Because of the slightly acidic pH (6.2-6.6) of the vaccine, patients may complain of burning and/or stinging of short duration at the injection site.

The adverse clinical reactions associated with the use of M·M·R II are those expected to follow administration of the monovalent vaccines given separately. These may include malaise, sore throat, headache, fever, and rash; mild local reactions such as erythema, induration, tenderness and regional lymphadenopathy; parotitis; orchitis; thrombocytopenia and purpura; allergic reactions such as wheal and flare at the injection site or urticaria; and arthritis, arthralgia and polyneuritis.

Moderate fever [101-102.9°F (38.3-39.4°C)] occurs occasionally, and high fever (above 103°F (39.4°C)) occurs less commonly. On rare occasions, children developing fever may exhibit febrile convulsions. Rash occurs infrequently and is usually minimal, but rarely may be generalized.

Clinical experience with live attenuated measles, mumps and rubella virus vaccines given individually indicates that encephalitis and other nervous system reactions have occurred very rarely. These might occur also with M·M·R II.

Experience from more than 80 million doses of all live measles vaccines given in the U.S. through 1975 indicates that significant central nervous system reactions such as encephalitis and encephalopathy, occurring within 30 days after vaccination, have been temporally associated with measles vaccine approximately once for every million doses. In no case has it been shown that reactions were actually caused by vaccine. The Center for Disease Control has pointed out that "a certain number of cases of encephalitis may be expected to occur in a large childhood population in a defined period of time even when no vaccines are administered". However, the data suggest the possibility that some of these cases may have been caused by measles vaccines. The risk of such serious neurological disorders following live measles virus vaccine administration remains far less than that for encephalitis and encephalopathy with natural measles (one per thousand reported cases).

There have been isolated reports of ocular palsies and Guillain-Barre syndrome occurring after immunization with vaccines containing live attenuated measles virus. The ocular palsies have occurred approximately 3-24 days following vaccination. No definite causal relationship has been established between either of these events and vaccination.

There have been reports of subacute sclerosing panencephalitis (SSPE) in children who did not have a history of natural measles but did receive measles vaccine. Some of these cases may have resulted from unrecognized measles in the first year of life or possibly from the measles vaccination. Based on estimated nationwide measles vaccine distribution, the association of SSPE cases to measles vaccination is about one case per million vaccine doses distributed. This is far less than the association with natural measles, 5-10 cases of SSPE per million cases of measles. The results of a retrospective case-controlled study conducted by the Center for Disease Control suggest that the overall effect of measles vaccine has been to protect against SSPE by preventing measles with its inherent higher risk of SSPE.

Local reactions characterized by marked swelling, redness and vesiculation at the injection site of attenuated live measles virus vaccines have occurred in children who received killed measles vaccine previously. M·M·R II was not given under this condition in clinical trials.

Transient arthritis, arthralgia and polyneuritis are features of natural rubella and vary in frequency and severity with age and sex, being greatest in adult females and least in prepubertal children. This type of involvement has also been reported following administration of MERUVAX II (Rubella Virus Vaccine, Live, MSD). In children, joint reactions are rare and of brief duration if they do occur. In women, incidence rates for arthritis and arthralgia are generally higher than those seen in children (children: 0-3%; women: 12-20%),[21] and the reactions tend to be more marked and of longer duration. Rarely, symptoms may persist for a matter of months. In adolescent girls, the reactions appear to be intermediate in incidence between those seen in children and in adult women. Even in older women (35-45 years), these reactions are generally well tolerated and rarely interfere with normal activities.

NOTES:

MEASLES

1) subacute scleros panencephalitis "SSPE" (fatal hardening of brain) Modern Medicine, 1/7/74 and "Occurence of Measles in Previously Vaccinated Individuals, 1979", American Society for Microbiology meeting at Ft. Detrick, Md., April 27, 1987

*2) toxic epidermal nercrolysis (dying of skin "scalded skin") also reported to occur secondary to polio, diptheria, and tetanus vaccinations. "Toxic Epidermal Nercrolysis Following Measles Vaccination", Robert G. Shoss, M.D., Arch. Dermatol, Vol 110, Nov. 1974

*3) ataxia (inability to coordinate muscle movements), mental retardation, aseptic meningitis, seizure disorders, hemiparesis (paralysis affecting one side of body), multiple sclerosis, Reyes syndrome, juvenile-onset diabetes. How to Raise a Healthy Child In Spite of Your Doctor, Robert S. Mendelsohn, M.D., 1984, Contemporary Books, Inc.

RUBELLA

*1) thrombocytopenia (blood clotting problem) "Thrombocytopenia Associated With Rubella Vaccination", Henry R. Bartos M.D., F.A.C.P; New York State Journal of Medicine, Feb. 15, 1972

2) arthritis and arthralgia. In United States, 87 cases of congenital rubella syndrome were reported, 12 in New Jersey. 17% of all children vaccinated in N. Jersey developed arthritis and arthralgia. Science, March 26, 1977

(29)

Boffins claim the cure can kill

By HARRY NELSON

ST PETERSBURG, (Florida).— New findings about the way viruses ebave once more point to their possible role in causing cancer — and perhaps diseases such as arthritis and multiple sclerosis.

The findings, reported here at a seminar for science writers spnsored by the American Cancer Society, raise questions about the possible harmful effects of immunization programmes to prevent influenza, measles and polio.

The new findings came from Dr Robert W. Simpson, of Rutgers University in New Jersey, and Dr Wendell D. Winters, a University of California at Los Angeles virologist now working at the University of Texas in San Antonio.

Last year, the Nobel Prize for medicine was given to David Baltimore and Howard Temin for discovering that viruses that cause cancer in animals are equipped with a very special enzyme called reverse transcriptase.

The viruse that carry the enzyme are called RNA viruses. Possession of the enzyme allows the RNZ viruses to form strands of DNA. thus enabling them to become cftegrated with the DNA of the cells they infect.

It is this integration of the DNA transcribed by the virus with the cell's DNA that somehow triggers cancer, at least in animals.

(The genetic material of all living things, includin viruses, is either RNA (ribonucleic acid) or DNA (deoxyribonucleic acid). Before the discovery of reverse transcriptase, which enables RNA viruses to transcribe their genetic material into a DNA form, scientists had trouble understanding how RNA cancer viruses could transform DNA cells.)

A in cells without expressing themselves in any way.

Simpson raised the question whether immunization programmes against flu, measles, mumps and polio may actually be seeding humans with RNA to form proviruses which will then becme latent in cells throughout the body.

He said some of these latent proviruses could be "molecules in search of disease" which under proper conditions become activated and cause a variety of diseases.

Of diseases that could be caused in this manner, the chief possibilities are rheumatoid arthritis, multiple sclerosis, lupus erythematosus, Parkinson's disease and perhaps cancer.

Winters, the UCLA virologist, has added a new dimension to the subject of viruses being a possible cause of human cancer.

Cells grown

He has been working in the laboratory with tumour cells removed frm UCLA surgery patients. The cells were then grown in dishes.

When he added a common respiratory virus known as Adenovirus 5 to the cells, the Adenovirus caused large numbers of latent RNA particles to be released.

"It is possible but not proven that the RNA particles were the cause of the human tumours. Perhaps they are also the seeds released into the bloodstream which float to other parts of the body where they infect cells and start cancer viruses into action.— Los Angeles Times service.

More recently, Simpson has found that RNA viruses which do not cause cancer also can form DNA, even though they lack reverse transcriptase.

DNA formed in this way from an RNA virus is called a provirus.

No effect

It is known from earlier work that some non-cancerous viruses have a tendency to exist as proviruses for long periods of time in cells without causing any apparent disease.

Some examples of common RNA viruses that do not cause cancer but may have the capacity to form proviruses are influenza, measles, mumps and polio viruses.

Simpson showed in laboratory experiments that proviruses derived from the measles virus and the respiratory syncytial virus (a cause of respiratory disease in newborn babies) can exist

Expert links AIDS to bovine viruses

By PHILIP M. BOFFEY
New York Times

WASHINGTON — Jeremy Rifkin, an outspoken critic of genetic engineering and other biotechnologies, Monday asked three federal agencies to determine whether cattle viruses play a role in causing AIDS.

In a petition submitted to the Agriculture Department, the Federal Centers for Disease Control and the National Institutes of Health, Rifkin called the cattle viruses "an extraordinary potential threat to public health."

Rifkin speculated in an interview that the AIDS virus might have evolved from cattle viruses, or that the cattle viruses might themselves play a role in the development of acquired immune deficiency syndrome in humans.

The petition cited scientific papers indicating a "close correlation" between the HIV, or human immunodeficiency virus, that causes AIDS in humans, and a virus found in cattle called bovine visna-like virus or bovine immunodeficiency-like virus. The petition warned that a range of viruses "exist in domestic animal herds in the U.S. and thus could pose a potential health hazard."

It also speculated that the cattle virus, BIV, might have infected cell cultures used to make some human vaccines, perhaps thereby contributing to the global spread of AIDS.

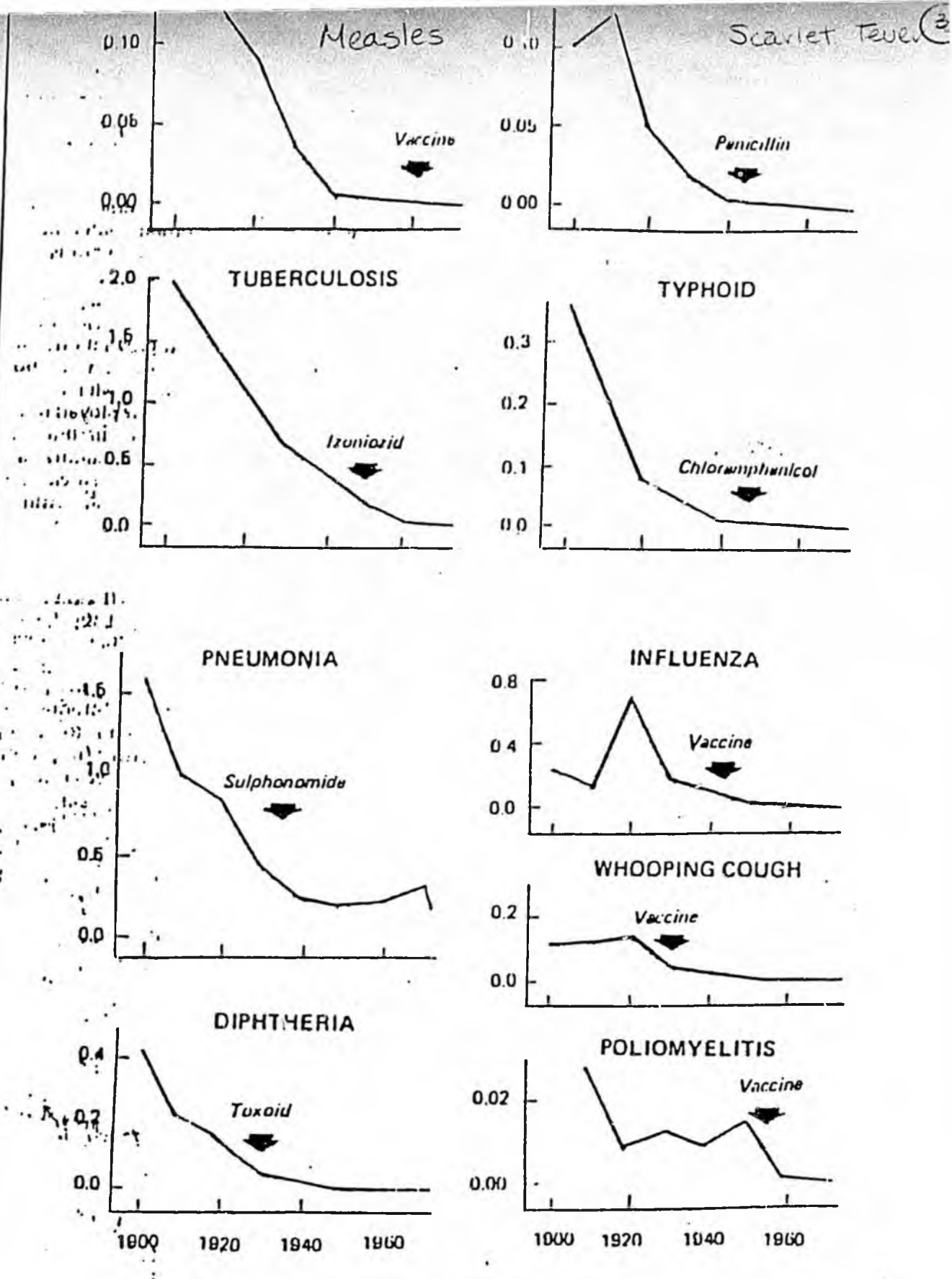
However, two of the scientists whose papers were cited by Rifkin expressed doubt in interviews that the cattle viruses played any role in causing AIDS.

One of them, Dr. Matthew A. Gonda, a virus expert who has performed detailed studies of the structural and genetic makeup of BIV as compared to the AIDS virus, said that the two were close enough to be considered members of the same family of viruses, called lentiviruses.

In fact, Gonda and his colleagues at Program Resources, Inc., which conducts research for the National Cancer Institute in Frederick, Md., have proposed that the cattle virus be used as a model for studying the AIDS virus. But the cattle virus is not close enough to be considered the progenitor of the AIDS virus or the cause of AIDS, Gonda said.

"I don't think that BIV could cause AIDS in humans," he said. "I don't want people to say this is an AIDS virus. It's not something that somebody should be afraid will jump into humans or that should make people fear cows."

The second expert, Dr. Martin J. Van der Maaten, of the Agriculture Department's National Animal Disease Laboratory in Ames, Iowa., who first isolated BIV from cattle, said he believed there was "very little chance of it infecting humans."



The Fall in the Standardized Death Rate (per 1,000 Population) for Nine Common Infectious Diseases in Relation to Specific Medical Measures, for the United States, 1900-1977.

From "Contribution of Medical Measures to Mortality Decline", by John B. McKinlay and Sonja M. McKinlay

Letters to the editor

DPT parent responds to report on interview of health official

To the editor:

This is in regard to the article, "Klatt urges parents to immunize children," by Janet Hevly, Jan. 18.

I am president of the Alaska chapter of Dissatisfied Parents Together (DPT), parents concerned with vaccine safety, efficacy and awareness. We are not anti-vaccine, but stress that each parent should be educated as to all the risks as well as the benefits of any vaccine to be administered to their child. We also stress that each parent should be allowed to choose what vaccines their child is to receive without threat of exclusion from public school.

I wish to clarify and comment on several of the misleading statemets made by Mr. Klatt, so that local parents will not fall prey to the scare tactics so willingly employed by our public health department.

As it is true that the pertussis disease can be fatal, the high death rate (600,000 yearly worldwide) does not exist in developed countries. In Sweden and West Germany, where mandatory pertussis vaccinations have been discontinued due to high reaction rates, the death rate is virtually nonexistent. According to the official Annual Summary 1983 of Morbidity and Mortality Weekly Report, distributed by the U.S. Department of Health and Human Services, only six fatalities due to the pertussis disease occurred in the U.S. in 1981. According to this publication, six deaths per year due to pertussis is the average in our country. An interesting note: the only part of Europe where pertussis vaccination is universally imposed is in the communist countries, such as the Soviet Union, East Germany, Poland and Czechoslovakia.

In regards to the 1985 whooping cough epidemic, I have correspondence from Michael Klatt stating that only 9 of the 30 reported whooping cough cases were actually confirmed pertussis. Approximately half had received pertussis vaccinations. There were no deaths. According to this letter and future correspondence, Mr. Klatt stated that he "was unable to ascertain the immunization histories, because immunization histories were not gotten (for whatever reasons) for all reported cases." How did he manage to come up with the in-depth information then for his interview with Ms. Hevly?

While our group of concerned parents is glad to see that the health department is finally allowing that their adverse-reaction reporting system is inefficient and has been underreporting both immediate severe reactions and long-term illnesses suffered from vaccinations, it is not heartening to realize that this same health department expects parents to disregard these facts and keep on injecting our children with this highly reactive pertussis vaccine. Also, Mr. Klatt failed to mention that his office does not accept an adverse-reaction form unless it meets minimum criteria. One of these is that the reaction must have been severe enough to require a visit to a doctor, health-care facility or hospital. None of these places are required to report any reaction, however.

If a report form does not include this visit, it is shredded. According to the 1987 Goals and Objectives, published by our health department, this criteria is not scheduled to change.

In regard to the statistics Mr. Klatt quoted in relation to reported adverse reactions, they are not only questionable, because they are admittedly underreported, but they do not begin to address the long-term damage associated with many immediate adverse reactions; epilepsy, chronic blood diseases, deafness, blindness, cerebral palsy, severe retardation, death, etc.

Our organization finds it amazing that though there have been four studies published in the 1980s in the Unites States showing a direct causal relationship between DPT vaccinations and SIDS, our government and public officials (e.g., Mr. Klatt) have chosen to disregard these findings in favor of another study that shows only a temporal relation. I have correspondence from our Alaska Health Department that states that no vaccine information is collected on SIDS victims, supposedly because such information is too hard to analyze!

Also, Mr. Klatt failed to mention that the DPT vaccination series is not effective until all three shots of that first series are completed at the age of six months (if the vaccination schedule is strictly adhered to), so by the time a child is "protected," he's already out of the danger zone. "Whooping cough is most fatal to children under six months of age," Klatt, quoted from Clarion article.

As a last comment, I'd like to let Alaskan parents know that there is legislation being drafted to require mandatory adverse-reaction reporting by all sectors, to require accurate parent information, extensive long-term followup and to allow Alaskan parents to object to any or all state mandated vaccines without exclusion from public school as is allowed in 22 other states.

Shannon Kohl
Soldotna

PEDIATRIC CONSULTANTS OF ALASKA, INC.
Clinton B. Lillibridge, M.D., F.A.A.P.
Peter H. Michelson, M.D., F.A.A.P.

December 10, 1987

Representative Kay Brown
3111 C Street, Suite 435
Anchorage, Alaska 99503

RE: HOUSE BILL 277 (Amendment to immunization regulations, making them optional)

Dear Kay:

I am terribly upset at the amount of misinformation and emotionalism exhibited by the proponents of this bill. The facts which are pertinent have been ignored. Specifically, pertussis, diphtheria, and tetanus organisms are widespread throughout the community and are easily caught. The rate of death for even something as simple as pertussis is about 10%. One out of a thousand children who catch pertussis will survive, but be permanently brain-damaged. The shot itself causes brain-damage in 1 out of 310,000 people. There have been six infants in Alaska this year who caught whooping cough (they were not immunized) and nearly died. The parents had huge hospital bills because of that, but luckily their children survived.

I strongly urge you to do everything you can to work against House Bill 277.

Sincerely,

Clint

Clinton B. Lillibridge, M.D.
Pediatrician

CBL:pm

1200 Airport Heights Drive, Suite 230 • Anchorage, Alaska 99508
Telephone (907) 276-5517

The People's Doctor

ANTI-VACCINE ARGUMENTS - Part One



Robert Mendelsohn, M.D.

Are Tetanus Shots Necessary?

It wasn't hard for me to give up vaccines for whooping cough, measles, and rubella because of their disabling and sometimes deadly side effects. The mumps vaccine, a high-risk, low-benefit product, struck me and plenty of other doctors as silly from the moment it was introduced. Arguments for the diphtheria vaccine were vitiated by epidemics during the past 15 years which showed the same death rate and the same severity of illness in those who were vaccinated vs. those who were not vaccinated. As for smallpox, even the government finally gave up that vaccine in 1970, and I gave up on the polio vaccine when Jonas Salk showed that the best way to catch polio in the United States was to be near a child who recently had taken the Sabin vaccine. But the tetanus vaccine exercised a hold on me for a much longer time.

I gave up belief in this vaccine in stages. For a while I still held onto the notion that farm families and people who work around stables should continue to take tetanus shots. But in spite of my early indoctrination with fear of "rusty nails," in recent years, I have developed a greater fear of the hypodermic needle. My reasons are:

1. Scientific evidence shows that too-frequent tetanus boosters actually may interfere with the immune reaction.

2. There has been a gradual retreat of even the most conservative authorities from giving tetanus boosters every one year, to every two years, to every five years,to every l0 years (as now recommended by the American Academy of Pediatrics), and according to some, every 20 years. All these numbers are based on guesses rather than on hard scientific evidence.

3. There has been a growing recognition that no controlled scientific study (in which half the patients were given the vaccine and the other half were given injections of sterile water) has ever been carried out to prove the safety and effectiveness of the tetanus vaccine. Evidence for the vaccine comes from epidemiologic studies which are by nature controversial and which do not satisfy the criteria for scientific proof.

4. The tetanus vaccine over the decades has been progressively weakened in order to reduce the considerable reaction (fever and swelling) it used to cause. Accompanying this reduction in reactivity has been a concomitant reduction in antigenicity (the ability to confer protection). Therefore, there is a good chance that today's tetanus vaccine is about as effective as tap water.

5. Until the last few years, government statistics admitted that 40 percent of the child population of the U.S. was not immunized. For all those decades, where were the tetanus cases from all those rusty nails?

6. There now exists a growing theoretical concern which links immunizations to the huge increase in recent decades of autoimmune diseases, e.g., rheumatoid arthritis, multiple sclerosis, lupus erythematosus, lymphoma, and leukemia. In one case, Guillain-Barre paralysis from swine flu vaccine, the relationship turned out to be more than just theoretical.

Risks of Tetanus Vaccine

In preparing my courtroom testimony on behalf of a child who allegedly was brain-damaged as a result of DPT (diphtheria, pertussis, tetanus) vaccine, I reviewed the prescribing information (package insert) for the Connaught Laboratories product which was administered to this child. The 1975 and 1977 package insert information which measured 7-1/2 inches long listed three scientific references in support of the indications, contraindications, warnings, cautions, and adverse reactions to this vaccine. By 1978, the length of the insert had grown to 13 1/2 inches, and the number of scientific references had increased to 11. By 1980, the package insert was 18 inches long, and the references numbered 14. Of those newly-added references, seven (three from U.S. medical journals and four from foreign medical journals) dealt specifically with reactions to the tetanus DPT portion of the (toxoid) vaccine.

An article in the *Archives of Neurology* (1972) described brachial plexus neuropathy (which can lead to paralysis of the arm) from tetanus toxoid. Four patients who received only tetanus toxoid noticed the onset of limb weakness from 6 to 21 days after the inoculation. A 1966 article published in the *Journal of the American Medical Association* reports the first case of "Peripheral Neuropathy following Tetanus Toxoid Administration." A 23-year-old white medical student received an injection of tetanus toxoid into his right upper arm after an abrasion of the right knee while playing tennis. Several hours later, he developed a wrist drop of his right hand. He later suffered from complete motor and sensory paralysis over the distribution of the right radial nerve (one of the major nerves innervating the arm and hand). One month later, no residual motor or sensory deficit could be found.

Reference is made to an article in the *Journal of Neurology*, 1977, entitled "Unusual Neurological Complication following Tetanus Toxoid Administration." The author reports 36-year old female who received tetanus toxoid in her left upper arm following a wound to her finger. Five days later she noticed a weakness first of the right, and then of the left arm and later of both legs. She complained of dizziness, instability, lethargy, chest discomfort, difficulty in swallowing, and inarticulate speech. She staggered when she walked, and she could take only a few steps. Her EEG showed some abnormalities. After a month, she was discharged without neurologic disturbance, but she continued to feel weak and anxious. Examinations during the next 11 months showed continued emotional instability and some paresthesias

Anti-Vaccine Arguments Cont'd. On Next Page

(numbness and tingling) in the extremities. The medical diagnosis was "a rapidly progressing neuropathy with involvement of cranial nerves, myelopathy, and encephalopathy."

The Journal of Allergy and Clinical Immunology, 1973, carried an article entitled "Hypersensitivity to Tetanus Toxoid," and in a volume entitled "Proceedings of the II International Conference on Tetanus" (published by Hans Huber, Bern, Switzerland, 1967), an article appeared entitled "Clinical Reactions to Tetanus Toxoid."

A 44-year-old article in the *Journal of the American Medical Association* (1940) was entitled "Allergy Induced by Immunization with Tetanus Toxoid." That same year, an article in the *British Medical Journal* reported on "Anaphylaxis (a form of shock) Following Administration of Tetanus Toxoid." In 1969, a German medical journal reported a case of paralysis of the recurrent laryngeal nerve (the nerve to the voicebox) after a booster injection of tetanus toxoid. The patient developed hoarseness and was unable to speak loudly, but the nerve paralysis subsided completely after approximately two months.

Should any doctor reassure you that tetanus vaccine is completely safe, or that "the benefits outweigh the risks," or that one should have a shot "just in case," why not share these citations with him?

DPT and SIDS

A study from UCLA's School of Medicine linking DPT vaccine to sudden infant death appeared in the journal Pediatric Infectious Disease (January 1983). Conducted by Larry Baraff, M.D., and co-workers, this is the third major research project which links childhood immunizations, and more specifically, the whooping cough (pertussis) component, to crib deaths.

As far as the other two studies are concerned, in 1979 I reported on the work of Robert Hutcheson, director of Epidemiology of Tennessee's State Department of Public Health. Dr. Hutcheson statistically associated Wyeth's DPT vaccine with sudden infant death. In June 1982, I reported on the work of Nevada's William Torch, M.D., which established the same relationship.

The latest study of Dr. Baraff, carried out together with the Los Angeles County Health Department, found that 53 of 145 SIDS (Sudden Infant Death Syndrome) victims whose families were interviewed had received a DPT immunization. Of these 53, 27 had received this immunization within 28 days of death. Six of these 27 deaths occurred within 24 hours of DPT immunization, and 17 occurred within one week of immunization. The most striking finding of this study was that no deaths occurred in the fourth week following immunization. The authors conclude that "The excess of deaths in the 24 hours and first week following immunization, and the absence of deaths in the fourth week following immunizations, were all statistically significant." They call for more studies to substantiate their findings, despite the fact that this is already the third investigation, and all three have pointed in the same direction.

Since sudden infant death is one of the major causes of mortality in the pediatric age group (aproximately one in six-hundred live births), every parent must take immediate action to protect his own child from becoming a DPT/SIDS statistic. Therefore, when a doctor says its time for a baby to get a DPT shot, one should ask him if he has carefully read the studies of Hutcheson, Torch, and Baraff. Ask what he thinks of the last sentence in the Baraff study which suggests that "If further studies substantiate our findings, it seems prudent to consider rescheduling DPT immunization until after the period of highest risk of SIDS, i.e., the latter half of the first year of life." Ask the doctor if he might even go as far as Dr. Mendelsohn and junk DPT altogether. Or more significantly, ask him if he's giving DPT shots to members of his own family. Finally, if you have patients, friends or relatives who have lost a baby to SIDS and who were told by doctors that the cause of SIDS is "unknown," encourage them to get a copy of that doctor's records in order to determine the exact time relationship between DPT immunization and death.

Pennsylvania Doesn't Require Pertussis Vaccine

The laws requiring mandatory immunization for school entry are becoming curiouser and curiouser. When I recently appeared on a Pittsburgh TV station to discuss the hazards of immunizations, a list was displayed which gave the vaccines required before a child can enter school in the State of Pennsylvania. Surprisingly, whooping cough (pertussis) was not on the list.

On my return to Chicago, my editor, Vera Chatz, telephoned the State of Pennsylvania Department of Public Health in Harrisburg to check out this information. She confirmed that, while the whooping cough vaccine is "recommended" for children at earlier ages, it is not required for school entry.

Mrs. Chatz then called our own Illinois State Department of Public Health and discovered that the pertussis vaccine is required for school entry, but is not required after the age of six because everyone agrees that this vaccine is too dangerous to use after age six. She, therefore, logically asked, "If my child has never received the whooping cough vaccine, why not wait until his sixth birthday to start him in school?" The man at the other end laughed and replied, "I guess you're right."

What do we learn from this? First, we learn there is apparently quite a significant variation from one state to the next, even in those 28 states with have no shots/no school laws. Therefore, if a dispute should arise about vaccinations between parents and the school their child attends, they must immediately contact their own State Department of Public Health and ask (in writing, if necessary) for their exact rule. Second, if a doctor insists that a little infant must receive the DPT vaccine or he will be unable to enter school later in life, he should be asked (if the patient lives in Pennsylvania, or other states with similar regulations) whether he is aware that the pertussis component of DPT vaccine is *not*, repeat *not*, required for school entry.

The doctor then may retre to a fall-back position on DPT (since there is general agreement among doctors that the whooping cough component is certainly the vaccine most likely to cause severe neurological damage such as epilepsy, cerebral palsy, and mental retardation), saying that he will give the child only DT vaccine. At that point, instead of quietly acquiescing, this is the opportunity to ask that doctor for the readily available information (e.g., included in the package insert of Connaught Laboratories vaccine) which documents the short-term and long-term risks of the tetanus component.

Robert Mendelsohn, M.D.
Evanston, Illinois

Look for the eye-opening conclusion of Anti-Vaccine Arguments in our January 1, 1988 issue of Dynamic Chiropractic.

Dr. Mendelsohn's monthly newsletter, "The Peoples Doctor" is available for only $24 per year to those who send their check to Post Office Box 982, Evanston, Illinois 60204.



Robert S. Mendelsohn, M.D.

The People's Doctor

Anti-Vaccine Arguments Part Two

Editor's note:
The following is Part Two and the conclusion of Dr. Mendelsohn's article "Anti-Vaccine Arguments".

Polio

Those of you who still are enthusiastic about the polio vaccine should know that a Wichita, Kansas jury awarded $10 million to a father who contracted polio after his infant daughter was vaccinated against the disease with Orimune, the live oral polio vaccine manufactured by Lederle Laboratories. This verdict, reported in the *National Law Journal*, June 18, 1984, is the largest verdict thus far in the product liability suits involving Orimune.

The father, Emil Johnson, first showed symptoms of polio 10 to 12 days after his child was immunized. Since then, he has suffered from irreversible bulbar poliomyelitis paralyzing his lungs. He can barely walk across a room before he keels over.

The jury found that Orimune was marketed without adequate warnings of its risks and found Lederle negligent in failing to warn that non-immunized people (Johnson had never been immunized) faced an increased risk of contracting polio by coming into contact with anyone who had received the oral vaccine.

Johnson's lawyers based their case on an inter-office memo written by a Lederle doctor that discussed "the possibility of reduced Orimune sales if the company took steps to inform doctors of the risks associated with administering the drug."

The son of polio vaccine developer, Jonas Salk, Dr. Darrell Salk of the University of Washington Medical School, testified on behalf of Johnson. The younger Salk advocated a return to his father's vaccine, a killed virus vaccine given by injection. Dr. Salk said he is aware of 16 pending lawsuits involving Orimune, but Lederle declined to reveal how many cases have been brought against them.

We now have the opportunity to watch the Doctors Salk attack the Sabin vaccine. In previous years, Doctor Sabin attacked the Salk vaccine. I think they're both right.

Wyeth Halts DPT Manufacture

In June, 1984, Wyeth Laboratories, one of the most distinguished pharmaceutical companies in this country, gave up the manufacture and distribution of DPT vaccine. This, then, left only two commercial producers (of the original 17) of this injection designed to prevent diphtheria, whooping cough and tetanus — Lederle Laboratories here in the U.S., and Connaught Laboratories from Canada.

My first reaction to the Wyeth decision was delight that the American system of free enterprise was working. Faced with the loss of millions of dollars a a result of legal action by parents of vaccine-damaged children, the drug manufacturers had increased the price of the vaccine tenfold. As judges and juries throughout the country have had the opportunity to carefully listen to and deliberate on the vaccine controversy, increasing numbers of children who suffer from convulsions, epilepsy, mental retardation, cerebral palsy, and other forms of neurologic damage, are receiving the financial compensation to which they are justly entitled. Now, the true cost of vaccines is becoming known not only to the manufacturers, but to the American public at large.

I could hardly wait for Connaught and Lederle to follow Wyeth's example, so that the DPT controversy would be clearly settled by the law of supply and demand: No vaccine available because no one wants it.

However, on second — and more sober — thought, another more sinister scenario seems possible. What if Connaught and Lederle do indeed throw in the towel, leaving the U.S. without a supply of DPT? (Connaught Laboratories has withdrawn from manufacturing DPT vaccine — and then there was one.) Won't the top vaccine cheerleaders — the Centers for Disease Control and the American Academy of Pediatrics — immediately predict the return of those diseases?

Indeed, an epidemic of whooping cough in this country had already been invented. But, thanks to former top government virologist, J. Anthony Morris Ph.D. (and the honest editors of the *Maryland State Journal* who in 1983 published his analysis), the so-called "epidemic" turned out to consist almost exclusively of three categories:

1. bacteriologically unproven cases
2. children under two months of age and thus not even eligible for DPT and
3. cases in children who were completely immunized.

This kind of careful analysis conceivably should scotch such episodes of "creative diagnosis" in the future.

But if this strategy of vaccine-pushers were to go into operation, the American public might well panic and put enough pressure on congress to rush through legislation which immunizes the manufacturers, just as they did with the ill-fated swine flu vaccine program of the mid-70s. For those of you who don't remember, the vaccine manufacturers refused to produce that material unless the government assumed liability for damage. The doctors, especially those at the Centers for Disease Control, whipped the public into a frenzy of fear, and the government caved in. Of the 80 million people (led by President Gerald Ford) who rolled up their sleeves to receive shots for an epidemic which never occurred, thousands now are paralyzed by Guillain-Barre syndrome. It is you and I, as taxpayers, and not the vaccine manufacturers, who are paying the cost.

I recommend that every reader of this column:

1. Learn about whooping cough, a very difficult disease to definitely diagnose and one which is easy to confuse with other diseases. Pertussis may look like little more than the common cold, or it may show the full-blown picture of whooping, vomiting and respiratory distress.

2. Learn about the contraindications and adverse reactions to the vaccine.

3. If a medical doctor claims that your patient has whooping cough, check to make sure that he has carried out the proper laboratory tests, including special culturing techniques and blood tests.

American medical physicians, as well as drug manufacturers, have been enraged at the failure of a bill proposed by Florida Senator Paula Hawkins which is piously described as "compensation for vaccine-damaged children." If that were indeed the case, why haven't doctors pushed such legislation during the past 40 years? Why did it take media disclosures educating members of the public (who legitimately responded by going to the courts) to spur those doctors to belatedly run to government? No, the real motivating force behind the Hawkins bill is to protect the medical doctors and the manufacturers. Indeed, that bill may well limit the compensation to damaged children.

If your local newspapers are not carrying details of this latest attempt to shift to the taxpayers a responsibility which traditionally has been assumed by business, you may contact former top government virologist, J. Anthony Morris, Ph.D. (P.O. Box 40, College Park, Maryland 20740) who, together with attorney Robert Kaufman of Gaylord, Michigan, is spearheading the effort to keep the liability for this vaccine, whose dangers are increasingly being recognized, right where it belongs — with the companies who make the vaccine and the doctors who administer it.

Rubella Update

The latest recommendations from the Centers for Disease Control (*Journal of the American Medical Association*, July 12, 1984) contain a few interesting lines. First, let me tell you the bad news and then the good news about rubella vaccine-induced arthritis. The bad news is that up to 40 percent of those vaccinated in the large-scale field trials suffered joint pain (arthralgia). The good news is that less than two percent developed frank arthritis.

Second, in its zeal to completely eliminate rubella, the CDC now recommends that

— proof of rubella immunity for attendance at day care centers should be required and enforced

— licensure should depend on such requirements

— vaccination should be extended to include all post-abortions

— should become routine before discharge from a hospital for any reason

— vaccines should be offered to adults any time contact is made with the medical system

— consideration should be given for making rubella immunity a condition of employment

— immunity should be required for attendance for both male and female (college) students.

The CDC explains its drive for enforcement by saying, "Less rigorous approaches, such as voluntary appeals for vaccination, have not been effective."

Tough guys, those government docs. Perhaps they should be transferred to the State Department to conduct diplomatic relations with the Russians.

Robert S. Mendelsohn, M.D.
Evanston, Illinois

EDITOR'S NOTE:

Dr. Mendelsohn's monthly newsletter, "The People's Doctor" is available for only $24 per year to those who send their check to Post Office Box 982, Evanston, Illinois 60204

May 3, 1987

Representative Koponen
Alaska State Legislature
Pouch V (MS 3100)
Juneau, Alaska 99811

Dear Representative Koponen:

I am writing to you to let you know how important I feel House Bill 277 is.

I support House Bill 277 and I would like you to support it too.

I had know idea of the problems that could arise from the DPT shots until I contacted my local Chapter of Dissatisfied Parents Together. I was very thankful for the information I received because my daughter did have a reaction to the shot and I was able to know what to look out for and stop any damage that could have been done.

Representative Kaponen
Page 2
May 8, 1987

It seems a shame that we carry these children so carefully for 9 months; we eat well, take vitamins, and watch out for hazards in our environment that might affect them, and then we turn around and inject them with something that can cause so much harm.

Please pass House Bill 277 through the committee without change.

Sincerely,

Kim Hutto
3955 Nichols
Soldotna, Alaska 99669

Reports of S.I.D.S. Following DTP Immunization

Jan. 1 - July 31 1979

Manufacturer	DTP Lots	Polio	Injection No.	Age of Child	Location	Time of Death
A	2041 WA	546-137	2nd	7 mo.	Mississippi	Within 48 hr
B	1948-429P	Yes	1st	2 mo.	Connecticut	Within 24 hr
	#1 1948-430	Yes	3rd	6 mo.	Ohio	4-5 days later
	#2	Yes	2nd	3 mo.	Indiana	3 days later
	#3	555-113	1st	2 mo.	Texas	Within 24 hr
C	#1 64201	543-143	1st	2 mo.	Tennessee	Within 24 hr
	#2	543-143	1st	2 mo.		Within 24 hr
	#3	546-137	1st	2.5 mo		Within 24 hr
	#4	555-113	1st	2 mo.		Within 24 hr
	#1 64601	1	1st	2-3 mo.	California	3 days later
	#2	1	2nd	3 mo.	Pennsylvania	2 days later
	64702	1	2nd	4.5 mo.	New Jersey	8 hr later
	#1 64801	1	1st	2 mo.	New York	4 days later
	#2	Yes	1st	2 mo.	Pennsylvania	Within 24 hr
	65001	Yes	1st	6 wk	Pennsylvania	9.5 hr
	65101 or 61991	1	1st	3 mo.	Illinois	Within 24 hr
	64901	Yes	1st	2 mo.	California	Within 24 hr
	65501	Yes	1st	2 mo.	California	Within 4 days

INTERESTING INTERNAL CDC DOCUMENT What's missing are the autopsy findings and the symptoms between DPT and death that might clarify [illegible] SIDS deaths or DPT deaths.....

(written especially for "SIDS" parents who may really be "DPT" parents; please copy and share)

SIDS AND DPT VACCINATION

In Sept. of 1984 our 6 week old son John was given his first DPT. He died 5 days later, following seizures that commenced within 24 hours of the shot. His death was ruled SIDS, despite non-SIDS findings in his brain at autopsy. In the months that followed his death, our research uncovered some startling and painful facts.

1. It was relatively easy to find doctors who confirmed that the SIDS designation was questionable; but our questions about the role of DPT were met by blanket denials, even defensive hostility--despite the fact that the vaccine enclosure (Lederle, 1984) acknowledges death as a possible DPT outcome. We finally found 2 physicians who urged us to suspect that DPT had caused his death.

2. Through the nationwide network of Dissatisfied Parents Together (D.P.T.), we found we were far from alone in our experience of a baby dying in close proximity to DPT, suffering a number of recognized DPT severe reactions, and/or having non-SIDS autopsy findings---and having the death misclassified as SIDS.

3. We learned that 4 studies exist in the US pointing to a link in time between DPT and deaths ruled (accurately or not) SIDS; only 1 study failed to find such a relationship. 8 studies from around the world point to a link between DPT and deaths ruled SIDS. (Source: Medical World News, June 7, 1982, p.136).

Why we are sharing our information and experience with you: it is our belief that all parents deserve to know what really killed their babies---be it DPT, SIDS, or something else---so they can take the appropriate precautions for subsequent babies. You will find that investigating your baby's death is not an easy task; we hope that this little brochure will lighten the effort. Please feel free to contact us for anything at POB 38272, Atlanta, Ga. 30334. No medical advice is intended here; it is our sole purpose to offer information to parents. God bless you; we pray for the health of your family, and that you may continue to heal from your terrible loss.....

Leslie and Robb Chapman

A note before we begin: obviously DPT is not responsible for all SIDS deaths. Many die before any DPT is given, and it is simply not known what percentage of immunized victims had deaths caused by DPT. It is widely acknowledged that SIDS is a catch-all for many causes of death, some unknown and some suspected.

ABOUT THE STUDIES

Before we discuss individual studies, we must look at the theories of the possible relationships between DPT and SIDS:

Theory #1: DPT deaths are misdiagnosed as SIDS

A small example: Dr. Kevin Geraghty of Physicians for Study of Pertussis Vaccines (POB 345, 11072 San Pablo, El Cerrito, Ca. 94530) reviewed all histories of babies under 1 year of age, whose deaths had been ruled SIDS in Contra Costa County, Ca. in the first half of 1983. There were 10. 3 died shortly (4 hours, 24 hours, 3½ days) after DPT, and all 3 had symptoms of severe DPT reactions prior to death. PSPV believes these are DPT deaths, misclassified as SIDS. (Source: Geraghty, K.C. Death Events Shortly Following DPT in Northern California. In: Hearings on S. 2117: The National Childhood Vaccine Injury Compensation Act. The Committee on Labor and Human Resources, US Senate, May 3, 1984. US Government Printing Office (S. Hrg. 98-1060): 68-80, 1984. Ask your Senator for a copy.)

Unfortunately, there are no autopsy findings that can absolutely prove whether a death was caused by DPT or SIDS. Non-SIDS findings, especially but not exclusively, if in the brain, can only point toward DPT, and away from SIDS. To further complicate matters, even a typical SIDS autopsy does not prove that DPT had no role in the death. Obviously, it is easy for coroners to make mistakes in the diagnoses of DPT and SIDS deaths. (We must also consider that ruling a death SIDS removes legal liability from the attending physician, and does not jeopardize public trust of DPT immunization.)

Since autopsies cannot absolutely differentiate between DPT and SIDS deaths, we are left looking toward the history between DPT and death to clarify the possible role of DPT. More on this later.

Theory #2: DPT as Trigger for SIDS

This theory postulates that for a baby who is predisposed to SIDS, DPT can be the stress that "breaks the camel's back." In March, 1979, Dr. Daniel Shannon of NSIDSF reported to the FDA's Bureau of Biologics his experience where 40 of 200 babies who were already on monitors for apnea ("near-SIDS-miss") episodes had to be resuscitated within 24 hour of DPT. (Source: USDHHS, PHS, FDA, Bureau of Biologics, Ad Hoc Meeting on Relation between DPT Vaccines and Sudden Infant Death Syndrome (SIDS), March 19, 1979. If you cannot obtain this, we will mail you a xerox of relevant portions.)

Further, there is greater confidence in discontinuing monitoring, according to many SIDS/apnea monitoring manuals, if a baby has had a DPT and does not require resuscitation. Unintentionally, this advice supports this theory.

In light of the current trend to differentiate between apnea and SIDS, this theory might be renamed the "DPT as trigger for apnea (and apnea death) theory. Note that theories 1 and 2 are not mutually exclusive of each other, i.e. both may be occurring.

Theory #3: The relationship between DPT and SIDS is purely coincidental, i.e.

brain damage and death from DPT than from whooping cough. (Source: Strom, J. 1967. Further experience of reactions, especially of a cerebral nature, in conjunction with triple vaccination: a study based on vaccinations in Sweden 1959-1965. British Medical Journal, 4:320-23.) Since 1977, Sweden has had a lot of whooping cough, but no deaths from it. West Germany has followed Sweden's lead with similar results. (Source: Coulter, H. and Fisher, B., DPT: A Shot in the Dark, Harcourt, Brace, Jovanovich, 1985, pp. 163-173.)

On the other hand, Japan reported 41 whooping cough deaths in 1979, after DPT was discontinued following the deaths of 2 babies. Japan now has a safer acellular vaccine, given to babies starting at 2 years of age. This late start for DPT does not appear to have jeopardized infant survival in Japan--- Japan far surpasses the US in infant survival. (Source: NY Times, Feb. 24, 1985, Decline Slowing For Death Rate of US Infants, by Robert Pear.)

There are also serious questions about the effectiveness of "P": a report in the CDC's MMWR, July 5, 1985, reported on 162 cases of whooping cough in Cook County, Washington. Some 50% had been properly immunized for their age. There was no mention of any deaths or cases of brain damage, despite the fact that over 30 of the victims were under 1 year of age. This report raises two tough questions: How effective is P vaccine? Just how severe is whooping cough today?

But again, a deeper discussion of the DPT issue is beyond the scope of this report. We urge you to follow up with your investigation, and to share your information as widely as possible.

FURTHER READINGS

For a copy of the only major DPT study in the US (FDA/UCLA), call 703-487-4650 and ask for PB81-140-634. Cost is $14.50. VISA OK.

The Fresno Bee DPT Reprint: free copies@ 1626 E Street, Fresno, Ca. 93786.

The Vaccine Machine (winner of the White House Correspondents' Bingham Award for Journalism): free copies@ Gannett News Service, POB 7858, Wash., DC 20044.

Dissatisfied Parents Together Parent Info Brochure; send $3 to D.P.T., 128 Branch Rd., Vienna, Va. 22180.

DPT: A Shot in the Dark by Harris Coulter and Barbara Loe Fisher, published by Warner Books ($ 4.50). The most comprehensive and documented source. Available from Dissatisfied Parents Together for $6 postpaid.

DPT: Vaccine Roulette (transcript): send $4 to WRC-TV Consumer Dept., DPT Box 4, Washington, DC 20044.

20/20 Feb. 5, 1985 DPT Transcript: $3 to 20/20 Transcripts, Box 2020, Ansonia Station, NYC, NY 10023. Ask for Show# 505.

A full discussion of the pros and cons of the DPT is beyond the scope of this brochure, but here are some basics. It is universally acknowledged that it is the "P" (pertussis or whooping cough) part of the DPT that can lead to brain damage or death. The debate centers around how often these reactions occur, and whether these dangers are worse than the dangers of whooping cough.

The American Academy of Pediatrics and the US Public Health Service claim that the benefits of P outweigh the risks. Alan R. Nelson, of the AMA's Board of Trustees, says that 1 in 32,500 cases of whooping cough lead to brain damage or death. (Source: Journal of the AMA, Dec. 7, 1984, p.3013). The AAP and the USPHS claim that 1 in 100,000 children (or 1 in 300,000 shots) suffer permanent damage from DPT. This is highly speculative, as we have no actual figures on brain damage or death from DPT in the US, because doctors are not required to report DPT reactions. If DPT deaths are frequently misdiagnosed as SIDS, the picture is further distorted.

And the 1/100,000 (300,000) figures derive from British research (Miller et al. 1981. British Medical Jrnl. 282: 1595-99); this study is of highly questionable relevance to the US:

1. The British exclude certain high-risk groups of children from DPT; many of the same groups are not excluded in the US.
2. The British recommend giving the first DPT at 6 months; US babies often receive their first DPT at 6 weeks. (Source: 1981. Whooping cough: Reports from the Committee on Safety of Medicines and the Joint Committee on Vaccination and Immunization. London. Her Majesty's Stationery Office.)
3. The British vaccine meets World Health Organization standards for safety; ours does not. (Source: Cameron in 1978 International Symposium on Pertussis, NIH, pp. 245-46, Government Printing Office.)
4. The study contained a disclaimer against using its findings to predict DPT outcomes in other groups of children (like US children).

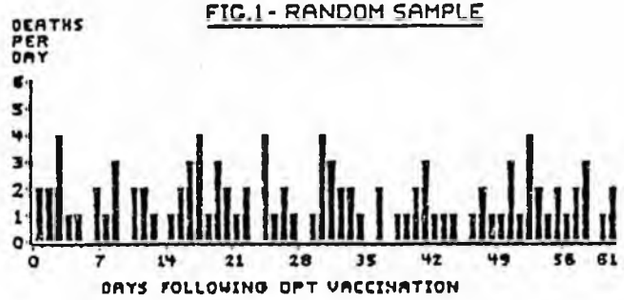
Physicians for Study of Pertussis Vaccines found evidence in documents received from the USPHS(CDC) that indicate 1 in 15,000 children are permanently damaged, and 1 in 35,000 die from DPT. PSPV has called the current "P" a "brain poison," and is calling for emergency efforts toward a safer vaccine.

According to Dr. A. Hinman, head of immunization for the CDC, 8484 children will suffer shock/collapse after DPT in the US/year (JAMA 1984. 251(23):3109-13). It is medically ridiculous to think that none or only a few of these events, primarily occurring in infants, would lead to death.

Sweden has the lowest SIDS rate in the documented world: .06/1000, according to the Ca. Dept. of Health Services SIDS Newsletter, Vol. 1 #3, Nov. 1979. Our more conservative SIDS estimates are about 33 times worse. Sweden discontinued DPT after studies involving over 200,000 children found 3 times more

the ages at which most infants receive the primary series of DPT, 2 to 6 months, coincide with the ages at which most SIDS deaths occur. This is, in itself, not necessarily suspicious. What is suspicious is the unexpectedly large proportion of infants who die within a few days of DPT. Children in this age group generally receive 3 DPTs at 2 month intervals, or about 60 days apart. If there were no connection between DPT and SIDS, then a child should be no more likely to die on the day of the shot than to die on the 20th day, or the 31st, or any other day in the 60 day interval. If we were to examine a sizeable number of immunized SIDS victims, and count the number who died on the first day after the shot, the second day, the third day, etc., up to the 60th day, the number of deaths per day should be about equal. Undoubtedly there would be some variation from day to day due to chance, but this variation should "even out" in the long run. The probability of finding an extremely large number on any one day would be small---similar to the probability of rolling a dice 20 times, and having 10 of the rolls turn up the number "1". We could plot these deaths on a graph, and despite the "bumps" that would occur fom day to day, see at a glance that the chance of death was about equally distributed over time. Figure #1 is a computer generated illustration of this imaginary situation.

FIG.1 - RANDOM SAMPLE



Computer generated random distribution of 100 deaths over 61 days intended as an example of the type of distribution expected were there no relationship between DPT and SIDS.

As it turns out, a number of surveys exactly like this have actually been performed, and the results are graphed in Figures #2-#6. Figures #2 through #5 obviously show a very large number of deaths occurring in the first few days following DPT. These are not "bumps" in the graphs; they are mountains.

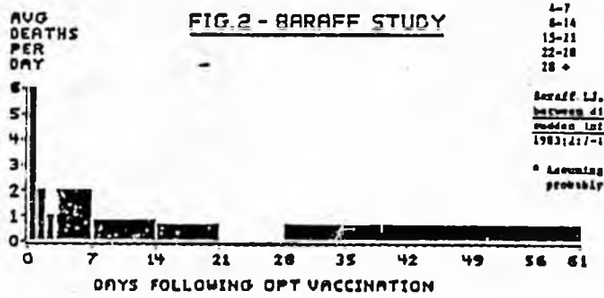


FIG.2 - BARAFF STUDY

53 of 165 SIDS victims had received DPT:

Days from DPT to Death	Number Deaths	Avg. Num per Day
1	6	6
2	2	2
3	1	1
4-7	8	2
8-14	6	0.86
15-21	4	0.57
22-28	0	0
28 +	26	0.79*

Baraff LJ, Ahlen WJ, Weiss HC. Possible temporal association between diphtheria-tetanus toxoid-pertussis vaccination and sudden infant death syndrome. Pediatric Infectious Disease 1983;2:7-11.

* Assuming a maximum number of 61 days between DPT and SIDS; probably a conservative assumption.

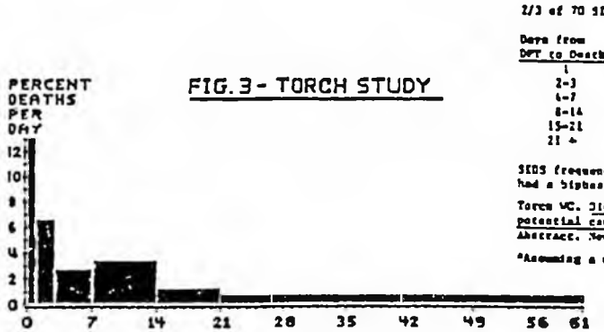


FIG.3 - TORCH STUDY

2/3 of 70 SIDS cases had received DPT:

Days from DPT to Death	# of Cases	% per Day
1	13	13
2-3	13	6.5
4-7	11	2.75
8-14	26	3.43
15-21	9	1.29
21 +	18	0.75*

SIDS frequencies peaked at age 2 months in the non-DPT group and had a biphasic peak occurrence at 2 and 4 months in the DPT group.

Torch WC. Diphtheria-pertussis-tetanus (DPT) immunization: a potential cause of the Sudden Infant Death Syndrome (SIDS). Abstract. Neurology 1981;31:A194.

*Assuming a maximum number of 61 days between DPT and SIDS.

IF YOU DO SUSPECT DPT, WHERE CAN YOU GET FURTHER HELP?

Dissatisfied Parents Together (national), 128 Branch Rd., Vienna, Va. 22180; 703-938-DPT3. President: Jeffrey Schwartz; Director: Kathi Williams. D.P.T. can offer resources to help you investigate your child's death; they can also introduce you into a support network of parents. Dissatisfied Parents Together is a non-profit educational organization, and is not anti-vaccine. It supports the development of a new safer vaccine, and extremely cautious use of the current one. For $3 they will send anyone a parent information brochure, which describes high-risk children, and details monitoring-after-DPT instructions. D.P.T. drafted the National Childhood Vaccine Injury Compensation Act with the American Academy of Pediatrics; this legislation (S.827) is currently under consideration in the US Senate. S.827 addresses many needed reforms.

Kevin C. Geraghty, M.D., Diplomate American Board of Allergy and Immunology, and Diplomate, American Board of Pediatrics: 10102 San Pablo Ave., El Cerrito, Ca. 94530; 415-527-9919. For legal reasons, Dr. Geraghty may not communicate directly with parents. But he can communicate with physicians, lawyers, or coroners.

DPT Lawyers: Advocates for a Safe Vaccine
Even if you have no interest in pursuing legal channels, they can offer numerous resources; there are many such groups, but the firm with the longest track record is McDowell and Colantoni, 35 E. Wackers Dr., Chicago, Illinois, 60601; 312-726-0393.

Mark Thoman, M.D., 1426 Woodland, Des Moines, Iowa 50309. Dr. Thoman is a Fellow of the American Academy of Clinical Toxicology, and Diplomate of the American Board of Medical Toxicology. He can offer recommendations about immunizing subsequent children.

DPT: A Shot in the Dark, by Harris Coulter and Barbara Loe Fisher, published in paperback ($4.50) in 1986 by Warner Books. Extensive discussion of the DPT-SIDS question. You can order it postpaid for $6 from Dissatisfied Parents Together (address above).

If you want a medical exemption from DPT for surviving or subsequent children, write to: Robert Mendelsohn, M.D., 1210 Lake Street, Evanston, Illinois 60201.

1986 UPDATE, continued.....

1986: CDC's Director of Immunization, Dr. Alan Hinman, promises to implement "in the future" investigation of all deaths ruled (accurately or not) "SIDS" within 30 days of immunization that are reported to the CDC. Such deaths should be reported to: CDC Division of Immunization, CPS, 1600 Clifton Rd. NE, Freeway Park, Bldg. 1600B, Atlanta, Ga. 30333, regardless of whether DPT is suspected. The report should be on a MSAEFI form, if possible. These forms should be available at all public health clinics.

And finally a quotation from Vincent Fulginiti, M.D., past president of the American Academy of Pediatrics' Red Book committee and pertussis vaccine researcher for Wyeth. Notice that this was written after the preliminary results of the NICHHD (NICH-SIDS) study were being touted as "proof" that DPT doesn't cause SIDS:

> "We do not know what causes SIDS. We do not know if DTP does. We should attempt to find out. It is not a trivial question." (emphasis added)
> Source: Pediatric Infectious Diseases 2(1): 5-6. 1983.

----------(end of 1986 update)----------

WHAT FACTORS SHOULD MAKE PARENTS SUSPECT DPT?

1. Parents should suspect DPT if a baby died in close proximity to DPT, even if no apparent symptoms intervened. The death itself could be the severe reaction. Fulginiti and Dales have posited the biologic plausibility of such. (Sources: Fulginiti, V.R. 1983. Sudden Infant Death Syndrome, Diptheria-tetanus toxoid-pertussis vaccination and visits to the doctor: Chance association or cause and effect? Pediatric Infectious Diseases 2(1): 5-6. Dales, L. 1984. Pertussis Vaccine and SIDS. California State Dept. Health Services: SIDS Newsletter, Summer, 1984.)

Note that about 1.7% of SIDS deaths will occur within 24 hours of DPT by chance alone, but this figure is so small that DPT should be suspected.

2. Parents should suspect DPT if a baby demonstrated an acknowledged DPT reaction before death. It matters little if a few weeks intervened between DPT and death; DPT should be suspected if any of the following reactions appeared within 1-7 days (approximately) of DPT:

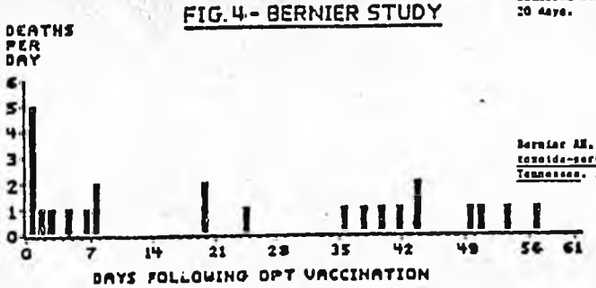
RECOGNIZED SEVERE REACTIONS (by CDC, AAP, and/or vaccine manufacturers):

1. collapse/shock (symptoms might include baby cool to touch, limp, unresponsive, sleeps through feedings, difficult to rouse);
2. persistent or high pitched screaming;
3. temperature of 103F or above;
4. convulsion/seizure (symptoms might include jerking, twitching, staring, unusual eye movement, stiffness, unprecedented vocalizing, even bursts of rapid sucking, severe sleep disturbance);
5. systemic allergic reactions (might include swelling of lips, wheezing, projectile vomiting, diarrhea, shock, rash);
6. symptoms of hemolytic anemia or thrombocytopenia;
7. over somnolence or severe alterations of consciousness

SUSPECTED SEVERE REACTIONS: severe local reaction (large &/or red &/or hot lump), cold/ear infection/cough, hypoglycemic reactions.

FIG.4- BERNIER STUDY

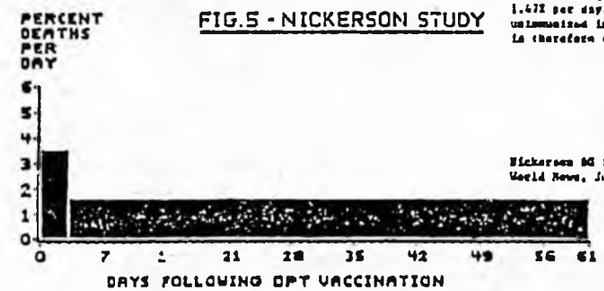
33 of 35 SIDS victims had received DPT; the number of deaths as shown were recorded on a per day basis. An additional 9 deaths occurred between 61 and 240 days, or on the average 1 every 20 days.



Bernier RH, Frank JA JR, Donders TJ Jr et al. Diphtheria-tetanus toxoids-pertussis vaccination and sudden infant deaths in Tennessee. Journal of Pediatrics 1982 101:169—71.

FIG.5 - NICKERSON STUDY

Of 601 SIDS victims 10.4% died within 72 hours of immunization, or an average of 3.47% per day. Assuming a baseline of 61 days the remaining 89.6% of deaths would occur at an average rate of 1.47% per day. NOTE: This group includes both immunized and unimmunized infants; the clustering effect in the first 3 days is therefore reasonably "diluted".



Nickerson BG in: SIDS-Immunization Link Questioned. Medical World News, June 10, 1983.

Could these "mountains" have occurred just by chance? The answer is yes, but the likelihood of their occurrence by chance is extremely small. Dr. Baraff, for example, calculated the chances of finding 6 of 53 deaths occurring on the day of the shot to be less than 1 in 2000. Dr. Daniel Shannon of the NSIDSF calculated a very similar probability with regard to the data of the Bernier study. That is a very small probability, and the probability of obtaining virtually the same results by chance alone in 4 independent surveys is smaller still---ridiculously small. The obvious explanation of course is that DPT is causing some deaths that are rightly or wrongly called SIDS. If DPT did not cause these "mountains", what did?

But what about Figure #6, the NICHHD study? Here is a large-scale study, conducted by a whole panel of SIDS experts, which demonstrates no apparent connection between DPT and SIDS. The number of deaths per day is almost perfectly uniform. How can this discrepancy be explained? Is this study right and the others wrong, or vice versa? Or was a different method used in the NICHHD study which might help to explain how such an opposite conclusion could be reached?

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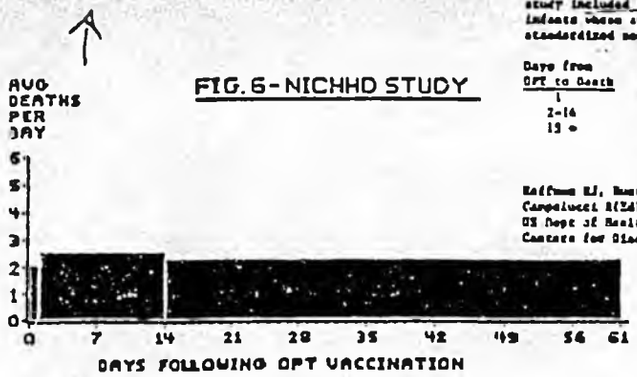


FIG. 6 - NICHHD STUDY

145 of 340 SIDS victims had received DPT. Cases screened from study included infants on whom no autopsy was performed and infants whose autopsies exhibited "major deviations from standardized necropsy protocol". encephalopathy or cerebral hemorrhage

Days from DPT to Death	Number Deaths	Avg. Num per Day
1	2	2
2-14	33	2.54
15 +	110	2.34

Kaffman MJ, Hunter JC, Hasselmeyer EG. SIDS and DPT. Int Conference Proceedings. US Dept of Health & Human Services, Public Health Service, Centers for Disease Control, Atlanta, Ga. 79-88.

The answer here is that the NICHHD study did in fact employ a different method than the other 4 surveys, and the difference lies in the method of selecting SIDS cases for study. Whereas Baraff, Torch, Bernier, and Nickerson counted any and all infants in the time period and area under examination who were reputed to have died of SIDS, i.e. whose death certificates read "SIDS" or "crib death", the NICHHD panel screened out certain cases beforehand. Some excluded from study were infants on whom no autopsy had been performed, and infants whose autopsies contained findings that varied from a "standardized" SIDS autopsy as defined by the panel. It is extremely common for autopsies of "suspicious DPT-SIDS" victims to contain deviations from the classic SIDS autopsy; a few examples of such non-SIDS findings (of the many we are personally aware of) are encephalopathy of the brain and cerebral hemorrhage. The question is: which types of cases did the NICHHD panel exclude and which did they include in their prescreening process? Unfortunately, despite repeated attempts to have this question answered, no reply has been forthcoming. Did the NICHHD, perhaps unwittingly, "load the dice" by excluding from study those cases they needed most to include? And where does this leave the parents of babies whose deaths have been ruled SIDS by the local coroner, and are now ruled not SIDS by the NICHHD? It is important to underscore: If the NICHHD did inadvertantly exclude DPT deaths (ruled SIDS) by excluding atypical autopsies, when Baraff, Torch, Nickerson, etc. included these atypical autopsies, this would explain the apparent contradictions in findings, and lead us to suspect that: indeed DPT does not appear to cause real SIDS deaths, but some DPT deaths are being misdiagnosed as SIDS. And a footnote on the apnea babies (used to be called "near-SIDS-miss") with regard to all of this: current research is only finding a 5% overlap between apnea-suffering babies and SIDS victims. This overlap is so small that we would not expect any of the studies we've discussed to clearly demonstrate DPT risk for apnea-prone babies. Until more studies on the effect of DPT on such babies are done, we are left with Dr. Shannon's frightening experience where about 20% of such babies required resuscitation within 24 hour of DPT.

The jury is still out on the question of whether or not DPT causes some real SIDS deaths. There are many, including Dr. Loring Dales, head of immunization for the state of California, for whom the NICHHD does not settle this issue: "...enough other evidence exists to cause continued concern that the vaccine may rarely cause SIDS, so that need is felt for continued investigation of the matter...". (Source: Dales, L. 1984. Pertussis Vaccine and SIDS. Cal. State Dept. Health Services: SIDS Newsletter, Summer, 1984.)

A final note on the studies: the experts have engaged in a lot of debate over the merits of the various studies. Baraff and Torch, for example, have been criticized for not using a "case-control" method, like that used by the NICHHD. And yet Alvan Feinstein, Professor of Medicine at Yale, and a widely respected authority on medical statistics, said about the "case-control" method: "hidden bias can substantially distort the results." This is a particular danger when a group is treated as being homogenous when it is really comprised of many different entities. Everyone agrees that SIDS is a catch-all term for many different causes of death, i.e. SIDS victims are not a homogenous group.

The debate over study design can go on (and will) indefinitely, and is beyond the scope of this brochure. Meanwhile, babies are dying. It is true that Baraff and Torch had no control groups, but it is equally true that no plausible explanation for their findings, outside of DPT's responsibility, has ever been advanced. "It's all a coincidence" is hardly a plausible explanation. The treasure of our babies' lives deserve a better explanation than that, and immediate intensive research.

A final note: The poor quality of SIDS autopsies and the misclassification of DPT deaths as SIDS is hindering progress on the prevention of many types of infant deaths. If we could exclude DPT (and other non-SIDS) deaths from SIDS studies, true SIDS risk factors would be more likely to become clear. The DPT (and other non-SIDS) victims could be "cloudying the water," and postponing the discoveries that will save babies' lives.

1986 UPDATE

The "abstract" of the Nickerson study has been published (Nickerson BG, Robinson BK: How many Sudden Infant Death Syndrome victims were recently immunized? Abstract, A261, J Soc Ped Res).

Nickerson concludes that "a relationship between SIDS and immunization accounts for less than 6.3% of total SIDS deaths." If we apply his finding of an approximate 6% excess of deaths beyond those expected by chance within 3 days of DPT, to the 8,000-10,000 estimated deaths ruled SIDS (correctly or not) each year, we find 480-600 babies in the U.S. each year whose deaths are "vaccine-related".

This study raises serious questions about the DPT benefit/risk ratio, as CDC has estimated 450 deaths from whooping cough per year in the absence of pertussis vaccine. (Hinman A et al. 1984. Journal of the AMA 251(23): 3109-13.)

FOR FURTHER DPT INFORMATION CONTACT:
DISSATISFIED PARENTS TOGETHER (NATIONAL OFFICE), 128 BRANCH RD., VIENNA,
VIRGINIA 22180. Send $3 for parent information materials.
DR. KEVIN GERAGHTY c/o PHYSICIANS FOR STUDY OF PERTUSSIS VACCINES, BOX 345,
11072 SAN PABLO, EL CERRITO, CA. 94530.



MUNEHIRO HIRAYAMA

Faith in the DPT vaccine has been restored, said Dr. Hirayama, with about 90 percent of the Japanese child population undergoing inoculation, usually three doses during their first year of life, and one booster after age 1.

"It is a recommendation for school — there is an immunization law — but it is not forced," said Dr. Hirayama who noted that free immunizations are available for those who cannot afford them.

St. Luke's International Hospital in Tokyo is one place where DPT vaccinations are available twice weekly for Japanese children. Dr. Kozo Mishimura, chief of pediatrics at St. Luke's, said he has noticed the difference in reactions since the arrival of the new DPT vaccines.

"Not many children develop fever — many children had had a fever reaction (with old DPT vaccine)," noted Dr. Mishimura. "It is very rare now that there are side effects."

The success of Japan's new acellular DPT vaccine has not gone unnoticed, said Dr. Hirayama. It is being extensively tested in Sweden, and officials from the U.S. Food and Drug Administration have consulted Dr. Hirayama about the new DPT vaccine, he said.

A growing number of American parents are blaming adverse reactions to the whole cell DPT vaccine — the one formerly used in Japan — for serious illnesses and deaths in their children.

"I recommend to the people in the United States to please have confidence in the efficacy and safety of the Japanese vaccine," added Dr. Hirayama. "Please use it."

October 25, 1985

Presentation to Immunization Practices Advisory Committee

Centers for Disease Control

Atlanta, GA

From the Ad Hoc Committee of Parents & Physicians

for Safe Immunization

Leslie Chapman, Secretary
163 Lindbergh Drive, NE
Atlanta, GA. 30305

Contents:

Statement of Mrs. Karen Cline
Statement of Mrs. Judith Glomb
Statement from parents whose children's deaths are reported today
Parents' position paper
Attachments

STATEMENT OF MRS. KAREN CLINE

Mr. Chairman and Members of the Committee:

My name is Karen Cline. I want to first express our thanks for allowing these members of the Ad Hoc Committee for Safe Immunizations to have a few moments of your time today.

I am a housewife and mother from Haskell, Oklahoma. I am now also the State Co-ordinator for Dissatisfied Parents Together. I have come here today representing my husband, two sons and their grandparents and great-grandparents who all live with endless pain because of the needless death of our only daughter.

My daughter was named Sabra Lynn. She was born April 30, 1985 following a normal pregnancy. There were no complications at birth. Sabra had colic and milk allergy, but no major health problems prior to receiving her first DPT.

Sabra was a beautiful little person with her own individual personality. She would absolutely light up and make sounds of delight whenever her brothers would play with her. Four-year-old Christopher already knew exactly what he would give her for Christmas this year.

On June 17, Sabra received her first DPT at the age of seven weeks. Almost immediately, she was screaming in a way she never had before. Then she fell into a deep sleep and I could not wake her at her normal feeding time. Hours later she was screaming again.

The next day, she was pale and limp, staring at the ceiling. She did not respond to sound or light or touch. Her eyes looked vacant and would occasionally cross or roll back in her head. She refused to

Japanese deaths led to new DPT

By PATTI MENCIER
Daily Times Staff Writer

TOKYO, Japan — Two infants who died here a decade ago may one day be indirectly responsible for saving the lives of millions of others around the world.

They are the two who, in December 1974 and January 1975, were inoculated with the combined, whole cell diphtheria-pertussis-tetanus (DPT) vaccine, the same controversial vaccine that is now being used in the United States.

They are the two who died of neurological disorders within 24 hours of vaccination.

The Japanese government wasted no time in blaming the DPT vaccine for the deaths. It promptly banned the use of the vaccine.

From 1969 to 1974, it had recorded 21 sudden deaths of infants between the ages of three and six months who died within 48 hours after being immunized with whole cell DPT vaccine.

In 1970, Japan's Ministry of Health and Welfare started a closer watch, observing a high number of severe adverse reactions following DPT vaccinations and, in fact, instituted a compensation program for the victims.

"We had many problems with the pertussis vaccine," said Munehiro Hirayama, a medical doctor who heads the department of maternal and child health at the University of Tokyo.

Out of every million children inoculated, said Dr. Hirayama, 10.6 suffered shock, convulsions, brain damage or other afflictions of the central nervous system.

"Besides that, many had fevers — 20 percent of the children got fevers during the 24 hours after the immunization," noted Dr. Hirayama. "Our government decided to renew immunization goals."

But it wasn't until five years later, when the two infants died, that government officials realized immediate adjustments had to be made with the DPT vaccine.

Considering the potentially fatal risk of diphtheria and pertussis or whooping cough to children, however, the vaccinations could not remain banned.

By April 1975, DPT vaccinations resumed, but were restricted to children age two and older who could presumably better overcome any toxic effects of the whole cell vaccine.

However, fear of the vaccine's potential ill effects had gripped the people and rate of vaccination dropped. Some were vaccinated with only diphtheria and tetanus toxoid.

Recorded cases of pertussis rose from 206 in 1971 to 13,106 in 1979 when 41 deaths were reported. Clearly, a pertussis vaccine had to be developed which the people trusted.

The Japanese government's Immunization Research Group isolated two protective antigens, LPF-HA and F-HA, from the pertussis culture and purified them to reduce toxicity and create an acellular or cell-free vaccine.

It was added to diphtheria and tetanus toxoid and a new, less toxic DPT vaccine was licensed in Japan in February 1981. By autumn 1981, it totally replaced the whole cell DPT vaccine for use in vaccinations and is now manufactured by six Japanese drug companies, said Dr. Hirayama.

"The toxic factor (poisons) from the old vaccine was excluded," he explained. "Now we pick-up just the antigens (which stimulate disease-fighting antibodies)."

The acellular DPT vaccine has apparently proved safe for the Japanese. Temporary skin reactions such as redness, swelling and hardening were reported along with a low incidence of fever, but no systemic, convulsive or shock-like reactions have been reported. Three cases involving central nervous system reactions were found to have underlying diseases such as cerebral palsy which could have provoked the symptoms.

Most importantly, no deaths have been connected with Japan's new DPT vaccine.

"Since October 1981, we've had no serious side reactions — fevers are one to two percent compared to 20 percent," said Dr. Hirayama who is part of the medical team tracking the effects and efficacy of the new DPT vaccine. "There are no severe complications after the new vaccine and no encephalitis."

Moreover, the new vaccine appears to be effectively reducing the occurrence of pertussis with number of fatal cases reported at 14 in 1983 as compared to 41 in 1979. Efficacy rate is estimated at 93.8 percent for children under age five, 91.8 percent in all children.

why not in America?

IMPORTANT INFORMATION ABOUT DIPHTHERIA, TETANUS, AND PERTUSSIS AND DTP, DT, AND Td VACCINES

Please read this carefully

DTP 4/1/84

WHAT IS DIPHTHERIA? Diphtheria is a very serious disease which can affect people in different ways. It can cause an infection in the nose and throat which can interfere with breathing. It can also cause an infection of the skin. Sometimes it causes heart failure or paralysis. About 1 person out of every 10 who get diphtheria dies of it.

WHAT IS TETANUS? Tetanus, or lockjaw, results when wounds are infected with tetanus bacteria, which are often found in dirt. The bacteria in the wound make a poison which causes the muscles of the body to go into spasm. Four out of every 10 persons who get tetanus die of it.

WHAT IS PERTUSSIS? Pertussis, or whooping cough, causes severe spells of coughing which can interfere with eating, drinking, and breathing. In the United States, more than 75 percent of reported pertussis cases occur in children younger than 5 years. Pertussis is a more serious disease in young children and more than half of the children reported to have pertussis are hospitalized. In recent years, an average of 1,700 cases of pertussis have been reported each year in the United States. Complications occur in a substantial proportion of reported cases. Pneumonia occurs in one of every four children with pertussis. For every 1,000 reported pertussis cases, 40 develop convulsions and 4 develop inflammation of the brain. In recent years, an average of nine deaths due to pertussis occurred each year.

Before vaccines were developed, these three diseases were all very common and caused a large number of deaths each year in the United States. If children are not vaccinated, the risk of getting these diseases will go back up again.

DTP, DT, AND Td VACCINES: Immunization with DTP vaccine is one of the best ways to prevent these diseases. DTP vaccine is actually three vaccines combined into one shot to make it easier to get protection. The vaccine is given by injection starting early in infancy. Several shots are needed to get good protection. Young children should get three doses in the first year of life and a fourth dose at about 18 months of age. A booster shot is important for children who are about to enter school, and should be given between their fourth and seventh birthdays. The vaccine is very effective at preventing tetanus—over 95 percent of those who get the vaccine are protected if the recommended number of shots is given. Although the diphtheria and pertussis parts of the vaccine are not quite as effective, they still prevent most children from getting a disease and they make the disease milder for those who do get it.

Because pertussis is not very common or severe in older children, those 7 years of age and older should take a vaccine that does not contain the pertussis part. Also, because reactions to the diphtheria part of the vaccine may be more common in older children, those 7 years of age and older should take a form of the vaccine that has a lower concentration of the diphtheria part. This vaccine which contains no pertussis part and a lower concentration of the diphtheria part is called Td vaccine. Boosters with the Td vaccine should be received every 10 years throughout life.

DEFERRAL OF DTP IMMUNIZATION: Some children who are less than 7 years of age and have had a serious reaction to previous DTP shots should not receive additional pertussis vaccine. A preparation called DT vaccine is available for them which does not contain the pertussis part. Also, children who have previously had a convulsion should generally not receive DTP vaccine until it can be determined that an evolving neurological disorder is not present.

The United States Public Health Service and the American Academy of Pediatrics recommend DTP vaccine be used in children up to 7 years of age unless they have had a serious reaction to earlier shots or have a neurologic disorder.

POSSIBLE SIDE EFFECTS FROM THE VACCINE: With DTP vaccine, most children will have a slight fever and be irritable within 2 days after getting the shot. One half of children develop some soreness and swelling in the area where the shot was given. More serious side effects can occur. A temperature greater than 102°F may follow 1 out of 20 DTP shots. Convulsions or episodes of limpness and paleness may each occur after 1 in every 1,750 shots. Children who have previously had a convulsion may be more likely to have another one after pertussis shots. Unusual, high-pitched crying may occur after 1 in every 1,000 shots. Rarely, about once in every 110,000 shots, inflammation of the brain (encephalitis) may occur and permanent brain damage may occur about once in every 310,000 shots. Side effects from DT or Td vaccine are not common and usually consist only of soreness and slight fever. Where is death mentioned?

WARNING—SOME PERSONS SHOULD NOT TAKE THESE VACCINES WITHOUT CHECKING WITH A DOCTOR:

- Anyone who is sick right now with something more serious than a cold.
- Anyone who has had a convulsion or other problems of the nervous system.
- Anyone who has had a serious reaction to DTP shots before, such as: a temperature of 105°F or greater; a convulsion; an episode of limpness and paleness; unusual high-pitched crying; or inflammation of the brain (encephalitis).

QUESTIONS: If you have any questions about diphtheria, tetanus, or pertussis or DTP, DT, or Td vaccination, please ask us now or call your doctor or health department before you sign this form.

REACTIONS: If the person who received the vaccine gets sick and visits a doctor, hospital, or clinic in the 4 weeks after vaccination, please report it to:

_____

Form 3177 (1-84) **PLEASE KEEP THIS INFORMATION SHEET FOR YOUR RECORDS**

sat for twelve hours and did not urinate for fifteen hours.

I called the doctor, very worried about the condition of my baby. I was told to give Pedialyte and call back the next day. We did not know that Sabra was dying. When I called the doctor again, Sabra was limp, pale, cold and clammy. She was gasping for breath. While I was on the phone, trying desperately to get help for my baby, she died in my arms. A part of me and all our dreams for the future died along with her. There will never be the first day of school. There will never be that first date. We will never know the joys that might have been.

If DPT death is as rare as you obviously believe, I wish you would explain to me why I have learned of several other suspicious deaths within a twenty mile radius of my home, including at least one other in my small home town of 1500 people.

Oh, how I wish that the recommendation before you in April to begin vaccination at the age of eight months had become a reality for my little Sabra. I would not be here today. I would be at home, watching my daughter learning to crawl. Instead, we can only visit her grave.

YOU can save the lives of the future Sabras. My question to you is: WILL you do it? And will you do it NOW?

STATEMENT OF MRS. JUDITH GLOMB

Mr. Chairman, Members of the Committee:

My name is Judy Glomb, I live in a suburb of Philadelphia with my husband and three living children. I am also the President of the rapidly growing Pennsylvania Chapter of Dissatisfied Parents Together. I am speaking today on behalf of my family, whose lives have been devastated by the suspected pertussis vaccine death of our precious baby girl. Following CDC recommendations, I am reporting Bernadette's death. Neither her doctor nor the Pennsylvania Dept. of Health were aware of the proper reporting procedures. So, eight months later, her is her story.

Bernadette Joyce was born on Sept. 23, 1978, a normal, healthy baby. She received her first DPT at two months following no discussion of contraindications or adverse reactions. For a full day after the shot, she slept so deeply that I could not rouse her to nurse. Her skin was cold and very pale. When she finally woke she was extremely congested, and continued coughing up mucus for the next six weeks. During this time the doctor diagnosed an Upper Respiratory Infection. At three and one half months, two weeks before her second DPT, Bernadette appeared to be recovered; but within hours of this shot, she again was in a deep deep sleep. Again she would not nurse. Again she was pale and unusually cold. Again within 24 hours she awoke severely congested, coughing, and wheezing.

Her repeated coughing fits lasted three to four minutes, and the mucus was so heavy that we had to suction her nasal passages constantly.

Then her sleep and nursing patterns became erratic; now she was projectile vomiting.

Letter from CDC

Reports of S.I.D. Following DTP Immunization

Manufacturer	DTP Lots	Polio	Jan. 1 - July 31 1979 Location	Age of Child	Injection No.	Time of Death
A	2061 HA	546-137	Mississippi	7 mo.	2nd	Within 48 hr
B	1948-439P	Yes	Connecticut	2 mo.	1st	Within 26 hr
	#1 1948-430	Yes	Ohio	6 mo.	3rd	4-5 days later
	#2	Yes	Indiana	3 mo.	2nd	3 days later
	#3	555-113	Texas	2 mo.	1st	Within 24 hr
C	#1 64201	543-143	Tennessee	2 mo.	1st	Within 24 hr
	#2	543-143		2 mo.	1st	Within 24 hr
	#3	546-137		2.5 mo	1st	Within 24 hr
	#4	555-113		2 mo.	1st	Within 24 hr
	#1 64601	?	California	2-3 mo.	1st	3 days later
	#2	?	Pennsylvania	3 mo.	2nd	2 days later
	64702	?	New Jersey	4.5 mo.	2nd	8 hr later
	#1 64801	?	New York	2 mo.	1st	4 days later
	#2	Yes	Pennsylvania	2 mo.	1st	Within 24 hr
	65001	Yes	Pennsylvania	6 wk	1st	9.5 hr
	65101 or 61991	?	Illinois	3 mo.	1st	Within 24 hr
	64901	Yes	California	2 mo.	1st	Within 24 hr
	65501	Yes	California	2 mo.	1st	Within 6 days

indicate severe reactions; and clear "plain English" descriptions of emergency responses to these potentially life-threatening events. According to our reading of ACIP's Dr. Hinman and ACIP's Dr. Koplan in their 1984 article in the Journal of the AMA, 1 in every 194 American children will suffer either shock/collapse or convulsion/seizure in the 1st 48 hours after DPT.

c. Revisions of risk statistics so that a wide variety of studies are cited, and not only those that minimize the risks; and risk figures put in terms of children, not doses.

8. Immediate investigation by CDC of all deaths following severe reactions that occur within 7 days of DPT, with attention paid to parents' reports of symptoms prior to death. Dr. Hinman's and Dr. Koplan's article (JAMA 1984) leads us to expect almost 8500 cases of shock/collapse in the first 48 hours after DPT in the U.S. each year. It is preposterous to conclude that none of these episodes, many of which will either not be witnessed or not be identified, would lead to death. Many acknowledge the vaccine's lethal capabilities, and yet the CDC's reporting system does not include a category for "DPT death." We call for the creation of such a category.

9. We call on the CDC to conduct an immediate education program for coroners regarding the inappropriateness of calling deaths during severe reactions "SIDS." The National Sudden Infant Death Syndrome Foundation clearly states that a baby must appear to be healthy with minor exceptions (upper respiratory tract infection, cold, ear infection, etc.) to be classified as SIDS.

10. We call for an immediate escalation of CDC efforts to educate physicians in the appropriate use of pertussis vaccine. Recent guidelines from the AAP and ACIP have not filtered down to the local level. And physicians (and parents) need clear information with exact addresses and procedures for reporting severe reactions in both the private and the public sectors.

11. And finally we call for the immediate adoption of the safer acellular Japanese pertussis vaccine, believing that the FDA has the current regulatory authority to take such a step.

She had been such a calm, bright, happy baby, but now had screaming fits, stiffening her entire body, and then collapsing as if totally exhausted. She no longer took interest in the life around her. She would often stare blankly. She worsened rapidly and required a doctor's visit. He diagnosed allergies and prescribed Slophyllin and Pediamycin. We never questioned this as we have such a family history.

On Valentine's Day of this year, thirty six hours after this diagnosis, Bernadette was found dead in her crib by her sister Becky.

In these few minutes that I have today, I can not convey the heartache caused by her needless death but it is a pain that deeply touches not only her parents, brother and sisters, but of four generations who love and miss her so.

As we were not educated in identifying severe reactions that exclude further doses of pertussis vaccine, we unknowingly played a part in the death of our Bernadette. How can we live with that knowledge?

How could any parent accept this?

STATEMENT TO ACIP FROM PARENTS WHO HAVE ASKED US TO REPORT THEIR BABIES' DEATHS TODAY:

Members of ACIP, we call for your help. We are all fighting the most difficult battles of our lives: we have buried our babies, we are weathering the grief and the rage that has torn at our families, and we have inherited a passionate responsibility to try to stop these deaths.

We are personally aware of a great number of highly-suspected-pertussis vaccine deaths beyond those we report today. What sets us apart is our knowledge of this opportunity, and our desire to have our babies' stories told here, reflecting our hope that ACIP will act swiftly.

We must ask: why doesn't the CDC investigate deaths after DPT? It is our sorrow that ACIP recommends pertussis vaccine for 3.3 million children this year, when nobody knows how many died from it last year.

We call on ACIP to join us in our commitment never to rest until the safety of America's babies is secure. We will not quit as long as our beautiful ones continue to be misclassified in the SIDS category, where, silent in death, they are forced to participate in an obscuring of the truth. We will speak for them; and we promise you, there will be no silence until every parent in this country knows all there is to know about this vaccine. This is the only legacy we have left to leave our children, both the living and the dead.

Please join us.

Some of the parents have asked that their babies pictures be shown, so I'll ask Mrs. Chapman to share them with you, as we begin our presentation of the stories. In order to protect the identities of these babies, the pictures will not be shown in the same order as the stories.

To save time, I'll ask you to refer to the clinical chart you've been given. Please note that most of these children were extremely healthy from pregnancy until the receipt of DPT; none had any serious unresolved health problems. Please note they all died from their first injection, and the frighteningly similar family health histories.

Our first baby was a little girl. She got her first DPT at 2 months; she reacted with leg twitching, strange screaming, and did not eat. She was found dead 10 hours after DPT. The coroner ruled SIDS.

PARENTS' POSITION PAPER 25 OCTOBER 1985

Today we are sharing our dead babies' stories with ACIP, in the hope that ACIP will act to reduce DPT risks for America's most precious resources: our babies.

TODAY WE PARENTS CALL FOR:

1. Immediate inclusion (as recommended by the World Health Organization) of a family history of central nervous system impairment as a contraindication to receipt of pertussis vaccine.

2. Immediate inclusion of a family history of extensive allergies---especially asthma, excema, and cow milk allergy---as a contraindication to receipt of pertussis vaccine. Many of our cases had such history; and a similar observation has been made by Dr. James Cherry in a recent Cerebral Palsy Newsletter. And by Dr. Larry Steinman of Stanford.

3. Immediate inclusion of any recent or current illness, no matter how slight, as a reason to defer pertussis immunization. Dr. Jennison, Executive Director of the American Academy of Pediatrics, made a similar recommendation on the WRC-TV documentary DPT: One Year Later.

4. Immediate inclusion of a history of prematurity or cerebral irritation in the neonatal period as a reason to defer pertussis immunization.

5. Immediate inclusion of a family history of severe reactions to pertussis vaccine as a contraindication to receipt of pertussis vaccine. Dr. Jennison is quoted in the transcript of DPT: One Year Later as making a similar suggestion.

6. Immediate consideration of ACIP member Dr. Mortimer's suggestion to start DPT at 8 months. Our list of babies, like previous CDC statements, shows a tremendous bias toward death after the first injection. In the past both ACIP's Dr. Brunell (at the Pertussis Task Force meeting of the American Academy of Pediatric's Red Book Committee) and Dr. Robbins (FDA) have voiced similar ideas. Such a policy followed in Japan for the past several years has resulted in a marked decrease in severe adverse reactions.

7. Immediate redrafting of the CDC's Important Information Form to include:
   a. reinsertion of death as a possible DPT outcome;
   b. clear "plain English" descriptions of all symptoms that might

A footnote to the babies' stories: The National SIDS Foundation is quite clear on its requirement that a baby must appear to be in good health (with minor exceptions like colds, ear infections, upper respiratory tract infections) prior to death to be classified as a victim of SIDS. These babies clearly did not fit this requirement. Numerous medical consultants have advised us to suspect that pertussis vaccine caused these deaths.

We call your attention to our Parents' Position Paper, which delineates our proposed remedies for our nation's pertussis vaccine illness. As time does not permit reading it aloud, we ask that you consider it, and send us a formal response in the next month. Finally we ask that you address the following questions in the discussion after Dr. Geraghty's presentation:

1. What technical information do you give coroners to help identify DPT toxic deaths? Please provide us with a copy of these materials.
2. Dr. Hinman, why has the word death come and gone from the list of reactions to DPT found on your CDC's important information form? In 1978 and 1980 a mother was warned that her child could die from DPT; in 1983, that warning disappeared.
3. Hot lots of DPT have been identified on 5 separate occasions in the U.S. When studied, all of them had the same characteristic: double strength. What has the CDC done to expedite the identification and recall of hot lots? Why don't we have the capacity to recall hot lots overnight, as occurred in England with regard to Trivax #A57701 following the deaths of fraternal twins this year?
4. In 1975, 2 babies died in Japan. Results: superior vaccine given to older children, leading to a great reduction in the incidence of severe reactions. In 78-79, 9 babies died in Tennessee alone. As America's babies' lives tick away, where is our new vaccine, where are our new safety rules? Where is our American success story?
5. In the peak year of the English whooping cough epidemic, following 10 years of low immunization rates, there were 23 deaths. Dr. Hinman tells us to expect about 400 deaths per year in the U.S. in the absence of pertussis vaccine. Dr. Brunell's American Academy of Pediatrics warns us of 14,000! Please explain this discrepancy to us. We'd like Dr. Hinman to answer first, then Dr. Brunell.

Our second baby was a little girl. She had a cold when she got her first DPT at 2½ months. She reacted with extreme paleness, unresponsiveness, over-sleeping, and screamed as if in pain for most of the last day of her life. She was found dead 6½ days after DPT. The coroner ruled SIDS.

Our third baby was a little boy. He had a cold when he got his first DPT at 2 months. He reacted with hours of persistent screaming, and was found dead less than 12 hours after DPT. The coroner ruled SIDS.

Our fourth baby was a little boy. He got his first DPT at 2 months, and reacted with high-pitched screaming, limpness, diarrhea, and cold extremities. He died in his mother's arms 33 hours after DPT. The death was tentatively listed as a possible SIDS, but a thorough coroner, upon learning of the symptoms after DPT, made a final ruling of irreversible shock due to a probable DPT reaction.

Our fifth baby was a little boy. He got his first DPT at 2 months, and reacted with bouts of terrible screaming. He was found dead 15 hours after DPT. The coroner ruled SIDS.

Our sixth baby was a little boy. He was at the end of an ear infection, and had a trace of residual jaundice when he was given his first DPT at 1½ months. He reacted with unconsolable crying, jerking of extremities accompanied by high-pitched vocalizing, staring, diarrhea, and an episode of limpness about 7 hours prior to his death, 5 days after DPT. The coroner ruled SIDS.

Our seventh baby was a little boy. He got his first DPT at 3 months, and reacted with excessive sleeping, eyes bloodshot and swollen, congestion, episodes of eye-crossing, and a terrible cough. Symptoms progressively worsened, and he was seen at the emergency room and given a prescription for congestion and eyedrops. He was found dead 10 days after DPT. The coroner ruled SIDS.

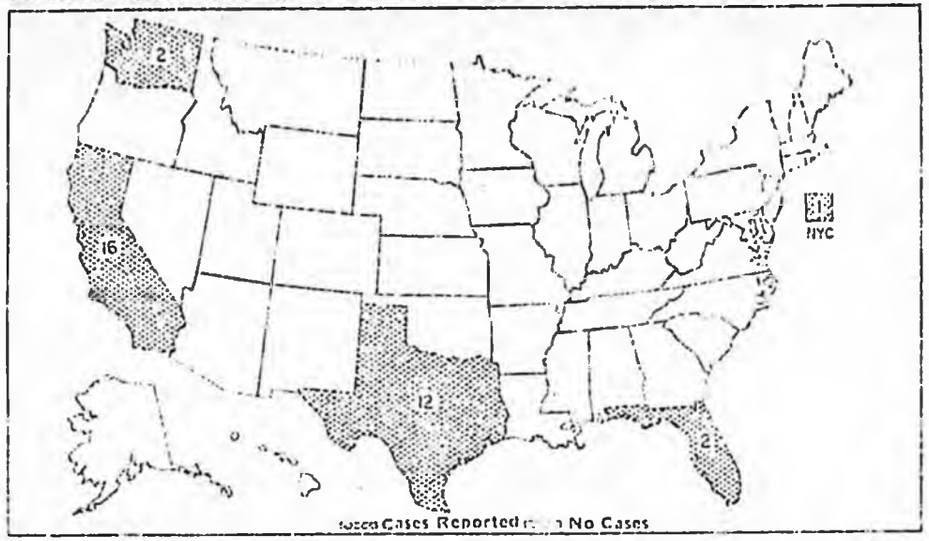
Our eighth baby was a little girl. A cold was clearing up when she got her first DPT at 3 months. She reacted with limpness and terrible screaming, and was found dead 4 hours after DPT. The coroner ruled SIDS.

Our ninth baby was a little girl. She had a cold when she got her first DPT at 2 months. She reacted with a stiff arched back, eyes rolling up, and a piercing scream at the time of the shot; later, high-pitched unconsolable screaming. She died 3 hours after DPT. The coroner ruled SIDS.

TOGETHER, MAY THEY ALL REST IN PEACE.

Case	Pregnancy	Birth	Health from birth to 1st DPT	Age & health at time of 1st DPT	Reactions	Interval DPT to death	Coroner ruling	Family History			
								Allergy	Severe DPT Reaction	Epilepsy	Other
Baby Girl 1	uneventful	normal	excellent	2 months; healthy	leg twitching; strange screaming; did not eat	10 hours	SIDS	asthma, excema, allergies	yes	yes	
Baby Girl 2	uneventful	normal	problems with formulas; otherwise excellent	2 months; had a cold; otherwise healthy	extreme paleness; unresponsive; oversomnolence; unconcolable screaming	6½ days	SIDS	allergies incl. cow milk			migraine
Baby Boy 3	uneventful	normal	excellent	2 months; had a cold; otherwise healthy	unconsolable screaming	12 hrs	SIDS	cow milk allergy			
Baby Boy 4	uneventful	normal	excellent	2 months; healthy	high pitched screaming; limpness; diarrhea; cold extremities	33 hrs	irreversible shock due to probable DPT reaction	milk intolerance	yes	yes	migraine
Baby Boy 5	uneventful	normal C Sec (labor failed to progress)	excellent	2 months; healthy	repeated bouts of high pitched screaming	15 hrs	SIDS				diabetes
Baby Boy 6	uneventful	routine repeat C Sec; TTN; O_2 support 6 hrs; Apgar 9,9	resolving breast jaundice; otherwise excellent	1½ mo; trace of jaundice; end of ear infection; otherwise excellent	unconsolable crying; jerking of extremities with high pitched vocalizing, staring, diarrhea, limpness	5 days	SIDS	cow milk & other allergies	yes, & severe reaction to other vaccines		migraine convulsions
Baby Boy 7	uneventful	vaginal; breathing support req. briefly; discharged 48 hrs after birth	Hosp 3 days w/ virus at age 2 mos; otherwise healthy	3 months; healthy	excessive sleeping; eyes bloodshot & swollen; congestion; episodes of eye-crossing; terrible cough	10 days	SIDS	asthma; excema; food allergies	yes		convulsions
Baby Girl 8	uneventful	normal	excellent	3 months; end of cold/ runny nose; otherwise healthy	terrible screaming; limpness	4 hours	SIDS	asthma; excema; allergy incl. cow milk	yes	yes	
Baby Girl 9	uneventful	normal	excellent	2 months; at end of cold; otherwise healthy	back arched scream at time of shot; eyes rolled up; high pitched unconsolable scream	3 hours	SIDS				migraine

FIGURE I. Reported measles cases — United States, weeks 40-52, 1985



The *Morbidity and Mortality Weekly Report* is prepared by the Centers for Disease Control, Atlanta, Georgia, and available on a paid subscription basis from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402, (202) 783-3238.

The data in this report are provisional, based on weekly reports to CDC by state health departments. The reporting week concludes at close of business on Friday; compiled data on a national basis are officially released to the public on the succeeding Friday.

The editor welcomes accounts of interesting cases, outbreaks, environmental hazards, or other public health problems of current interest to health officials. Such reports and any other matters pertaining to editorial or other textual considerations should be addressed to: ATTN: Editor, *Morbidity and Mortality Weekly Report*, Centers for Disease Control, Atlanta, Georgia 30333.

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☆U.S. Government Printing Office: 1986-746-149/21036 Region IV

DEPARTMENT OF
HEALTH & HUMAN SERVICES
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HHS 396

(HHS Publication No. (CDC) 86-8017

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MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT

January 10, 1986 / Vol. 35 / No. 1

1 Measles — United States, First 26 Weeks, 1985
5 Rapid Nutrition Evaluation during Drought Conditions — Burkina Faso, 1985
12 Penicillinase-Producing *Neisseria gonorrhoeae* — United States, Florida
14 Update: Influenza Activity — United States

Current Trends

Measles — United States, First 26 Weeks, 1985

Through December 28, 2,704 measles cases in the United States were reported to the *MMWR* for 1985. Results of detailed analyses are available for cases reported during the first 26 weeks, when a provisional total of 1,802 cases was reported, a 2.4% increase over the 1,759 cases reported during the same period in 1984 (1). The overall incidence rate in both years was 0.8 cases per 100,000 population for the 26-week period. Eight states accounted for 1,333 (73.9%) cases: Illinois (259 cases), Texas (236), Arizona (194), California (143), Montana (129), Idaho (126), New York (124), and Massachusetts (112). Ten states had incidence rates greater than 1/100,000 population: Arizona, Hawaii, Idaho, Illinois, Maryland, Massachusetts, Montana, Texas, West Virginia, and Wisconsin. During the first half of 1984 and 1985, 15 and 20 states, respectively, reported measles cases (indigenous or imported). For each year, 2.5% of the nation's 3,139 counties reported measles cases during the period.

Detailed information was provided to the Division of Immunization, Center for Prevention Services, CDC, on 1,601 of the cases reported during the first 26 weeks of 1985. Of these, 1,750 (72.2%) met the standard case definition for measles,* and 661 (36.7%) were serologically confirmed. In most cases (72.1%), onset of rash occurred between weeks 8 and 20 (weeks ending February 23 and May 25, respectively). There was a biphasic distribution of cases during this period (Figure 1).

In the first half of 1984, the highest incidence rate was reported among children 10-14 years of age (Table 1). By comparison, in the first half of 1985, the highest incidence rate was reported among 15- to 19-year-olds (3.1/100,000), followed by preschool-aged children (2.5/100,000). The incidence rate among 10- to 14-year-olds decreased from 2.9/100,000 in 1984 to 1.8/100,000 in 1985. Of the 466 preschool-aged children with measles, 137 (29.4%) were infants under 1 year of age; 81 (17.4%) were 12-14 months of age; 24 (5.2%) were 15 months of age, and 224 (48.1%) were 16 months-4 years of age.

Of the 1,256 (69.7%) patients for whom the setting of transmission was reported, 903 (71.9%) acquired measles in school†, 126 (10.0%), at home; 63 (5.0%), in medical settings; 41 (3.3%), in daycare centers; 18 (1.4%), in church, and 105 (8.4%), in a variety of other settings, including sporting events and summer camp.

Seventy cases (3.9%) were international importations. An additional 128 (7.1%) cases

*Fever (≥99.5°F [≥37.5°C] or higher, if measured), generalized rash of 3 days' or longer duration, and at least one of the following: cough, coryza, conjunctivitis.

†Includes kindergarten through college.

Measles – Continued

were epidemiologically linked to an international importation within two generations of infection. Therefore, 198 (11.0% of all cases) were classified as international importations during this period (2).

Vaccination status of patients in 1984 and 1985 was similar. Of the 1,801 cases reported during the first 26 weeks of 1985, 859 of the patients had been vaccinated on or after the first birthday; 247 had been vaccinated at 12-14 months of age (Table 2). A total of 846 measles patients were unvaccinated, and 96 had histories of inadequate vaccination (vaccinated before the first birthday).

FIGURE 1. Reported measles cases, by week of rash onset — United States, first 26 weeks, 1985

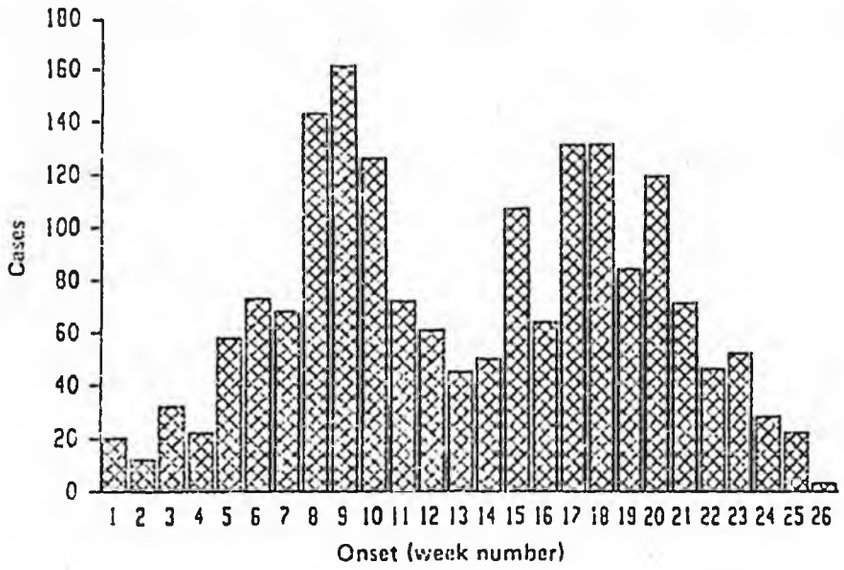


TABLE 1. Age distribution and estimated incidence rates of measles — United States, first 26 weeks, 1984 and 1985*

Age group (yrs.)	1984 No.	1984 (%)	1984 Rate†	1985 No.	1985 (%)	1985 Rate†	Rate change (%)
0-4	351	(19.9)	2.0	466	(25.9)	2.5	+25.0
5-9	201	(11.4)	1.3	152	(8.4)	0.9	-30.8
10-14	515	(29.2)	2.9	319	(17.7)	1.8	-37.9
15-19	470	(26.6)	2.4	603	(33.5)	3.1	+29.2
20-24	137	(7.8)	0.6	175	(9.7)	0.8	+33.3
≥ 25	91	(5.1)	0.1	86	(4.8)	0.1	0.0
Total	1,765§	(100.0)	0.8	1,801	(100.0)	0.8	0.0

*Provisional data.

†Per 100,000 population.

§The difference between this number and that in the text reflects differences between summary data reported to *MMWR* and more detailed data available to CDC's Division of Immunization.

Measles – Continued

Of the 1,801 cases, 466 (25.9%) were classified as preventable (2) (Table 3). The highest proportion of preventable cases occurred among persons who were not of school age: 69.2% of cases among children 16 months-4 years of age were preventable. Only 20.4% of cases among persons 5-19 years of age were preventable; however, 47.0% of all preventable cases occurred in this age group.

Of the 1,335 persons with nonpreventable cases, 242 (18.1%) were too young for routine vaccination (under 16 months of age), and 42 (3.1%) were too old (born before 1957) (Table 4). Of the 1,051 who were between 16 months and 28 years of age, 842 (80.1%) had been vaccinated on or after the first birthday; 11 (1.0%) had a prior physician diagnosis of measles; 34 (3.2%) were not U.S. citizens; and 163 (15.5%) had medical contraindications or exemptions under state law. One person (0.1%) had laboratory evidence of immunity.

Reported by Div of Immunization, Center for Prevention Svcs, CDC.

Editorial Note: In the prevaccine era, an average of 500,000 measles cases was reported

TABLE 2. Ages of measles patients at most recent vaccination — United States, first 26 weeks, 1984 and 1985*

Age at vaccination	1984 No.	1984 (%)	1985 No.	1985 (%)
< 12 mos.	135	(7.6)	96	(5.3)
12-14 mos.	255	(14.4)	247	(13.7)
15 mos.	34	(1.9)	46	(2.6)
16 mos.-4 yrs.	303	(17.2)	325	(18.0)
5-9 yrs.	139	(7.9)	165	(9.2)
10-14 yrs.	32	(1.8)	70	(3.9)
15-19 yrs.	8	(0.5)	5	(0.3)
≥ 20 yrs.	2	(0.1)	1	(0.1)
Unknown (> 12 mos.)	3	(0.2)	0	(0.0)
Unvaccinated	854	(48.4)	846	(47.0)
Total	1,765	(100.0)	1,801	(100.0)

*Provisional data.

TABLE 3. Age distribution and preventability of measles cases — United States, first 26 weeks, 1985*

Age group	Preventable No.	Preventable (%)	Nonpreventable No.	Nonpreventable (%)	Total
< 15 mos.	0	(0.0)	242	(100.0)	242
16 mo-4 yrs.	155	(69.2)	69	(30.8)	224
5-9 yrs.	32	(21.1)	120	(78.9)	152
10-14 yrs.	52	(16.3)	267	(83.7)	319
15-19 yrs.	135	(22.4)	468	(77.6)	603
20-24 yrs.	60	(34.3)	115	(65.7)	175
25-29 yrs.	32	(60.4)	21	(39.6)	53
≥ 30 yrs.	0	(0.0)	33	(100.0)	33
Total	466	(25.9)	1,335	(74.1)	1,801

*Provisional data.

Measles — Continued

each year (*3*). After measles vaccine was licensed in 1963, the incidence of measles markedly declined. Since 1981, the number of reported measles cases has remained relatively constant: 3,124 in 1981, 1,714 in 1982, 1,497 in 1983, and 2,534 in 1984. The number of cases reported during the first half of 1985 is similar to that reported during the first half of 1984 (*1*). As in recent years, measles was geographically restricted: 97.5% of the nation's counties were free of measles during this period.

While incidence rates during the first 26 weeks of 1984 and 1985 were comparable, there were differences in the age characteristics of patients. In 1984, persons 10-14 years of age accounted for approximately 29% of cases, compared with only 18% of cases in 1985. The incidence rate for 15- to 19-year-olds was higher in 1985. Over a third of measles patients were in this age group, due in part to the large number of outbreaks on college campuses in 1985 (*4*). Colleges and universities are now beginning to require evidence of immunity to measles for matriculation; this requirement should result in a decrease in measles in this population.

As the measles elimination strategy is successfully implemented, the proportion of preventable cases should decrease. The decrease in the percentage of preventable cases from 34.6% in 1984 (*1*) to 25.2% during the first half of 1985 is encouraging. As in 1984, preschool-aged children over 15 months of age had the highest proportion of preventable cases. Because these children are not reached by existing school laws, greater efforts need to be directed to this age group. School-aged persons accounted for the largest percentage of all preventable cases, and schools were the setting of transmission for the majority of cases. Therefore, continued enforcement of current school immunization laws is important for further reduction of measles in the United States.

References

1. CDC. Measles — United States, first 26 weeks, 1984. MMWR 1984;33:495-6, 501-4.
2. CDC. Classification of measles cases and categorization of measles elimination programs. MMWR 1982;31:707-11.
3. CDC. Measles surveillance report no. 11, 1977-1981. Atlanta, Georgia: Centers for Disease Control, 1982.
4. CDC. Measles on college campuses — United States, 1985. MMWR 1985;34:445-9.

TABLE 4. Reasons measles cases were classified as nonpreventable — United States, first 26 weeks, 1985*

Causes of nonpreventability	No. cases	(%)		Percentage of total cases
< 16 months		242	(18.1)	13.4
Born before 1957		42	(3.1)	2.3
16 mos -28 yrs		1,051	(78.7)	58.4
Adequately vaccinated	842	(80.1)		
Prior physician diagnosis	11	(1.0)		
Non-U.S. citizens	34	(3.2)		
Exemptions†	163	(15.5)		
Laboratory evidence of immunity	1	(0.1)		
Total		1,335	(100.0)	74.1

*Provisional data.
†Medical exemptions — 8; religious — 150; philosophic — 5.

International Notes

Rapid Nutrition Evaluation During Drought Conditions — Burkina Faso, 1985

Burkina Faso, a landlocked Sahelian country with a population of 7.2 million, experienced a severe drought in late 1984 and early 1985. At the request of the U.S. Agency for International Development and the Government of Burkina Faso, a rapid evaluation of the nutrition status of children 65-110 cm tall (approximately 6-59 months of age) was undertaken. The survey was conducted in Soum and GnaGna, two of the eight drought-affected provinces in northern Burkina Faso. Ten villages in each province were randomly selected for data collection (*1*).

A random sample of 339 children in Soum and 366 children in GnaGna were included in the survey. Height, weight, and arm circumference of the children in each village were measured, and clinical examinations for edema and avitaminosis A and C were done on 30-40 children. A standardized questionnaire to evaluate the children's measles vaccination status, recent illnesses, and food consumption was administered to the mothers of children in the sample.

Acute undernutrition (less than 80% of the median weight-for-height [*2,3*]) was found in 10.6% of children in Soum and 5.7% of children in GnaGna (Table 5). Severe acute undernutrition (less than 70% of the median weight-for-height) was found in 1.8% of children in Soum and in 1.1% of children in GnaGna. However, an additional 14.2% of children in Soum and 11.2% of those in GnaGna were between 80% and 84% of median weight-for-height. Similar

TABLE 5. Nutrition status and other health indicators among children 6-60 months of age — Soum and GnaGna provinces, Burkina Faso, April 1985

Characteristic	Soum No.	Soum (%)	GnaGna No.	GnaGna (%)
Median weight-for-height				
< 70%	6	(1.8)	4	(1.1)
70%-79%	30	(8.8)	17	(4.6)
80%-84%	48	(14.2)	41	(11.2)
Arm circumference				
< 12.5 cm	26	(7.7)	18	(4.9)
12.5-13.4 cm	56	(16.5)	49	(13.4)
Diarrhea	71	(20.9)	42	(11.4)
Vitamin A deficiency*	1	(0.0)	4	(1.1)
Scurvy†	0	(0.0)	4	(1.1)
Measles vaccine§	220	(64.9)	217	(59.3)
Total children	339		366	

*Diagnosed by presence of Bitot's spots, corneal ulceration, and/or corneal scarring.
†Diagnosed by presence of bleeding gums and/or swollen joints.
§Determined by immunization card.

STEVE COWPER
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STATE OF ALASKA
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JUNEAU

INTERIM COMMISSION ON CHILDREN AND YOUTH

June 19, 1987

Shannon Kohler, President
Alaska Chapter DPT
Box 1745
Soldotna, AK. 99669

Dear Ms. Kohler:

Thank you for your letter of June 11th regarding your organization's interests in and efforts on behalf of the rather controversial issue of mandatory immunization.

While I can't promise that the Commission on Children and Youth will specifically address this issue in the long term, I have forwarded the information you provided to Kayleen Lowe, who will be researching issues related to health care for the Commission's Committee on Comprehensive Child Care. I know that Kayleen is very personally involved in all aspects related to health and will be interested to know of your position. I would also like to forward the information to Caren Robinson, Special Assistant to the Governor, whose area of responsibility involves health and social service issues; and to Rep. Niilo Koponen, who is a member of the Commission and, as you know, Co-Chair of the House HESS Committee.

Please be assured that the Commission is very committed to involving the public in all aspects of its work, and would welcome any information and/or expertise you'd like to provide in this area. I've enclosed a listing of members of the Commission which includes mailing addresses and contact numbers. Please feel free to be in touch with me or Commission members if you have any questions or would like additional information.

The Committee on Comprehensive Child Care will be meeting in Anchorage on July 9-10. I'd be happy to add your name to our mailing list so that you'll receive notices of all meetings.

Thank you for your interest in the work of the Commission.

Sincerely,

Carla Timpone
Program Coordinator

enclosure

Shannon Kohler
Alaska Chapter DPT
Box 1746
Soldotna, Alaska 99669
262-3825

Ms. Niesje Steinkruger, Chairwoman
Governors Interim Commission on Children & Youth
c/o Director of Boards & Commissions
Office of the Governor
P.O. Box A
Juneau, Alaska 99811

June 11, 1987

Dear Ms. Steinkruger;

Hello. My name is Shannon Kohler. I am president of the Alaskan Chapter of Dissatisfied Parents Together. Our group has a network of members throughout Alaska. We are parents concerned with vaccine safety, awareness, and efficacy. I have sent this letter and packet to you to acquaint you and your commission with our group, goals and House Bill 277, proposed by AK. DPT and sponsored by Rep. Mike Navarre.

We are not anti-vaccine, but stress that parents should be presented all pertinent information as to the risks as well as the benefits of any vaccine to be administered to their child. We also stress that each parent have the right to claim a philosophical objection exemption to any immunization without threat of exclusion from public school. One of the most important aspects of this bill is the requirement that the reporting of adverse reactions to immunizations be made mandatory by all health care providers. As you may notice in our briefing paper, the only reporting system is passive, "relying on the integrity of the individual health care provider to comply." According to our research, very few adverse reactions get reported to the public health department, thus very few long term reactions (i.e. hearing loss, developmental delay, epilepsy, cerebral palsy, death) are recognized as being related to vaccinations when they often may be. According to the current system, parents are not presented an accurate benefit/risk ratio when trying to decide about vaccinations. Then, no matter what they may decide about this questionable medication, they are forced to comply if they want their children to attend public school.

H.B. 277 was introduced to the House on April 17, 1987 and referred to the H.E.S.S. committee. This committee has yet to have a hearing on it. According to Jeannie Martin, H.E.S.S. secretary, they have been receiving quite a bit of mail, calls, and p.o.m.'s concerning it. Ms. Martin also stated

that due to the constituent response it most likely will be necessary to refer this bill to your commission for perusal and public hearings.

If there are any public hearings to be held concerning H.B. 277, I would greatly appreciate being contacted in the formative stages of these proceedings. Our AK. DPT group has done extensive research on every aspect of this bill and it seems quite necessary that this information be presented to your commission and the public. I live in Soldotna but can travel to Anchorage if given reasonable notice. Also, I will gladly forward any item from our bibliography to your commission.

I am looking forward to meeting you and addressing the Commission on Children and Youth. Our group is convinced of the necessity of H.B. 277 and would like to see the commission's support on this bill as it travels through the legislative system.

Thank you for your time and effort.

Sincerely,

Shannon Kohler

Shannon Kohler
President, AK. DPT

BRIEFING PAPER

H.B. 277: A Bill relating to the immunization of minors proposed by Alaska DPT and sponsored by Rep. Mike Navarre

The following is an outline of the main components of H.B. 277, evidence that supports the need for each of these goals, and sources of this supporting information. Any item referred to can be obtained from Rep. Mike Navarre's office or by contacting Alaska DPT office at the address listed at the end of this paper.

I. Parental Choice: To allow philosophical objection (parental discretion) on administration of immunizations without threat of exclusion from a school, preschool, or day care in this state.

A. Twenty-two states in the United States allow this exemption. See attachment #1.

B. No studies have been conducted by the Center of Disease control to correlate use of this exception and greater rates of disease. Due to the small numbers that invoke this exemption, they state it would be difficult to make meaningful comparisons. (from AK. State Legislature House of Representatives Research Agency request: Laws concerning Mandatory Immunization, #87.065)

C. Questionable effectiveness of vaccines*

1. Approximately half of the cases of whooping cough (pertussis) in 1984/1985 epidemic had received pertussis vaccine at some point in their life. (from correspondence of May 1, 1986 , Ak. Public Health Dept.)
2. Nationally, of the 1,051 affected with measles who were between 16 months and 28 years of age, 842 (80.1%) had been vaccinated on or after their first birthday which is the currently recommended timetable for measles vaccination. (from Morbidity and Mortality Weekly Report, Jan. 10, 1986 Vol. 35, #1)

D. Questionable safety of vaccines*

1. All short term and long term possible adverse reactions recognized by National Center of Disease Control that may result from vaccinations (see official MSAEFI report form, attachment #2)
2. All of the above and more also listed in manufacturers inserts from vaccines

*See bibliography for additional information regarding safety and effectiveness

II. Parent Immunization Information:

To mandate that each parent receive extensive written information as to the risks as well as the benefits of each vaccine before vaccination and with immunization information provided by Public Health at birth. This information would include:

A. Manufacturer's product insert from each vaccine which includes ingredients of product, adverse reactions that may occur from use of product, and contraindications to warrant discontinuing use of product
   1. DPT vaccine: Lederle Lab Division, American Cyanamid Co., Pearl River N.Y., 10965, or from Public Health Dept.
   2. Polio; Live Oral: same as DPT. Please note that this insert contains a "Disclaimer of Representations and Warranties".
   3. MMR: (measles, mumps, rubella): Merck, Sharp & Dohme, Div. of Merck & Co., Inc., Westpoint PA., 19486 or from Public Health Dept.

III. Adverse Reaction Reports:

To mandate that all health care providers (physicians, nurses, etc.) report to the Public Health Dept., all occurences of serious adverse reactions resulting from immunizations, and that long-term follow-up investigations be included

A. From correspondence with Public Health Dept: "The State does not have any specific regulations regarding the reporting of adverse reactions following immunizations. Health care providers who administer vaccines are encouraged to report possible adverse reactions to this office. This is a passive surveillance system which relies on the integrity of the health care providers to comply." (from letter dated November 14, 1986)

B. Paragraph excerpt from newspaper interview with Michael Klatt, manager Ak. Immunization program: "He acknowledges that the reaction reporting system hasn't been effective in the past and that many parents may not have associated illnesses occurring after a vaccine as related to the vaccine. 'I have no doubt that the adverse reactions were under-reported.'" (from Peninsula Clarion, Feb. 18, 1987)

C. Interviews with Alaska parents and adverse reaction report forms on file with AK. DPT--all fit the criteria of severe adverse reactions, several contacted doctors, hospitals or health centers about reaction; none were reported until contact with AK. DPT, few still reported. Includes: one child partially paralyzed, 2 cases of 105 degree fever with development of cerebral palsy, one child with nerve damage deafness, one case of SIDS, developmental delay, convulsions, etc.

D. Alaska DPT stresses the importance of mandatory adverse reaction reporting with follow-up so that parents may be able to accurately ascertain the benefit/risk ratio when determining whether to immunize.

IV. Immunization Records: to insure that the vaccination manufacturer and lot # be kept on file for at least three years and to insure that reaction be recorded in minors permanent medical record so that no further doses of questionable vaccine be administered to minor, even if location of administration varies.

This briefing paper was prepared by:
Alaskan Chapter
Dissatisfied Parents Together
Box 1746
Soldotna, Alaska 99669
(907) 262-3294

Founded in 1982, Dissatisfied Parents Together is a National non-profit educational organization concerned with protecting children from death and injury from whooping cough (pertussis) and the pertussis vaccine, the "P" component of the DPT shot

The Alaskan Chapter of DPT has expanded their concerns to all diseases and all State mandated vaccines. We are not anti-vaccine, but stress that parents have the right to be educated about all the aspects of any vaccine to be administered to our children. We also stress that Alaskan parents should have the right to decide which if any vaccines are to be administered to our children without threat of exclusion from State schooling or liscensed day care.

Exemptions from Immunization Requirements (K-12)

▨ Allowed ☐ Not Allowed

State	Medical	Religious	Philosophical
Alabama	▨	▨	
Alaska	▨	▨	
Arizona	▨	▨	▨
Arkansas	▨	▨	
California	▨	▨	▨
Colorado	▨	▨	▨
Connecticut	▨	▨	
Delaware	▨	▨	▨
Dist. of Col.	▨	▨	
Florida	▨	▨	
Georgia	▨	▨	
Hawaii	▨	▨	
Idaho	▨	▨	▨
Illinois	▨	▨	
Indiana	▨	▨	▨
Iowa	▨	▨	
Kansas	▨	▨	
Kentucky	▨	▨	
Louisiana	▨	▨	▨
Maine	▨	▨	▨
Maryland	▨	▨	
Massachusetts	▨	▨	
Michigan	▨	▨	▨
Minnesota	▨	▨	▨
Mississippi	▨		
Missouri	▨	▨	▨
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Wisconsin	▨	▨	▨
Wyoming	▨	▨	

STATE OF ALASKA

BILL SHEFFIELD, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

DIVISION OF PUBLIC HEALTH
SECTION OF COMMUNICABLE DISEASE CONTROL

3601 "C" STREET, SUITE 576
TOUCH 6333
ANCHORAGE, AK 99502-0333
(907) 561-4235

May 1, 1986

The information you requested about DTP vaccine and whooping cough was not easily retrievable. The major reason being that I have only been on the job three months, therefore, I didn't know who to ask or where to look. However, this is what I have found.

1. There were five cases of whooping cough in 1984 and 30 cases in 1985.

2. Four of the five cases were confirmed in 1984 and nine of the 30 cases were confirmed in 1985.

3. A total of four of the 35 cases were hospitalized with no deaths.

4.

Age	1984	1985
unknown	0	4
<1	2	10
1	1	6
2	0	4
5-9	0	2
10-19	0	3
20-24	0	1
25-29	1	0
30-39	1	0

Approximately half of the cases had received pertussis vaccine at some point in their life , however, whether they were appropriately immunized for age I am unable to ascertain.

5. The parents/guardians of recipients who see a physician or who are hospitalized within one month of an immunization are supposed to notify the Alaska Immunization Program. When I receive notification of an adverse event following an immunization, I contact the parents/guardians, the immunization provider, and the attending physician. It is the physician's responsibility to determine whether or not the patient's problems are vaccine-related. All vaccine-related adverse reactions are documented on an official report form and sent to the Centers for Disease Control in Atlanta, Georgia.

I hope the enclosures are of help to you.

Sincerely,

Michael Klatt

Michael Klatt, Manager
Alaska Immunization Program

MK:db

BILL SHEFFIELD, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

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SECTION OF COMMUNICABLE DISEASE CONTROL

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November 14, 1986

Ms. Shannon Kohler
Alaska Chapter-DPT
Box 1746
Soldotna, AK 99669

Dear Ms. Kohler:

Thank you for the information relative to the pertussis poster containing incorrect information. We are not aware of any state-wide department offices displaying such a poster.

The "Dear Health Care Provider" contains information which has been in existence for at least two years and is considered common knowledge by most health care providers who administer vaccine. However, it maybe appropriate to reiterate the information in an upcoming edition of the Epidemiology Bulletin (a news bulletin sent to health care providers and other interested parties). Also, we will be rewriting the immunization standing orders for the Public Health Nurses and, if not already part of their standing orders, we will include this important information.

The State does not have any specific regulations regarding the reporting of adverse reactions following immunizations. Health care provders who administer vaccines are encouraged to report possible adverse reactions to this office. This is a passive surveillance system which relies on the integrity of the health care providers to comply.

The answers to your remaining questions are as follows:

1. Report Gathering

   A. How are adverse reactions gathered from parents? from public health officials administering vaccine? from doctors?

      Parents are to notify the provider of the vaccine if the vaccinee visits a doctor, hospital, or clinic within 4 weeks of vaccination, as requested on every Important Information Form. A public provider who is made aware of a possible adverse reaction completes the MSAEFI report form and submits it to this office. A private physician who is made aware of a possible adverse reaction notifies this office and the MSAEFI Coordinator completes the MSAEFI report form.

B. What is the estimated rate of compliance?

C. How exactly is the rate of compliance determined?

No estimated rate of compliance is determined.

2. Handling Reports

A. Once a report is received, where and how is it recorded?

All submitted MSAEFI report forms are entered onto a MSAEFI report form log sheet by the MSAEFI Coordinator. All submitted MSAEFI report forms which meet the minimal criteria for submission to the Centers for Disease Control are forwarded.

B. Is the original or copy of report kept by State office?

A typed carbon copy is retained by the State office.

C. Is the original or copy of report sent to the National Center of Disease Control (CDC) in Atlanta Georgia?

A typed copy is forwarded to the CDC.

3. Approximately how many adverse reaction reports does your office receive per year from public health officials?

1985 - 12 (2 of which were military)
1986 - 9

from doctors?

1985 - 3
1986 - 1

from parents?

1985 - 0
1986 - 0

(The numbers listed above indicate adverse reaction reports forwarded to the CDC, not the number received by this office.)

B. What are the symptoms and diagnosis included in reports?

See enclosed MSAEFI report form.

And, finally, your last request to "send me a copy of the annual Alaska State reports regarding immunizations and reactions that were sent to Atlanta, Georgia CDC in 1984 and 1985," will have to be more specific.

There are no annual reaction reports, however, there a quite a few immunization reports sent to the CDC quarterly and annually by this office. If the specific information you want is available, we will send it to you.

Sincerely,

Michael Klatt, Manager
Alaska Immunization Program

Robert I. Fraser, M.D. Chief
Sec. of Comm. Disease Control

MK+RIF:ew

Enclosure

cc: Elizabeth Ward, Director
Division of Public Health

People

Klatt urges parents to immunize children

By JANET HEVLY
Staff Writer

Parents who aren't immunizing their children because of concern about the safety of the pertussis vaccine are encouraged to consider the risks of the disease, says Michael Klatt, manager of the Alaska Immunization Program.

"The real risks of the pertussis disease far outweigh the theoretical risks of the pertussis vaccine," Klatt said in a recent interview. "The best way to protect your child and society from the disease is to immunize your child on schedule."

Pertussis, also called whooping cough, can be a fatal disease for children. According to information Klatt provided from various medical journals, the disease claims an estimated 600,000 lives a year throughout the world. The vast majority of these fatalities are children under six months of age.

For children, whooping cough is characterized by a distinctive wheezing gasp for air in coughing episodes that can last several minutes. The gasp is coupled by a choking build-up of thick mucus — appearing as a froth from the nose and mouth — that restricts the child's ability to breathe. Children may turn blue from lack of oxygen.

Several epidemics of whooping cough were reported in 1985, resulting in 30 reported cases of the disease in Alaska. During that year, 18 cases were reported in the Kenai-Soldotna area, with 13 of those cases occurring in children under the age of five, Klatt said.

Of the 13 preschoolers, four of the children were less than six months old, four were between the ages of six and 12 months, and five were reported in children between one and five years of age.

Klatt said 11 of the 13 children afflicted with the disease had not been properly immunized. Those children either hadn't received any immunizations, or hadn't been immunized according to the mandated immunization schedule. State and federal laws require children in public schools, in state day-care centers and in the federally funded Headstart program to be immunized at two, four and six months, and between 15 and 18 months of age. A booster shot is also recommended before entering school.

Klatt said five cases of whooping cough were reported in 1985, and three cases have been reported so far this year.

Many of the parents who aren't immunizing their children are worried about the adverse effects of the pertussis vaccine. Klatt said 15 adverse reactions were reported in Alaska in 1985. An adverse reaction is defined as anything more than a fever or minor reaction at the site of the injection.

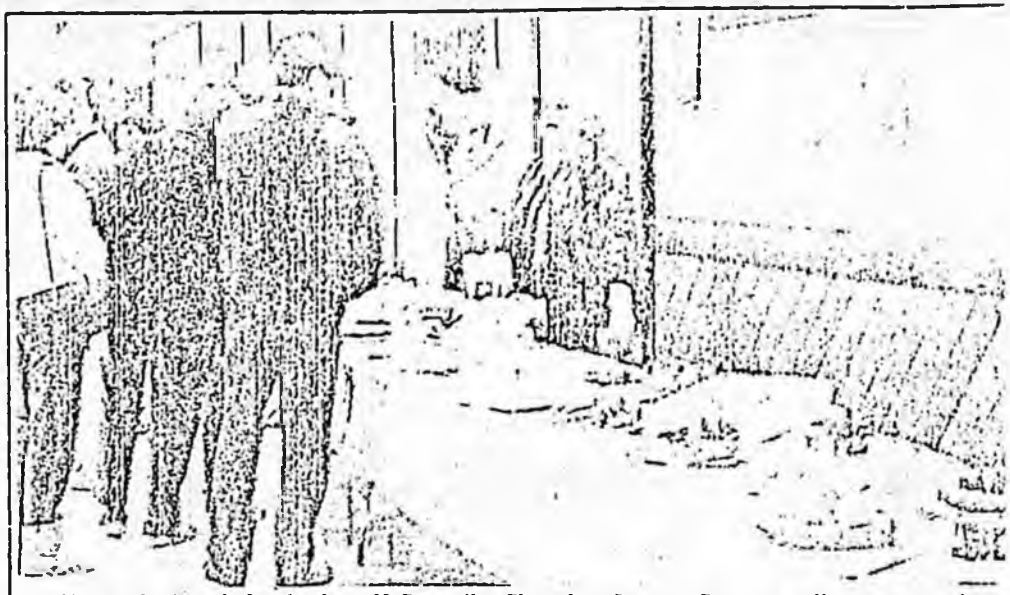
He acknowledges that the reaction reporting system hasn't been effective in the past, and that many parents may not have associated illnesses occurring after a vaccination as related to the vaccine. "I have no doubt that the adverse reactions were under-reported," Klatt said.

As of mid-1986, Klatt said the state is using vaccines purchased from the federal government which require parents to receive written information about the potential hazards of the vaccines. Parents must sign a form stating they understand the possible adverse reactions, and that any adverse reactions should be reported to the health-care provider.

Prior to the written warnings, parents having their children immunized only received verbal warnings about the potential adverse reactions to the shots, Klatt said.

"I anticipate an increase in reported adverse reactions," Klatt said, "And that's good because we want accurate reporting."

According to information from Klatt's medical journals, whooping cough is an extremely contagious disease. The odds indicate that if one of your children brings it home, the rest of the kids will get it. Recovery takes weeks; the Japanese name for whooping cough is translated to "the hundred-days cough."



Neva Black, a judge in the 4-H Council's Chocolate Lovers Contest, talks to passersby who were looking at entries to the contest this weekend at the Kenai Mall. (Photo by Nicky Donald)

Children have about a 50-50 chance of developing minor redness, swelling and pain at the site of the DTP injection. Fever, vomiting and drowsiness after a DTP vaccination occur about one in five times. One in 310,000 vaccinated children suffers brain damage, according to information supplied by Klatt. Despite the alarming number of side affects, he emphasized that a study in the United States indicates that SIDS victims were no more likely than non victims to have received a DTP vaccine.

Parents who delay having their children immunized until after six months of age are actually missing their prime opportunity to immunize against pertussis when it is most effective, Klatt said. Whooping cough is most fatal to children under six months of age.

Klatt said public health nurses are receiving an increasing number of requests for just a DT vaccine, without the "P" for pertussis. "They won't honor that request unless they have a written request [from a physician]," Klatt said. Only a private physician will give just a DT vaccine because a parent philosophically objects to the pertussis vaccine.

A more safe pertussis vaccine may be introduced in the near future, Klatt said. The United States is currently helping finance a study being conducted in Sweden on an acellular pertussis vaccine. The pertussis vaccine administered here is a whole cell vaccine, using all parts of the pertussis bacteria, Klatt said. The acellular vaccine separates the bacteria, attempting to use just the immune qualities of the bacteria and eliminate the other ingredients that may be causing the adverse reactions, he explained.

"The study should be done by the end of the summer, and the results written up by the end of the year," Klatt said. "If it is determined to be as effective at protecting against pertussis with less side affects, I would assume the U.S. would go for that vaccine."

Klatt said he obtained his information from articles on pertussis in Public Health Reports, Journal of the American Medical Association, the American Journal of Diseases of Children, the John Hopkins University School of Hygiene and Public Health

Letters to the editor

DPT parent responds to report on interview of health official

To the editor:

This is in regard to the article, "Klatt urges parents to immunize children," by Janet Hevly, Jan. 18.

I am president of the Alaska chapter of Dissatisfied Parents Together (DPT), parents concerned with vaccine safety, efficacy and awareness. We are not anti-vaccine, but stress that each parent should be educated as to all the risks as well as the benefits of any vaccine to be administered to their child. We also stress that each parent should be allowed to choose what vaccines their child is to receive without threat of exclusion from public school.

I wish to clarify and comment on several of the misleading statemets made by Mr. Klatt, so that local parents will not fall prey to the scare tactics so willingly employed by our public health department.

As it is true that the pertussis disease can be fatal, the high death rate (600,000 yearly worldwide) does not exist in developed countries. In Sweden and West Germany, where mandatory pertussis vaccinations have been discontinued due to high reaction rates, the death rate is virtually nonexistent. According to the official Annual Summary 1983 of Morbidity and Mortality Weekly Report, distributed by the U.S. Department of Health and Human Services, only six fatalities due to the pertussis disease occurred in the U.S. in 1981. According to this publication, six deaths per year due to pertussis is the average in our country. An interesting note: the only part of Europe where pertussis vaccination is universally imposed is in the communist countries, such as the Soviet Union, East Germany, Poland and Czechoslovakia.

In regards to the 1985 whooping cough epidemic, I have correspondence from Michael Klatt stating that only 9 of the 30 reported whooping cough cases were actually confirmed pertussis. Approximately half had received pertussis vaccinations. There were no deaths. According to this letter and future correspondence, Mr. Klatt stated that he "was unable to ascertain the immunization histories, because immunization histories were not gotten (for whatever reasons) for all reported cases." How did he manage to come up with the in-depth information then for his interview with Ms. Hevly?

While our group of concerned parents is glad to see that the health department is finally allowing that their adverse-reaction reporting system is inefficient and has been underreporting both immediate severe reactions and long-term illnesses suffered from vaccinations, it is not heartening to realize that this same health department expects parents to disregard these facts and keep on injecting our children with this highly reactive pertussis vaccine. Also, Mr. Klatt failed to mention that his office does not accept an adverse-reaction form unless it meets minimum criteria. One of these is that the reaction must have been severe enough to require a visit to a doctor, health-care facility or hospital. None of these places are required to report any reaction, however.

If a report form does not include this visit, it is shredded. According to the 1987 Goals and Objectives, published by our health department, this criteria is not scheduled to change.

In regard to the statistics Mr. Klatt quoted in relation to reported adverse reactions, they are not only questionable because they are admittedly underreported, but they do not begin to address the long term damage associated with many immediate adverse reactions; epilepsy, chronic blood diseases, deafness, blindness, cerebral palsy, severe retardation, death, etc.

Our organization finds it amazing that though there have been four studies published in the 1980s in the Unites States showing a direct causal relationship between DPT vaccinations and SIDS, our government and public officials (e.g., Mr. Klatt) have chosen to disregard these findings in favor of another study that shows only a temporal relation. I have correspondence from our Alaska Health Department that states that no vaccine information is collected on SIDS victims, supposedly because such information is too hard to analyze!

Also, Mr. Klatt failed to mention that the DPT vaccination series is not effective until all three shots of that first series are completed at the age of six months (if the vaccination schedule is strictly adhered to), so by the time a child is "protected," he's already out of the danger zone. "Whooping cough is most fatal to children under six months of age," Klatt, quoted from Clarion article.

As a last comment, I'd like to let Alaskan parents know that there is legislation being drafted to require mandated adverse-reaction reporting by all sectors, to require accurate parent information, extensive long-term followup and to allow Alaskan parents to object to any or all state mandated vaccines without exclusion from public school. This is allowed in 22 other states.

Shannon Kohl
Soldotna

FIGURE I. Reported measles cases — United States, weeks 49-52, 1985



The *Morbidity and Mortality Weekly Report* is prepared by the Centers for Disease Control, Atlanta, Georgia, and available on a paid subscription basis from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402, (202) 783-3238.

The data in this report are provisional, based on weekly reports to CDC by state health departments. The reporting week concludes at close of business on Friday; compiled data on a national basis are officially released to the public on the succeeding Friday.

The editor welcomes accounts of interesting cases, outbreaks, environmental hazards, or other public health problems of current interest to health officials. Such reports and any other matters pertaining to editorial or other textual considerations should be addressed to: ATTN: Editor, *Morbidity and Mortality Weekly Report*, Centers for Disease Control, Atlanta, Georgia 30333.

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*U.S. Government Printing Office: 1986-746-149/21936 Region IV

DEPARTMENT OF
HEALTH & HUMAN SERVICES
Public Health Service
Centers for Disease Control
Atlanta GA 30333

Official Business
Penalty for Private Use $300

Postage and Fees Paid
U.S. Dept. of H.H.S.
HHS 396

HHS Publication No. (CDC) 86-8017

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CENTERS FOR DISEASE CONTROL

MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT

January 10, 1986 / Vol. 35 / No. 1

1 Measles — United States, First 26 Weeks, 1985
6 Rapid Nutrition Evaluation during Drought Conditions — Burkina Faso, 1985
12 Penicillinase-Producing *Neisseria gonorrhoeae* — United States, Florida
14 Update: Influenza Activity — United States

Current Trends

Measles — United States, First 26 Weeks, 1985

Through December 28, 2,704 measles cases in the United States were reported to the *MMWR* for 1985. Results of detailed analyses are available for cases reported during the first 26 weeks, when a provisional total of 1,802 cases was reported, a 2.4% increase over the 1,759 cases reported during the same period in 1984 (1). The overall incidence rate in both years was 0.8 cases per 100,000 population for the 26-week period. Eight states accounted for 1,333 (73.9%) cases: Illinois (259 cases), Texas (236), Arizona (194), California (143), Montana (139), Idaho (126), New York (124), and Massachusetts (112). Ten states had incidence rates greater than 1/100,000 population: Arizona, Hawaii, Idaho, Illinois, Maryland, Massachusetts, Montana, Texas, West Virginia, and Wisconsin. During the first half of 1984 and 1985, 15 and 20 states, respectively, reported measles cases (indigenous or imported). For each year, 2.5% of the nation's 3,139 counties reported measles cases during the period.

Detailed information was provided to the Division of Immunization, Center for Prevention Services, CDC, on 1,801 of the cases reported during the first 26 weeks of 1985. Of these, 1,750 (97.2%) met the standard case definition for measles,* and 661 (36.7%) were serologically confirmed; in most cases (72%), onset of rash occurred between weeks 8 and 20 (weeks ending February 23 and May 25, respectively). There was a biphasic distribution of cases during this period (Figure 1).

In the first half of 1984, the highest incidence rate was reported among children 10-14 years of age (Table 1). By comparison, in the first half of 1985, the highest incidence rate was reported among 15- to 19-year-olds (3.1/100,000), followed by preschool-aged children (2.5/100,000). The incidence rate among 10- to 14-year-olds decreased from 2.9/100,000 in 1984 to 1.8/100,000 in 1985. Of the 466 preschool-aged children with measles, 137 (29.4%) were infants under 1 year of age, 81 (17.4%) were 12-14 months of age; 24 (5.2%) were 15 months of age, and 224 (48.1%) were 16 months-4 years of age.

Of the 1,256 (69.7%) patients for whom the setting of transmission was reported, 903 (71.9%) acquired measles in school†, 126 (10.0%), at home; 63 (5.0%), in medical settings; 41 (3.3%), in daycare centers; 18 (1.4%), in church, and 105 (8.4%), in a variety of other settings, including sporting events and summer camp.

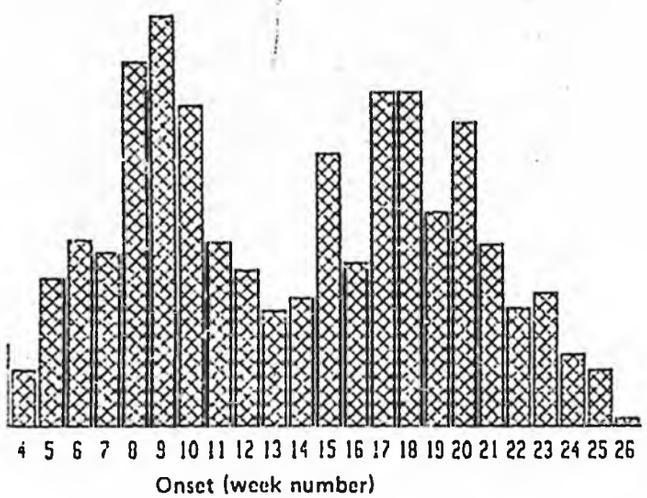
Seventy cases (3.9%) were international importations. An additional 128 (7.1%) cases

*Fever (38.3°C (101°F) or higher, if measured), generalized rash of 3 days' or longer duration, and at least one of the following: cough, coryza, conjunctivitis.
†Includes kindergarten through college.

y linked to an international importation within two generations of infec-
11.0% of all cases) were classified as international importations during

of patients in 1984 and 1985 was similar. Of the 1,801 cases reported
eks of 1985, 859 of the patients had been vaccinated on or after the
d been vaccinated at 12-14 months of age (Table 2). A total of 846
unvaccinated, and 96 had histories of inadequate vaccination (vac-
birthday).

measles cases, by week of rash onset — United States, first 26



outlon and estimated incidence rates of measles — United States,
and 1985*

	1984		1985			
	(%)	Rate†	No.	(%)	Rate†	Rate change (%)
	(19.9)	2.0	466	(25.9)	2.5	+25.0
	(11.4)	1.3	152	(8.4)	0.9	-30.8
	(29.2)	2.9	319	(17.7)	1.6	-37.9
	(26.6)	2.4	603	(33.5)	3.1	+29.2
	(7.8)	0.6	175	(9.7)	0.8	+33.3
	(5.1)	0.1	86	(4.8)	0.1	0.0
§	(100.0)	0.8	1,801	(100.0)	0.8	0.0

0.
en this number and that in the text reflects differences between summary data
more detailed data available to CDC's Division of Immunization

Measles — Continued

Of the 1,801 cases, 466 (25.9%) were classified as preventable (2) (Table 3). The highest proportion of preventable cases occurred among persons who were not of school age: 69.2% of cases among children 16 months-4 years of age were preventable. Only 20.4% of cases among persons 5-19 years of age were preventable; however, 47.0% of all preventable cases occurred in this age group.

Of the 1,335 persons with nonpreventable cases, 242 (18.1%) were too young for routine vaccination (under 16 months of age), and 42 (3.1%) were too old (born before 1957) (Table 4). Of the 1,051 who were between 16 months and 28 years of age, 842 (80.1%) had been vaccinated on or after the first birthday; 11 (1.0%) had a prior physician diagnosis of measles; 34 (3.2%) were not U.S. citizens; and 163 (15.5%) had medical contraindications or exemptions under state law. One person (0.1%) had laboratory evidence of immunity.

Reported by Div of Immunization, Center for Prevention Svcs, CDC.

Editorial Note: In the prevaccine era, an average of 500,000 measles cases was reported

TABLE 2. Ages of measles patients at most recent vaccination -- United States, first 26 weeks, 1984 and 1985*

	1984		1985	
Age at vaccination	No.	(%)	No.	(%)
< 12 mos.	135	(7.6)	96	(5.3)
12-14 mos.	255	(14.4)	247	(13.7)
15 mos.	34	(1.9)	46	(2.6)
16 mos.-4 yrs.	303	(17.2)	325	(18.0)
5-9 yrs.	139	(7.9)	165	(9.2)
10-14 yrs.	32	(1.8)	70	(3.9)
15-19 yrs.	8	(0.5)	5	(0.3)
≥ 20 yrs.	2	(0.1)	1	(0.1)
Unknown (> 12 mos.)	3	(0.2)	0	(0.0)
Unvaccinated	854	(48.4)	846	(47.0)
Total	1,765	(100.0)	1,801	(100.0)

*Provisional data.

TABLE 3. Age distribution and preventability of measles cases — United States, first 26 weeks, 1985*

	Preventable		Nonpreventable		
Age group	No.	(%)	No.	(%)	Total
< 15 mos.	0	(0.0)	242	(100.0)	242
16 mo-4 yrs.	155	(69.2)	69	(30.8)	224
5-9 yrs.	32	(21.1)	120	(78.9)	152
10-14 yrs.	52	(16.3)	267	(83.7)	319
15-19 yrs.	135	(22.4)	468	(77.6)	603
20-24 yrs.	60	(34.3)	115	(65.7)	175
25-29 yrs.	32	(60.4)	21	(39.6)	53
≥ 30 yrs.	0	(0.0)	33	(100.0)	33
Total	466	(25.9)	1,335	(74.1)	1,801

*Provisional data.

Measles -- Continued

each year (3). After measles vaccine was licensed in 1963, the incidence of measles markedly declined. Since 1981, the number of reported measles cases has remained relatively constant: 3,124 in 1981, 1,714 in 1982, 1,497 in 1983, and 2,534 in 1984. The number of cases reported during the first half of 1985 is similar to that reported during the first half of 1984 (1). As in recent years, measles was geographically restricted: 97.5% of the nation's counties were free of measles during this period.

While incidence rates during the first 26 weeks of 1984 and 1985 were comparable, there were differences in the age characteristics of patients. In 1984, persons 10-14 years of age accounted for approximately 29% of cases, compared with only 18% of cases in 1985. The incidence rate for 15- to 19-year-olds was higher in 1985. Over a third of measles patients were in this age group, due in part to the large number of outbreaks on college campuses in 1985 (4). Colleges and universities are now beginning to require evidence of immunity to measles for matriculation; this requirement should result in a decrease in measles in this population.

As the measles elimination strategy is successfully implemented, the proportion of preventable cases should decrease. The decrease in the percentage of preventable cases from 34.6% in 1984 (1) to 25.2% during the first half of 1985 is encouraging. As in 1984, preschool-aged children over 15 months of age had the highest proportion of preventable cases. Because these children are not reached by existing school laws, greater efforts need to be directed to this age group. School-aged persons accounted for the largest percentage of all preventable cases, and schools were the setting of transmission for the majority of cases. Therefore, continued enforcement of current school immunization laws is important for further reduction of measles in the United States.

References

1. CDC. Measles—United States, first 26 weeks, 1984. MMWR 1984;33:495-6, 501-4.
2. CDC. Classification of measles cases and categorization of measles elimination programs. MMWR 1982;31:707-11.
3. CDC. Measles surveillance report no. 11, 1977-1981. Atlanta, Georgia. Centers for Disease Control, 1982.
4. CDC. Measles on college campuses—United States, 1985. MMWR 1985;34:445-9.

TABLE 4. Reasons measles cases were classified as nonpreventable — United States, first 26 weeks, 1985*

Causes of nonpreventability	No. cases	(%)		(%)	Percentage of total cases
< 16 months			242	(18.1)	13.4
Born before 1957			42	(3.1)	2.3
16 mos.-28 yrs			1,051	(78.7)	58.4
Adequately vaccinated	842	(80.1)			
Prior physician diagnosis	11	(1.0)			
Non-U.S. citizens	34	(3.2)			
Exemptions†	163	(15.5)			
Laboratory evidence of immunity	1	(0.1)			
Total			1,335	(100.0)	74.1

*Provisional data.

†Medical exemptions—8; religious—150; philosophic—5.

International Notes

Rapid Nutrition Evaluation During Drought Conditions — Burkina Faso, 1985

Burkina Faso, a landlocked Sahelian country with a population of 7.2 million, experienced a severe drought in late 1984 and early 1985. At the request of the U.S. Agency for International Development and the Government of Burkina Faso, a rapid evaluation of the nutrition status of children 65-110 cm tall (approximately 6-59 months of age) was undertaken. The survey was conducted in Soum and GnaGna, two of the eight drought-affected provinces in northern Burkina Faso. Ten villages in each province were randomly selected for data collection (1).

A random sample of 339 children in Soum and 366 children in GnaGna were included in the survey. Height, weight, and arm circumference of the children in each village were measured, and clinical examinations for edema and avitaminosis A and C were done on 30-40 children. A standardized questionnaire to evaluate the children's measles vaccination status, recent illnesses, and food consumption was administered to the mothers of children in the sample.

Acute undernutrition (less than 80% of the median weight-for-height [2,3]) was found in 10.6% of children in Soum and 5.7% of children in GnaGna (Table 5). Severe acute undernutrition (less than 70% of the median weight-for-height) was found in 1.8% of children in Soum and in 1.1% of children in GnaGna. However, an additional 14.2% of children in Soum and 11.2% of those in GnaGna were between 80% and 84% of median weight-for-height. Similar

TABLE 5. Nutrition status and other health indicators among children 6-60 months of age — Soum and GnaGna provinces, Burkina Faso, April 1985

Characteristic	Soum No.	Soum (%)	GnaGna No.	GnaGna (%)
Median weight-for-height				
< 70%	6	(1.8)	4	(1.1)
70%-79%	30	(8.8)	17	(4.6)
80%-84%	48	(14.2)	41	(11.2)
Arm circumference				
< 12.5 cm	26	(7.7)	18	(4.9)
12.5-13.4 cm	56	(16.5)	49	(13.4)
Diarrhea	71	(20.9)	42	(11.4)
Vitamin A deficiency*	1	(0.0)	4	(1.1)
Scurvy†	0	(0.0)	4	(1.1)
Measles vaccine§	220	(64.9)	217	(59.3)
Total children	339		366	

*Diagnosed by presence of Bitot's spots, corneal ulceration, and/or corneal scarring.

†Diagnosed by presence of bleeding gums and/or swollen joints.

§Determined by immunization card.

Measles — Continued

each year (3). After measles vaccine was licensed in 1963, the incidence of measles markedly declined. Since 1981, the number of reported measles cases has remained relatively constant: 3,124 in 1981, 1,714 in 1982, 1,497 in 1983, and 2,534 in 1984. The number of cases reported during the first half of 1985 is similar to that reported during the first half of 1984 (1). As in recent years, measles was geographically restricted: 97.5% of the nation's counties were free of measles during this period.

While incidence rates during the first 26 weeks of 1984 and 1985 were comparable, there were differences in the age characteristics of patients. In 1984, persons 10-14 years of age accounted for approximately 29% of cases, compared with only 18% of cases in 1985. The incidence rate for 15- to 19-year-olds was higher in 1985. Over a third of measles patients were in this age group, due in part to the large number of outbreaks on college campuses in 1985 (4). Colleges and universities are now beginning to require evidence of immunity to measles for matriculation; this requirement should result in a decrease in measles in this population.

As the measles elimination strategy is successfully implemented, the proportion of preventable cases should decrease. The decrease in the percentage of preventable cases from 34.6% in 1984 (1) to 25.2% during the first half of 1985 is encouraging. As in 1984, preschool-aged children over 15 months of age had the highest proportion of preventable cases. Because these children are not reached by existing school laws, greater efforts need to be directed to this age group. School-aged persons accounted for the largest percentage of all preventable cases, and schools were the setting of transmission for the majority of cases. Therefore, continued enforcement of current school immunization laws is important for further reduction of measles in the United States.

References

1. CDC. Measles — United States, first 26 weeks, 1984. MMWR 1984;33:495-6, 501-4.
2. CDC. Classification of measles cases and categorization of measles elimination programs. MMWR 1982;31:707-11.
3. CDC. Measles surveillance report no. 11, 1977-1981. Atlanta, Georgia: Centers for Disease Control, 1982.
4. CDC. Measles on college campuses — United States, 1985. MMWR 1985;34:445-9.

TABLE 4. Reasons measles cases were classified as nonpreventable — United States, first 26 weeks, 1985*

Causes of nonpreventability	No. cases	(%)	Percentage of total cases
< 16 months	242	(18.1)	13.4
Born before 1957	42	(3.1)	2.3
16 mos.-28 yrs	1,051	(78.7)	58.4
Adequately vaccinated	842	(80.1)	
Prior physician diagnosis	11	(1.0)	
Non-U.S. citizens	34	(3.2)	
Exemptions†	163	(15.5)	
Laboratory evidence of immunity	1	(0.1)	
Total	1,335	(100.0)	74.1

*Provisional data.
†Medical exemptions — 8; religious — 150; philosophic — 5.

International Notes

Rapid Nutrition Evaluation During Drought Conditions — Burkina Faso, 1985

Burkina Faso, a landlocked Sahelian country with a population of 7.2 million, experienced a severe drought in late 1984 and early 1985. At the request of the U.S. Agency for International Development and the Government of Burkina Faso, a rapid evaluation of the nutrition status of children 65-110 cm tall (approximately 6-59 months of age) was undertaken. The survey was conducted in Soum and GnaGna, two of the eight drought-affected provinces in northern Burkina Faso. Ten villages in each province were randomly selected for data collection (1).

A random sample of 339 children in Soum and 366 children in GnaGna were included in the survey. Height, weight, and arm circumference of the children in each village were measured, and clinical examinations for edema and avitaminosis A and C were done on 30-40 children. A standardized questionnaire to evaluate the children's measles vaccination status, recent illnesses, and food consumption was administered to the mothers of children in the sample.

Acute undernutrition (less than 80% of the median weight-for-height [2,3]) was found in 10.6% of children in Soum and 5.7% of children in GnaGna (Table 5). Severe acute undernutrition (less than 70% of the median weight-for-height) was found in 1.8% of children in Soum and in 1.1% of children in GnaGna. However, an additional 14.2% of children in Soum and 11.2% of those in GnaGna were between 80% and 84% of median weight-for-height. Similar

TABLE 5. Nutrition status and other health indicators among children 6-60 months of age — Soum and GnaGna provinces, Burkina Faso, April 1985

Characteristic	Soum No.	Soum (%)	GnaGna No.	GnaGna (%)
Median weight-for-height				
< 70%	6	(1.8)	4	(1.1)
70%-79%	30	(8.8)	17	(4.6)
80%-84%	48	(14.2)	41	(11.2)
Arm circumference				
< 12.5 cm	26	(7.7)	18	(4.9)
12.5-13.4 cm	56	(16.5)	49	(13.4)
Diarrhea	71	(20.9)	42	(11.4)
Vitamin A deficiency*	1	(0.0)	4	(1.1)
Scurvy†	0	(0.0)	4	(1.1)
Measles vaccine§	220	(64.9)	217	(59.3)
Total children	339		366	

*Diagnosed by presence of Bitot's spots, corneal ulceration, and/or corneal scarring.
†Diagnosed by presence of bleeding gums and/or swollen joints.
§Determined by immunization card.

KOHLER



Nov 13, 1987

Representative Koponen,

I've included two more enclosures very pertinent to this issue.

Enclosure A is a summary of the severe adverse reactions to vaccinations that Alaska "DPT" gathered from Oct. 86 - Oct. 87.

Enclosure B is a letter I just received from the Ohio Dept. of Health. This information supports the fact that allowance of a philosophical exemption to immunizations does not necessary lead to disease initiation and/or propagation.

Sincerely,
Shannon Kohler
Alaska DPT.

A

November 12, 1987

SUMMARY OF SEVERE ADVERSE REACTIONS TO STATE MANDATED IMMUNIZATIONS

Data collected by: Dissatisfied Parents Together, Alaska Chapter

Dates of survey: October 1986-October 1987

Method used: Alaska "DPT" vaccine adverse reaction questionnaire

Number of subjects (reactions) - 25: 24 DPT
1 MMR

Range of survey: State of Alaska

1- College, AK.	1- Anchorage, AK.
1- Gustavis, AK.	1- Anchor Point, AK.
1- Sterling, AK.	1- Homer, AK.
4- Kenai, AK.	3- Fairbanks, AK.
2- Juneau, AK.	7- Soldotna, AK.
1- Palmer, AK.	2- Kasilof, AK.

Ages of subjects at date of response:

2- 4 months	1- 4 years
1- 6 months	2- 5 years
1-10 months	3- 6 years
1- 14 months	1- 8 years
1- 18 months	1- 17 years
5- 2 years	1- 20 years
4- 3 years	1- 23 years

Return to: Dissatisfied Parents Together
Box 1746
Soldotna, AK 99669
Shannon Kohler 262-3825

DPT SHOT REACTION QUESTIONNAIRE

Directions: Please place an "X" before the answer(s) you select or fill in the spaces when appropriate.

1. Before your child received his DPT shot(s), did a health professional inform you of the possible serious reactions to the shot?

   5 Yes (1) 19 No (2) 1 Don't Know (3)

2. Did the health professional who gave your child the DPT shot(s) tell you to look for and report severe reactions such as a high temperature, excessive crying or high pitched screaming, excessive sleepiness, etc.?

   6 Yes (1) 18 No (2) 1 Don't Know (3)

3. Before giving your child the DPT shot(s) did a health professional tell you when the shot should not be given (i.e. if the child has an active infection or a fever, if the child reacted severely to a previous DPT shot, etc.)?

   6 Yes (1) 16 No (2) 3 Don't Know (3)

4. Did you sign a consent form containing information about the DPT shot and its possible reactions before your child received his DPT shot?

   2 Yes (1) 15 No (2) 8 Don't Know (3)

5. Before your child received his DPT shot(s), did a health professional question you about your family's and your child's medical history?

   ____ Yes (1) 23 No (2) 2 Don't Know (3)

6. Do you believe your child reacted severely to any of his DPT shots? (Answer yes only if the reaction was more serious than a low fever, mild crying, or slight redness or puffiness around the site of the shot)

   25 Yes (1) ____ No (2) ____ Don't Know (3)

If you answered yes to question #6, please answer the rest of the questionnaire. If you answered no to question #6, skip the rest of the questions and fill in your name, address and telephone number at the end of the questionnaire.

7. After the DPT shot that caused your child to react severely, did he have:

   most children had more than one symptom of reaction

   4 convulsions (1)
   16 fever of more than 103 degrees (2)
   13 excessive crying or high pitched screaming for long periods (3)
   6 extreme sleepiness (4)
   ____ collapse or shock (5)
   5 loss of muscle control (temporary or pemanent paralysis) (6)
   ____ death (7) 1-nerve damage deafness 1-severe allergies & eczema 2-permanent partial paralysis 1-chronic cold sores
   ____ other (please explain) 1-severe congestion 1-whooping-like cough (8) 1-limping 1-severe swelling of arm 1-severe leg swelling 1-severe swelling of glands in head 1-temperature for 1 week 1-temperature for 10 days

8. How long after the shot did the reaction begin to occur?

24 Within 24 hours after the shot (1)
1 24-48 hours after the shot (2)
___ 2 days - 7 days after the shot (3)
___ 1 week - 2 weeks after the shot (4)
___ more than 2 weeks after the shot (5)

9. After which DPT shot did your child react severely? Some children reacted to more than 1 shot

15 First shot (1)
4 Second shot (2)
3 Third shot (3)
2 Fourth shot (4)
___ Fifth shot (5)
1 all shots

10. How old was your child when he was given the DPT shot that caused the severe reaction?

8 2-3 months old (1)
6 4-5 months old (2)
4 6-7 months old (3)
3 8-12 months old (4)
1 13-18 months old (5)
1 19-24 months old (6)
___ 25 months - 3 years old (7)
___ over 3 years old (8)
1 all
1 Don't Knows

11 How old is your child now?

See 1st page attachment

12. Did you report your child's severe reaction to the DPT shot to a health professional?

21 Yes (1) 4 No (2) ___ Don't Know (3)

13. If you did not report your child's severe reaction to the DPT shot, was it because you were not aware that the reaction was serious and should have been reported?

4 Yes (1) No ___ (2) ___ Don't Know (3)

14. If you did report your child's severe reaction to the DPT shot to a health professional, did that person report your child's severe reaction orally or in writing to: NO: 10

___ drug manufacturer (1)
___ federal government (2)
3 state health department (3)
___ any local health agency (4)
8 Don't Know (5) none of these parents had an official MSAEFI form completed

15. Was your child's severe reaction to the DPT shot written on his medical record?

6 Yes (1) 8 No (2) 11 Don't Know (3)

16. After your child reacted severely to a DPT shot, was he given another shot that contained the pertussis vaccine?

6 Yes (1) 17 No (2) 1 Don't Know (3) 1 n/a MMR Shot

17. Was your child mentally and physically normal before he received the DPT shot to which he reacted severely?

25 Yes (1) ___ No (2) ___ Don't Know (3)

18. Prior to the DPT shot to which your child reacted severely, did your child have a history of convulsions or neurologic disease?

____ Yes (1) 24 No (2) 1 Don't know

19. Does your family have a history of convulsions or neurologic disease?

1 Yes (1) 23 No (2) 1 Don't Know (3)

20. Did you or your husband ever have whooping cough?

1 Yes (1) 22 No (2) 2 Don't Know (3)

21. Is there a significant history of allergies in your family or has your child ever been diagnosed as having allergies?

9 Yes (1) 12 No (2) 4 Don't Know (3)

22. If your child has allergies were the allergies apparent before or after the DPT shot to which he reacted severely?

3 Before (1) 5 After (2) N/A 17

23. At the time your child had a severe reaction to the DPT shot, was he primarily bottle-fed?

9 Yes (1) 11 No (2) 5 Both

24. Has your child had a continuing physical or mental health problem since the DPT shot that caused the severe reaction?

12 Yes (1) 12 No (2) 1 dont know yet

If you answered yes to question #24, please answer the rest of the questions.

25. Is your child now:

1 experiencing motor delay
____ mentally retarded (1)
4 physicially handicapped (2)
3 experiencing convulsions (3)
4 exhibiting learning difficulties (4)
____ in an institution (5)
____ other (please explain) 1-nerve damage deafness 2-permanent partial paralysis 2-cerebral palsy 1-epilepsy 1-speech problem 1-severe allergies ~~asthma~~ (6)

26. Has a physician confirmed your belief that your child's present health problems were caused by the DPT shot?

7 Yes (1) 7 No (2)

27. Has your child required special medical treatment, medicine, hospitalization, or therapy since the DPT shot that caused the severe reaction?

11 Yes (1) 14 No (2)

28. The cost of your child's special medical treatment is estimated to have been:

1 Under $2,000
10 $2,000 - $7,000
____ $7,000 - $12,000
____ $12,000 - $20,000 (4)
____ $20,000 - $40,000 (5)
____ Over $40,000 (6)

29. Please feel free to use the back of this page to tell us your story of what happened to your child as a result of his severe reaction to a DPT shot. Try to be as specific as possible, giving names, dates, and places.

Name: See next page for Emergency Treatment Information

Address: _____

Telepone Numbers: _____ (home) _____ (work)

Date: _____

4 visits to emergency room
2 telephone contact only

a) 1st parent
B) 2nd parent
C) 3rd parent
D) 4th parent
e) 5th parent
f) 6th parent

30. Emergency room treatment of adverse reaction, if applicable

a) What hospital did you go to?
a) Central Pen Gen. Hospital
B) Kenai Emergency Medical Clinic
c) Central Peninsula Gen Hospital
D) Tanana, Alaska
e) Central Pen. Gen. Hospital
f) Homer South Peninsula General Hospital

b) Did you call the emergency room?
5 yes a) B) c) D) e) 1 no f)

c) Did you go to the emergency room?
4 yes a) B) D) f) 2 no c) e)

d) How were you treated? (if more room needed, use back of sheet)
a) told not to worry; give cold bath & tylenol
B) O.K.
C) told not to worry; give cold bath & tylenol
D) hospital did not even record visit
e) give cold bath & tylenol
f) good

e) Were you advised to tell your doctor of reaction?
___ yes 6 no a) B) c) D) e) f)

f) Were you advised to tell Health Dept. of reaction?
___ yes 6 no a) B) c) D) e) f)

31. Was your child hospitalized?
1 yes f) 5 no a) B) c) D) e)

a) Where? Homer South Peninsula General Hospital

b) For how long? 3 days

c) How was reaction treated? not treated as vaccine reaction

IMMUNIZATION COMPLIANCE RATES OF SCHOOL AGE CHILDREN (K-1ST GRADE) AND INCIDENCE OF VACCINE PREVENTABLE DISEASES (1986)

	compliance rate:	reported cases of: measles	rubella	mumps	pertussis	tetanus	diptheria	polio
Michigan	91%	185	24	467	36	1	INA	INA
Utah	93%	13 [38.5%] {61.5%}	15	16	44 [65.9%] {34.1%}	0	0	0
Washington	95.7%	176 [65%] {35%}	15	30	163 [56%] {44%}	0	0	0
Missouri	98.3%	32	1	23*	32*	2(2)*	0	0
California	93.4%	497 [50%] {50%}	242	336	310 [40%] {60%}	3	0	1
Pennsylvania	99.2%	28	1	63	52	1	0	0
Oklahoma	97.6%	39	0	INA	134	1	0	0
Nebraska	96.5%	1	0	2	10	INA	INA	INA
Indiana	97%	39	0	339	39	2	0	0
Delaware	98%	35	INA	INA	INA	INA	INA	INA

INA: information not available
*: immunization not mandatory in state
(n): fatalities
[n]: percent of ill fully immunized
{n}: percent of ill unimmunized

} only 3 states provided this data - all were asked some stated: "information not available"

Data received from State Health Departments of states listed
22 states contacted - 10 states responded to date - November 10, 1987

Data compiled by the Alaska Chapter of Dissatisfied Parents Together

All states included in survey have philosophical objection to state mandated immunizations in statutes.

RICHARD F. CELESTE
Governor

November 4, 1987

Shannon Kohler
Alaska Chapter-DPT
Box 1746
Soldotna, Alaska 99669

Dear Ms. Kohler:

I am responding to your July 27 letter regarding immunization exemptions. I am sorry for the delay, but the mail had apparently been misrouted.

While immunization exemptions are a concern, immunization-exempt children have not contributed to disease initiation or propagation in Ohio.

In Ohio immunization levels exceed 95 percent in schools; in fact, in kindergarten they are 97 percent or greater. Immunization exemptions have not exceeded Ø.3 percent - Ø.5 percent among children new to Ohio schools. (The table enclosed gives you information regarding immunization levels, exemptions and reported cases of the vaccine-preventable diseases you requested.)

The measles cases in Ohio (1Ø last year) can virtually all be attributed to importations and spread from importations among persons either inadequately vaccinated or vaccine failures, but not persons who are immunization exempt. In 1986, only two of the 1Ø cases were not previously vaccinated. Because of their small number, exemptions have not played a major part in outbreaks.

In 1986 Ohio reported 17Ø cases of pertussis. Of these we were able to determine the age and vaccine status of 115. Most of these cases were just too young to have completed a full series of DTP immunizations. While an analysis of immunization exemptions was not made, only two of the cases were of school age.

Mumps cases have been declining in Ohio since the inclusion of mumps in the school immunization law beginning in 1984. The 15Ø cases reported in 1986 can not be attributed to immunization exemptions.

I hope this answers most of your questions, please let me know if I can provide any further information.

Sincerely,

Thomas J. Halpin, M.D., M.P.H.
Chief
Bureau of Preventive Medicine

KOHLERLE.PRN
Enclosure:

Deborah Gravel
Peter Dwyer
Rt. 2 Box 48
Ketchikan, Ak.99901

To Concerned Legislators,

We seriously question the safety of the DPT vaccine. We cannot ignore the dangers to our children's health that compulsory vaccinations represent. We feel that we must have a choice of whether to vaccinate our children or not.

We will not try to convince you of all the risks involved with vaccinations. We hope only that you will research this topic enough to acknowledge that there are good reasons to be concerned about the safety of children being vaccinated.

We feel that HB 277 is a beginning for concerned parents. We need a reporting system to document how children are reacting to the shots. Vaccines are administered with no guarantees as to their safety or effectiveness, Yet parents are urged to vaccinate despite the fact that Sudden Infant Death Syndrome, polio, encephalitis, and rheumatoid arthritis have been conclusively linked to vaccination.

We will not vaccinate our children. We are gravely concerned with their wellbeing and as responsible parents cannot take the risk to their health that vaccines represent.

We urge you to pass HB 277 as it is written. We feel it is our personal right to safe guard our children's health and we ask you to respect our rights.

Sincerely,

Deborah Gravel
Peter Dwyer

Alaska State Legislature

(1)

Please enter into the record my testimony to the HESS committee name

committee on HB 277 bill/subject, dated 3-10-88.

My Name is Cheryl Rykaczewski.

I am a supporter of HB277 for a variety of reasons. At this time, I will address one of these reasons.

It has been the experience of members of the Alaska Chapter of DPT that Doctors and Public Health Providers who administer vaccines refuse to admit that symptoms a child experiences after a vaccination can possibly be a reaction to that vaccine.

This fact leads me to Question the current system of voluntary reporting of adverse reactions first to the State Health Department and then on to the Center for Disease Control for the purpose of compiling statistics. It appears that there is a Conflict of Interest for a physician to diagnose a vaccine induced injury in a child whom they themselves vaccinated. How objective can they be when their livlihood may be threatened

Signed: _____
Testifier

_____
Representing (Optional)

_____
Address

_____
Phone No.

Alaska State Legislature

(2)

Please enter into the record my testimony to the HESS
committee name

committee on HB 277 , dated 3-10-88 .
bill/subject

by financial liability if a lawsuit occurs. Cont'd. The emotional repercussions of watching a child suffer as a result of a drug that they administered.

Now, Put yourself in the frightening position of a parent who has a child reacting to a vaccination. No one will even acknowledge the reaction or take responsibility for treating your childs reaction. Where do you turn?

The Alaska Vaccine Reform Legislation, HB 277, strives to correct these inconsistencies in the reporting of reactions. One long term benefit will be accurate statistics on adverse reactions to vaccinations.

Signed: Cheryl Rykaczewski (RYKACZEWSKI)
Testifier

Representing (Optional)

Box 311 KASILOF, AK 99610
Address

262-4937
Phone No.

Alaska State Legislature

Please enter into the record my testimony to the HES S
committee name

committee on HB 277, dated 3-10-88.
bill/subject

Feel HB 277 unnecessary. Many dollars and much time spent in effort toward immunized population. Prevention important! Medical and religious exemptions in place. That is enough!

Signed: Beth Taeschner
Testifier

Self - Retired School Nurse. Former PHN
Representing (Optional)

P.O. Box 56 Soldotna, AK 99669
Address

262-4287
Phone No.

Teleconference

— I support bill HB277

— I believe parents have the right to free choice regarding the health of their children

— I feel parents in Alaska are concerned enough and informed enough to make the choice that is best for their children.

— I do not feel the medical community should take this choice away from parents.

Lee Conay
PO Box 3234
Soldotna, AK 99669

MAR 10 '88 18:02 LEG. AFFAIRS - SOLDOTNA

Jacqui Conway

I believe that all parents have the responsibility to educate themselves and to use that knowledge in making decisions regarding their children's welfare. Society has demanded that all children be immunized. However most parents are unaware there are many risks associated with all vaccines. When my daughter received her first DPT shot she cried, a loud piercing cry for 2 days. In my ignorance, I just accepted it as an inevitable side effect of the vaccine. Later, as her second DPT was approaching, I started to question how anything that could affect my healthy 2 month old so strongly, could really be beneficial. So I began reading and learning about immunizations. I found that many parents and doctors agree that mass immunization ~~are~~ are neither a guaranteed preventative against the illnesses nor were they risk free. I also found that because of this many states and other countries do not require them. I was not informed by any health care worker of any of this information. Alaska does not require that this very pertinent information be shared with parents or allow exemptions based on this knowledge. It is time for this state to adopt HB 277.

Alaska State Legislature

Please enter into the record my testimony to the HESS
committee name

committee on HB 277, dated 3/10/85.
bill/subject

I want to urge HB 277 NOT to pass. A philosophical exemption would endanger the health of Alaskan children. As a society we chose to protect our children in various ways & I believe it is reasonable to continue to require mandatory immunizations. The apparent many people have been lulled into complacency, forgetting the past & potential future ravages of vaccine preventable diseases. Regardless the education required in the bill - it's important for people to know that Public Health Nurses administer a large percentage of immunizations in the state & because of a required procedure of informing parents about risks, benefits, & adverse reactions, parents are well informed. Also, too, engaging with parents & reassuring can sound convincing, however it's important to let parents to decide. There is a big difference between temporal association of vaccine & reactions - most of the time, the vaccines, unfortunately are not the cause, but a coincidental symptom is why the vaccine. Exemption of vaccination will outweigh risks.

Signed: Tonia Zidek
Testifier

Representing (Optional)

Address

Phone No.

9/85 Legislative Information Office

Alaska State Legislature

Please enter into the record my testimony to the HESS committee name

committee on HB 277 Immunizations bill/subject, dated 4/17/87.

I support HB 277 due to the personal experience with both of my children. My son was given the measles by his measles vaxination and my daughter received an "extreme allergic reaction" - as stated by her doctor from her DPT. She had a 105° F fever and was limp & lifeless for 10 days. This happened 2 times as when we moved to another state another DPT booster was required. Again she had the same reaction. The subject of immunization needs more investigation & the public needs to be informed. I have seen illness come and go. Could it be that by immunizing we → (over)

Signed: N. Suzanne Rich
Testifier

Representing (Optional)

1451 Flat Mtn. Rd.
Address

487-[illegible]
Phone No.

Alaska State Legislature

Please enter into the record my testimony to the HESS
committee name

committee on HB 277 , dated 03/10/98 .
bill/subject

There is a growing body of scientific evidence indicating that animal retro-viruses may have contaminated the live vaccines with which we have all been inoculated for the past 30 yrs. These animal viruses, injected into the human body, may have combined with human genetic material to form the AIDS virus. One of the retro viruses only 4 have been identified, all in domestic animals - is apparently the closest virus to AIDS yet discovered. We've pumped live viruses into millions of people over 3 decades, to believe there's no downside is naive. The AIDS virus is widely believed to have begun in Africa where massive small pox inoculations were conducted from late 60s to 80-81. The standard method for developing the vaccine in Africa was to grow the pox in the bellies of cows. Most cow herds are thought to

Signed: _____
Testifier

Dave Jones

Representing (Optional)

Box 81785

Address

456 2977

Phone No.

contain retro-viruses.

Alaska State Legislature

Please enter into the record my testimony to the H.E.S.S
committee name

committee on HB 277 - Immunizations, dated 3/10/88
bill/subject

There is a school of medical science called Natural Hygiene. The following discussion against immunizations is from an Australian physician Alex Burton's (MD, D.C.D.F.) speech taped at the July 1987 Natural Hygiene Society's international conference at St. Catharines, Ontario.

At this conference, Burton said that generally disease is thought of as an "attack" of an "invader" - and that the physician is supposed to destroy this "attacker" or "conquer the disease." A natural hygiene physician conversely sees a disease not as something negative, but positive: disease is seen as the process of the body healing itself. For example, if you say that "on Monday I was ~~see~~ well, but on Tuesday I was sick," the Natural Hygienist would say that on Monday you were sick and on Tuesday you were getting well.

The concept of immunization - ie. to make someone immune, →

Signed: Linda Redman LINDA REDMAN
Testifier

Representing (Optional)

21282 Goldhill Rd.
Address

479-3796
Phone No.

implies that a person can have the freedom to do as he or she pleases without any consequences. Nature is not like that, Burton says. He continued, disease has three stages: the cause, the process of healing, & the effect. Immunization suspends causality.

Immunization relates to certain foreign substances that gain entrance to the body. These foreign substances are often protein substances and are called "antigens." The body's means of resisting these antigens is to produce substances by lymphocytes called "antibodies."

As a side note, according to Natural Hygiene, prevention of disease is possible by optimum nutrition. Intaking "high octane-type fuels" and maximizing fitness will trap the body's energy reserve level overflowing and thus can help prevent disease. If disease occurs a high health and energy level can help the process of disease to successfully repair the body.

The theory of auto immune disease says that the body no longer recognizes itself, and the antibodies attack the body's own tissue, destroying it. Dr. Burton continues, ~~says~~ that this is a process that results from a long time of ignoring causes and suppressing disease. The cause of auto immune deficiency, for example is that a person's body is so toxemic and enervated (= a poor nutrition, and thus a low vital force) that the result is an almost total collapse of the body's mechanisms to heal itself.

Basically, I believe immunization tends to overrule the body's own immune system. There is growing concern that many vaccines serve to inhibit the body's natural defense mechanisms and suppress the full healing process thus allowing the later onset of immune deficient diseases such as cancer and AIDS. I suspect AIDS is a belief system in the body that is the most important choice of disease that a belief can be in the body should have. The most important choice of disease that a belief can be in the body should have.

Alaska State Legislature

Please enter into the record my testimony to the H.E.S.S.
committee name

committee on HB200 Vaccinations, dated 3/10/88.
bill/subject

I support HB200. It is wrong the state should use force to compel people to subject themselves or their children against their will. This is a civil rights issue.

The long-term effects of vaccines are not known. There has been a dramatic increase in chronic degenerative diseases in countries with widespread vaccination programs. Some authorities argue that AIDS may be related to weakened immune systems in vaccinated persons.

The situation is much like that of radiation. Thirty years ago we knew little about long-term effects of radiation, especially at low levels. Until medical science can answer the question what are the long-term effects of vaccinations? How could we in good conscience, like Prometheus, bring fire to mankind without knowing the consequences?

People should have the right to determine the safety and value of their own bodies, based upon informed choice.

Sen. Beck — Planned Parenthood opposes HB 5 [illegible]

Signed: _____
Testifier

_____
Representing (Optional)

_____
Address

_____
Phone No.

9/86 Legislative Information Office

Please enter as testimony
3/10 - HHESS - HB277: IMMUNIZATION of MINOR

H. E. S. S. TELECONFERENCE

I support HB 277 which would provide more information on the benefits and risks if the D.P.T. program.

I as a parent am uninformed of the risks and benifits of these shots, manditory by the State with no garantee or liabelity by the State in case of mental, physical, or mortal damage to my child.

I as a parent have become alarmed to see the negative reaction my child has had from these D.P.T. shots.

I as a parent demand to know the risk factor of the diseases. Are they in remission, currently life threatning or readily treatable by modern medicine? Does the D.P.T. vaccine garantee safe protection or in fact cause illness itself ?

Please help answer these questions. SUPPORT HB 277.

Sincerly Terry Eastham Nancy Eastham

Terry and Nancy Eastham

Soldotna

My name is Eileen Wagner. I am the parent of a 3 1/2 year old boy who has severe allergies which began right after his first DPT shot. I think the shot triggered the allergies. Doctors do not think so. Onset of allergies is not considered a contraindication to further shots. There is a great gray area of vaccine reactions, there are many children who don't collapse, die, or suffer brain damage from the shot, but who are "slightly" injured, and never reported.

John seemed to be a normal baby at the time of his first DPT shot at 3 1/2 months of age. As the public health nurse prepared the shot, I asked "Don't I have to sign something?" "oh no, we don't do that," she replied. I remember being surprised, since we had lived in Wisconsin when one of my older children was getting her shots, and each time I had had to read and sign a lengthy warning about vaccine risk. (I have 2 older fully vaccinated children.)

I was given no information of any kind. After the shot, John went to sleep for 16 hours. It was a profound, deathlike sleep - he didn't move a muscle during that time, even when I felt his head for fever.

Within 2 weeks the skin trouble had started.

It was the beginning of a year of agony for my son. He itched intensely at all times, clawed himself bloody, even had hives on the soles of his feet. His nose and eyes ran constantly, his body was swollen all over. He writhed in my arms as I nursed him. He was completely breastfed, and exquisitely sensitive to the foods I was eating. Gradually we have learned what makes John tick, and he is now living a normal life, though his diet and environment are rigidly controlled. We carry an injection of epinephrine for emergencies. He still has occasional swelling of the windpipe, as well as many lesser allergic reactions.

The important thing for you to know is that the many doctors, both here and in Seatttle, I saw during that first year steadfastly denied any connection with the DPT shot. It was all so unbelievable to me that I began to do research at the State Library about vaccines, allergies, the immune system. I don't pretend to be an expert. But found out enough to decide that further vaccination is too risky for John. And I found a Canadian doctor who had studied babies like John for 30 years. We had many phone conversations and during one he said that vaccination had triggered the allergies of many of the most severely allergic infants. "It's quite common, actually." The reason this doctor could level with me and admit that the shot triggered the allergies, whereas 4 American doctors denied it, is that Canada, although they recommend vaccination, does not mandate it.

The mandatory nature of the vaccine policy puts doctors in the position of having to deny a lot of reactions, to deny in their own minds as well as to the patient. When my dr. urged me to continue to vaccinate John, offering to withold the pertussis component, he said, "I'll admit I'll be biting my fingernails waiting to see if John has a reaction."
The fault does not lie with individual doctors but with the AAP, which provides doctors with guidelines.

I am uneasy about not having John vaccinated against tetanus and polio. I would really like to do it. I would like to be able to study state or national statistics and compare the number of children reported to have had allergic reactions after their DPT to the number of allergic reactions after DT, without pertussis. My question is, was it the pertussis component? or was it the shock of vaccination to a child who apparently had latent allergies? There is no way to get an answer to my question - no statistics exist. For this reason, I urge you to require health care providers to report <u>all</u> adverse reactions to vaccines.

There is a moral question here - can a free society require citizens to be injected with a toxic vaccine and continue to deny the full extent of risk involved? We look to you to get the facts out on the table. Only if we know the facts can we decide if the benefits really do outweigh the risks.

TESTIMONY BEFORE THE HOUSE H.E.S.S. COMMITTEE
March 10, 1988 by: Judy Ames, Box 824, Soldotna, Alaska 99669

I am a supporter of HB 277. This bill effectively addresses the vaccination issue so that I as a parent may try and raise my healthy child by known and safe health standards.

For this testimony, I would like to address one issue in particular - the questionable ingredients contained in these vaccines. Particularly, formaldehyde, mercury, and aluminum. These 3 ingredients are listed on the manufacturer's insert for the DPT vaccine with the exception of Connought Co. making no mention of formaldehyde. I am very particular about the substances I and my family consumes and I object to any level of formaldehyde, mercury or aluminum entering my child's body. It does not take many supposed or concrete findings to raise my objections to vaccinating my child with vaccines containing these potentially harmful toxins. Our state health dept. is not required to provide parents with a list of ingredients along with other vaccination information. The new Federal law, "National Childhood Vaccine Injury Act of 1986" under Sec. 2126 (c) Information Requirements, has no mention of requiring the manufacturer's product insert be presented to parents along with other pertinent vaccination information. Parents need to be informed of the ingredients entering their child's body at the time of vaccination. HB 277 would see to those requirements.

There are many uncertainties as to the rise and cause of certain diseases and immunological disorders in our society. For example, we are seeing an increase in allergies. In their article entitled "Bringing Vaccines into Perspective," Harold E. Buttram, M.D. and John Hoffmann suggest ..."current mass vaccination programs must be highly suspected as contributing to the increased incidence of allergic disorders. And from James Gibson's book, Formaldehyde Toxicity, "The characteristics of an allergic mechanism are that the response can be evoked in sensitized individuals with very small amounts of formaldehyde."

I am concerned about the possible link between aluminum (a cumulative carcinogen) and Alzheimer's disease, as reported in research entitled Physiological Behavior and Frontiers in Neurology and Neuroscience Research.

According to the Merck Index, ethylmercuric chloride used in preparation of thimerosal (another ingedient in the DPT vaccine) has a caution of being highly toxic.

I am concerned about the standards by which the ingredients used in vaccines are screened as in the monkey kidney cells used in growing the polio vaccine. Can we be guaranteed they contain no latent virus or disease harmful to the human body?

(1)

The list of questions and concerns goes on and on. The manufacturer claims the ingredients used in these vaccines are set at safe levels. What long term studies ON HUMAN BEINGS are being done to prove these safeties? If our own health department calls its vaccine reaction reporting system passive, what can be said about studies tracing the effect of the potential toxins being injected as part of our vaccines. How can any conclusive, concrete findings about the effect of these ingredients on infants and all human bodies be established when a system has obvious flaws?

From my point of view it appears that vaccine safety is not proven, however, the risks are substantial. Please consider this issue is full depth. Thank-you.

(2)

Kay Brown

Alaska State Legislature
House of Representatives

December 18, 1987

Clinton Lillibridge, M.D.
Pediatric Consultants of Alaska, Inc.
1200 Airport Heights Drive - Suite 230
Anchorage, Alaska 99508

Dear Dr. Lillibridge,

Thank you for your recent correspondence regarding House Bill 277. Until I received your letter, I was not aware of this proposal. Although I have not yet had a chance to study this issue in depth, I am very aware of the value of immunization. I am inclined to agree with you.

As you may know, the bill was only introduced at the end of last session and has not yet been heard by the Health and Social Services Committee, the first committee of referral. I have taken the liberty of providing a copy of your letter to the co-Chairs of that Committee, as well as to the bill's prime sponsor.

Again, thank you for bringing this issue to my attention. As the bill is considered by the Legislature in the coming session, I will be sure to raise the points you have made.

Sincerely,

Kay Brown

Representative Kay Brown

cc: Representative Mike Navarre
Representative Johnny Ellis
Representative Niilo Koponen

P. O. Box 20-2661
Anchorage, AK 99520-2661
(907) 272-0207

During Session:
P. O. Box V
Juneau, AK 99811
(907) 465-4998

THE FOLLOWING IS AN OUTLINE OF THE MAIN COMPONENTS OF H.B. 277, PROPOSED BY ALASKA DPT AND SPONSORED BY REP. MIKE NAVARRE. IF YOU WOULD LIKE A COPY OF THE BILL, CONTACT YOUR LOCAL LEGISLATIVE INFORMATION OFFICE OR FOR ADDITIONAL INFORMATION CONTACT:

DISSATISFIED PARENTS TOGETHER
ALASKA CHAPTER
BOX 1746
SOLDOTNA, ALASKA 99669
(907) 262-3294

I. PARENTAL CHOICE: To allow philosophical objection (parental discretion) on administration of immunizations without threat of exclusion from a school, preschool, or day care in this state.

II. PARENT IMMUNIZATION INFORMATION: To mandate that each parent receive extensive written information as to the risks as well as the benefits of each vaccine before vaccination and with immunization information provided by Public Health Dept. at birth.

III. ADVERSE REACTION REPORTS: To mandate that all health care providers (physicians, nurses, etc.) report to the Public Health Dept., all occurences of serious adverse reactions resulting from immunizations, and that long-term follow-up investigations be included.

IV. IMMUNIZATION RECORDS: To insure that the vaccine manufacturer and lot # be kept on file for at least three years and to insure that reaction be recorded in minors permanent medical record so that no further doses of questionable vaccine be administered to minor, even if location of administration varies.

Shannon Kohler
Alaska Chapter - DPT
Box 1746
Soldotna, Alaska 99669
262-3825

July 27, 1987

Blanche Brunk
co-facilitator
Economic & Family Opportunities Committee
Dept. of Health and Social Services
P.O. Box H-01
Juneau, Alaska 99811

Dear Blanche;

Many thanks to you, your sub-committee and the Governor's Commission on Children and Youth for addressing the problems of Alaska's children and trying to resolve them. Thank you all for providing a forum for the public to be heard in regard to these issues.

While attending the two day teleconference of both committees in Anchorage, I sensed a feeling of frustration emerging as each member of the commission struggled to identify all the issues and the right path to take in the resolving of each issue. I have great faith that once the irregularities are ironed out, both committees will proceed to make recommendations and changes to improve the quality of life for Alaska's children.

I was especially impressed by your compassion and integrity, not only during the public testimony portion, at which our DPT group was heard, but throughout the July 10th committee meeting. I was both pleased and dissatisfied when all was said and done and you were assigned to the "Health" sub-committee. I feel that in regard to health issues, you are the expert and the most accessible to health information. Due to the tight time schedule this interim committee must adhere too, I understand the need to have you on the "Health" sub-committee. I am concerned because I fear that due to a possible conflict of interest, your sub-committee may not be able to recommend the endorsement of H.B. 277 by the Commission. As H.B. 277 is written right now, each desired legislative change involves the Alaska Public Health Dept., of which you are an employee. I am concerned that if the Public Health Dept. takes a stance against any part of H.B. 277, you will not be able to view the bill objectively and may not be able to see the recommendations as possible. I fear a conflict of interest may arise. As you recommended, Rep. Mike Navarre and I will arrange a meeting with Dr. Middaugh in the fall to discuss all aspects of this bill.

I don't intend to offend you by broaching this subject. As I mentioned earlier, I admire your compassion and integrity. I'm only putting this possible conflict on the table because it needs to be considered. Our group's main concern, as testified to by so many parents, is that Alaska's infants and children will no longer be needlessly injured by an inefficient , uninformative immunization program. This program needs to be changed to allow for better education of parents and health care providers alike. Our group supports every aspect of H B. 277 and stresses that every item needs to be included to effect the improvements needed in Alaska's immunization program.

We addressed the Commission on both days in the hope that it would endorse H.B. 277. We are cautiously optimistic that this endorsement may be achieved. We would hate to have a conflict of interest be the insurmountable obstacle in our path.

I have faith that you will regard this letter objectively and do what you feel needs to be done to best approach the immunization safety issue.

I am looking forward to a response. Please feel free to contact me in regard to any information you or your sub-committee may desire from our office. A bibliography of some of the material we are able to provide is enclosed.

Sincerely,

Shannon Kohler

cc to: Annie Calkins
Niesje Steinkruger

KOHLER



①

August 3, 1987

Shennan Kohler
Alaska Chapter - DPT
Box 1746
Soldotna, AK 99669
262-3825

Rep. Niilo Koponen
Alaska State Legislature
Co-Chairmen H.E.S.S. committee
Box V (MS 3100)
Juneau, AK 99811

Dear Representative Koponen,

Thank you, your committee, and the Governor's Interim Commission on Youth and Children for attempting to identify and resolve the major issues that affect the well being of Alaska's children. Thanks, too, for the compassionate response in regard to our DPT groups public testimonies. It was quite emotional, especially the public testimony of July 10th before the Comprehensive Child Care Systems Committee. I've included a copy of the public comment in this packet. Also included is a copy of House Bill #277, our briefing paper, supporting evidence, a bibliography of some materials available from our group, and a copy of my letter sent to Blanche Brunk outlining a possible conflict of interest that may (or may not) arise in regard to the Commission's endorsement of H.B. #277.

Our DPT group came to the meetings to give public testimony to encourage the commission to endorse H.B. 277.

KOHLER



We stressed that only through these much needed regulation changes will our immunization program aspire to help, instead of injure our children. We are cautiously optimistic that this endorsement may be obtained. As you can see by the enclosed materials there are many problems associated with our immunization program. Our group feels that due to inadequate education, poor communication, etc., many more children (and parents) are being adversely affected by ~~their~~ immunizations that we can begin to realize. This is only the tip of the ice berg. Our groups short term goal is to try to reach more affected families to provide support and to gather more evidence to present to the Legislature. It saddens me that the most effective argument our group can present is vaccine injured children. It saddens me even more that our immunization program is designed to ignore these children.

I recently attended a three day immunization training seminar taught by people from the federal CDC; Center of Disease Control, Atlanta, Georgia in Anchorage. I came away from that seminar even more committed to the necessity of the passage of H.B 277 to protect the health of our children. In regard to serious adverse reaction reporting, the trainers stressed that it is up to the parent to recognize and duly report in person any serious adverse reaction they ~~is~~ may be aware enough to diagnose. If the parent can't afford to pay a doctor, can't arrange (travel, time, etc.) to see a public health nurse, etc



within 28 days, the report will not be accepted "into the system" and thus will not be accepted as a statistic. The immunization benefit/risk ratio is seriously affected and any long term damage that may occur goes undiagnosed as vaccine related. If a parent does go to a doctor (as they should with a serious reaction), the doctor is not required to report anything anyway. Emergency room personnel aren't required to report either. I could go on and on about what was presented (and not presented) during this seminar but won't. Perhaps we can discuss it at a later date. The main concern of the CDC was to immunize the "target" population; never mind that the measles vaccination only seems to "work" for ten years if it works at all, that the only polio disease in the United States since 1979 was caused by the polio vaccine, and that there have been no studies of the long term effects of the toxic immunization ingredients formaldehyde, mercury, aluminum, etc. on the human body in these instances.

I hope this enclosed material is helpful to you and sheds some light on this issue. I've labeled it all for convenience sake. I hope I haven't included too much information here. I surely don't want to overwhelm you with excess paper. I have found that information is truly lacking about this issue and since you are so directly involved with the outcome of this legislation the more information you have the better. I am waiting to receive more copies of the video, Vaccine Roulette, as listed in enclosed bibliography. It pretty much encapsulates the major difficulties with our currently liscensed DPT vaccine. As soon as I receive these videos, I'll forward one on to you.

KOHLER



(4)

On regard to the H.E.S.S. Committee and its future involvement with H.B. 277, Rep. Mike Navarre suggested that perhaps the committee may be able to hold a hearing with teleconference participation before the House reconvenes to set some early groundwork. I support this idea and hope it can be arranged.

Thanks again for your interest, time, and effort.

Sincerely,
Shannon Kohler
President AK-DPT

INFORMATION MAY BE FOUND IN THESE ARTICLES, TRANSCRIPTS, VIDEO AND BOOKS *

1. Video: DPT: Vaccine Roulletie, April 19, 1982, WRC-TV, Washinton D.C.

2. Transcript: 20/20, (DPT segment), February 5, 1985

3. Public Information Packet, DPT National,

4. Coulter, Harris L. and Fischer, Barbara Loe. DPT: A Shot in the Dark.

5. Mendelsohn, Dr. Robert. "The Medical Time Bomb of Immunization Against Disease" from Raising a Healthy Child in Spite of Your Doctor.

6. Mortimer, Edward A. "Pertussis Immunization: Problems, Perspectives, Prospects". Case Western Reserve University, Cleveland. October, 1980.

7. Stewart, Gordon T. "Vaccination Against Whooping Cough-Efficacy vs. Risks". University of Glasgow, Ruchill Hospital. Pritnted in "The Lancet", Jan. 29, 1977.

8. "Influenza-The World Problem". The Medical Journal of Australia Special Supplement, June 2, 1973.

9. Edwards, Kathryn and Lawrence, Eileen and Wright, Peter. "Diptheria, Tetanus, & Pertussis Vaccine", "A Comparison of the Immune Response & Adverse Reactions to Conventional and Acellular Pertussis Components"/ May 23, 1986.

10. U.S. Dept. of Health, Education & Welfare, Center for Disease Control. MMWR (Morbidity, and Mortality Weekly Report) Epidemiologic Notes & Reports. Measles, Massachusetts, July 22, 1977.

11. White, Kerr L. "Life & Death & Medicine". Scientific American, Vol. 229, Number 3, Sept. 1973.

12. Fox, Rosemary. "Immunization Against Whooping Cough". British Medical Journal. Feb. 21, 1976

13. Cockrell, J. "Vaccine Reactions: The Challenge to Pediatricians." Virginia Medical Journal. 1982; 109:380-381

14. Cody, C., Baraff, L., Cherry, J. et al. "Nature and Rates of Adverse Reactions Associated with DPT and DT Immunizations in Infants and Children." Pediatrics. 1981; 68:5: 650-659.

15. Berg, J. "Neurological Complications of Pertussis Immunization." British Medical Journal. 1956; 2: 24-27.

16. Strom, Justus. "Is University Vaccination Against Pertussis Always Justified?" British Medical Journal. 1960; 2: 1184-1186

17. "Immunizations: Are they Necessary?" Hering Family Health Clinic.

18. Toomey, J. "Reactions to Pertussis Vaccine." Journal of American Medical Association. 1949; 139:7: 448-450

19. Harrison, H. and Fulginiti, V. "Bacterial Immunizations." American Journal of Diseases of Children. 1980; 134. 184-193

20. National Women's Health Network. "How the F.D.A. Determines the Safety of Drugs-Just How Safe is Safe?"

21. Strom, Justus. "Further Experience of Reactions, Especially of a Cerebral Nature, in Conjunction with Triple Vaccination: A Study Based on Vaccinations in Sweden, 1959-1965", British Medical Journal, 1967; 4: 320-323

*All the above information and more available from Alaska Chapter-DPT.

Feb 19, 1988

Shannon Kohler, President
Alaska "DPT"
Box 1746
Soldotna, Alaska 99669
262-3825

Lisa - She mentions (on last pg) your suggestion of a joint letter. What do you think? JE

Rep. Johnny Ellis
Box V
Juneau, Alaska 99811

FEB 22 1988

Dear Rep. Ellis,

Thank you for scheduling the H.E.S.S. committee hearing on H.B. 277 and meeting with me afterwards. I appreciate your concern and am confident it is justified. Alaska DPT is very excited about the upcoming teleconference. We are expecting it to be held March 10. If this changes, please notify me as soon as possible.

I've included in this packet copies of all the completed petitions we have received to date. We have many more circulating. As you can see, there are quite a few people who support H.B. 277. (I've made copies on front & back to save paper & money!)

I've also included an article titled "Adults with Pertussis". This article is especially pertinent because it supports what I've been told by many health care professionals, Dr. Fraser of the AK. Health Dept. as one, that adults can harbor and spread pertussis. Add to this information the fact that no one over the age of seven years is vaccinated with pertussis vaccine (for a variety of reasons) and that the immunity conferred by the vaccine lasts only 3 to 5 years and one may begin to question the actual effectiveness of the mandatory pertussis vaccine requirement. True this vaccination

schedule does offer partial immunity to children 6 months to 12 years but it leaves a major portion of our population able to spread pertussis often undetected ... very able to spread it to the highest risk group of all; children under 6 months. I'm sure that it would be quite impossible to ascertain who coughed on who and when during a pertussis outbreak. Was it the once vaccinated adult that coughed on the partially vaccinated four month old that coughed on the fully vaccinated four year old that coughed on the ~~ca~~ unvaccinated 2 month old or was it the other way around? All are quite able to contract the disease and spread it ....

Earlier this year I sent a video titled "Vaccin Roulette" to Rep. Koponen's office. Lisa MacClaren has told me that it is on file in her office for those who wish to view it. This twenty minute video nicely encapsulates the issues surrounding the pertussis vaccine. Please watch it if you can find the time!

I met with Elizabeth Ward, Director of Public Health while I was in Juneau. She mentioned that the health dept. wanted to recommend me via Senator Ted Stevens to a federal commission being appointed by the Secretary of Health to oversee the enactment of the National Childhood Vaccine Injury Compensation Act. I would very much like to serve on this commission. I've included an excerpt from the federal bill that refers to it and a copy of the letter Senator Paul Fischer has sent to Senator Stevens. I know that I could be very effective if allowed to address this issue at the federal level. I know, too, that some very important aspects of this issue (i.e. philosophical exemption, ingredient info, etc) need to be addressed at the State level. I would greatly appreciate a letter of recommendation from you (if you think I qualify, of course) since I am a member of the general public whose child has not suffered a vaccine-related injury I am eligible for just one place on this commission

I'm relating the same request to Rep. Koponen so it might suit you both to write a joint letter. (Lisa MacCleren suggested this possibility) I called Senator Stevens office to get more data as to deadline and they responded that recommendations need to be in "as soon as possible". Thank you for consideration of this request.

Thanks again for your time and effort.

Shannon Kohler

return to: Box 1746 262385
Soldotna AK
99669

I support the Alaska State Vaccine Reform Legislation proposed and drafted by the Alaska Chapter of Dissatisfied Parents Together, parents concerned with vaccine safety, awareness, and efficacy. In particular, I support the requirement that parents be presented all available information concerning the benefits and especially the risks of all vaccines to be administered. I support mandatory record keeping and adverse reaction reporting by private physicians and public health clinics. I also support the mandatory "follow up" system to accurately discern any long term impairments suffered in relation to immediate adverse reactions. I also support an Alaskan parent's right to exempt their child from any immunization due to philosophical objection, as is allowed in twenty two states of these United States.

Please Print

Name	Street Address	City,State	Zip
Michelle Hardner	192 Riverview	Soldotna AK	99669
Laura Pietro	Debbie Circle	Soldotna Ak	99669
Kristie Fairchild	Box 4251	Kenai, Ak	99611
Therese Sangster	Box 1744	Soldotna, Ak	99669
Angie Hemingway	Box 1443	Soldotna, AK	99669
Jana Klalick	[illegible]	[illegible]	[illegible]
Dottie Eggleston	145 Soldotna	Soldotna Ak	99669
Jennifer Thompson	Box 2552	Soldotna Ak	99669
Sheila Hanson	[illegible]	[illegible]	[illegible]
Wendy Morgan	Box 2491	Soldotna, AK	99669
Scott Rosin	Box 1505	Soldotna, Ak	99669

Return to: Box 1446 Soldotna, AK 262-3825

*needs newsletter

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Please Print

Name	Street Address	City, State	Zip
Melissa Reese	Box 1681	Soldotna, AK	99669
Christine Hebel	425 W. Redoubt. Ave #305	soldotna	
*Rachel Kitson	Box 72	Sterling, AK	99669
Kevin Carlisle	Box 69	Soldotna	99672
Cindy Litzenberger	Box 4091	Soldotna	99669

Please Print

Name	Street Address	City, State	Zip
Mary Bea Byrne	Box 47	Sterling, AK	99672
Ramona Perkins	Box 4471	Soldotna, AK	99669
Ray Dowdy	44433 Carver Drive	Kenai,	99611

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Please Print

Name	Street Address	City, State	Zip
Shannon Kohler	Box 1746	Soldotna, AK	99669
Shannon Kohler			
Jeanette D. Long	Box 1981	Soldotna, AK	99669
Shelley Vola	P.O. Box 3377	Soldotna AK	99669
Mickey Hammack	POBox 579	Kasilof	99610
Leah Vienna	Box 773	Sterling	99672
PM Swearingen	POBOX617	Soldotna	AK 99669
Terry Eastham	POB 2891	Soldotna	AK 99669
Lisa H. MacLeod	BOB 515	Clam Gulch,	AK 99568
Darlene Wallis	Box 455	Nanwalek,	AK 99639
Shallee Bell	Knight Dr #65	soldotna	AK 99669
Kathy Mary	SR2 Box 311	Soldotna	AK 99669
Diane M. Gerber	SR12 box 560-2	Kasilof	AK 99610
Sharon Keer	P.O Box 622	Sold.	HK 99669

99669

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Please Print

Name	Street Address	City, State	Zip
Robin Courser	Robin Courser Box 598	Soldotna, AK	99669
Mary Mize	Mary Mize SR 1 Box 3910	~~Soldotna~~ Sterling	99672
Pamela Clark	Pamela Clark Box 13	Kenai Ak	99611

HB 277

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Name	Street Address	City, State	Zip
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Michael Christianson	CHRISTIANSON	Soldotna Ak	Box 1857 262-2859
? Dorothy Denison		Soldotna Ak	NO phone listing
? Dwight Ashley		Soldotna AK	NO PHONE LISTING
? Kathy Wilks		Soldotna AK	
Heather L. Heames		PO Box 73 Clam Gulch AK	99568
✓ Danielle Daniel		Kenai 283-3890	Box 2618, Kenai AK 99611
Pam Sarko		Kenai 283-7975	
MICHELLE LAMBOURNE		SOLDOTNA NO PHONE LISTING	99669
✓ Glenda Landua		39918 Dawn ave	Kenai, ak 99611
✓ William E. McDonald		POB 4052 Kenai, AK	99611 283-71
✓ Steve Battershall (Battershall)		PO Box 4232	Kenai Ak 99611

I support the Alaska State Vaccine Reform Legislation proposed and drafted by the Alaska Chapter of Dissatisfied Parents Together, parents concerned with vaccine safety, awareness, and efficacy. In particular, I support the requirement that parents be presented all available information concerning the benefits and especially the risks of all vaccines to be administered. I support mandatory record keeping and adverse reaction reporting by private physicians and public health clinics. I also support the mandatory "follow up" system to accurately discern any long term impairments suffered in relation to immediate adverse reactions. I also support an Alaskan parent's right to exempt their child from any immunization due to philosophical objection, as is allowed in twenty two states of these United States.

Please Print

Name	Street Address	City,State	Zip
✓ Tom Hackshey	(see also Diana) Box 244	Kenai, Alc.	99611
★ June Harris	520 Pine Ave.	Kenai	99611

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Please Print

Name	Street Address	City, State	Zip
CHERYL RYKACZEWSKI	Box 311	KASILOF, AK	99610 262-4937
Lori Raymond	Box 32	Kenai, AK	99611 283-7680
Nancy Harris	425 W Redoubt #206	Soldotna, AK	99669 262-2919
Jaralyn Barnes	11568 Spur Highway	Kenai AK	99611
Tina Doyle	Box 582	Kenai, AK	99611 283-3729
Deanna Doyle	Rte 1 Box 1225	Kenai, AK	99611 776-8552
Mary Jane Yragui	P.O. Box 4778	Kenai, AK	99611 283-328[illegible]
Diana Hackney	P.O. Box 244	Kenai Alaska	99611 262-9515
Tracy Scarbrough	P.O. Box 1872	Kenai, Alaska	99611 283-730[illegible]
Wilma Scarbrough	P.O. Box 1872	Kenai AK.	99611 283-7302
Rhonda Manzer	P.O. Box 1786	Kenai, AK	99611 283-5949
Jay Barnes	11568 Spur Highway	Kenai AK,	99611 283-3718
Wilma Staton	P.O. Box 1093	Soldotna	99669 262-484[illegible]

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Please Print

Name	Street Address	City, State	Zip
Judy Ames	Box 824	Soldotna	99669
Judy Ames			
Lillyn Kincaid	Box 269	Kasilof, Alaska	99610 (new address)
Lillyn Kincaid			
* Molly McNally	P.O. Box 151	Soldotna AK	99669
Eric Sandberg	338 Columbine St B8	Soldotna	99669
* Sarah Thapp	Rt. 2 Box 579	Kasilof, AK	99610
Paulette Jacobson	SR 1 Box 121-Z	Soldotna AK	99669
Jamie Selby	Box 4414	Soldotna AK	99669
John Selby	Box 1252	Kenai AK	99611
Nancy Wyatt	4839 Bryn Mawr #5	Anch AK	99504
* Angela Brinkerhoff	P.O. Box 2142	Soldotna AK	99669
* Sharon L.H. Stoney	905 DUK A-5	Kenai AK	99611
* Ronald Boyson	Box 3970	Soldotna Ak	99669

Return to: Box 1746 262-3825
Soldotna AK
99669

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Name	Street Address	City, State	Zip
1. Elizabeth Szczesny	Box 404	Sterling AK	99672
2. Russell H. Phipps	PO Box 163	KENAI AK.	99611
3. DEBRA D. SCOTT	P.O Box 1785	KENAI, AK	99611
4. Patricia Gavoute	P.O Box 1785	KENAI AK	99611
5. Dennis Simmons	P.O. Box 935	Soldotna AK	99669
6. Inia Harman	~~RO Box~~ 372 N. Forward	Sol. Ak.	99669
7. Kate O'Dell	44580 Woodlake Ave	Soldotna	99669
8. Matthew Dale	Soldotna Lt-Box 1576	[illegible]	99611
9. Ron Clark	208 Evergreen Apt. #4	Kenai, AK.	99611
10. JoAnn Doyle	11568 Spur Hwy	Kenai, AK	99611
11. Tamara Medcoff	Box 4476	Kenai, AK	99611
12. Wilma Allred	Box 3791	Kenai AK	99611 (res. Mile 30 Spur Hwy, "
13. Ty Miller	Po Box 3791	Kenai [illegible]	
14. Marilyn Cordell	PO Box 8174	Nikiski	99635
15. Joanne W. Cobban	201 Sterling Ct.	Kenai	99611
16. Kathy Doyle	17 1 Box 1205	Kenai, AK	99611
17. Lynne Doyle	1, Box 1205	Kenai, AK	99611
18. P Doyle			

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So Naknek, AK
99669

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Please Print

Name	Street Address	City, State	Zip
J Wisniewski	5839 Spur. Hwy	Kenai	99611
Bill Hemmy Callahan	2720 Vip Dr.	Kenai	99611
Dana Gerstlauer	535 Shane Ct.,	Kenai	99611
Eileen Bryson Bryan	1205 Third Ave.	Kenai	99611
Ruth Decker	Box 1887	Kenai	99611
Mary Mussman	P.O. Box 55	Kenai	AK 99611

[redacted] MORE INFO? CALL 235-6028

I support the Alaska State Vaccine Reform Legislation proposed and drafted by the Alaska Chapter of Dissatisfied Parents Together, parents concerned with vaccine safety, awareness, and efficacy. In particular, I support the requirement that parents be presented all available information concerning the benefits and especially the risks of all vaccines to be administered. I support mandatory record keeping and adverse reaction reporting by private physicians and public health clinics. I also support the mandatory "follow up" system to accurately discern any long term impairments suffered in relation to immediate adverse reactions. I also support an Alaskan parent's right to exempt their child from any immunization due to philosophical objection, as is allowed in twenty two states of these United States.

Please Print

Name	Street Address	City, State	Zip
AROI E BUTLER	BRUCE RD	P O BOX 4221 HOMER	AK 99603
Marjorie Belien	Meadow Dr.	P.O. Box 2163 Homer,	Ak 99603
Jersey Lescoe	442 E Lee DR	Homer,	AK 99603 (NOT entered Look up new address)
Lynne A. Sinnhuber (SINNhuber)	BOX 1657	Homer,	AK 99603
PATRICIA OLDENHEIMER	966 HILLTOP #2	Homer,	AK 99603
RAY HODGE	248 W. PIONEER AVE	HOMER	AK 99603
LAURA INGLIMA	HCR 1259 OLD STERLING	ANCHOR PT,	AK 99556

DMW

n Soldotna AK 99669

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Please Print

Name	Street Address	City, State	Zip
Lisa Brosseau-Parcoy	Po Box 2842	Homer, AK	99603
Debbie Haakenson	PO Box 109	Anchor Pt, AK.	99556
Michelle Perdue	SR Box 1273	Anchor Pt, AK	99556
Michelle Perdue	Box 3630	Homer, Ak	99603
Francine Trygstad	Box 407	Anchor Pt, AK	99556
Robin Jaime (Glanville)			
Diann Glanville	Box 1166	Homer. AK	99603
Joan M. Crane	Box 395	Anchor Point,	99556
Judy E. Martin	P.O. Box 3874	Kenai, AK.	99611

newsletters & volunteer sheet sent

Soldotna, AK 99669 262-3725 N 235-6038

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Please Print

Name	Street Address	City, State	Zip
Kay Jaylko	P.O. Box 2633	Homer, AK	99603
Kenneth R. Kline	39955 Highview Ct.	Homer 235-6708	603
Jeanne Parker	PO Box 233	Homer	99603
IRISANN MEIER	Box 1675	Homer	99603
Shirley Heusel	Box 320	Homer	99603
Marjorie Belien	Box 2163	Homer	99603
Kim Smith	Box 2235	Homer	99603
D. SWANSON	Box 2633	"	99603
Nikki Lopez	Box 1522 FCI	Homer	99603-6022
Bettie Ulmer	Box 1950	Homer	99603
Stan Jacobs	Box 1773	Homer	99603
Elaine Wagman	Box 2964	Homer	99603
Julie Cesario	P.O. Box 812	Homer, AK.	99603
Michael Sheppard	P.O. 2229	" "	"

1 Please return to Box 1740 99645 262-3003

I support the Alaska State Vaccine Reform Legislation proposed and drafted by the Alaska Chapter of Dissatisfied Parents Together, parents concerned with vaccine safety, awareness, and efficacy. In particular, I support the requirement that parents be presented all available information concerning the benefits and especially the risks of all vaccines to be administered. I support mandatory record keeping and adverse reaction reporting by private physicians and public health clinics. I also support the mandatory "follow up" system to accurately discern any long term impairments suffered in relation to immediate adverse reactions. I also support an Alaskan parent's right to exempt their child from any immunization due to philosophical objection, as is allowed in twenty two states of these United States. House Bill 377

Please Print

Name	Street Address	City, State	Zip
✓ LISA WOOD LONG	BOX 592	HOMER AK.	99603
✓ Kathleen Stier	607160 Skyline Dr.	Homer. Ak	99603

3991B Dawn Ave
Kenai, AK 99611

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Name	Street Address	City, State	Zip
Candy Macy	P.O. Box 56205	N. Pole AK	99705
Barbara Reed	P.O. Box 2795	FBKS AK.	99707
Tota Munnna	P.O. Box 2795	Fairbanks AK	99707
Burnie Chapman	921 Cold Ln.	Fairbanks, AK	99712
[illegible]	[illegible]	[illegible]	[illegible]
Kathleen Tulmer	1374 Grenac Rd.	Fairbanks, AK	99709
[illegible]	710 10th Ave	Fairbanks AK	99701
Jacqueline Conducy	4021 Fahrenkamp	Fairbanks	99708
CHUCK BECKERT	476 NORDALE RD	NORTH POLE	99705
Cheryl LaValley	1764 Pine Ridge Dr.	FBKS	99712
Mary Patania	1201 McCarty	Fairbanks, AK.	99701
Amy Daunais	P.O. Box 80105	Fairbanks, AK	99708
Robert Brooks	703 Front St.	Fairbanks, AK	99701

39918 Dawn ave
Kenai, AK 9961

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[redacted]

Name	Street Address	City, State	Zip
	P.O. Box or		
VANESSA GARBEN	147 KNIFFEN RD	FAIRBANKS, ALASKA	99712
Dave Lacey / Lacey	P.O. Box 81765	College	99708
Mary Shepenger / Shepenger	701 A Tanana	Fairbanks, AK	99775
Katy Nolan	12½ M. Old Nenana Box 96	Ester Ak	99725
ROBERT L. LAYNE	Box 81915	College, AK	99708
Lyn Roberts	[illegible]	[illegible]	99709
Eleanor G. Vierock	1207 Red Fox Dr.	Fbx	99709
Andrea L Lorsink ANDREA L CORSINK	Box 1347	[illegible]	[illegible]707
Amy K. Hebel	404 College Ct	Fbx AK	99701
Dorothy Truman? CT ENDORSED	1930 Lynx	Fbks	99709
Rivka Miller	1418 Wood View	Fbks	99701
Sally Sessoms	1137 Violet	Fbks	99712
Barbara Bradley	1501 Marika #8 Marika	Fbks	99710
Kathleen Lorsen Kathleen M. Lorsen	2320 Good Hill Rd	Fairbanks, Alaska	99701
Pauline Higdon	1235 [illegible] Rd	Fairbanks, AK	99709

Please return to: Gena Landau
39918 Dawn ave
Kenai, AK 99611

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Name	Street Address	City, State	Zip
Edie Hopper	1969 Holmes Road	North Pole, AK	99705
Judy Whitt	3729 Gretta Ln	North Pole, ak	99705
Gail Mattice	593 Florence Rd	North Pole, AK	99705
Anthony G. Mamo	P.O.Box 140031	Salcha-Ak.	99714
Tim Byrnes	311 Noyes St.	~~North Pole~~ Fairbanks	99705
Jeanne Byrnes	311 Noyes St.	Fairbanks, AK.	99701

return to:
Box 1746
So Hotna, AK 99669

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Name	Street Address	City, State	Zip
gail carlo	1918 Central	Fairbanks, Ak.	99709
Ruth Jacobs	253 Farmers Loop.	Fbks AK.	99712
Jeanne Hurtt	2085 Van Horn Rd.	Fbks AK	99709

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Please Print

Name	Street Address	City, State	Zip
Heidi M. Kyllonen	8199 Cascade St	Juneau	99801
Jennifer Landolfinger	[illegible]	[illegible]	[illegible]
Pauline Lerma-Bignell	5003 Steelhead St	Juneau, Ak	99801
M. Johnathan Reynolds	1003 2nd	Douglas	99824
Mrs Grace Caldwell	Chateroft 4551 Klondike Way	Juneau	99801
Linda R Harrigan	P.O. Box 32973	Juneau, AK	99803
Herde Little	P.O. Box 34472	Juneau, AK	99803
Connie Harjer	P.O. Box 546	Douglas, Ak	99824
John Wm Foster	8193 Thunder Street	Juneau, ak	99801
[illegible]	8428 Steep Pl.	Juneau, AK	99801
Dania Credo	P.O. Box 020169	Juneau AK	99801
Denny R Mankart	9632 Stikine	Juneau, Alaska	99801
Penny S Pearson	PO Box 33439	Juneau, AK	99803
Diana L Gilbert	8481 Thunder Mt. Rd	Juneau, Ak	99801
Teresa Narvag	8303 Valley Ave	Juneau, ak	99801

Box 1746, Soldotna, AK 99669 262-3522

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Name	Street Address	City, State	Zip
Keith L Hedrick DC	413 Cook St.	Kodiak Alaska	99615
Katzu Dohm	Kitzu Dohm P.O. 1338	"	"
Eileen Hedrick	413 Cook St	"	"
[illegible]	[illegible]	[illegible]	[illegible]
Nimrod Salvaggio	PO Box 382	Kodiak	99615
[illegible]	[illegible]	[illegible]	[illegible]
Don E Parker	P.O. Box 2948	Kodiak	99615

Return to: Box 1746
So Hbg, Ak
99669

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Please Print

Name	Street Address	City, State	Zip
David Ctfeson	712 West 9th	Juneau AK	99801
Sharon Hem?	104 Troy	Juneau AK	99801
Mary Alice McKeen	212 W 9th	Juneau AK	99801
Jody Daniels	Box 210588	Auke Bay, AK	99821
Joan Cahill	PO210313	Auke Bay, AK	99821
Robert Cahardt	BOX 33057	Juneau, AK	99803
Joan Scott	Bx 210587	Auke Bay AK	99821
Sheri Kochman	420 East St	Juneau	99801
Jim Alderdale	343 Tongass	Juneau	99801
Jane Stricker	P.O. Box 022115	Juneau	99802
Ken Burch	316 Distin	Juneau	99801
Calary Blue	127 Behrends	Juneau	99801
Eileen Wagner	517 Kennedy	Juneau	99801
Anne Hanes	217 5th St.	"	"
Judy Hall Blaback	11320 N Douglas	"	99801
Lynn Waller	Box 02-1003	Juneau	99802
William Zuther	19191 Randall Rd	Juneau	99801
Anna Romano	1015 Willoughby Ave	Juneau	99801

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Name	Street Address	City, State	Zip
Kilroy	+ Meadowridge ?		
Martin Kilroy	8185 Threadneedle St.	Juneau, Ak.	99802
Theresa Kinney	4447 Taku Blvd.	Juneau, Alaska	99802
Rae Lynn Craigo	BM 2-2272	Juneau, AK	99802
Jody Daniels	PO Box 210588	Auke Bay, AK	99821
Mary J Hayton	2516 Scott Dr.	Juneau, Alaska	99801
Jason Kilroy	115-2nd St.	Juneau, Alaska	99801
LeOna Kendrickson	8601-Hayes Way	Juneau, AK	99801
(CHARLIE DANIEL HANSEN)	2878 DAN 10 ST. #23	JUNEAU, AK.	9980
Martha A. Ecklund	8521 Forest Lane	Juneau, AK	99801
Nancy A. Taylor	POB 210566	Auke Bay AK	99821
Jo-Ellen Benedict	8523 Forest Lane,	Juneau, AK	99801
Sharon Armstrong	8183 Ewan St,	Juneau AK.	99801
J Cybris	19161 Randall Rd	Juneau	99801
Allen Samet	16.9mi. Chena Hot Springs Rd. Box 82676	FAIRBANKS, AK	99708

Please return to: AK-DPT
Box 1746
Soldotna, AK. 99669
262-3825

I support House Bill #277, an act relating to the immunization of minors, sponsored by Rep. Mike Navarre and proposed by the Alaska Chapter of Dissatisfied Parents Together, parents concerned with vaccine safety, awareness, and efficacy. In particular, I support the requirement that parents be presented all available information concerning the benefits and especially the risks of all vaccines to be administered. I support mandatory record keeping and adverse reaction reporting by private physicians and public health clinics. I also support the mandatory "follow up" system to accurately discern any long term impairments suffered in relation to immediate adverse reactions. I also support an Alaskan parent's right to exempt their child from any immunization due to philosophical objection, as is allowed in twenty-two states of these United States.

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Name	Street Address	City, State	Zip
Carol Smith	PO Box 4117 Mile 5 K-Beach	Kenai, AK	99611
Richard Gerber D.C.	35749 Kenai Spur Hwy	Soldotna	99669
Mary Corrigan	115 Crooked Fox	Soldotna	
Nancy Nichols	107 Jackson	Soldotna	
Lorraine Lyon	Box 354, Kasilof, Alk.	99610	
Elaine Lovell	Box 951,	Soldotna AK	99669
Rachel J Knapp	Box 1592	Soldotna, AK	99669
Marta Kuenzi	Box 1796.	Soldotna, AK.	99669
Skip Collins	Box 2399	Soldotna AK	99669
Linda Clark	374 Lee Dr.	Kenai, Alk	99603
Larry D Stand	35594 Mi Dr.	Soldotna, Alk	99669
Marie Beauchamp	PO Box 955	Soldotna	99669

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Box 1746
Soldotna, AK. 99669
262-3825

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Please Print

Name	Street Address	City, State	Zip
TORRY Goodman	P.O. Box 3877	Soldotna	99669
Mary Kaiser	P.O Box 365	Kenai	99611
Mary Burnell	PO Box 3297	Soldotna	99669
Karlene Michel 262-5076 Karlene Michel	Box 609	Sterling	99672
Lori Curry	Box 3416	Soldotna	99669
Catherine Ryan	Box 3416	Soldotna	99669

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Soldotna, AK
99669

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Please Print

Name	Street Address	City, State	Zip
Phoebe Jane Abbott	Box 75	Sterling, Alaska	99672
[illegible]	Box 423	Sterling, Alaska	99672
[illegible]	Box 304	[illegible], AK.	99672
[illegible]	[illegible]	[illegible], AK	99672
[illegible]	[illegible]	[illegible]	[illegible]
Jean Ann Kleng	Box 522	Sterling, AK	99672
Mary McNally	Box 151	Soldotna AK	99669
Dale H. Auldridge	Box 606	Sterling Ak.	99672
Nonie M. Conway	Mail Box 366	Sterling Alaska	99672
Joan Jackanicz	Box 90278 APO	Fairbanks, Ak.	99775
Linda C. Dennis	SR2 Box 904	SOLDOTNA AK	99669
Steven D. McLeod	Box 4132	Soldotna, Alaska	99669
Diane E. McLeod	Box 4132	Soldotna, AK	99669

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I support the Alaska State Vaccine Reform Legislation proposed and drafted by the Alaska Chapter of Dissatisfied Parents Together, parents concerned with vaccine safety, awareness, and efficacy. In particular, I support the requirement that parents be presented all available information concerning the benefits and especially the risks of all vaccines to be administered. I support mandatory record keeping and adverse reaction reporting by private physicians and public health clinics. I also support the mandatory "follow up" system to accurately discern any long term impairments suffered in relation to immediate adverse reactions. I also support an Alaskan parent's right to exempt their child from any immunization due to philosophical objection, as is allowed in twenty two states of these United States. H.B. 277

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Adults with pertussis

D. W. MACLEAN, MB, FRCGP
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SUMMARY Eighty adults were diagnosed in one general practice as having infection due to *Bordetella pertussis*, type 1.3, during a period of 30 months. Their clinical presentation and progress is recorded. A plea is made for attention to be paid to this infection in adults.

Introduction

BECAUSE whooping cough is a disease of childhood it is not surprising that children have received most attention over the years. No age is exempt, although the illness may be atypical in adults (Christie, 1980). The DHSS report on whooping cough (1981) states that 3.3 per cent of all notifications between 1977 and 1979 were of adults. These notifications must be only the tip of the iceberg. For example, the Swansea Research Unit (RCGP, 1981) has recorded 11.1 per cent over the fifteenth birthday. Children may be infected by adults; the Swansea survey and others (Phillips, 1921; Nelson, 1978) detail mothers and nurses infecting neonates. Infected staff can also contribute to the spread of pertussis to children in hospital (Kurt *et al.*, 1972). The risk to the individual adult is less clear, but in the past it has been described as a "very serious affliction" in the elderly (Osler, 1901). The recent epidemic has focused attention on whooping cough, but have adults received a fair share of this interest?

This paper describes the presentation and progress of 80 patients aged 16 or over, diagnosed as having whooping cough due to *Bordetella pertussis*, type 1.3, in a general practice of 5,000 patients, between November 1978 and May 1981.

Diagnosis

The criteria for diagnosis were a relevant clinical history together with serological evidence. The serological method used was direct agglutination against a suspension of *Bord. pertussis*, type 1.3, as described in the Combined Scottish Study (1970). (No serological test was available for other serotypes of *Bord. pertussis* or for *Bord. parapertussis*.) A titre of 60 or greater was regarded as significant. Sera from 36 controls in the practice, who were not coughing, were matched for age and sex with the first 36 patients, and failed to agglutinate the suspension in a titre of greater than 30.

Because the interval between onset of symptoms and clinical suspicion of pertussis was usually long, isolation of the organism was not attempted.

Patients

Eighty patients between the ages of 16 and 79 years were diagnosed (Table 1). Fifty other patients were tested because they had similar symptoms; however, in these the disease was not confirmed. All but two of the 80 persons diagnosed were British or Irish. They came from 76 households, half of which contained no children. Socio-economic status varied, ranging across the whole spectrum from those with professional qualifications to unskilled workers. Fifty were in employment and some, including three nurses and two ward domestics, had occupations carrying a special risk of infecting others.

Thirty-five of these 80 patients were already being treated or were under observation for significant illness when the diagnosis was made. Eight had chronic obstructive airways disease (two with cor pulmonale); 10 others were at special risk, suffering from hypertension, myocardial ischaemia, recent cardiac surgery, epilepsy or chronic neurological disease. Four pregnant women have been the subject of a separate report (MacLean and Calder, 1981).

Nineteen patients said that they had previously had whooping cough. Practice records of 15 to 25 years before confirmed this in four of the patients, although, unfortunately, no bacteriological evidence was available. One woman of 56 had been in hospital at the age of 18 with a previous adult attack.

Seven of the 19 patients under the age of 26 were known to have had full pertussis immunization.

There was a reasonable probability that the source of infection was known in 20 cases (own children, seven; grandchildren, three; other children, two; and adults, eight). The majority, however, had no idea of the origin of their illness and were very surprised at the diagnosis.

Table 1. Age, sex and agglutination titres to *Bordetella pertussis*, type 1.3 (highest or only titre where no ≥ four-fold rise). Total positive = 80, total negative = 50

Age group		≥ Four-fold rising titre	≥960	480	240	120	60	30	<30
16-25		2	4	1	6	4	2	1	9
26-35		1	3	2	4	3	4	1	5
36-45		1	1	2	2	8	1		4
46-55		4	1		4				12
56-65		2	2	2	3	4	2		8
Over 65				1	2	2			10
Male		0	3	4	4	4	5	0	9
Female		10	8	4	17	17	3	2	39

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...llege of General Practitioners, 1982, 32,

Symptoms and progress

The main symptom at first consultation is shown in Table 2. A quarter had had symptoms for several weeks before consulting, but about half the patients came in the first week, before the typical clinical picture developed. In only 33 was the diagnosis suspected at the first consultation. Many of the remaining 47 did not reappear for some time—over three weeks in nine cases.

Once established, the cough came in spasms, at first dry but usually with the later production of tenacious sputum. There was a feeling of choking. Patients with a chronic cough could detect something different about this cough. The cough was invariably worse at night and usually on exertion. Going out of doors or changing rooms, eating or drinking could precipitate spasms. Only one patient came with a whoop. Six had haemoptysis. The cough was forceful and six complained of muscle pains around the costal margins and one had a subconjunctival haemorrhage. One man, suffering from pseudobulbar palsy, had several drop attacks.

Symptoms often persisted for a long time (Table 3) but a quarter, mostly younger patients, had a mild illness of three weeks. The longest history of cough, without complications, was of 32 weeks. The next most frequent complaint, sore throat, was usually better by four weeks. Vomiting, when present, lasted under one week in two thirds of those with this symptom. Malaise was recorded not only for those feeling physically unwell but also for those with post-infective psychological symptoms. Four patients had loss of concentration and memory: one was referred to a psychiatrist, who described her disability as a post-infective neurasthenia.

Erythromycin was prescribed to 38, usually after diagnosis, in the hope of reducing infectivity. Only 18 were not given an antibiotic at some time during the illness. A large variety of symptomatic medication was also used.

Chest x-rays were taken in 25 patients and six showed significant new abnormalities, mainly pneumonic. Two patients were found to have unsuspected bronchogenic carcinomas (MacLean, 1981).

Paired sera from 18 patients and single convalescent sera from 15 more were also examined at the regional virus laboratory. These specimens were not sent by any routine and merely reflect different diagnostic action by doctors in the practice. Current or recent infection by influenza B in five patients and respiratory syncytial virus in two was revealed, at times when these viruses were prevalent in the community.

Table 2. Main presenting complaints and duration in weeks at first consultation for the episode

	Weeks					
	−1	−2	−4	−6	−8	−10
Chesty	4	1				
Cold/flu	10	2	1	1		
Cough and sore throat	4	2	1	1		
Cough	15	14	6	7	1	3
Sore throat	6	1				
Total	39	20	8	9	1	3

Table 3. Duration of main symptoms (weeks)

Symptom	Total with symptom	Weeks 1	2	3	4	6	8	12	16	>16	Not recorded
Cough	80			20	11	19	5	8*	8*	6	3
Sore throat	36	9	12	5	4	2	2				2
Vomiting	32	20	5	2	2		2	1			
Malaise	34	5	2	9	1	1	5	4*	1*	4	

*One of four patients who died.

Complications

Four patients are now dead, including the two found to have malignant disease. It is difficult to determine the part played by pertussis in the deterioration of the others. A 45-year-old woman, known to have had cor pulmonale and mental illness, spent 18 months after her pertussis alternating between acute respiratory and psychiatric units until she died of pulmonary emboli. The fourth patient, a hypertensive woman of 65, was admitted to hospital 11 weeks after onset of pertussis with a chest infection and left ventricular failure. She subsequently developed a hemiplegia and died four weeks later.

Another woman, aged 48, developed a hemiplegia in the second month of coughing and, although mobile, she is now incapacitated and cannot work. The only other patient admitted to hospital (twice) was a respiratory cripple with cor pulmonale; she has now recovered from her pertussis. Bronchiectasis has been diagnosed in one elderly woman after outpatient investigation.

Discussion

The symptomatology in this series is similar to that described by Mannerstedt (1934), with symptoms lasting from 24 to over 80 days. His report differs in recording costal muscle pain in half his patients and throat symptoms in the majority. The most striking finding relevant to NHS general practice at the present time was the large proportion consulting early in their illness. Other patients may have come early, been reassured about a simple cough and not returned. They may then have infected others, for the patients were generally unaware of their condition. (Even among the doctors in the practice there was a marked difference in the number of cases detected.)

Second attacks of whooping cough have been reported by many authors but rarely with bacteriological proof. This paper is no exception, although about a quarter gave such a history. The failure of past immunization could be expected because of the lapse of time since last injection (Lambert, 1965) and because the efficacy of some of the vaccines used before 1968 has been questioned (PHLS, 1969).

There is little value in calculating attack rates in one practice, but the national figures (DHSS, 1981) show the highest adult rate in the 25-34 age group, with women in the majority. The female:male ratio of 3:1 in this series equals that found in adults by Stocks (1933). The true incidence of pertussis in adults is unknown, although there have been suggestions that adults constitute a reservoir of infection (Linnemann and Nasenbeny, 1977). Sixty years ago Phillips (1921) wrote, "The prevalent idea among the laity and sometimes among physicians and nurses, that adults seldom contract whooping cough, is responsible for lack of quarantine." This is probably still true today and may be a significant factor in spreading and maintaining an epidemic.

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Acknowledgements

The author thanks Dr Margaret Calder and her staff in the Department of Bacteriology, City Hospital, Edinburgh, for carrying out the serological testing and his medical, nursing and secretarial colleagues in the Department of General Practice for their help in this study.

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Words our patients use

"I feel umpty"—I feel out of sorts (South Yorkshire).
"I feel neither lost nor won"—I don't know how I feel (South Yorkshire).
'Towty'—lethargic, or not well (Glasgow).
'Hinging'—pale, wan or listless (Glasgow).
'Guttered'—drunk (Dundee).
'Hangy'—the malaise of an acutely febrile child (South Scotland).
'Marred'—coddled or protected: "He has been marred all his life" (Staffordshire).
'Spail' or 'spale'—splinter (Scotland and Northern England).

Leg ulcers in the eighteenth and early nineteenth centuries. II. Treatment.

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In a previous article it was shown that in the eighteenth and early nineteenth centuries leg ulcers were extraordinarily common compared to today.[1] It was also shown that the underlying pathology was much more varied and that ulcers due to venous insufficiency (varicose ulcers), although they existed, probably formed only a minority of cases. The relative youth of leg ulcer patients and the excess amongst males was demonstrated, and the part played by ascorbic acid deficiency was discussed, not only in the case of leg ulcers among men in the Navy, where true scorbutic ulcers were very common, but also amongst the civilian population. Little was mentioned in that paper, however, about methods of treatment, and it is that aspect which is discussed here.

Introduction

HISTORICAL accounts of medical treatment are apt to seem quaintly archaic—and certainly that could be said about some of the methods of treating leg ulcers. But to describe past treatment solely for its quaintness would be a trivial undertaking. The main importance of historical descriptions of medical and surgical treatment lies in the way in which they can illuminate past ideas about the nature of disease, particularly when methods are changing and are the subject of controversy.

Methods of treatment may be determined by past authority ("it has always been done this way"), by empiricism ("we do not know why this treatment works, but it seems to"), or by rationality, where treatment is logically based on current pathological theory. All three approaches were evident in the treatment of leg ulcers in the period with which we are concerned,[1] but there was a gradual change to an increasing emphasis on rational methods. This is illustrated by the decline in the influence of humoral pathology, which dominated the management of leg ulcers until the last decades of the eighteenth century.

© *Journal of the Royal College of General Practitioners*, 1982, 32, 301-309.

The humoral theory and leg ulcers

In essence, the humoral theory held that ulcers anywhere, but especially 'inveterate' ulcers of the legs, were the result of acrid humors in the blood. Not only could the humors cause ulcers, but the ulcers—even if they had an obvious origin such as a cut or graze—acted as drains through which such humors could escape. The corollary was that the surgeon, faced with a chronic ulcer, was forced to consider the wisdom of curing it. Alleviation was justified, but complete healing ran the risk that the acrid humors, denied their exit through the ulcer, could accumulate, ascend to the lungs or other organs and cause serious illness or death. Thus the chronic ulcer was at one and the same time a serious disability and an essential requirement for continued health. A balancing act was demanded of the surgeon in which he had to achieve maximum alleviation short of cure. A anonymous article published in 1764 expressed current views on this subject well. Surgeons were advised to think:

> "whether a conglutination of inveterate Sores or Ulcers in the feet and legs can be effected with safety, because there are instances in the writings of most experienced physicians where the consequences of such cases have been very severe and dangerous disorders and oftentimes most certain and present death".

This was most likely to occur when the patient was "far advanced in years and of a very bad habit of the body", for then the ulcers were "a great means of health, as being so many issues or outlets by which nature is accustomed to expel the noxious or superfluous humors".[2]

There were two ways round this dilemma. One was to prevent an ulcer that appeared too eager to heal from doing so. If a long-discharging ulcer dried up too quickly, 'topics' should be applied to it:

> "roots of gentian, or Florentine orris bruised; or if these prove not strong enough, the root of Hellebore reduced to powder or in globules; or, in the last place, if this be ineffectual, powder of Cantharides, or a globule of blister-plaster of the shops. By this method such ulcers are stimulated and irritated to such a degree as some-

vaccine, no petition may be filed for compensation under the Program for such injury after the expiration of 36 months after the date of the occurrence of the first symptom or manifestation of onset or of the significant aggravation of such injury, and

"(3) a vaccine set forth in the Vaccine Injury Table which is administered after the effective date of this title, if a death occurred as a result of the administration of such vaccine, no petition may be filed for compensation under the Program for such death after the expiration of 24 months from the date of the death and no such petition may be filed more than 48 months after the date of the occurrence of the first symptom or manifestation of onset or of the significant aggravation of the injury from which the death resulted.

"(b) EFFECT OF REVISED TABLE.—If at any time the Vaccine Injury Table is revised and the effect of such revision is to permit an individual who was not, before such revision, eligible to seek compensation under the Program, such person may file a petition for such compensation not later than 2 years after the effective date of the revision, except that no compensation may be provided under the Program with respect to a vaccine-related injury or death covered under the revision of the table if—

"(1) the vaccine-related death occurred more than 8 years before the date of the revision of the table, or

"(2) the vaccine-related injury occurred more than 8 years before the date of the revision of the table.

"(c) STATE LIMITATIONS OF ACTIONS.—If a petition is filed under section 2111(b) for a vaccine-related injury or death, limitations of actions under State law shall be stayed with respect to a civil action brought for such injury or death for the period beginning on the date the petition is filed and ending on the date a final judgment is entered on the petition.

"SUBROGRATION

42 USC 300aa-17.

"SEC. 2117. (a) GENERAL RULE.—

"(1) Upon payment of compensation to any petitioner under the Program, the trust fund which has been established to provide such compensation shall be subrogated to all rights of the petitioner with respect to the vaccine-related injury or death for which compensation was paid, except that the trust fund may not recover under such rights an amount greater than the amount of compensation paid to the petitioner.

Courts, U.S. Records. Claims.

"(2) In any case in which it deems such action appropriate, a district court of the United States may, after entry of a final judgment providing for compensation to be paid under section 2115 for a vaccine-related injury or death, refer the record of such proceeding to the Secretary and the Attorney General with such recommendation as the court deems appropriate with respect to the investigation or commencement of a civil action by the Secretary under paragraph (1).

"(b) DISPOSITION OF AMOUNTS RECOVERED.—Amounts recovered under subsection (a) shall be collected on behalf of, and deposited in the trust fund which has been established to provide compensation under the Program.

"SEC. 2118. The compensation under subsections (a)(2) and (a)(4) of section 2115 and the civil penalty under section 2127(b) shall, effective December 1 of each year beginning 1 year after the effective date of this title, be increased by the percent change in the Consumer Price Index for the base quarter of such year over the Consumer Price Index for the base quarter of the preceding year, adjusted to the nearest ⅒ of 1 percent. For purposes of this section, the term 'base quarter', as used with respect to a year, means the calendar quarter ending on September 30 of such year and the price index for a base quarter is the arithmetical mean of such index for the 3 months comprising such quarter.

"ADVISORY COMMISSION ON CHILDHOOD VACCINES

42 U 300a

"SEC. 2119. (a) ESTABLISHMENT.—There is established the Advisory Commission on Childhood Vaccines. The Commission shall be composed of:

"(1) Nine members appointed by the Secretary as follows:

"(A) Three members who are health professionals, who are not employees of the United States, and who have expertise in the health care of children, the epidemiology, etiology, and prevention of childhood diseases, and the adverse reactions associated with vaccines, of whom at least two shall be pediatricians.

"(B) Three members from the general public, of whom at least two shall be legal representatives of children who have suffered a vaccine-related injury or death.

"(C) Three members who are attorneys, of whom at least one shall be an attorney whose specialty includes representation of persons who have suffered a vaccine-related injury or death and of whom one shall be an attorney whose specialty includes representation of vaccine manufacturers.

"(2) The Director of the National Institutes of Health, the Assistant Secretary for Health, the Director of the Centers for Disease Control, and the Commissioner of Food and Drugs (or the designees of such officials), each of whom shall be a nonvoting ex officio member.

The Secretary shall select members of the Commission within 90 days of the effective date of this subtitle. The members of the Commission shall select a Chair from among the members.

"(b) TERM OF OFFICE.—Appointed members of the Commission shall be appointed for a term of office of 3 years, except that of the members first appointed, 3 shall be appointed for a term of 1 year, 3 shall be appointed for a term of 2 years, and 3 shall be appointed for a term of 3 years, as determined by the Secretary.

"(c) MEETINGS.—The Commission shall first meet within 60 days after all members of the Commission are appointed, and thereafter shall meet not less often than four times per year and at the call of the chair. A quorum for purposes of a meeting is 5. A decision at a meeting is to be made by a ballot of a majority of the voting members of the Commission.

"(d) COMPENSATION.—Members of the Commission who are officers or employees of the Federal Government shall serve as members of the Commission without compensation in addition to that received in their regular public employment. Members of the

Government shall be compensated at a rate not to exceed the daily equivalent of the rate in effect for grade GS-18 of the General Schedule for each day (including travel time) they are engaged in the performance of their duties as members of the Commission. All members, while so serving away from their homes or regular places of business, may be allowed travel expenses, including per diem in lieu of subsistence, in the same manner as such expenses are authorized by section 5703, title 5, United States Code, for employees serving intermittently. 5 USC 5332.

"(e) STAFF.—The Secretary shall provide the Commission with such professional and clerical staff, such information, and the services of such consultants as may be necessary to assist the Commission in carrying out effectively its functions under this section.

"(f) FUNCTIONS.—The Commission shall—

"(1) advise the Secretary on the implementation of the Program,

"(2) on its own initiative or as the result of the filing of a petition, recommend changes in the Vaccine Injury Table,

"(3) advise the Secretary in implementing the Secretary's responsibilities under section 2127 regarding the need for childhood vaccination products that result in fewer or no significant adverse reactions,

"(4) survey Federal, State, and local programs and activities relating to the gathering of information on injuries associated with the administration of childhood vaccines, including the adverse reaction reporting requirements of section 2125(b), and advise the Secretary on means to obtain, compile, publish, and use credible data related to the frequency and severity of adverse reactions associated with childhood vaccines, and

"(5) recommend to the Director of the National Vaccine Program research related to vaccine injuries which should be conducted to carry out this subtitle.

"PART B—ADDITIONAL REMEDIES

"AUTHORITY TO BRING ACTIONS

"SEC. 2121. (a) ELECTION.—After the judgment of a district court of the United States under section 2111 on a petition filed for compensation under the Program for a vaccine-related injury or death has become final, the person who filed the petition shall file with the court— 2 USC 300aa-21.

"(1) if the judgment awarded compensation, an election in writing to receive the compensation or to file a civil action for damages for such injury or death, or

"(2) if the judgment did not award compensation, an election in writing to accept the judgment or to file a civil action for damages for such injury or death.

An election shall be filed under this subsection not later than 90 days after the date of the entry of the court's judgment with respect to which the election is to be made. If a person required to file an election with a court under this subsection does not file the election within the time prescribed for filing the election, such person shall be deemed to have filed an election to accept the judgment of the court. If a person elects to receive compensation under a judgment of a court or is deemed to have accepted the judgment of a court, death for which the judgment was entered.

"(b) LIMITATIONS OF ACTIONS.—A civil action for damages arising from a vaccine-related injury or death for which a petition was filed under section 2111 shall, except as provided in section 2116(c), be brought within the period prescribed by limitations of actions under State law applicable to such civil action. State

"STANDARDS OF RESPONSIBILITY

"SEC. 2122. (a) GENERAL RULE.—Except as provided in subsections (b), (c), and (e) State law shall apply to a civil action brought for damages for a vaccine-related injury or death. State

"(b) UNAVOIDABLE ADVERSE SIDE EFFECTS; WARNINGS.—

"(1) No vaccine manufacturer shall be liable in a civil action for damages arising from a vaccine-related injury or death associated with the administration of a vaccine after the effective date of this subtitle if the injury or death resulted from side effects that were unavoidable even though the vaccine was properly prepared and was accompanied by proper directions and warnings.

"(2) For purposes of paragraph (1), a vaccine shall be presumed to be accompanied by proper directions and warnings if the vaccine manufacturer shows that it complied in all material respects with all requirements under the Federal Food, Drug, and Cosmetic Act and section 351 of the Public Health Service Act (including regulations issued under such provisions) applicable to the vaccine and related to vaccine-related injury or death for which the civil action was brought unless the plaintiff shows— 21 U 42 U

"(A) that the manufacturer engaged in the conduct set forth in subparagraph (A) or (B) of section 2123(d)(2), or

"(B) by clear and convincing evidence that the manufacturer failed to exercise due care notwithstanding its compliance with such Act and section (and regulations issued under such provisions).

"(c) DIRECT WARNINGS.—No vaccine manufacturer shall be liable in a civil action for damages arising from a vaccine-related injury or death associated with the administration of a vaccine after the effective date of this subtitle solely due to the manufacturer's failure to provide direct warnings to the injured party (or the injured party's legal representative) of the potential dangers resulting from the administration of the vaccine manufactured by the manufacturer.

"(d) CONSTRUCTION.—The standards of responsibility prescribed by this section are not to be construed as authorizing a person who brought a civil action for damages against a vaccine manufacturer for a vaccine-related injury or death in which damages were denied or which was dismissed with prejudice to bring a new civil action against such manufacturer for such injury or death.

"(e) PREEMPTION.—No State may establish or enforce a law which prohibits an individual from bringing a civil action against a vaccine manufacturer for damages for a vaccine-related injury or death if such civil action is not barred by this subtitle. S

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February 12, 1988

Honorable Ted Stevens
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Dear Senator Stevens,

Please consider this letter recommendation for the appointment of Shannon Kohler to the Advisory Commission on Childhood Vaccines.

Shannon has been active in Alaska Dissatisfied Parents Together (DPT) for a number of years. During this time she has completed extensive research with regard to vaccine safety and efficacy. She has been instrumental in the introduction of HB 277, a copy of which is enclosed, and the improvement of the vaccination program within the State of Alaska. Many of these concerns need to be addressed at the Federal level especially in regard to National Childhood Vaccine Injury Act of 1986.

Shannon has expressed a willingness to serve on the Commission. Taking into consideration her background, dedication, and motivation she would be an asset to the Commission.

Thank you for your time and consideration.

Cordially,

Paul

Senator Paul A. Fischer

PAF/ssw

Feb 19, 1988

Shannon Kohler, President
Alaska "DPT"
Box 1746
Soldotna, Alaska 99669
262-3825

Rep. Niilo Koponen
Co-chairman House H.E.S.S.
Box V (MS 3100)
Juneau, Alaska 99811

Dear Rep. Koponen,

Thank you for scheduling the H.E.S.S. committee hearing on H.B. 277 and meeting with me before hand. I appreciate your concern. Alaska DPT is very excited about the upcoming teleconference. We are expecting it to be held March 10. If this changes, please notify me as soon as possible.

I've included in this packet copies of all the completed petitions we have received to date. We have many more circulating. As you can see, there are quite a few people who support H.B. 277. (I've made copies on front & back to save money & paper!)

I've also included an article titled "adults with Pertussis." This article is especially pertinent because it supports what I've been told by many health care professionals, (Dr. Fraser of the Ak. Health Dept as one) that adults can harbor and spread pertussis. Add to this information the fact that no one over the age of seven years is vaccinated with pertussis vaccine (for a variety of reasons) and that the immunity conferred by the vaccine lasts only 3 to 5 years and one may begin to question the actual effectiveness of the mandatory pertussis vaccine requirement. True this vaccination schedule

does offer partial immunity to children 6 months to 12 years but it leaves a major portion of our population able to spread pertussis often undetected... very able to spread it to the highest risk group of all; children under 6 months. I'm sure that it would be quite impossible to ascertain "who" coughed on "who" and "when" during a pertussis outbreak. Was it the once vaccinated adult that coughed on the partially vaccinated four month old that coughed on the fully vaccinated four year old that coughed on the unvaccinated 2 month old or was it the other way around? All are quite able to contract the disease and spread it...

I met with Elizabeth Ward, Director of Public Health while I was in Juneau. She mentioned that the Health Dept. wanted to recommend me via Senator Ted Stevens to a federal commission being appointed by the Secretary of Health to oversee the enactment of the National Childhood Vaccine Injury Compensation Act. I would very much like to serve on this commission. I've included an excerpt from the federal bill that refers to it and a copy of the letter Senator Paul Fischer has sent to Senator Stevens. I know that I could be very effective if allowed to address this issue at the federal level. I know, too, that some very important aspects of this issue (i.e. parental choice, ingredient info, etc.) need to be addressed at the state level. I would greatly appreciate a letter of recommendation from you (if you think I qualify, of course). Since I am a member of the general public whose child has not suffered a vaccine-related injury, I am eligible for just one place on this commission. I'm relating the same request to Rep. Ellis. Lisa MacCleren suggested that you both may ~~write~~ wish to write a joint letter as co-chairs of H.E.S.S. Any way would be great! I called Senator Stevens' office to get more data as to deadline and they responded that recommendations need to be sent to Senator Ted Stevens as soon as possible. Thank you for consideration of this request.

Sincerely,

Shannon Kohler

the People's Doctor
A MEDICAL NEWSLETTER FOR CONSUMERS by Robert S. Mendelsohn, MD
P.O. Box 982 Evanston, Illinois 60204

VOL. 7, NO. 10

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IN THIS ISSUE:

Avoiding Immunizations and their Dangers



Dr. Robert Mendelsohn

This is my sixth Newsletter on the subject of immunizations. It updates and elaborates on the documented information on vaccine dangers which I have tried to bring to your attention during the past seven years. Those of you who have closely followed the immunization arguments know that the case against vaccines becomes stronger with each passing year. However, I never would have predicted that this issue—which only I and a few others used to regard as controversial—would, within my lifetime, consciously concern millions of American mothers and fathers whose children must be immunized before they can be admitted to school. The controversy escalates—in the media, in AMA meetings, in the pages of scientific journals, and in the minds of the public.

This Newsletter brings to your attention publications of doctors who have recently joined with the opponents of mandatory immunization. It also tries to help those who are unfortunate enough not to live in one of the 21 "loophole" states which allow parents to reject immunization on the basis of personal conviction or belief.

Because of compulsory immunization, some parents have opted out of the school system, turning instead to home schooling. In the words of one mother, "If I'm smart enough not to immunize my kids, I ought to be smart enough not to send them to school." For those of you who feel that school is important, in this Newsletter I offer some opportunities for legal maneuvering within the system.

Since researchers already are hinting that vaccines against chicken pox, gonorrhea, and meningitis are about to appear, I hope my Newsletters on immunizations will immunize you against the promotional efforts which are sure to accompany these new breakthroughs.

Aids Nift ?

Abscesses linked to DPT vaccine

The official publication of the Centers for Disease Control (MMWR, October 1, 1982) carried an article headlined "Group A Streptococcal Abscesses after DTP Immunization—Georgia." The article began, "From July 19 to July 20, 1982, a cluster of severe local reactions with prolonged fever occurred among children immunized with diphtheria-tetanus-pertussis (DTP) vaccine at a private pediatric office in Atlanta, Georgia. Twelve children developed abscesses at the injection site within 2 weeks of vaccination; four of these were hospitalized because of the severity of symptoms or for incision and drainage of their abscesses.

"Group A streptococci were cultured from the abscesses of nine of the 12 children. The remaining three had been on antibiotics for at least five days before being cultured. In addition, two of the hospitalized children had blood cultures positive for Group A streptococcus."

As a word of explanation, the finding of germs such as streptococci in the blood is referred to as "septicemia" or "blood poisoning." Septicemia is a potentially fatal condition.

The children affected had high temperatures, irritability, vomiting, and rash. A subsequent CDC investigation of this group of abscesses "suggests that one multi-dose vial of the lot had been contaminated with Group A streptococci."

This is not the first time this has happened. The CDC publication states, "This is the second cluster of abscesses caused by Group A streptococcus following DTP immunization reported to CDC during the past 18 months. In the other outbreak, seven children developed abscesses after vaccination with DTP vaccine from a different manufacturer."

Q My grandson, who will be four in October, has a nervous twitch that causes him to draw his mouth down while opening his eyes very wide. This action causes the veins in his neck to stand out.

When we took him to the doctor nine months ago, the doctor suggested "Turrets." After a while, the symptoms ceased, but now the condition is back full force. We try to blame it on a nervous habit, but we are afraid.

After seeing you talking about DPT shots on the Phil Donahue show, I began to wonder whether those shots might cause "Turrets." What do you think?--Mrs. J.B.

Tourette's and DPT shots

A When your grandson received the diagnosis of that unusual condition from the doctor, why didn't you ask that doctor to write down the diagnosis for you? Then at least you would have learned that the correct spelling is "Tourette's" syndrome. Had you then done your homework, you would have learned that this neurologic disease involving tics and peculiar speech patterns was named after a 19th century French physician, Gilles de la Tourette. You also would have learned that, for practically 100 years, doctors knew of no cause for Tourette's syndrome. However, in the last decade, Tourette's syndrome has been linked to the administration of Ritalin (methylphenidate), a drug widely used for hyperactive children.

You are the first person who has asked me whether Tourette's (which seems to be increasing in frequency) might also be produced by infant vaccines. Since no-one knows the answer to your question, I recommend that you--an obviously articulate and concerned grandmother--undertake a little research. First, ask your doctor to contact the leading national authorities on Tourette's syndrome to see whether they have investigated such a possible linkage. If not, it should be fairly easy for them to question the parents of children with Tourette's syndrome regarding a possible relationship between the time of immunization and the onset of neurologic symptoms.

Second, you might ask a lawyer to help you contact the growing number of lawyers who now concentrate on malpractice cases involving immunization-damaged children. These legal experts have developed a considerable body of knowledge in this area and may have information about such a linkage.

Let me know if the results of your research produce any association between immunizations and Tourette's syndrome.

Hospitals breed whooping cough

Doctors have been threatening those who reject the whooping cough vaccine with dire predictions that they may contract whooping cough. This really may come to pass if one takes one's child to a hospital.

Eleven years ago, the University of Colorado Medical Center published an article (JAMA, July 17, 1972) entitled "Spread of pertussis (whooping cough) by hospital staff." A resident physician developed whooping cough and, while still in the catarrhal (running nose) phase, he infected two children whom he saw in the outpatient clinic on the same day. This same house officer also infected his wife and a hospital clerk. Intrafamily spread occurred again during this outbreak when the head nurse transmitted whooping cough to her husband.

In a second outbreak, a nurse who made home visits to children with whooping cough developed whooping cough herself and transmitted pertussis to a hospital nurse who attended a graduate course, thus permitting re-entry of the organism into the hospital environment. The Colorado study concludes that "Pertussis is much more common in the hospital environment than is generally appreciated."

Moral of the story: If you hear of any cases of proven whooping cough, carefully check whether the patient has been in contact with anyone who works in a hospital.

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Expert says whooping cough doesn't return if shots cease

If the whooping cough vaccine is abandoned, will the disease return? Recently, the Maryland Health Department tried to blame a whooping cough outbreak (41 cases) in that state on television programs which had attacked the pertussis vaccine. In response, J. Anthony Morris, Ph.D., formerly top virologist for the U.S. Division of Biological Standards, analyzed the original data provided by Robert E. Langenecker, Immunization Program Coordinator for the State of Maryland's Department of Health and Mental Hygiene.

Dr. Morris concluded that exactly the opposite was true (copies of Morris' full report are available from P.O. Box 40, College Park, Maryland 20740), pointing out that some of the children who had developed whooping cough were less than two months old, too young to even receive the first injection. Furthermore, 20 cases occurred in children who had received at least one injection of DPT vaccine. Of seven cases of whooping cough that occurred in children over one year of age and in adults, six had received one or more DPT injections; of these six, three had received four vaccine injections. Using the Health Department's own reports, Dr. Morris points out that, in many of these cases, there was not enough clinical evidence (symptoms) to justify the diagnosis, nor was there sufficient laboratory evidence (cultures, etc.) to confirm the diagnosis. Indeed, of the 34 children whose cases were reported, 18 had not even experienced a "whooping" cough.

In Dr. Morris' opinion, only in five of the 41 cases was there sufficient evidence to presume that the diagnosis of whooping cough was correct. Each of these children had received one or more doses of DPT vaccine, one as many as four doses. Thus, far from proving the value of pertussis vaccine, the Maryland "epidemic" raises serious questions about the efficacy of DPT vaccine, while also casting serious doubt on the criteria that were used to reach the diagnosis of whooping cough. These criteria, says Dr. Morris, "have led to seriously flawed conclusions."

Doctors don't take shots

In an article entitled "Rubella Vaccine and Susceptible Hospital Employees: Poor Physician Participation," the Journal of the American Medical Association (February 20, 1981) reported that the lowest vaccination rate for the German measles vaccine occurred among

obstetrician-gynecologists (less than 10 per cent of those known by blood tests to be susceptible). The next lowest rate occurred among pediatricians (less than one-third). The authors concluded that the disappointing vaccination rate of physicians, which also has been shown in other studies, was due to "fear of unforeseen vaccine reactions." House officers were particularly concerned about the Guillain-Barre syndrome, seen with influenza vaccine.

Another doctor attacks compulsory immunizations

The latest physician to join the mounting chorus of voices within medicine opposing the vaccines is a young doctor who received his M.D. from New York University as recently as 1963.

Dr. Richard Moskowitz had previously graduated Phi Beta Kappa from Harvard. After receiving his medical education, he held a Graduate Fellowship in philosophy at the University of Colorado. In addition to his classical medical education, he is a member of the American College of Home Obstetrics and has attended more than 400 home births. An expert in homeopathic medicine, he is a member of the American Institute of Homeopathy.

In Dr. Moskowitz' new publication, "The Case Against Immunization" (available through the National Center for Homeopathy, 1500 Massachusetts Avenue, N.W., Washington, DC 20005), he describes his growing disenchantment with routine immunizations, a disenchantment which began 10 years ago. At first, he felt people had the right to make the choice. Later, he discovered, "I could no longer bring myself to give the injections to children even when the parents wished me to."

Dr. Moskowitz' thoroughly documented treatise points out that some diseases (e.g., measles) have continued to break out, even in highly immunized populations, and while the incidence of measles in the U.S. has dropped sharply, the death rate remains the same (!).

Dr. Moskowitz refers to a scientific publication which describes a recent outbreak of mumps in supposedly-immune schoolchildren. Several children developed vomiting, loss of appetite, and rashes without any involvement of the parotid gland (the gland at the angle of the jaw, usually enlarged in mumps). The diagnosis required extensive blood testing to rule out other diseases. Thus, immunizations have resulted in new diseases such as "atypical measles" and "atypical mumps," diseases often more dangerous than the typical forms of those diseases. Moskowitz speculates that the whooping cough vaccine today is one of the major causes of recurrent fevers of unknown origin (F.U.O.) in small children and that introducing the vaccine directly into the blood--thus bypassing the nose and throat route of natural whooping cough infection--may promote deeper pathology. He reports a case of leukemia which first appeared following a DPT vaccination. This five-year-old boy's family physician--a friend and teacher of Dr. Moskowitz--did not communicate his suspicion of vaccine-related leukemia to the parents, let alone to the general public.

Dr. Moskowitz suggests that immunization, instead of protecting us against an acute disease, actually drives the disease farther into the interior of the body, leading to a chronic state in which the body has been "tricked" so that it no longer initiates a responsive defense mechanism: "Since routine vaccination introduces live viruses and other highly antigenic material into the blood of virtually every living person, it is difficult to escape the conclusion that a significant harvest of auto-immune disease must automatically result...then what we have done by artificial immunization is to trade off our acute, epidemic diseases of the past century for the far less curable chronic diseases of the present."

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to school. She had confronted the principal in his office and then had marched into the child's classroom, sitting down with him and challenging the school administration to remove her by force.

I expressed my admiration for this courageous mother who stood up for her rights--even at the cost of considerable embarrassment to her child--and I added that since this was the first time I had heard of any parent accompanying a child into the classroom to protest compulsory immunization, Arkansas may well be setting a national precedent. (For a moment, my mind flashed back two decades to another school confrontation in Arkansas when then-Governor Orval Faubus tried to block the entry of black children into school.)

When several parents in my audience stood up and pledged that they were going to take the same action as Mrs. Cook with their own children, I suddenly realized that all my efforts to help unimmunized children enter school (serving as an expert witness in legal actions, making media appearances, writing books, newsletters and my syndicated column, writing letters of exemption), were not nearly as powerful as the determined action of a parent who physically accompanied her child into the classroom.

Just before writing this Newsletter, I telephoned reporter Larry Sullivan of the Arkansas Democrat for an up-to-date report. He told me that Mrs. Cook again had appeared in the classroom with her child on Friday and that the child had remained in school all day Thursday and all day Friday. He predicted that the next confrontation would occur Monday (tomorrow) when the school superintendent returns from vacation. I passed the news of this sit-in on to my friends on the staff of the Phil Donahue television show, and I will keep you informed on what may well turn into an historic confrontation.

A new booklet, "Dangers of Compulsory Immunizations: How to Avoid them Legally," written by Florida attorney Tom Finn (Family Fitness Enterprises, Inc., P.O. Box 1658, New Port Richey, Florida 33552, $5.95), provides concise, authoritative, and easily understandable directions for parents who have decided against immunizing their children. Uniquely qualified by a major victory in immunization litigation, Finn has written a book which is important not only to patients but also to every doctor who vaccinates patients.

Other lawyers who also are experienced in immunization cases include:

James Filenbaum, Nanuet (Rockland County), New York; Robert Kaufman, Gaylord, Michigan; Alan McDowell, Chicago, Illinois; Clifford Neumann, Boulder, Colorado.

Legal experts are handling hundreds of cases of children who allegedly have been damaged by DPT (cerebral palsy, mental retardation, epilepsy). A new organization, Dissatisfied Parents Together (Barbara Fisher, Box 563, 1377 K Street, N.W., Washington, DC 20005), has been created.

The 21 "loophole" states which allow parents to reject immunizations on the basis of personal objection are: California, Colorado, Idaho, Indiana, Iowa, Louisiana, Maine, Michigan, Minnesota, Missouri, Montana, Nebraska, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, Utah, Vermont, Washington, and Wisconsin.

If you didn't read the American Medical Association News of July 16, 1983, here's what you missed: According to this publication, "A confrontation between syndicated columnist Robert Mendelsohn, M.D., and the director of the American Academy of Pediatrics unexpectedly enflamed a report on pediatric immunization at the American Medical Association Annual Meeting.

"Dr. Mendelsohn made a surprise appearance before a reference committee to state his widely published views that vaccinations, particularly for pertussis, should be halted pending further research."

At this AMA meeting, the AAP Executive Director had tried to personally insult me after I made my statement. However, my fellow medical school alumnus, Joe Skom, M.D., past president, Illinois Medical Society, came to my defense, recollecting that I had been his children's pediatrician and pointing out that, while he did not agree with my views on immunization, he objected to the ad hominem attack on me. Nor did the AMA's Council on Scientific Affairs agree with me. After conceding that "Some pediatricians agree, at least in part, with his (Dr. Mendelsohn's) assessment and do not administer the pertussis vaccine," the Council solemnly declared: "These physicians are ignoring the lessons of the past."

At the end of the discussion, I thanked the chairman for giving me the opportunity to speak out in front of the American Medical Association. I pointed out that I have been a dues-paying member of the AMA for 31 years. The chairman responded, "Dr. Mendelsohn, continue to pay your dues and you may continue to speak."

Q I never have given my son DPT shots, and he's about to start school. He always has been very healthy, and I do not want to immunize him now. The state in which I live only allows exemptions on religious or medical grounds Can you provide me with a medical exemption?--M.U.

A If you will obtain from your child's doctor a statement on his stationery certifying that he has examined your child and found him to be healthy, and if you send that letter to me, I will return it to you along with a letter on my stationery stating that routine immunizations are contraindicated in your child.

(Another View, *cont'd from page 8*)

nized. I know I'm not alone in feeling this way, but I don't want to put him in the middle of a fight with the school administration at the age of four and-a-half.

"I feel like the government is asking me to trade my son's healthy body for an education."

"MalePractice: How Doctors Manipulate Women," Dr. Mendelsohn's latest book, is now available in paperback from Contemporary Books

"Confessions of a Medical Heretic" is available from WarnerBooks

The People's Doctor Newsletter
P.O. Box 982
Evanston, Illinois 60204

Published monthly. Subscription rate: $24.00 annually.
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Vera Chatz, Managing Editor

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Another View

by Marian Tompson
Executive Director,
Alternative Birth Crisis Coalition



"It was so degrading, I'll never do it again! I was furious at the government, and I felt helpless. It makes me angry that my husband and I have no choice in the matter, short of denying our son an education." Janis was on the telephone, calling me after returning home from the county health department where her son had received his pre-kindergarten MMR (measles, mumps, rubella) inoculation.

"Our doctor had suggested we go to the health department for the MMR because it is quite expensive. My husband and I really didn't want him to have the vaccine in the first place, but when I checked with the health department and the school, I was told the only acceptable exception would have to be made on religious grounds. When I asked why boys need rubella vaccine, the answer was: 'What if one of the teachers is pregnant?'

"So we went to the health department this morning, and a woman who I imagine is a nurse asked me what shots my son had already received. I told her he had received a DPT shot and the oral polio vaccine last month from our doctor. All he needed now was an MMR. 'Oh we can give him another DPT, since it's been a month,' she said. When I questioned if he should really be getting another shot, she stopped, thought a moment and then said, 'Oh, that's right, he won't need a DPT booster for another year.' If I hadn't questioned her, would he automatically have received another shot? And how would it affect him if he had it on the same day as an MMR shot?

"Next, I was given a release form to sign. The form describes the diseases and possible side effects of the vaccine. It states that, if a person who receives the vaccine gets sick within four weeks after the shot, it should be reported. But the blank which should have contained the information on where to report such a reaction was not filled in. At the bottom of the page was room for the parent's signature and a place for the lot number, site of injection and date, along with a notation to please keep the upper portion of the form for your records.

"After my son received his shot, the nurse put the form on a pile without filling in the information on lot number and date. I asked her whether a record of the lot numbers was kept, and she said I could call at any time and get that information. With so many children being taken care of in one day, I wonder about the accuracy of information that is not filled in until later in the day.

"When I tried to tear off the upper portion of the form, the nurse stopped me, explaining that they had to keep the whole sheet for their files. But since I wanted to keep the information on the side effects, she told me to speak to the receptionist (who was busy interviewing mothers) and maybe she would give me a copy. This meant I had to cut into the long line of mothers and babies, and while I felt badly about doing this, the only alternative was to wait another hour or two. The receptionist insisted she couldn't give me a blank release form because she needed them for the patients. When I persisted, she offered to Xerox a copy of the form. This involved her leaving her desk and going down the hall to another office, keeping everyone waiting until she got back. When she returned, I realized she had Xeroxed both sides of the release form and handed me a piece of paper identical to the ones she was holding in her other hand!

"It bothers me that the people handling the immunizations not only seemed to be inept, but also that they acted as though they were doing me a favor and that they knew what's best for me and for my children. There was no time for discussion about my feelings or fears. It's hard to believe that here in America we have no freedom of choice about the kind of medical care our children receive. My son was breastfed and he is very healthy, and if I were allowed to do what I feel is best for him, he would not be immu-

(Cont'd on page 7)

Doctors aren't the only critics of immunizations. An anonymous lay person, writing under the pseudonym, Elben, has published an almost 500-page book entitled, "Vaccination Condemned" (Better Life Research, P.O. Box 42002, Los Angeles, CA 90042, $12.50). The most significant feature of this book is an extensive presentation of more than 100 years' historical opposition to immunizations.

Immunization fight heats up

Now that millions of Americans are becoming aware of the dangers of immunizations (particularly, but not exclusively DPT), a counterattack is being launched against those who have pointed out those dangers. While some doctors now are admitting that immunizations may cause mental retardation, cerebral palsy, and other forms of brain damage, they concurrently are saying that the incidence of these complications is so low that the benefits of the immunizations outweigh the risks. They claim that epidemics of whooping cough, polio, and other diseases will return if people reject immunization.

Meanwhile those who have critized immunizations are continuing their attacks. A new booklet, "Vaccinations and Immune Malfunction," written by Harold E. Buttram, M.D., and John Chriss Hoffman (The Humanitarian Publishing Co., Quakertown, PA 18951, 1982) reinforces the same company's earlier publications ("The Dangers of Immunizations" and "How to Legally Avoid Unwanted Immunizations of all Kinds").

AIDS?

While vaccine enthusiasts claim that vaccinations enhance one's immunity, the above authors conclude, "The real danger appears to be an indirect effect with impairment of the immune system." Vaccinations lower the body's resistance, but since this effect (malfunctioning of the immune system) often is delayed, indirect and masked, its true nature is seldom recognized.

During Congressional hearings investigating immunizations, Dr. J. Anthony Morris characterized the testimony of the vaccine enthusiasts as "either misleading, self-serving, or both." The transcript of these hearings (the May 7, 1982 hearings were chaired by Senator Paula Hawkins; transcripts available from her, c/o Senate Office Building, Washington, DC), contains statements from proponents of these vaccines, from opponents, and from parents whose children have been damaged.

On Thursday, September 15, I gave a public lecture in Little Rock, Arkansas. That same morning, the Arkansas Democrat had carried a story about six-year-old Justin Douglas Cook of Pine Bluff, Arkansas, who was excluded from first grade because his mother had refused to let him be immunized. She had objected because of problems that had occurred after DPT shots given when Justin was a baby. The Health Department had granted a waiver on the DPT series of shots, but the department insisted that Justin receive vaccines against measles, rubella, and polio. Mrs. Cook maintained, "If they can't tell me, in writing, that he will not go into a coma or die after the shots, I don't want him to have it."

Since the audience to which I spoke was keenly interested (as are audiences I speak to around the country) in the immunization controversy, I mentioned the story to them, pointing out how fortuitous it was for me to be in Little Rock at that particular time. Several members of the audience then told me that, after the article had appeared that morning, television news had carried reports that Mrs. Cook had taken her child

ZATION

y Carol Horowitz

Back to school means many things to American families—time to buy schoolbooks, pencils, maybe new shoes, and now in forty-nine states it means pulling out the children's immunization records and checking to see whether they'll require any back-to-school shots. In every state except Wyoming, children are not allowed to enter school unless they are current on all the immunizations mandatory in the state or their parents refuse to permit immunization on religious grounds.

Wyoming is the only state without mandatory immunization because it has the highest voluntary immunization rate. It was when a rubella (German measles) epidemic hit Casper, Wyoming, in 1971. The health officials were shocked that a well-immunized community should not have a rubella epidemic. And it did, and because of this epidemic Casper is now famous in the medical world as the place where the entire theoretical basis of rubella immunization was proved false.

Soon after the epidemic, Drs. Louis Sexton and Te-We Chen wrote an editorial for the highly respected *New England Journal of Medicine*. They discussed the Casper case and other well-known examples of immunization failure, and concluded that "Although immunization of young children may not be given up, it strikes us that laws to make immunization against rubella compulsory that have been passed in some parts of the country cannot be defended and should be repealed."

These laws have not been repealed. In fact, they are being enforced more vigorously than ever before.

The Immunization Drive: Who's Behind It?

The state legislatures have passed laws mandating immunizations primarily at the urging of the Center for Disease Control (CDC), a powerful arm of the Department of Human Services (previously HEW) based in Atlanta, Georgia. With the establishment of laws requiring certain immunizations, CDC took a big step toward taking children's health out of the realm of parental choice and placing it in the hands of politicians.

On the surface, there may seem to be nothing wrong with this move: public health officials often make recommendations to state legislatures, and in turn the states pass laws mandating the recommendations. Looking beneath the surface, however, it is possible to find a lot wrong with the legislation of health care, both from the standpoint of civil liberties and the standpoint of health.

CDC does more than just set health policy on immunization; it also distributes vaccines to state immunization programs, providing them with the financial advantages of bulk buying. But who really benefits from bulk buying? The drug companies, who then need only one contract for millions of doses and can cut down on shipping and packaging costs. The drug companies even save on advertising, since CDC also distributes "educational information" about the vaccines to clinics, doctors, and parents. CDC's main educational materials were in fact produced by Merck, Sharpe, and Dohme on a grant. Merck is one of the largest producers of vaccines in the world. The information that the company provides is, naturally, totally proimmunization; it ignores potential problems with the vaccines (including side effects) and plays heavily on parental fears and guilt. In essence, CDC, using our tax money, paid Merck, Sharpe, and Dohme to promote its own products.

What Are Vaccines?

Vaccines are injections that contain small amounts of the disease virus that they are meant to protect against. They work by stimulating the body to produce antibodies—proteins that defend the body from an invasion by harmful microorganisms. Ordinarily, the body develops antibodies in two ways: (1) A mother shares antibodies with her child while it is still in utero and through breast-feeding; and (2) the body develops antibodies during exposure to a disease. In most cases, antibodies produced naturally will provide permanent, lifelong immunity.

Vaccines, on the other hand, generally induce an immunity as good as that produced by a wild virus. Blood tests measuring the levels of antibodies present for various diseases show that vaccine viruses produce fewer antibodies, and follow-up tests show that in many cases these levels continue dropping—even to the point of no longer providing any protection.

Horowitz, M.P.H., lives and works in New Mexico, where her independent research on immunization cost her a job with the State Health Agency.

Photo by Terry Hansen

Problems with Vaccines

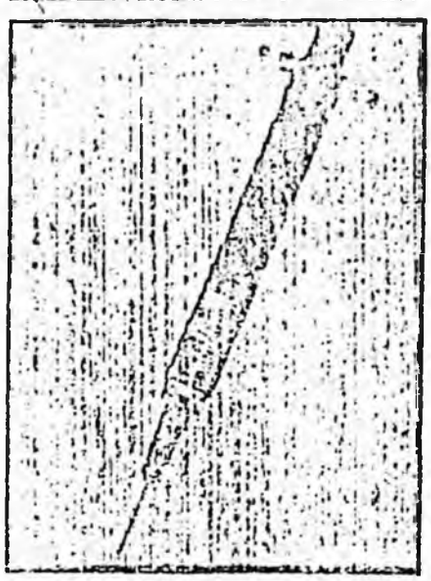
Every vaccine produces side effects in some of the people who take it. The most famous example is the swine flu vaccine, which caused such serious side effects—including death among the elderly and Guillain-Barre syndrome, a painful and crippling nerve disease – that it had to be taken off the market only six months after its development. A fiasco in every sense, the swine flu vaccination campaign nonetheless remained a financial success for the drug companies involved: of the $135 million appropriated by Congress to fund the entire drive, $100 million went directly to drug companies to buy the vaccine.

This expensive debacle led to the first massive public questioning of our national immunization policy, and many health practitioners, like Dr. Sidney Wolfe of the Washington DC Health Research Group, began to express the belief that "Unless there is a real need and unless the preventive measure is effective and also safe, relative to the disease it seeks to prevent, the prevention or cure may be worse than the disease."

". . . Every vaccine produces side effects in some people, and many vaccines present some very real risks . . ."

Many vaccines present some very real risks,* and it is indeed questionable whether the diseases they're designed to prevent merit taking chances. Now that many serious and life-threatening diseases such as smallpox, polio, and diphtheria have fairly effective vaccines, research scientists—with vast economic support from the drug companies—have been developing vaccines against less serious illnesses such as rubella, mumps, and measles in a race for patents and profits. As the influential British medical journal *The Lancet* noted as long ago as 1969, early on in the vaccine era, "More and more vaccine viruses should not be foisted upon us just because it is possible to make them."

How Vaccines Are Born



The federal government requires that vaccines, like all new drugs, be tested by the Food and Drug Administration (FDA). However, in actual practice, most of the testing is conducted by the companies themselves or by university professors paid by company grants. A human rights crisis exists with the selection of human test subjects: almost without exception, new drugs are tested on poor and powerless people in the U.S. and around the world—Third World citizens, prisoners, and, in the case of vaccines for childhood diseases, the mentally retarded.

The testing of vaccines is especially controversial because they must be tried out on healthy people (whereas drugs designed to cure an illness are generally tested on those already afflicted, who are likely to have a personal interest in seeing a cure developed). Outrage at the unprincipled testing of vaccines led the World Health Organization to draw up some guidelines at an international hearing held in 1976: WHO stressed that all participation should be voluntary, and the risks should be clearly explained. Such ideals are commendable yet impractical, for at the time of testing, the risks remain theoretical; in fact, the express purpose of the tests is to determine whether the benefits outweigh the risks.

The introduction of a pneumonia vaccine onto the market—this new vaccine became commercially available in February 1978—provides a much more realistic picture of how vaccines are tested in the world today. A prototype of pneumonia vaccine was first tested on South African gold mine workers in 1912, and again in 1970. Brought from warm, sunny areas of Africa on work contracts to live and work in horrible, overcrowded, dark and wet conditions, these miners, not surprisingly, have the highest rate of pneumonia of any group in the world.

The tests begun in 1970 involved 12,000 gold mining novices at the East Rand Proprietary mine near Johannesburg. The mine ownership received a gratuity from Merck, Sharpe, and Dohme for the testing, but the miners were unpaid "volunteers." Rather than urge their South African corporate counterparts to improve the working and living conditions of the miners in an attempt to eliminate or reduce pneumonia, the American drug company chose to take advantage of these conditions to search for a vaccine that could earn them billions of dollars.

A second test of the vaccine was done on 12,000 adults in the isolated highlands of New Guinea. The number of cases of pneumonia was not reduced during the study; however, the company—with no apparent scientific basis—claims that the severity was reduced.

Thus far, federal recommendations for the use of pneumonia vaccine appear cautious, but in reality large numbers of people are being urged to receive this vaccine, including the elderly, and people with sickle cell anemia, diabetes, and liver disease. Since the government is under constant pressure by the drug companies, it seems likely that mass immunization against pneumonia will be suggested soon.

Some Prevalent Vaccines

Rubella vaccine provides the most blatant example of a very strong drug being universally abused through the recommendation of the federal government. Rubella (also known as German measles or three-day measles) is a mild disease in both children and adults; it only causes problems for pregnant women, since the rubella virus can attack the fetus and cause severe deformities called congeni-

* The information provided to parents about vaccines is usually oversimplified and tends to gloss over potential side effects. If you want to find out the problems with vaccines that generally only doctors know about, ask to read the package inserts that the drug companies are required to provide by federal law.

he ruth bout IMMUNIZATION

rubella syndrome (CRS). Thus, there absolutely no medical basis for ever immunizing males against the disease; only sensible application for rubella vaccine would be for nonimmune women childbearing age. (The vaccine would ve to be administered at least a few nths before a planned pregnancy, ce the vaccine alone can cause CRS.) e logical approach, followed by many ntries in Europe, involves testing and ating a maximum of 20 percent of the men of childbearing age, since 80-85 rcent of the population develops *ural* immunity by adolescence, by ving been exposed to the disease.

CDC, however, has declared an all-out ar on rubella: in 1977 more than 70 million doses of rubella vaccine were administered. This deluge may have done little r public health, but at an average cost f $12 per vaccination, the drug companies—with the encouragement of the deral government—managed to generate $840 million in revenue by pro- a treatment that is totally unnecessary in the majority of cases.

Ironically, CDC's ultimate goal is 80 rcent immunization—some 5 percent ve than the natural immunity level. Sad, as is the case with many vaccines, e protection provided by immunization is apt to be less dependable than xposure to the wild virus: reinfection has en proven to occur ten times more ften in vaccinees than in natural mmunes. Many times the reinfection is ubclinical, which means that there are o apparent symptoms. This situation is ery serious because it means that more eople—including pregnant women—may be unwittingly exposed to the virus. As the *New England Journal of Medicine* noted in 1970, under the present olicy "the potential risk of fetal rubella might be *increased* rather than *decreased*."

Measles vaccine originally appeared to make more sense as a potential antidote for what can be a very serious disease. However, it too has engendered ntroversy in recent years. The main oblem with measles vaccine is that it cannot help the group most at risk from the complications of measles: very young children. When the vaccine was originally licensed, infants were immunized, however, continuous vaccine failure indicates that the vaccine does not provide protection to children younger than fifteen months, because of the amounts of maternal antibodies still present in their bodies. A study done in St. Louis after a large measles epidemic concluded that the possibility of eliminating measles via immunization was "bleak."

Since measles can be a serious disease, it's easy to understand the search for a vaccine to prevent it. Mumps, however, is in a class with rubella—neither very serious nor long-lasting, especially among children. Mumps can be a very uncomfortable disease when contracted by teenagers and adults, but even then it has few dangerous side effects. One possible side effect—though an *extremely* rare one, despite popular belief—is sterility among mature males. Thus it might make sense to immunize preadolescent and older males who have not had the disease, but to inoculate an entire population against such a benign disease is clearly worth neither the effort nor the expense involved.



Merck, Sharpe, and Dohme, however, has found a way to get more out of its mumps vaccine patent. (Each vaccine patent gives the pharmaceutical company exclusive rights to the vaccine for thirteen years.) The company has come up with a triple vaccine which combines measles, mumps, and rubella vaccines in one injection. With CDC's endorsement, and the practical advantage of combining three trips to the doctor in one, this "multi-vaccine," known as MMR, is well on its way to becoming the most commonly administered vaccine. Yet it is so new, there is no way of telling whether it will work—whether a child receiving three different viruses at the time will develop enough antibodies to each virus to actually provide protection. Also unknown is the effect of dosing young children with three viruses simultaneously. Since all three of the component parts can incur problems, it is hard to imagine that the combination will be free of harm.

Immunization Policy and Personal Choice

Unfortunately, at present the choice whether to immunize a child is not left to the parents, but dictated by the government—and ultimately by the drug companies. In many states parents who do not wish to have their children immunized *can* fill out a "Certificate of Conscientious Objection to Immunization," but the reasons they cite must be religious beliefs—whether held "individually or with others." To date no provision is made for parents with scientific objections to specific immunizations (even those which the medical community questions): they cannot legally refuse to immunize their children for medical reasons and still keep them in school.

Gradually, though, the government's arbitrary, overzealous approach to immunization is forcing parents, community-minded lawyers, and dissident health professionals to band together to put an end to mandatory immunization. If enough people begin to refuse immunizations by becoming conscientious objectors, perhaps the laws will be changed and choice returned to the people.

■

Carol Horowitz would like to hear from people who have refused immunization, for a possible follow-up; please write her c/o New Age

VACCINATIONS—A TIME RELEASED DISEASE ?

(Continued from Page7)

childhood disease is more severe when an adult contracts the disease.

The measles vaccine was developed exclusively to prevent measles encephalitis. The vaccine has become exclusively associated with the cause of measles encephalitis. Also frequently occurring with this measles vaccination are neurological and fatal conditions such as ataxia (dis coordination, retardation, hyperactivity, aseptic meningiditis, seizures, and hemiparesis (paralysis of one side of the body). The German measles or Rubella vaccine also appears to do more harm than good. There is a very high risk of arthritis in children (Robert S. Mendelsohn wonders whether the current epidemics of hyperactivity in children may have its origins, at least part, in the measles vaccine (Confessions of a Medical Heretic)

All these diseases and vaccines to combat them are something to be quite concerned about. Recently published in the Aug 60 Issue of Good House Keeping was a two page article, once again hailing the miraculous vaccines and the diseases they prevent. Not one word was printed as to the side effects of the vaccines themselves.

They reported the phenomenal success the United States Government, the same group who brought you swine Flu Vaccines, was having in combatting and preventing all seven commonly occurring childhood diseases. Not one word was written on the adults contracting these childhood diseases because the vaccines had for stalled the childhood disease and then failed. Also within the article was the statement "no shots, no admittance to school"! This statement is totally wrong and misleading. No one can be forced to submit to any vaccination. In fact compulsory vaccination or any tax supported vaccine program violates the Declaration of Independance, The United States Constitution, Article IX and X 1789, The Preamble, and Article Six of The Bill of Rights.

The Declaration of Independance states that "All men are endowed by their creator with certain unalienable rights, among which are life, liberty and the pursuit of happiness."! Forced vaccination violates all these rights. The Sixth Article of the Bill of Rights promises, "The right of the people to be secure in their persons shall not be violated" Enforced innoculation violates these rights.

This year, once again the Flu Scare is being promoted, for 1981 the vaccine will immunize against Type A Brazil, Type A Bangkok, and Type B Singapore but because the strains are changeable, the vaccine is prepared according to which strains experts believe will be prevalent in the next year. Could this just be a way of using up the left over Swine flu vaccine, which really was never made because there was no swine flu?, or could it be any number of other vaccines less widely used but also in abundance?

Just recently the Philadelphia Inquirer, (July 13, 1980), printed an article titled "Smuggled report contends Soviet germ-plant blast killed thousands." It was an eyewitness account of a mysterious epidemic that swept the Soviet city of Sverdlovsk in April 1979. The reports alleges that "1000 people died of gases released by an explosion in the plant. The officials stated anthrax was the problem, but not one animal died although many people did. The residents were forced to undergo vaccinations, but these proved ineffective and caused deaths according to the author."

The point is, no one can deny the proof that vaccinations do kill. If one person dies, it is one person too many, and the program should be stopped and investigated. There is a catch 22 in all this vaccination business. The vaccines are called preventative measures against disease, they have never been proven to prevent. And yet they have never been halted even though thousands of people have died and who knows how many millions of people are paralysed even in the slightest degree. You can't enter school to gain an education without submitting yourself to being injected with these vaccines which might retard, cripple, and possibly kill you.

The public must seek out the other side of the story. They must read books and newspapers and have faith in their own decision and their bodies own natural defence mechanisms for if they do not, it has been said, "Those who do not learn from the past are condemned to repeat it." (George Santayana)

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pgs 207 and 208 Aug 1980

SPECIAL THANKS TO:

Joe Strauss
Lee Stewart, D.C.
Mike Frigiola D.C.
Glenn Stenwagon D.C.
Larry Bird
Carm Miceli

This ruling clearly shows that the federal government, [illegible]

VACCINATIONS—A TIME BORROWED DISEASE!

by LEE DeBILL

or many years now vaccines
ve been given to the public
h the claims of wiping out
ks, smallpox, diptheria,
shoid and other contagious
ases. Many believe, this is a
e statement and could not be
ther from the truth. Some
ieve it was the introduction of
sanitation and improved nutri-
s which reduced disease. Let
s review history for some far-
sight.

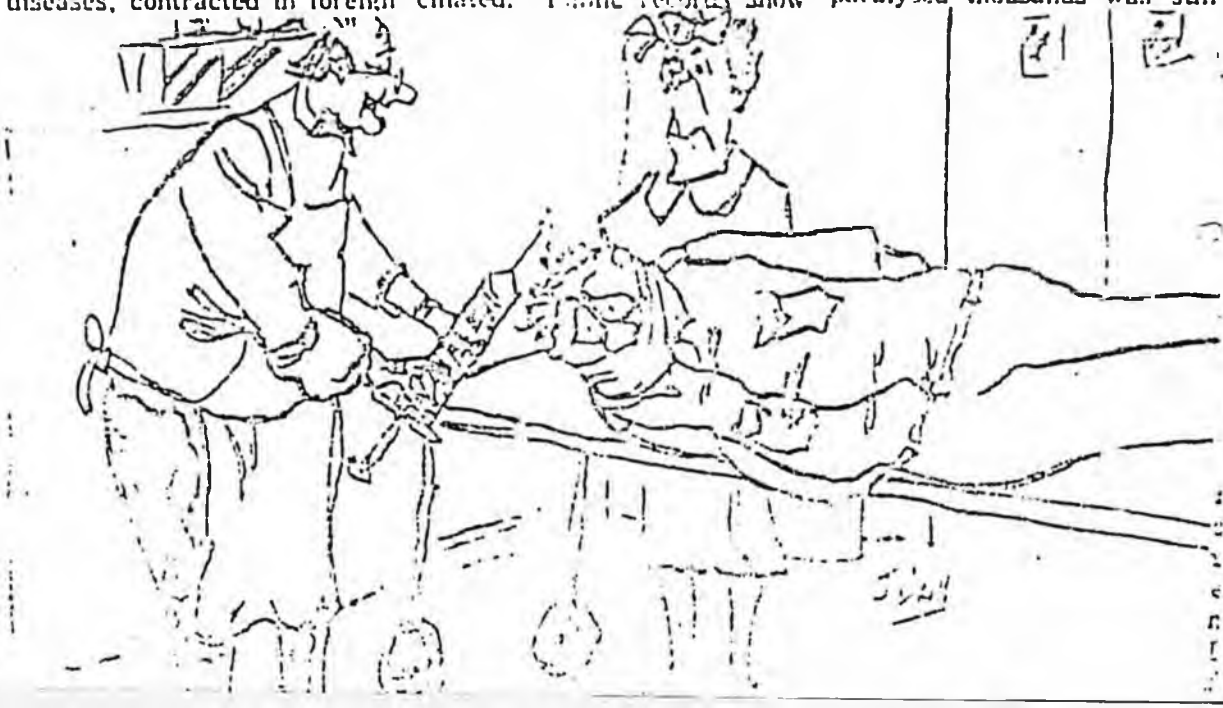
When the epidemics swept
rope in the 18th century, we
re taught to believe that they
re finally controlled by vac-
nation. Checking the records,
opposite situation can be
ld to be true, that these
lemics were actually caused
vaccination. Following, are a
medical reports of that time
iod.

ipan startedcompulsory vac-
ation in 1872 and continued
over 100 yearswithdisastrous
lts. Small pox was not
ed out as expected but in-
sed every year. By 1892 the
ords showed that 165,774
es of small pox had occurred
29,079 deaths, all of whom
e vaccinated. While in
tralia where they had no
pulsory vaccination, only 3
hs due to small pox were
rded in 15 years.

Germany at the beginning
W. II (1939) vaccination for
heria was made compulsory
the diptheria rate soared to
0 cases. All these cases
ere vaccinated. At the
back in history to that 1918 flu
period we will see that it suddenly struck just after W.W. I, when our soldiers were returning home from Europe. That was the first war that all known vaccines were forced on all servicemen. The drugs and proteins of which the vaccines were composed of caused such wide spread disease and death among the soldiers that it was common talk of the day that more of our men were being killed by medical shots than enemy shots. Theusands of men were quarantined to home or military hospitals as hopeless cases long before they ever saw a day of battle. The death and disease rate was four times higher than among unvaccinated civilians. At this same time, the civilians were told the soldiers were coming home with many dreaded diseases, contracted in foreign

The polio vaccination drive of 1954-1955 was a similar disaster. Records reveal thousands of previously healthy people were killed or paralyzed by vaccines (Salk and Sabin). Millions of dollars in damages were paid to the victims of that polio vaccine campaign, but most cases were hushed up by calling them another name or disease. During the vaccination disaster of 1954-1960 Morris A. Beale, a publisher and writer offered $50,000.00 to anyone who could prove that the polio vaccine was not a killer and a fraud. No one ever collected that $50,000.00. The lawsuits proved that the vaccine was deadly from the start.

There was a marked increase in polio among the vaccinated as compared to the unvaccinated. Public records show



and programs. Dr. James A. Shannon of the National Institute of Health stated "The only safe vaccine is a vaccine that is never used." The famous scientist Dr. Wm. F. Koch, M.D., Phd. stated "The injection of any serum, vaccine or even penicillin has shown a very marked increase in the incidence of polio, at least 400 percent.

"Statistics on this are so conclusive no one can deny it." Surgeon General Leonard Scheele, who was overseeing the countries largest polio drive told the A.M.A. convention in 1955 that "No batch of vaccine can be proved to be safe before it is given to children." Dr. Salk, the inventor of the polio vaccine admitted "No reliable test of safety to the vaccine is known." Yet this vaccine which killed and paralysed thousands was still

flu, measles, mumps and polio may actually be seeding humans with RNA to form pro viruses which will then become latent cells throughout the body. . .some of these latent pro viruses could be molecules in search of diseases' which under proper conditions become activated and cause a variety of diseases. . .(including rheumatoid arthritis, multiple sclerosis, lupus erythematosus, parkinson's disease and perhaps cancer)" (Report to Consumer, June 76-No. 127).

In 1968 a paper was published in Arch Intern Med which proved that Guillain-Barre paralysis was caused by vaccinations, not just in Isenza vaccine but other vaccines as well. In 1969 (Epid. Aspects of Imunization) another paper proved that blindness and brain damage was associated with innoculations.

In an article, published in Science (March 4, 1977) Jonas Salk was quoted "Live virus vaccines against influenza and paralytic poliomyelitis may in each instance produce the disease it intended to prevent. . .the live virus vaccine against measle and mumps may produce side effects as encephalitis (brain damage), and the killed virus vaccines against measles and the respitory syncitial virus have caused undesirable hypersensitivity reactions in individuals subsequently exposed to natural infections."

More recently, in 1976, the Swine Flu Vaccine program was enacted by President Ford. At that time there was not one

Ask Dr or nurse giving the shots:

Will you guarantee its safety and effectiveness?

way there were [illegible] 50 cases.

And in yet another country, the Netherlands (1929-1929), there were 129 cases of post-vaccinal encephalitis (inflamation of the brain from vaccine poisoning) and 40 deaths from it.

Two hundred and fifty years ago, in 1717, arm to arm vaccination was introduced into England and Europe. In 1796 Edward Jenner started the cowpox vaccination craze which increased the small pox epidemic to such an extent in 1838 that 22,681 people died from it.

Years later, in spite of absolute proof that vaccination had deadly effects a compulsory vaccination law was passed in [illegible] in 1853. The epidemics increased, and by 1872 the small pox epidemic of all time killed 44,840 people. The English people fought the vaccine promotors until they were able to abolish compulsory vaccines in England in 1948. They have had no epidemics in England since.

Our own U.S. Government staged a compulsory vaccine campaign in the Philippines which brought on the largest small pox epidemic in the history of that country with 162,502 cases and 71,153 deaths. All of these people were vaccinated. This occurred between 1917 and 1919.

Very few people even realize that the worst epidemic ever to hit America, The Spanish Influenza of 1918, was the after effect of a massive nation-wide vaccine campaign. If we check lands and that it was the patriotic duty of every man, woman and child to get protected by going to the vaccination centers and receiving all the shots.

The biggest tragedy here was that most people believed their doctors and government officials and did exactly what they said. The result was submission to shots without question. It was only hours later that people started dropping dead with a disease of such virulence that no one had ever seen before. These diseases all had the symptoms of the diseases they had been vaccinated against. The high fever, chills, pains, cramps, diarrhea of typhoid, the pneumonia congestion of diptheria, the hepatitis of jungle fever, sores from small pox plus paralysis from all the shots.

The doctors did not want this massive vaccine disease to reflect upon them so it was called Spanish influenza. 20 million people died from the flue epidemic. Greece and a few countries who did not except the vaccine, were the only ones who did not contract the flu.

The only people in the United States who escaped the influenza were there who refused the vaccinations.

that the vaccine did not wipe out polio but caused it.

In the Illinois Medical Journal (Aug. 1950 pp 61-63) a statement appeared by Dr. Langmuir (Head of Polio Surveillance of U.S. Public Health Service). After the nationwide polio drive of 1954 and 1955, he was quoted as saying "I will predict that by 1957 there will be less than 100 cases of paralytic polio in the United States." The record shows that within 4 years there were 5,694 cases of polio. The highest incidense of polio was in the five states that had compulsory shots.

1. North Carolina - 78 cases in 1958, 313 cases after the shots.
2. Connecticut - 45 cases in 1958, 123 cases after the shots.
3. Tennessee - 119 cases in 1953, 303 cases after the shots.
4. Ohio - 17 cases in 1958, 52 cases after the shots
5. Los Angeles California - 39 cases in 1958, 149 cases after the shots.

Note - In 1931 California enacted an escape clause for the shots.

Even though public records showed beyond shadow of doubt [illegible] caused the disease [illegible] promoted.

Casualties were also reported from the Sabin oral vaccine. Many of these cases were proven in court. Eleven cases of paralysis were reported September 15, 1961 in Syracuse, N.Y., and the vaccine promoters had to pay millions of dollars in damages. Failure of the vaccine, and the lawsuits brought about by it, caused four out of five companies producing it to drop out of the market. The fifth, Lederle, is still making the vaccine today, but will not give any guarantee of its effectiveness or safety. No doctor will guarantee safety or effectiveness either.

In October 1976 the Senate Committee heard testimony proving that the polio vaccine had caused all the reported cases of polio since 1961 and that the vaccine may be riskier than no vaccine at all. Since 1973 the Center for Disease Controll has admitted that over one half of all polio cases were vaccine associated. In July 1969 the International Medical Journal was advising the profession to "re-evaluate the principles, purposes, and hazards of immunization."

Dr. Robert W. Simpson of Rutgers N.J. stressed that "Mass immunization programs against

Dis was diagnosed as having Victorian Flu. But e swine flue had been fou vaccine would not have st it anyway. Dr. Anthony Mo noted vaccine experimen said that there was nev authentic swine flue va made, because there w swine flu to test it on. million was spent in advan the vaccine companies develop a vaccine for a existant disease. As of 23, 1979, 3,637 claims were for personal injury tot $3,351,065,797. 34 of these cl were for wrongful death t ing $344,908,214, and 1,045 cl werefor Guillian-Barre para totalling $952,549,317.

Many people who died were paralysed could have sparial if information had released as to the side effe any vaccine whether it be f flu, measles, mumps, whoo cough or diptheria.

Diptheria which is virt non-existant is still being cinated against even thoug percent of the people recei the vaccine contract the dis Upon vaccination for whoo cough, the possibility of fev convulsions and brain damag too high to ignore. Danger great that many p authorities prohibit the us the vaccine after the age o The Mumps vaccine exp children to the disease later in life after the vaccine wo [illegible] done by

(Continued on Page 5)

AS14.30.125 DOCUMENT= 1 OF 1 PAGE = 1 OF 2

CHAPTER = 14.30
SECTION = 14.30.125
TITLE = 14

HEADINGS TITLE 14.
Education.
CHAPTER 30.
Pupils and Educational Programs for Pupils.
ARTICLE 2.
Physical Examinations and Screening Examinations.

CITATION Sec. 14.30.125.

CATCH LINE
IMMUNIZATION.

TEXT If in the judgment of the commissioner of health and social services it is necessary for the welfare of the children or the general public in an area, the governing body of the school district shall require the children attending school in that area to be immunized against the diseases the commissioner of health and social services may specify.

HISTORY (Sec. 45 ch 98 SLA 1966; am sec. 2 ch 131 SLA 1967; am sec. 6 ch 104 SLA 1971)

(b) District boards shall determine which employees, if any, are exempt from the physical examination requirements.

(c) These regulations shall not be construed as exempting employees from taking physical examinations required by other regulations or law – i.e., food handlers, bus drivers, etc.

(d) Repealed 6/10/83.

(e) Each employee of a school district or private elementary or secondary school shall obtain a tuberculin skin test annually in the manner required by AS 18.15.145. (Eff. 10/9/66, Reg. 24; am 10/10/69, Reg. 29; am 5/30/71, Reg. 38; am 7/9/72, Reg. 42; am 10/4/73, Reg. 47; am 5/10/78, Reg. 66; am 6/10/83, Reg. 86; am 8/30/86, Reg. 99)

Authority: AS 14.07.020(7)
AS 14.07.060
AS 18.15.145

Editor's Note: The history note that appeared under 4 AAC 06.050 before Register 86 (July 1983) was found to be incorrect. With the distribution of that register, the note has been corrected.

4 AAC 06.055. IMMUNIZATIONS REQUIRED. (a) Prior to first entry in an Alaska public school district or nonpublic school offering pre-elementary education through the 12th grade, or any combination of these grades, a child shall be immunized against diphtheria, tetanus, polio, pertussis, measles and rubella, except that pertussis is not required in children over six and rubella is not required in children 12 years or older

(b) This section does not apply if the child

(1) has a valid immunization certificate defined as

(A) an international immunization certificate; or

(B) a statement by a physician listing the dates of immunizations; or

(C) a copy of clinic or health center record showing the immunization requirement has been fulfilled;

(2) has an affadavit signed by a physician (M.D.) or osteopath (D.O.) licensed to practice in Alaska affirming his opinion that immunization would be injurious to the health and welfare of the child or members of his family or household;

(3) has an affidavit signed by his parent or guardian affirming that immunization conflicts with the tenets and practices of the church or religious denomination of which the applicant is a member.

(c) A student registering in a school in a community where regular medical services are not available on at least a weekly basis and who does not have the required immunizations, may be provisionally admitted to a pre-elementary, elementary or secondary program for a reasonable period of time for the prevailing circumstances but not exceeding 90 days after

enrollment. No children will be provisionally admitted except in exceptional circumstances. Where exceptions are granted, they shall be reported to and discussed with the Communicable Disease Section of the Division of Public Health, Department of Health and Social Services, who will then be responsible for determining that the required immunizations are completed during the provisional period.

(d) If a parent or guardian is unable to pay the cost of immunization, or immunization is not available in the district or community, immunization shall be provided by state or federal public health services.

(e) Immunizations shall be recorded on each pupil's permanent health record form.

(f) School districts shall initiate action to exclude from school any child to whom this section applies but who has not been immunized as required by this section. (Eff. 1/13/73, Reg. 44; am 8/28/77, Reg. 63)

Authority: AS 14.07.020(7) and (8)
AS 14.30.125

4 AAC 06.060. SUSPENSION OR DENIAL OF ADMISSION. (a) In the district schools, the superintendent or principal may suspend pupils under the provisions of AS 14.30.045, and the pupils may be reinstated by the superintendent or principal or by the school board.

(b) Expulsion or denial of admission of a pupil shall be only upon the action of the governing school board in a district school.

(c) A pupil suspended or expelled under this section may appeal to the district board. (In effect before 7/28/59; am 9/24/65, Reg. 20; am 9/8/66, Reg. 24; am 1/9/68, Reg. 26; am 5/10/78, Reg. 66)

Authority: AS 14.30.045

4 AAC 06.070. ELEMENTARY COURSE OF STUDY. The Course of Study for the Elementary Schools in Alaska, reissued by the department in 1971, is officially adopted as the standard for elementary schools. (In effect before 7/28/59; am 5/30/71, Reg. 38)

Authority: AS 14.07.020(4)

4 AAC 06.075. HIGH SCHOOL GRADUATION REQUIREMENTS. (a) Each chief school administrator shall develop and submit to the district board for approval a plan consisting of district high school graduation requirements. The plan must require that, before graduation, a student must have earned at least 21 units of credit.

(b) Specific subject area units-of-credit requirements must be set out in each district plan and must require that, before graduation, a student must have completed at least the following:

(1) language arts – 4 units of credit;

(2) social studies – 3 units of credit;

(3) mathematics – 2 units of credit;

(4) science – 2 units of credit;

(5) health/physical education – 1 unit of credit.

(c) Districts which do not require 21 units of credit for graduation on June 16, 1984, must increase their requirements by at least one unit each school year until the number of units required attains or exceeds 21.

(d) Transfer students who have earned 13 units of credit while in attendance outside the district may, at the discretion of the district, be excused from the district subject area units-of-credit requirements.

(e) Districts which do not require the subject area units of credit for graduation required by (b) of this section on June 16, 1984, must increase their subject area units-of-credit requirements by at least one each school year until the number of units of credits required in each subject area attains or exceeds the requirements imposed by (b) of this section.

(f) As used in this section, "unit of credit" means the credit that a student is awarded for achieving a passing grade in a course of study consisting of at least 8,100 minutes of class time during the school term. (Eff. 3/1/78, Reg. 65;

TRUTH BULLETIN # 25:
A M.D. who was an AMA employee for 10 years and who called himself "Sore Throat," sent copies of secret AMA documents and memos to various outsiders that revealed that the powerful doctors' union "will stop at nothing to increase its own power" and increase the flow of money to itself and the drug makers. The documents showed that the AMA used every method it could to get AMA members placed in government positions, that it "'laundered' AMA money so it could be secretly given to politicians who would look out for AMA interests," that it managed to avoid $21 million in taxes on money made from massive drug ads in its journals, that some of the "Sore Throat" material indicated'"the AMA is involved in a kind of conspiracy with the federal government, the purpose of which is the elimination of drugless healing in the United States.'" The AMA defines "quackery" to mean "anything that the AMA doesn't agree with."[From: PREVENTION, Feb.,1976,"Things Here and There,"by M. Bricklin, pp.89-90]

TRUTH BULLETIN # 26:
Americans swallow more than 80 million aspirin tablets every day; that's 29 billion tablets each year. Few realize that aspirin can kill; a small overdose(about 30 tablets) can be fatal to adults, and aspirin disguised as candy for children poses a real menace. Too much aspirin depresses the brain's respiratory system, causing the victim to stop breathing, but even a standard 1-3 tablet dose can have serious side effects. In conjunction with alcohol, aspirin can cause ulcers. Large amounts of aspirin taken for long periods cause ear ringing and even deafness, may damage the lungs' lining, and in pregnant females influences the fetus.[From: SCIENCE DIGEST, June,1986,"Aspirin The Newest Wonder Drug," by S. Shapiro, pp.50-55]

TRUTH BULLETIN # 27:
"Immunization programs against flu, measles, mumps and polio," said Robert Simpson, M.D. of Rutgers University,"may actually be seeding humans with RNA to form proviruses, which will then become latent cells throughout the body...whichunder proper conditions become activated and cause a variety of diseases...including rheumatoid arthritis, multiple sclerosis, lupus, Parkinson's disease and perhaps cancer."[From:THE SPOTLIGHT, "Researchers Rap Vaccinations as Cause, Not Cure of Diseases,"by G. Deal,Ph.D,D.C., March 3,1986,pp.26-27]

TRUTH BULLETIN # 28:
'"Never in modern history has the medical profession been weaker. To a great extent, physicians are becoming seen as highly successful businessmen who are functioning with the business ethic rather than the professional ethic,'" wrote Dr. George Lundberg in the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION.

Doctors, wrote Dr. Peter H. Gott recently, have "...become more conspicious in thei devotion to money.""I think," he said,"that conspicious avarice is a major character flaw in many of today's M.D.'s"We doctors could not have predicted during our training period"...the many wavs in which financial concerns corrupt our altruism,"Gott said. [From:THE ORANGE COUNTY REGISTER,May 7,1986,"Doctors Can Treat Image by Choosing Caring Over Money,"by P.H.Gott,M.D.]

TRUTH BULLETIN # 29:
"The AMA gives generously to key congressmen and senators. And the AMA has a lot of special interest legislation in the hopper at any given time."[From: HEALTH FREEDOM NEWS, Editorial response to a Letter to the Editor, April,1986,p.30]

TRUTH BULLETIN # 30:
"According to Norman Shumway,chairman of the department of cardiovascular surgery at Stanford Medical Center, the artificial heart is a 'dangerous' device and a'gimmick to get a donor.'"[From: SCIENCE DIGEST,"Artificial Heart:A Gimmick?"June,1986,p.16]

THE FIRST TRUTH BULLETIN HAS 12 WEEKLY ITEMS. THIS SECOND MAILING HAS 18 more, WHICH will CARRY OUR CAMPAIGN TO THE END OF NOVEMBER. GODWIN.



STATE OF ALASKA
Immunization Program
IMPORTANT INFORMATION LOG SHEET

MOA C/D. 3/27/87.

Clinic/Provider Identification

I have read the information contained in the "Important Information" form(s) about the disease(s) and the vaccine(s). I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s) and request that the vaccine(s) indicated below be given to me or to the person named below for whom I am authorized to make this request.

IMPORTANT INFORMATION ABOUT MEASLES, MUMPS, AND RUBELLA AND MEASLES, MUMPS, AND RUBELLA VACCINES

WHAT IS MEASLES? Measles is the most serious of the common childhood diseases. Usually it causes a rash, high fever, cough, runny nose, and watery eyes lasting 1 to 2 weeks. Sometimes it is more serious. It causes an ear infection or pneumonia in nearly 1 out of 10 children who get it. Approximately 1 child out of every 1,000 who get measles has an inflammation of the brain (encephalitis). This can lead to convulsions, deafness, or mental retardation. About 2 children in every 10,000 who get measles die from it. Measles can also cause a pregnant woman to have a miscarriage or give birth to a premature baby.

Before measles vaccine shots were available, there were hundreds of thousands of cases and hundreds of deaths each year. Nearly all children got measles by the time they were 15. Now, wide use of measles vaccine has nearly eliminated measles from the United States. However, if children are not vaccinated they have a high risk of getting measles, either now or later in life.

WHAT IS MUMPS? Mumps is a common disease of children. Usually it causes fever, headache, and inflammation of the salivary glands, which causes the cheeks to swell. Sometimes it is more serious. It causes a mild inflammation of the coverings of the brain and spinal cord (meningitis) in about 1 child in every 10 who get it. More rarely, it can cause inflammation of the brain (encephalitis) which usually goes away without leaving permanent damage. Mumps can also cause deafness. About 1 out of every 4 adolescent or adult men who get mumps develops painful inflammation and swelling of the testicles. While this condition usually goes away, on rare occasions it may cause sterility.

Before mumps vaccine shots were available, there were more than 150,000 cases each year. Now, because of the wide use of mumps vaccine, the number of cases of mumps is much lower. However, if children are not vaccinated, they have a high risk of getting mumps.

WHAT IS RUBELLA? Rubella is also called German measles. It is a common disease of children and may also affect adults. Usually it is very mild and causes a slight fever, rash, and swelling of glands in the neck. The sickness lasts about 3 days. Sometimes, especially in adult women, there may be swelling and aching of the joints for a week or two. Very rarely, rubella can cause inflammation of the brain (encephalitis) or cause a temporary bleeding disorder (purpura).

The most serious problem with rubella is that if a pregnant woman gets this disease, there is a good chance that she may have a miscarriage or that the baby will be born crippled, blind, or with other defects. The last big rubella epidemic in the United States was in 1964. Because of that epidemic, about 25,000 children were born with serious problems such as heart defects, deafness, blindness, or mental retardation because their mothers had rubella during the pregnancy.

Before rubella vaccine shots were available, rubella was so common that most children got the disease by the time they were 15. Now, because of the wide use of rubella vaccine, the number of cases of rubella is much lower. However, if children are not vaccinated, they have a high risk of getting rubella and possibly exposing a pregnant woman to the disease. If an unvaccinated woman later becomes pregnant and catches rubella, she may have a defective baby.

Since rubella is a mild illness, many women of childbearing age do not recall if they had rubella as a child. A simple blood test can show whether a person is immune to rubella or is not protected against the disease. Overall, about one in five women of childbearing age is not protected against rubella.

MEASLES, MUMPS, AND RUBELLA VACCINES: The vaccines are given by injection and are very effective. Ninety percent or more of people who get the shot will have protection, probably for life. Since protection is not as likely to occur if the vaccines are given very early in life, these vaccines should be given to children after their first birthday; measles vaccine should be given at 15 months of age or older. Measles, mumps, and rubella vaccines can be given one at a time or in a combined vaccine (measles-rubella [MR], measles-mumps-rubella [MMR]) by a single shot. If they are given in combined vaccine, they should be given at 15 months of age or older.

Experts recommend that adolescents and adults—especially women of childbearing age—who are not known to be immune to rubella should receive rubella vaccine (or MMR if they might also be susceptible to measles or mumps). Women should not receive the shot if they are pregnant or might become pregnant within 3 months. There is no known risk in being vaccinated against any or all three of these diseases if you are already immune to any of them.

POSSIBLE SIDE EFFECTS FROM THE VACCINES: About 1 out of every 5 children will get a rash or slight fever lasting for a few days, 1 or 2 weeks after getting measles vaccine. Occasionally there is mild swelling of the salivary glands after mumps vaccination.

About 1 out of every 7 children who get rubella vaccine will get a rash or some swelling of the glands of the neck 1 or 2 weeks after the shot. About 1 out of every 20 children who get rubella vaccine will have some aching or swelling of the joints. This may happen anywhere from 1-3 weeks after the shot. It usually lasts only 2 or 3 days. Adults are more likely to have these problems with their joints—as many as 1 in 4 may have them. Other temporary side effects, such as pain, numbness, or tingling in the hands and feet have also occurred but are very uncommon.

Although experts are not sure, it seems that *very rarely* children who get these vaccines may have a more serious reaction, such as inflammation of the brain (encephalitis), convulsions with fever, or nerve deafness.

With any vaccine or drug, there is a possibility that allergic or other more serious reactions or even death could occur.

WARNING—SOME PERSONS SHOULD *NOT* TAKE THESE VACCINES WITHOUT CHECKING WITH A DOCTOR:

- Anyone who is sick right now with something more serious than a cold.
- Anyone who had an allergic reaction to eating eggs so serious that it required medical treatment (does not apply to rubella vaccine).
- Anyone with cancer, leukemia, or lymphoma.
- Anyone with a disease that lowers the body's resistance to infection.
- Anyone taking a drug that lowers the body's resistance to infection (such as cortisone, prednisone or certain anticancer drugs)
- Anyone who has received a gamma globulin (immune globulin) within the preceding 3 months.
- Anyone who had an allergic reaction to an antibiotic called neomycin so serious that it required medical treatment.

PREGNANCY: Measles, mumps, and rubella vaccines are not known to cause special problems for pregnant women or their unborn babies. However, doctors usually avoid giving any drugs or vaccines to pregnant women unless there is a specific need. To be safe, pregnant women should not get these vaccines. A woman who gets any of these vaccines should wait 3 months before getting pregnant.

Vaccinating a child whose mother is pregnant is not dangerous to the pregnancy.

QUESTIONS: If you have any questions about measles, mumps, or rubella vaccination, please ask us now or call your doctor or health department before you sign this form.

REACTIONS: If the person who received the vaccine gets sick and visits a doctor, hospital, or clinic in the 4 weeks after vaccination, please report it to the facility which provided the vaccine.

PLEASE KEEP THIS PART OF THE INFORMATION SHEET FOR YOUR RECORDS

IMPORTANT INFORMATION ABOUT DIPHTHERIA, TETANUS, AND PERTUSSIS AND DTP, DT, AND Td VACCINES

Please read this carefully

DTP 2/1/86

WHAT IS DIPHTHERIA? Diphtheria is a very serious disease which can affect people in different ways. It can cause an infection in the nose and throat which can interfere with breathing. It can also cause an infection of the skin. Sometimes it causes heart failure or paralysis. About 1 person out of every 10 who get diphtheria dies of it.

WHAT IS TETANUS? Tetanus, or lockjaw, results when wounds are infected with tetanus bacteria, which are often found in dirt. The bacteria in the wound make a poison which causes the muscles of the body to go into spasm. Four out of every 10 persons who get tetanus die of it.

WHAT IS PERTUSSIS? Pertussis, or whooping cough, causes severe spells of coughing which can interfere with eating, drinking, and breathing. In the United States, more than 75 percent of reported pertussis cases occur in children younger than 5 years. Pertussis is a more serious disease in young children and more than half of the children less than 1 year of age reported to have pertussis are hospitalized. In recent years, an average of 1,700 cases of pertussis have been reported each year in the United States. Complications occur in a substantial proportion of reported cases. Pneumonia occurs in one of every four children with pertussis. For every 1,000 reported pertussis cases, 22 develop convulsions and/or have more severe problems of the brain. In recent years, an average of eight deaths due to pertussis occurred annually.

Before vaccines were developed, these three diseases were all very common and caused a large number of deaths each year in the United States. If children are not vaccinated, the risk of getting these diseases will go back up again.

DTP, DT, AND Td VACCINES: Immunization with DTP vaccine is one of the best ways to prevent these diseases. DTP vaccine is actually three vaccines combined into one shot to make it easier to get protection. The United States Public Health Service and the American Academy of Pediatrics recommend DTP vaccine be used in children up to their seventh birthday. The vaccine is given by injection starting early in infancy. At least three shots are needed to provide initial protection. Young children should get three doses in the first year of life and a fourth dose at about 18 months of age. A booster shot is important for children who are about to enter school and should be given between their fourth and seventh birthdays. The vaccine is very effective at preventing tetanus—over 95 percent of those who get the vaccine are protected if the recommended number of shots is given. Although the diphtheria and pertussis parts of the vaccine are not quite as effective, they still prevent most children from getting disease and they make the disease milder for those who do get it.

Because pertussis is not very common or severe in older children, those 7 years of age and older should take a vaccine that does not contain the pertussis part. Also, because reactions to the diphtheria part of the vaccine may be more common in older children, those 7 years of age and older should take a form of the vaccine that has a lower concentration of the diphtheria part. This vaccine which contains no pertussis part and a lower concentration of the diphtheria part is called Td vaccine. Boosters with the Td vaccine should be received every 10 years throughout life.

(PLEASE READ OTHER SIDE)

DEFERRAL OF DTP IMMUNIZATION: Children who have had a serious reaction to previous DTP shots should not receive additional pertussis vaccine (see WARNING). A preparation called DT vaccine is available for them which does not contain the pertussis part. Also, children who have previously had a convulsion or are suspected to have a problem of the nervous system should not receive DTP vaccine until a full medical evaluation has been made.

POSSIBLE SIDE EFFECTS FROM THE VACCINE: With DTP vaccine, most children will have a slight fever and be irritable within 2 days after getting the shot. One half of children develop some soreness and swelling in the area where the shot was given. More serious side effects can occur. A temperature of 105°F or greater may follow 1 out of 330 DTP shots. Continuous crying lasting 3 or more hours may occur after 1 in every 100 shots and unusual, high-pitched crying may occur after 1 in every 900 shots. Convulsions or episodes of limpness and paleness may each occur after 1 in every 1,750 shots. Children who have previously had a convulsion may be more likely to have another one after pertussis shots. Rarely, about once in every 110,000 shots, other more severe problems of the brain may occur, and permanent brain damage may occur about once in every 310,000 shots. Side effects from DT or Td vaccine are not common and usually consist only of soreness and slight fever. As with any drug or vaccine, there is a rare possibility that allergic or more serious reactions or even death could occur.

Although some people have questioned whether DTP shots might cause Sudden Infant Death Syndrome (SIDS), in careful studies DTP shots have not been shown to cause SIDS.

PREGNANCY: Babies born under unsanitary conditions to unimmunized women have a risk of developing tetanus during the newborn period (neonatal tetanus). Neonatal tetanus can be prevented by immunization of adult women. Women who have not received Td earlier and who are thought to be at risk of delivering their babies under unsanitary conditions should be immunized during pregnancy. Td is not known to cause special problems for pregnant women or their unborn babies. Doctors usually do not recommend giving any drugs or vaccines to pregnant women unless there is a specific need. Pregnant women who need Td should receive it, preferably during the second and/or third trimesters.

WARNING—SOME PERSONS SHOULD *NOT* TAKE THESE VACCINES WITHOUT CHECKING WITH A DOCTOR:

- Anyone who is sick right now with something more serious than a cold.
- Anyone who has had a convulsion or is suspected to have a problem of the nervous system.
- Anyone who has had a serious reaction to DTP, DT, or Td shots before, such as: an allergic reaction to any vaccine component; a temperature of 105°F or greater; an episode of limpness and paleness; prolonged continous crying; an unusual, high-pitched cry; or a convulsion or other more severe problem of the brain.
- Anyone taking a drug or undergoing a treatment that lowers the body's resistance to infection, such as: cortisone, prednisone, certain anticancer drugs, or irradiation.

QUESTIONS: If you have any questions about diphtheria, tetanus, or pertussis or DTP, DT, or Td vaccination, please ask us now or call your doctor or health department before you sign this form.

REACTIONS: If the person who received the vaccine develops a temperature of 105°F or greater, continuous crying lasting 3 or more hours, an unusual high-pitched cry, a convulsion, an episode of limpness and paleness, or a severe problem of the brain, the person should be evaluated promptly by a doctor.

If the person who received the vaccine gets sick and visits a doctor, hospital, or clinic in the 4 weeks after vaccination, please report it to the facility which provided the vaccine.

PLEASE KEEP THIS PART OF THE INFORMATION SHEET FOR YOUR RECORDS

IMPORTANT INFORMATION ABOUT POLIO AND ORAL POLIO VACCINE

Please read this carefully

OP 3/1/83

WHAT IS POLIO? Polio is a virus disease that may cause permanent crippling (paralysis) and occasionally death. There used to be thousands of cases and hundreds of deaths from polio every year in the United States. Because of the widespread use of polio vaccines, which became available beginning in the mid-1950's, polio disease has nearly been eliminated from the United States. Although thousands of cases continue to occur each year in the rest of the world, in the United States during the past 5 years there have been only 67 cases of polio reported, an average of 13 cases per year. Our success in preventing the spread of wild polio virus has been so great that most of the recent cases (approximately nine per year) have resulted from the rare side effects of oral polio vaccine (see below). Because of this fact, some people have asked why we should continue to use polio vaccine. The reason is that, even though we may not have much wild polio virus spreading here now, there is so much of it in the rest of the world that there is a great risk of its being reestablished if our children are not vaccinated.

ORAL LIVE POLIO VACCINE: Immunization with oral live polio vaccine (OPV) is one of the best ways to prevent polio. It is given by mouth starting in early infancy. Several doses are needed to provide good protection. Young children should get two or more doses in the first year of life and another dose at about 18 months of age. An additional dose is important for children when they enter school or when there is a high risk of polio, for example, during an epidemic or when traveling to a place where polio is common. The vaccine is easy to take and is effective in preventing the spread of polio. In over 90 percent of people, OPV gives protection for a long time, probably for life. Because OPV viruses live for a time in the intestinal tract of the person who is vaccinated, some of the viruses pass in the stool and can spread from the vaccinated person to those in close contact (usually household members). This may help to immunize these persons and is one of the advantages of OPV. The Immunization Practices Advisory Committee of the Public Health Service and the American Academy of Pediatrics recommend oral live polio vaccine as the preferred polio vaccine for people up to the 18th birthday.

POSSIBLE SIDE EFFECTS FROM THE VACCINE: OPV very rarely (once in about every 8.1 million doses of OPV distributed) causes paralytic polio in the person who is vaccinated. The risk may be slightly higher in adults being vaccinated and substantially higher in persons with abnormally low resistance to infection. Also very rarely (once in about every 5 million doses of OPV distributed) paralytic polio may develop in a close contact of a recently vaccinated person. Even though these risks are very low, they should be recognized. The risk of side effects from the vaccine must be balanced against the risk of the disease, both now and in the future.

(PLEASE READ OTHER SIDE)

PREGNANCY: Polio vaccine experts do not think oral polio vaccine can cause special problems for pregnant women or their unborn babies. However, doctors usually avoid giving any drugs or vaccines to pregnant women unless there is a specific need. Pregnant women should check with a doctor before taking oral polio vaccine.

WARNING—SOME PERSONS SHOULD NOT TAKE ORAL POLIO VACCINE WITHOUT CHECKING WITH A DOCTOR:

- Anyone with cancer, leukemia, or lymphoma.
- Anyone with a disease that lowers the body's resistance to infection.
- Anyone taking a drug that lowers the body's resistance to infection, such as cortisone or prednisone.
- Anyone who lives in the same household with anyone who has one of the conditions listed above.
- Anyone who is sick right now with something more serious than a cold.
- Pregnant women.
- Most persons age 18 and older because adults have a slightly bigger risk of developing paralysis from oral polio vaccine than children (However, if the risk of polio is increased-as may occur, for example, when there is an outbreak in your community-most polio experts recommend that unprotected persons receive oral polio vaccine regardless of age.)

NOTE ON INJECTABLE (KILLED) POLIO VACCINE: Besides the oral polio vaccine (OPV), there is also a killed polio vaccine (IPV) given by injection which protects against polio after several shots. This killed polio vaccine has no known risk of causing paralytic polio. Because OPV may provide lifetime protection, seems to provide stronger immunity in the intestinal tract (where infection first occurs), is simpler to administer, and is more effective in preventing the spread of polio virus than IPV, most polio experts feel that oral vaccine is more effective for controlling polio in the United States. Injectable polio vaccine is recommended for persons needing polio vaccination who have low resistance to serious infections or who live with persons with low resistance to serious infections. It may also be recommended for previously unvaccinated adults who plan to travel to a place where polio is common or for previously unvaccinated adults whose children are to be vaccinated with OPV. It is not widely used in this country at the present time, but it is available. If you would like to know more about this type of polio vaccine, or wish to receive this vaccine, please ask us.

QUESTIONS: If you have any questions about polio or polio vaccination, please ask us now or call your doctor or health department before you sign this form.

REACTIONS: If the person who received the vaccine gets sick and visits a doctor, hospital, or clinic in the 4 weeks after vaccination, please report it to the facility which provided the vaccine.

PLEASE KEEP THIS PART OF THE INFORMATION SHEET FOR YOUR RECORDS

Parents suing for child's ills

The parents of a 5-year-old boy who allegedly suffered permanent injuries from a DTP vaccination received a few months after birth has filed suit against the vaccine manufacturer and the state of Washington.

James and Joan Dunn claim in the suit filed Wednesday in Spokane County Superior Court that their son, Christopher, continues to suffer severe convulsions and seizures caused by the vaccination.

Listed along with the state as a defendant in the suit are Lederle Laboratories Division of American Cyanamid Co. and Connaught Labs Inc.

The companies are described as foreign corporations which manufacture and distribute the Tri-Immunol vaccine, commonly referred to as DTP vaccine, for immunization against diptheria, tetanus and pertussis.

The suit says the couple's son was born June 23, 1979, and received his first DTP vaccination Sept. 10, 1979, at the Spokane County Health District.

It claims the vaccine has caused the child severe neurological and physiological damages which render him permanently disabled.

The suit contends the manufacturer was negligent in failing to adequately test the vaccine for possible severe adverse reactions or to warn the medical profession or the public about its potential for causing such reactions.

The state of Washington is negligent for distributing the "defective and unreasonably dangerous" vaccine to the Spokane County Health District and other municipal entities, the suit claims.

SPOKANE CHRONICLE June 6, 1985 p. C1 6

Boy's not shots



Family Doctor

By DR. ROBERT MENDELSOHN

DEAR DR. MENDELSOHN: Please help me with this problem. We apparently are going to be required by law to immunize our school-age children. I have put off getting rubella and mumps shots for our 12-year-old daughter in the hope that she would get these illnesses naturally, but she has not. I read in the July and August 1975 issues of Today's Health that rubella immunization is not very long-lasting, with 25 percent of those immunized losing protection within five years after innoculation.

When my daughter was immunized against red measles at the age of 18 months, she became very ill, and her eyes were crossed for years afterward because of the high fever she had developed. The daughter of a friend of mine suffered from arthritis after being immunized against German measles, and she still has the condition—10 years later. I looked this up in the Physicians' Desk Reference and discovered that in my daughter's age group, there is a 5 to 10 percent chance of joint pain, swelling, stiffness and, rarely, encephalitis after rubella immunization.

Is it best to get these shots or not?—Mrs. B. C., Spokane, Wash.

DEAR MRS. B. C.: You are a smart lady! Even though medical societies, the pharmaceutical industry and government agencies are pushing these shots, each mother and father still has the ultimate responsibility of examining both sides of the story in order to decide whether to place their child in the line forming for immunizations.

Of course, vaccine enthusiasts advocate their product on the grounds that, while they certainly produce complications, they are safer than the disease itself. Nevertheless, the adverse reactions listed in the prescribing information for measles vaccine include encephalitis and encephalopathy occurring within 30 days after vaccination, as well as sub-acute sclerosing panencephalitis in children who had no history of natural measles but who did receive measles vaccine.

Listed under adverse reactions for rubella (German measles) vaccine are arthritis, arthralgia (painful joints) and polyneuritis. "Symptoms relating to joints (pain, swelling, stiffness, etc.) and to peripheral nerves (pain, numbness, tingling, etc.) occurring within approximately two months after vaccination should be considered as possibly vaccine related."

The Journal of the American Medical Association, Jan. 23, 1978, reported that of the 18 cases of polio in 1977, three of the patients were persons who were in the United States, but not residents, and two of the other 15 victims apparently contracted the disease abroad. Three cases occurred in recent vaccine recipients, and 10 cases had been in close contact with recently immunized people. Only three cases occurred in persons without known vaccine associations.

As far as the whooping cough vaccine (a component of the triple DPT baby shots) is concerned, Dr. Edward B. Shaw, a distinguished University of California physician, has stated (JAMA, March 1975): "I doubt that the decrease in pertussis (whooping cough) is due to the vaccine, which is a very poor antigen and an extremely dangerous one, with many very serious complications. . . the decline in pertussis began long before the widespread use of vaccine." Dr. Shaw then proceeds to question the conventional view that the decrease in polio is a result of the polio vaccine.

These negative aspects and views on immunizations abound in the medical literature, and this column will continue, as it has in the past, to make this information available to those who do not have ready access to these publications. The information you gathered on the pros and cons of current immunizations will also help you when you are faced with the vaccines currently being developed for chicken pox and venereal disease.

From the letters reaching me from all parts of the country, I am aware that many school authorities have decided to exclude unimmunized children from classes. Thus, vaccination, once a medical matter, now has become a political issue.

As a case in point, some Alaskan chiropractors had sought to excuse healthy children in their practices from compulsory immunization. A Superior Court ruling that only M.D.s and D.O.s have the right to decide when a child's health will be harmed by a vaccination is now being appealed to the Alaska Supreme Court.

As with all political issues, the question of immunization will be resolved by lawyers, by elected representatives and, ultimately, by informed public opinion. ©

(Dr. Mendelsohn welcomes questions from readers. While he cannot reply to them all individually, he will answer those of general interest in his column. Write to Dr. Mendelsohn in care of this newspaper.)

HEALTH

School Shots: More Harm than Good?

By Michael D'Antonio


Elena Amity

DPT. The letters stand for diphtheria, pertussis and tetanus, three diseases that were often lethal for children of past generations. Today the DPT vaccine — a series of five shots administered between 3 months of age and school entry — has all but eliminated the risk of these childhood nightmares. But some doctors are starting to wonder if the vaccine for pertussis, commonly known as whooping cough, is more risky than the actual disease.

In Britain, West Germany and some Scandinavian countries, parents are no longer required to have children vaccinated against pertussis before they enter school. Medical authorities in Europe have isolated the pertussis component in the DPT inoculation, blaming it for serious brain damage and lesser brain-related conditions — such as shock and convulsions — found in thousands of vaccinated children. Millions of European children have not been vaccinated.

In the U.S., school systems in most states still require the DPT series. In fact, every year hundreds of unvaccinated 6-year-olds are sent home on the first day of class and barred from school until they bring proof of vaccination. Court cases have upheld laws requiring the shots, and for more than a generation parents have routinely sought the inoculations. In most cases, the shots are harmless. But recent media focus on the exceptions — cases of crippled and brain-damaged children — now has many parents alarmed about the DPT vaccine.

Scott Grant is one of the exceptions. Vaccinated in 1961, Scott suffered a severe reaction to the shot. "He literally wilted before our eyes," his mother, Marge Grant, sadly remembers. The brain damage, which Scott's doctors say was caused by the vaccine, has left him immobile and mentally retarded.

What makes the DPT controversy a quandary for parents is the danger of pertussis. The disease starts with symptoms similar to the common cold. But as weeks go by, the cough and congestion get so bad that children struggle to breathe (the inhalation of air sounds like a whoop). And the bronchial system becomes so irritated from coughing that pneumonia is easily contracted. Before the DPT vaccine was developed in the 1930's, whooping cough was a killer. And some survivors suffered brain damage and convulsions.

"It is tragic that events such as brain damage may occur as a result of pertussis vaccination," says Dr. William H. Foege, director of the Federal Government's Centers for Disease Control in Atlanta. "However, we must all remember that pertussis itself causes complications more severe than these and may cause death."

The scientists studying the pertussis vaccine have little conclusive evidence of its side effects. For years, crying spells that develop on the day the shot is given were considered insignificant. Today some doctors believe they are evidence of a neurological reaction to the shot. And the manufacturers of the vaccine now recommend that children with such reactions do not receive further shots.

A study on DPT effects by researchers at the University of California, the first such study to be done in the U.S. in 25 years, found that one in 13 vaccinated children suffers persistent, piercing crying spells the day after receiving a DPT injection. Because the first three shots are given to children when they are still under 1 year old, they can't explain the exact nature of their distress. However, the crying is usually accompanied by a fever and drowsiness. Some experts theorize the crying is due to slight damage to the nervous system, but the connection has not been proven.

The statistics developed by studies here and abroad are critical in the DPT debate. The study cited above also found that one in 700 children who received the vaccine suffered convulsions or went into shock. Foreign studies found that serious brain damage, causing severe retardation and motor disability, occurs in one of every 50,000 recipients. Britain and Japan now have national programs to compensate thousands of children who suffered serious side effects due to DPT. The State of California has now begun its own compensation program, but so far only one child has been compensated.

The statistics related to whooping cough are also frightening. In 1934 more than a million cases of the disease were reported, and more than 7,500 children were killed by it. Final figures have not been compiled, but the Government estimates there were fewer than 2,000 cases of pertussis last year, and six deaths. Proponents of the vaccine say that without it the nation risks a return to whooping cough epidemics and deaths. There is still no specific treatment for pertussis — except intravenous fluids to prevent dehydration and respiratory care (antibiotics are not effective).

Britain's recent experience should be a warning to America, insists Dr. Vincent Fulginiti of the American Academy of Pediatrics. Following a decline in use of the pertussis vaccination, that country has suffered an epidemic of more than a hundred thousand cases of whooping cough and 28 deaths. "The United States is in potential danger of a similar assault," he says, if DPT is abandoned.

But public concern about DPT is rising. In the metropolitan Washington area, a parents group has organized to study the problem and lobby for a change in the laws making the shots mandatory. Inoculations without the pertussis component have fewer side effects, and the parents want to be free to choose whether their children get the full DPT vaccine or not.

The Government and the drug industry are working on safer vaccines, and new ones are expected in the next few years. In the meantime, Congress has scheduled hearings to investigate the controversy, and individual members of Congress, led by Senator Paula Hawkins (R.-Fla.), are calling on the Government and doctors to warn parents of the risks of both the vaccine and the shot, to screen children susceptible to side effects and to develop better vaccines.

Until new, exhaustive studies are completed, parents will have to consult with their family doctors before making their own decision about DPT.

Michael D'Antonio is a freelance writer.

Warning for Parents

Possible side effects from DPT vaccine include: high fever, convulsions, shock, excessive crying and loss of awareness. Consult your pediatrician if they occur. The American Academy of Pediatrics and DPT manufacturers say a child who suffers serious side effects should not receive additional inoculations.

This ad appeared in the newspaper in Anchorage.

Nurse Position

Full-time, Bethel, AK. Exceptional opportunity to work on an ongoing vaccine efficacy trial conducting well-baby assessments, administering vaccine and conducting disease surveillance and related research. Frequent travel to villages. Prefer public health or similar experience. Send resume to: Centers for Disease Control, 225 Eagle St., Anchorage, AK 99501 or call 271-4011.

persons may call: (907)842-5201 ext. 331 for more information.

NURSE POSITION
Full-time, Bethel, AK. Exceptional opportunity to work on an ongoing vaccine efficacy trial conducting well-baby assessments, administering vaccine and conducting disease surveillance and related research. Frequent travel to villages. Prefer public health or similar experience. Send resume to: Centers for Disease Control, 225 Eagle St. Anchorage, AK 99501 or call 271-4011.

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Concerning House Bill 277,

I support this bill because I think parents should have freedom of choice concerning immunizations. Parents are ultimately responsible for their childrens health, and I think provided with all the facts they can make wise choices about all aspects of health care.

I believe that most parents will make the choice to have their children immunized, the important factor being that it is parents choice. If parents do not have a choice and their child has an adverse reaction to a vaccine, they then feel victimized. If they themselves made the decision to immunize knowing all the pros and cons, they are more willing to accept any adverse reactions because they were fully informed about the possibilities.

Kaye Kanne
116 Wire Street
Juneau, Alaska 99801

TURNING POINT
Family Wellness Center

Edward H. Chapman, M.D.
Dolores Heeb, Reg. Ac.
Richard P. Ingrasci, M.D., M.P.H.
Richard Moskowitz, M.D.
Geri Schumacher, R.N.

November 25, 1987

Alaska State Legislature
Health Education and Social Affairs Committee
c/o Glenda Landua, Alaska DPT
39918 Dawn Avenue
Kenai, Alaska 99611

Dear Sir:

I am writing in support of House Bill No. 277, "An Act Relating to the Immunization of Minors."

I am a family physician and have been practising medicine for the past twenty years. During that time I have been impressed with the number and variety of chronic diseases that can be provoked or exacerbated by the various childhood vaccines in general use. My thoughts and observations on this subject are summarized in the articles enclosed herewith.

I am especially troubled by the fact that investigations of vaccine-related illness have generally been limited to acute complications occurring within thirty (30) days of the administration of the vaccine, thus excluding any condition occurring more gradually or not evident until months or years later.

Requiring all children to be vaccinated with foreign proteins or live viruses clearly presupposes the moral and legal obligation to prove both that the corresponding natural diseases constitute a serious public health hazard, and that the vaccines themselves are in no way detrimental to health. Furthermore, it implies full legal and financial liability for any illness or injury sustained by those vaccinated against their will.

Adequate investigation of chronic vaccine-related illness will necessarily be prolonged and difficult. It will require following large numbers of both vaccinated and unvaccinated children for at least a decade or more, to determine any differences in their overall health patterns, and in the incidence and severity of various chronic diseases (recurrent otitis media, asthma, epilepsy, behavior disorders, etc.).

(2)

Until these studies are completed, it would be reckless indeed to continue routine childhood vaccination on a compulsory or statutory basis. I personally favor making all vaccines completely optional, i.e., freely available to all who want them, and allowing parents to make the choice with and for their children, as is now being done in West Germany and many other countries. This practice will effectively reduce the liability of the state, if and when complications do occur. Furthermore, it will create a sizeable control group of unvaccinated children for the long-term studies that urgently need to be done.

For all of these reasons, I urge you to support H. B. 277, and to make it as simple as possible for parents not to vaccinate their children. I would suggest, for example, amending the opening section so as to allow parents to accept some vaccines, and to reject others, without having to give a reason, and without any discrimination or penalty. The term "religious or philosophical beliefs" implies a principled, across-the-board repudiation, while many parents actually prefer to obtain the tetanus and oral polio vaccines, for example, but not the others. The right to make such choices should perhaps be stated explicitly.

But, even in its present form, the proposed law is an important step forward, bringing Alaska abreast of the other states that have been most progressive in this respect. It deserves your full support.

Thank you.

Truly yours,

Richard Moskowitz, M.D.

The Nevada Clinic
6105 W. Tropicana Ave., Las Vegas, NV 89103
(702) 871-2700

(3)

January 13, 1988

Shannon Kohler, President
Alaska Dissatisfied Parents Together
Box 1746
Soldotna, Alaska 99669

Dear Shannon:

I have received your letter and am in complete sympathy with your efforts to modify the immunization laws as they exist in your state. Thank you very much for sending me a copy of the House Bill No. 277. I wish you all the success in the world in getting it passed.

I am enclosing a photocopy of a fairly recent article from the April, 1987 issue of the British Homeopathic Journal that deals with the use of pertussin as a prophylactic treatment to prevent whooping cough. As you can see from the articles enclosed, the battle goes on in other countries, as well as in various states in the United States.

I believe that homeopathy offers tremendous advantages over the standard and routine immunization programs, which have been pushed by allopathic medicine since the beginning of time (Pasteur's time, that is).

Our clinic has seen several infants and children who have not had a good response as a result of D.P.T. immunizations. I can recall three small children who developed "infantile spasms" and seizures as a result of the pertussin part of the D.P.T. immunization. Of course, none of the physicians who administered the injections, nor the company that made the serum, would in any way admit any kind of a connection between the immunization and the child's problems. Nevertheless, when treated homeopathically to remove the pertussin from the brains and nervous systems of these infants, they all have totally recovered without any further seizures or spasms.

There has not been a great deal of research done that I am aware of in this country with regards to an immunization program based on the treatments utilized by homeopathic physicians for the past 150 years. Nevertheless, these programs have proven very effective. In fact, during the 1917 flu epidemic in this country, the only patients who survived were those who were fortunate enough to find a homeopathic physician and be treated homeopathically.

I hope this information is of some help to you. There are obviously other journals and articles that could be sent, but I don't have them in hand at the present time.

Sincerely,

F. Fuller Royal, M.D.

FFR/erm

IMMUNIZATION COMPLIANCE RATES OF SCHOOL AGE CHILDREN (K-1ST GRADE) AND INCIDENCE OF VACCINE PREVENTABLE DISEASES (1986)

ALL STATES INCLUDED IN SURVEY HAVE PHILOSOPHICAL OBJECTION TO STATE MANDATED IMMUNIZATIONS IN STATUTES

	compliance rate:	reported cases of: measles	rubella	mumps	pertussis	tetanus	diptheria	polio
Michigan	91%	185	24	467	36	1	INA	INA
1971 (approx.) - mandatory law implemented 1971 (approx.) - philosophical objection allowed								
Utah	93%	13 [38.5%] {61.5%}	15	16	44 [65.9%] {34.1%}	0	0	0
1975 - mandatory law implemented **1982 (approx.) - philosophical exemption allowed**								
Washington	95.7%	176 [65%] {35%}	15	30	163 [56%] {44%}	0	0	0
Missouri	98.3%	32	1	23*	32*	2(2)*	0	0
California	93.4%	497 [50%] {50%}	242	336	310 [40%] {60%}	3	0	1
1961-mandatory law implemented 1961-philosophical exemption allowed								
Pennsylvania	99.2%	28	1	63	52	1	0	0
Oklahoma	97.6%	39	0	INA	134	1	0	0
1976-mandatory law implemented 1976-philosophical exemption allowed								
Nebraska	96.5%	1	0	2	10	INA	INA	INA
1973-mandatory law implemented 1973-philosophical exemption allowed								
Indiana	97%	39	0	339	39	2	0	0
1976-mandatory law implemented 1976-philosophical exemption allowed								
Delaware	98%	35	INA	INA	INA	INA	INA	INA
1982-mandatory law implemented 1982-philosophical exemption allowed								

COMPLIANCE RATES CONT'D.

	compliance rate:	reported cases of: measles	rubella	mumps	pertussis	tetanus	diptheria	polio
Ohio	95%	10 [80%] {20%}	0	150	170	0	0	2
1959-mandatory law implemented **1970 (approx.)-philosophical exemption allowed**								
Arizona	95.1%	252	2	209	78	1	0	0
1976-mandatory law implemented **1981-philosophical exemption allowed**								
Minnesota	99%	50 [89%] {21%}	1	86 [88.8%] {11.2%}	50	0	0	0
1967-mandatory law implemented **1978-philosophical exemption allowed**								
Colorado	96.3%	11	1	17	84 (2)	0	0	0
1974-mandatory law implemented **1979-philosophical exemption allowed**								
Maine	INFORMATION NOT AVAILABLE							
1977-mandatory law implemented 1977-philosophical exemption allowed								
Wisconsin	96.5%	287	1	325	111	0	0	0
1975-mandatory law implemented **1980-philosophical exemption allowed**								
Vermont	98%	0	1	6	5	0	0	0
1979-mandatory law implemented 1979-philosophical exemption allowed								

INA: information not available
*: immunization not mandatory in state
(n): fatalities
[n]: percent of ill fully immunized
{n}: percent of ill unimmunized

Data received from State Health Departments of states listed
22 states contacted - 17 states responded to date - January 20, 1988

All states implement exclusion of unimmunized children from school during vaccine prevertable disease occurances.

13 of 17 states have mandatory disease reporting laws; 7 of those have penalties for non-reporting of contagious diseases

Data compiled by the Alaska Chapter of Dissatisfied Parents Together

(7)

[illegible]
[illegible] Box 118
[illegible]mbus, Ohio 43266-0118

Telephone (614) 466-3543

RICHARD F. CELESTE
Governor

November 4, 1987

Shannon Kohler
Alaska Chapter-DPT
Box 1746
Soldotna, Alaska 99669

Dear Ms. Kohler:

I am responding to your July 27 letter regarding immunization exemptions. I am sorry for the delay, but the mail had apparently been misrouted.

While immunization exemptions are a concern, immunization-exempt children have not contributed to disease initiation or propagation in Ohio.

In Ohio immunization levels exceed 95 percent in schools; in fact, in kindergarten they are 97 percent or greater. Immunization exemptions have not exceeded Ø.3 percent - Ø.5 percent among children new to Ohio schools. (The table enclosed gives you information regarding immunization levels, exemptions and reported cases of the vacc ne-preventable diseases you requested.)

The measles cases in Ohio (1Ø last year) can virtually all be attributed to importations and spread from importations among persons either inadequately vaccinated or vaccine failures, but not persons who are immunization exempt. In 1986, only two of the 1Ø cases were not previously vaccinated. Because of their small number, exemptions have not played a major part in outbreaks.

In 1986 Ohio reported 17Ø cases of pertussis. Of these we were able to determine the age and vaccine status of 115. Most of these cases were just too young to have completed a full series of DTP immunizations. While an analysis of immunization exemptions was not made, only two of the cases were of school age.

Mumps cases have been declining in Ohio since the inclusion of mumps in the school immunization law beginning in 1984. The 15Ø cases reported in 1986 can not be attributed to immunization exemptions.

I hope this answers most of your questions, please let me know if I con provide any further information.

Sincerely,

Thomas J. Halpin, M.D., M.P.H.
Chief
Bureau of Preventive Medicine

KOHLERLE.PRN
Enclosure:

(9)

November 12, 1987

SUMMARY OF SEVERE ADVERSE REACTIONS TO STATE MANDATED IMMUNIZATIONS

Data collected by: Dissatisfied Parents Together, Alaska Chapter

Dates of survey: October 1986-October 1987

Method used: Alaska "DPT" vaccine adverse reaction questionnaire

Number of subjects (reactions) - 25: 24 DPT
1 MMR

Range of survey: State of Alaska

1- College, AK.	1- Anchorage, AK.
1- Gustavis, AK.	1- Anchor Point, AK.
1- Sterling, AK.	1- Homer, AK.
4- Kenai, AK.	3- Fairbanks, AK.
2- Juneau, AK.	7- Soldotna, AK.
1- Palmer, AK.	2- Kasilof, AK.

Ages of subjects at date of response:

2- 4 months	1- 4 years
1- 6 months	2- 5 years
1-10 months	3- 6 years
1- 14 months	1- 8 years
1- 18 months	1- 17 years
5- 2 years	1- 20 years
4- 3 years	1- 23 years

Return to: Dissatisfied Parents Together (11)
Box 1746
Soldotna, AK 99669
Shannon Kohler 262-3825

DPT SHOT REACTION QUESTIONNAIRE

Directions: Please place an "X" before the answer(s) you select or fill in the spaces when appropriate.

1. Before your child received his DPT shot(s), did a health professional inform you of the possible serious reactions to the shot?

5 Yes (1) 19 No (2) 1 Don't Know (3)

2. Did the health professional who gave your child the DPT shot(s) tell you to look for and report severe reactions such as a high temperature, excessive crying or high pitched screaming, excessive sleepiness, etc.?

6 Yes (1) 18 No (2) 1 Don't Know (3)

3. Before giving your child the DPT shot(s) did a health professional tell you when the shot should not be given (i.e. if the child has an active infection or a fever, if the child reacted severely to a previous DPT shot, etc.)?

6 Yes (1) 16 No (2) 3 Don't Know (3)

4. Did you sign a consent form containing information about the DPT shot and its possible reactions before your child received his DPT shot?

2 Yes (1) 15 No (2) 8 Don't Know (3)

5. Before your child received his DPT shot(s), did a health professional question you about your family's and your child's medical history?

____ Yes (1) 23 No (2) 2 Don't Know (3)

6. Do you believe your child reacted severely to any of his DPT shots? (Answer yes only if the reaction was more serious than a low fever, mild crying, or slight redness or puffiness around the site of the shot)

25 Yes (1) ____ No (2) ____ Don't Know (3)

If you answered yes to question #6, please answer the rest of the questionnaire. If you answered no to question #6, skip the rest of the questions and fill in your name, address and telephone number at the end of the questionnaire.

7. After the DPT shot that caused your child to react severely, did he have: most children had more than one symptom of reaction

4 convulsions (1)
16 fever of more than 103 degrees (2)
13 excessive crying or high pitched screaming for long periods (3)
6 extreme sleepiness (4)
____ collapse or shock (5)
5 loss of muscle control (temporary or pemanent paralysis) (6)
____ death (7) 1-nerve damage deafness 1-severe allergies & eczema 2-permanent partial paralysis 1-chronic cold sores
____ other (please explain) 1-severe congestion 1-whooping-like cough (8)
1-limping 1-severe swelling of arm 1-severe leg swelling
1-severe swelling of glands in head
1-temperature for 1 week 1-temperature for 10 days

(12)

8. How long after the shot did the reaction begin to occur?

24 Within 24 hours after the shot (1)
1 24-48 hours after the shot (2)
___ 2 days - 7 days after the shot (3)
___ 1 week - 2 weeks after the shot (4)
___ more than 2 weeks after the shot (5)

9. After which DPT shot did your child react severely? Some children reacted to more than 1 shot

15 First shot (1)
4 Second shot (2)
3 Third shot (3)
2 Fourth shot (4)
___ Fifth shot (5)
1 all shots

10. How old was your child when he was given the DPT shot that caused the severe reaction?

8 2-3 months old (1)
6 4-5 months old (2)
4 6-7 months old (3)
3 8-12 months old (4)
1 13-18 months old (5)
1 19-24 months old (6)
___ 25 months - 3 years old (7)
___ over 3 years old (8)
1 Don't Know
1 all

11. How old is your child now?

See 1st page attachment

12. Did you report your child's severe reaction to the DPT shot to a health professional?

21 Yes (1) 4 No (2) ___ Don't Know (3)

13. If you did not report your child's severe reaction to the DPT shot, was it because you were not aware that the reaction was serious and should have been reported?

4 Yes (1) No ___ (2) ___ Don't Know (3)

* 14. If you did report your child's severe reaction to the DPT shot to a health professional, did that person report your child's severe reaction orally or in writing to: NO: 10

___ drug manufacturer (1)
___ federal government (2)
3 state health department (3)
___ any local health agency (4)
8 Don't Know (5) none of these parents had an official MSAEFI form completed

15. Was your child's severe reaction to the DPT shot written on his medical record?

6 Yes (1) 8 No (2) 11 Don't Know (3)

16. After your child reacted severely to a DPT shot, was he given another shot that contained the pertussis vaccine?

6 Yes (1) 17 No (2) 1 Don't Know (3) 1 n/a MMR Shot

17. Was your child mentally and physically normal before he received the DPT shot to which he reacted severely?

25 Yes (1) ___ No (2) ___ Don't Know (3)

18. Prior to the DPT shot to which your child reacted severely, did your child have a history of convulsions or neurologic disease?

____ Yes (1) 24 No (2) 1 Don't know

19. Does your family have a history of convulsions or neurologic disease?

1 Yes (1) 23 No (2) 1 Don't Know (3)

20. Did you or your husband ever have whooping cough?

1 Yes (1) 22 No (2) 2 Don't Know (3)

21. Is there a significant history of allergies in your family or has your child ever been diagnosed as having allergies?

9 Yes (1) 12 No (2) 4 Don't Know (3)

22. If your child has allergies, were the allergies apparent before or after the DPT shot to which he reacted severely?

3 Before (1) 5 After (2) N/A 17

23. At the time your child had a severe reaction to the DPT shot, was he primarily bottle-fed?

9 Yes (1) 11 No (2) 5 Both

24. Has your child had a continuing physical or mental health problem since the DPT shot that caused the severe reaction?

12 Yes (1) 12 No (2) 1 don't know yet

If you answered yes to question #24, please answer the rest of the questions.

25. Is your child now:

1 experiencing motor delay mentally retarded (1)

4 physicially handicapped (2)

3 experiencing convulsions (3)

4 exhibiting learning difficulties (4)

____ in an institution (5)

____ other (please explain) 1-nerve damage deafness 2-permanent partial paralysis 2-cerebral palsy 1-epilepsy 1-speech problem 1-severe allergies (6)

26. Has a physician confirmed your belief that your child's present health problems were caused by the DPT shot?

7 Yes (1) 7 No (2)

27. Has your child required special medical treatment, medicine, hospitalization, or therapy since the DPT shot that caused the severe reaction?

11 Yes (1) 14 No (2)

28. The cost of your child's special medical treatment is estimated to have been:

1 Under $2,000

10 $2,000 - $7,000

____ $7,000 - $12,000

____ $12,000 - $20,000 (4)

____ $20,000 - $40,000 (5)

____ Over $40,000 (6)

29. Please feel free to use the back of this page to tell us your story of what happened to your child as a result of his severe reaction to a DPT shot. Try to be as specific as possible, giving names, dates, and places.

Name: See next page for Emergency Treatment Information

Address: _____

Telepone Numbers: _____(home) _____(work)

Date:

(14)

4 visits to emergency room
2 telephone conduct only

a) 1st parent
b) 2nd parent
c) 3rd parent
d) 4th parent
e) 5th parent
f) 6th parent

30. Emergency room treatment of adverse reaction, if applicable.

a) What hospital did you go to?
a) Central Pen Gen. Hospital
B) Kenai Emergency medical Clinic
c) Central Peninsula Gen Hospital
D) Tanana Alaska
e) Central Pen. Gen. Hospital
f) Homer South Peninsula Gen Hospital

b) Did you call the emergency room?
5 yes a) B) C) D) e) 1 no f) e) Central Pen. Gen. Hos

c) Did you go to the emergency room?
4 yes a) B) D) f) 2 no c) e)

d) How were you treated? (if more room needed, use back of sheet)
a) told not to worry; give cold bath & tylenol
B) O.K.
C) Told not to worry; give cold bath & tylenol
D) hospital did not even record visit
e) Give cold bath & tylenol
f) good

e) Were you advised to tell your doctor of reaction?
___ yes 6 no a) B) C) D) e) f)

f) Were you advised to tell Health Dept. of reaction?
___ yes 6 no a) B) C) D) e) f)

31. Was your child hospitalized?
1 yes f) 5 no a) B) C) D) e)

a) Where? Homer South Peninsula General Hospital

b) For how long? 3 days

c) How was reaction treated? not treated as vaccine reaction

Attachment 3

COMPREHENSIVE CHILD CARE COMMITTEE

Public Comment
July 10, 1987

loyd Richmond, Executive Director of Women in Safe Homes, (WISH). ox 6552, Ketchikan, AK, 99901, 225-9474. Richmond expressed that the overnment has a role in providing freedom of choice to work outside the ome or in the home. This can only be achieved through a system of ffordable, quality child care. Note: Written testimony from Richmond s available by contacting the office.

hannon Kohler, President of the Alaska chapter of Dissatisfied Parents ogether (DPT), Box 1746, Soldotna, AK 99669, 262-3825. Kohler poke on behalf of AK-DPT. This organization is actively working for he passage of HB 277, sponsored by Rep. Navarre. This legislation ould 1) require all public health officials to report all adverse eactions to immunizations, 2) require that prior to vaccination that ll parents are given accurate benefit/risk information with regard to accine safety, and 3) amend Alaska statues to allow a parent to enroll child in public schools with out vaccinating the child. Note: Written estimony and supporting documents presented by Kohler are available in he office.

Margeret Green, Tom Thumb Montessori Schools, 1901 Spenard Road, nchorage, AK 99503, 272-5033
[redacted]n has b
een involved with this private school since 1956. Their rogram works with children from three years old through sixth grade. She attributes their success to emphasizing developmentally appropriate curriculum. Green shared that she is apprehensive about creating new statutes and regulations that would impact their successful program.

leather Heames, DPT, Box 73, Clam Gulch, AK 99568, 262-6287
leames is the mother of a child that suffered a severe reation to a DPT vaccine. She urged the Committee to do what it could from subjecting others to the problems that her child has faced.

Mary Wilson, Tom Thumb Montessori Schools, 1823 Beaver Pl., Anchorage, AK, 338-1669. Wilson is a teacher/supervisor at the Montessori school and is a certified elementary and montessori teacher. This school is self supporting. In response to questions it was calculated that the typical cost per child per month, for the full day program is $295.

Cheryl Rykaczewski, DPT, Box 311, Kasilof, AK. She is a parent concerned about vaccine safety. She urge the Committee to support the passage of HB 277- The Alaska Vaccine Reform Act.

Terry Victor, DPT, Box 1752, Fairbanks, AK 99708, 488-9531. Victor is the parent of a 15 month old child that suffered a severe reaction to a vaccine. She urged the Committee to support passage of HB 277, which [redacted]ld require health care providers to report adverse reactions.

Mary Jo Hotchkiss, Instructor at Anchorage Community College, 2333 Providence Dr., 99508. She explained that in 1980 the University deleted their degree program in Early Childhood Education. This was a

result of there being few graduates in the program, which she attributed to the lack of incentives with in the field for pursuing a degree. She urged the Committee to support changes in the University that would establish training and possibly degrees in Early Childhood Education.

Regina Olszewski, 4003 Garfield , Anchorage, AK. She has a niece that suffered a stroke following a DPT vaccination. She urge the Committee to support the passage of HB 277.

Cecelia Bumanglage, Box 2708, Palmer, AK, 745-2528. She is the parent of a child that suffered a stroke following a DPT vaccination. Since there is no pediatric neurologist in Alaska, they have had to make medical trips to Seattle. The process of treating her now handicapped child is financially difficult. She urges the Committee to support the passage of HB 277, and possibly save one family this pain as the result of mandatory vaccination.

Susan Adams, Illilgaat Tupqaat, Inc., Box 1130, Kotzebue, AK, 442-3157. Adams is the Director of Illilgaat Tupqaat, a day care center. She agreed with the statements shared by Floyd Richmond of Ketchikan with regard to the State's responsibility in assisting in providing affordable, quality child care. She shared the story of a mother of four children, ages 4 months to 6 years, who wants to work outside the home, but can not afford a babysitter and does not qualify for day care assistance. Adams urged the Committee to assist the government in taking a leadership role in establishing quality day care in Alaska.

Carolyn Barnes, 5131 Hatcher, Anchorage, AK, 333-6028.
She is the parent of a child that became deaf after a DPT vaccine. She urged the Committee to support the passage of HB 277.

Dianne Gerber, DPT, St. Rt. 2, Box 560-Z, Kasiloff, AK 99610, 262-1714. She is the parent of a child that had severe reactions to the DPT vaccine and to the MMR vaccine. The child suffered fours days of high fever following the MMR vaccine. She urged the Committee to support the passage of HB 277.

Sharon Wells, 9340 Stratamore, Anchorage, AK, 243-4148. She is a medical foster parent for infants and premature babies. She is very concerned that many infants stay in foster care too long. Because of problems in the Indian Child Welfare Act, many infants that are adoptable stay in foster care past the point of being easily adoptable.

Kathy Boucha-Roberts, Director of Child Development at Providence Hospital, 3200 Providence Dr., Anchorage, AK, 99519, 261-3075. Roberts directs the corporate sponsored child care facility at Providence Hospital. The program cares for approximately 500 children and has a staff of 65. The fee for a child is based on age and the type of care, (i.e. daytime, night time, full time, drop in). They provide services 18 hours a day, 7 days a week, 365 days a year. This program also provides parenting education through classes taught at the hospital that provide interaction between parents and teachers.

Dee Ann Mueller, DPT, 501 Cole Dr., Kenai, AK 99611, 283-7459. She expressed her strong concern that parents should have a choice in deciding to vaccinate a child. Her child had adverse reactions to two DPT vaccines. She was not given any precautionary information, nor was the reaction reported. As a result of the vaccine her child now suffers with mild cerebral palsy.

Pertussis (Whooping Cough)

definition: an infectious disease typically of children marked by paroxysms of violent coughing followed by a shrill, whooping drawing in of breath. from: Nelson's Medical Dictionary

the following from: Vaccine Preventable Diseases - manual published by CDC

diagnosis: It has fastidious growth requirements that make it difficult to isolate with multiple serotypes. There are other causes of paroxysmal coughing that may also be confused with pertussis. These include bronchiolitis, bronchopneumonia, Bortetella parapertussis, B. bronchiseptica infections, adenovirus infections, chlymydia trachomatis, and others. Difficult to diagnose. Some success with swabs taken from posterior nasopharynx or immunoflourescent antibody testing.

treatment: erythromycin antibiotic of choice to decrease communicability and treat bacteriological secondary infections such as bronchopneumonia (most common and most severe secondary infection). Intensive nursing care essential. Pertussis immune globula may help shorten illness.

complications: 10% of all pertussis cases may be hospitalized. 1982-1983 encephalopathy occurred in 3/1,000 cases, 2.5% of cases in children less than 1 year may have convulsion Average of 6 deaths per year in United States due to pertussis.

Diptheria

definition: highly contagious bacterial disease spread by coughing and sneezing. Patches can be observed in throat that cause swelling, may obstruct breathing in severe cases and cause victim to choke to death.

diagnosis: usually made based on clinical presentation; swab of pharyngeal area. variety of types; nasal, tonsillar, pharyngeal, laryngeal, etc.

treatment: antibiotics and antitoxin. respitory support and airway maintenance if needed

complications: respiratory diseases. 9% respiratory diptheria fatal. approx. 1 death per year in U.S. 1983; 5 cases, 0 deaths

Tetanus

definition: an acute infectious disease characterized by spasms of the muscles especially of the jaw caused by a baccillic toxin introduced through a wound. not contagious.

diagnosis: many medical conditions simulate tetanus. no laboratory findings characteristic of tetanus. Diagnosis is entirely clinical.

complications: spasms, coma, aspiration pneumonia. 20% of tetanus deaths attributed to tetanus toxoid. average 91 cases, 30 deaths per year in U.S. (no information as to vaccination rate of inflicted)

NOTES ABOUT TETANUS:
1) "....the mortality in reported cases of tetanus is higher in the U.S. than in developing countries." (Am J. Dis. Child, Vol 135, June 1981, pg. 571)
2) "nosocomial" (hospital acquired pneumonia) pneumonia is a major cause of death in these patients that come to autopsy." (J. Arkansas Med. Soc., Vol 80, No. 3, Aug. 1983, pg. 136)

GENERAL DPT (DIPTHERIA, PERTUSSIS, AND TETANUS) VACCINE INFORMATION

All vaccines come combined unless specifically requested separate via medical prescription. The following is from Lederle and Connaught manufacturer's inserts.

Ingredients: Lederle Co.: FORMALDEHYDE, potassium phosphate monobasic, sodium phosphate dibasis, glycine, THIMEROSAL (mercury derivative), sodium chloride, ALUMINUM, inactivated diptheria and tetanus toxoids, inactivated pertussis bacteria. Connought Co: basically the same but no mention of formaldehyde.

Minor-Moderate Adverse Reactions: (See manufacturer's product insert for complete list)

1) local reactions, adscess formation at sight of injection, fretfulness, drowsiness, vomiting, anorexia

Severe Adverse Reactions: (See manufacturer's product insert insert for those recognized by manufacturer. Read large print under ADVERSE REACTIONS.)

ADVERSE REACTIONS

Local reactions manifested by erythema and induration with or without tenderness are common after administration of DTP. Such local reactions are usually self-limited and require no therapy. A nodule may be palpable at the injection site for a few weeks.

Abscess formation at the site of injection has been reported.[1,2,3] Cervical lymphadenopathy has been reported following DTP injections into the arm.[4]

Mild to moderate temperature elevations frequently follow DTP administration and are often accompanied by fretfulness, drowsiness, vomiting, and anorexia.[1,2,3,5] Approximately 50% of DTP recipients will develop temperature elevations > 38° C (100.4° F) after one or more doses of the series, approximately 6% > 39° C (102.2° F), and approximately 1.5% > 40° C (104° F). Some data suggest that febrile reactions are more likely to occur in those who have experienced such responses after prior doses.[6]

SIGNIFICANT REACTIONS ATTRIBUTED TO THE PERTUSSIS VACCINE COMPONENT HAVE BEEN: HIGH FEVER OF 40.5° C (105° F), A TRANSIENT SHOCK-LIKE EPISODE, EXCESSIVE SCREAMING (PERSISTENT CRYING OR SCREAMING FOR THREE OR MORE HOURS DURATION), SOMNOLENCE, CONVULSIONS, AND ENCEPHALOPATHY. THESE REACTIONS HAVE BEEN REPORTED TO OCCUR RARELY FOLLOWING THE INJECTION OF THIS PRODUCT AND THEY MAY BE FATAL OR RESULT IN PERMANENT DAMAGE TO THE CENTRAL NERVOUS SYSTEM. PERTUSSIS VACCINE HAS BEEN ASSOCIATED WITH A GREATER PROPORTION OF ADVERSE REACTIONS THAN MANY OTHER CHILDHOOD IMMUNIZATIONS.[7,8] SHOULD SYMPTOMATOLOGY REFERABLE TO THE CENTRAL NERVOUS SYSTEM DEVELOP FOLLOWING ADMINISTRATION, FURTHER IMMUNIZATION WITH THIS PRODUCT IS CONTRAINDICATED (SEE CONTRAINDICATIONS). SUCH REACTIONS ALMOST ALWAYS APPEAR WITHIN 24 TO 48 HOURS AFTER INJECTION, BUT HAVE BEEN THOUGHT TO OCCUR AFTER AN INTERVAL AS LONG AS SEVEN DAYS.

NEUROLOGICAL COMPLICATIONS FOLLOWING TETANUS TOXOID ADMINISTRATION, SUCH AS PARALYSIS OF THE RADIAL NERVE,[9] RECURRENT PHARYNGEAL NERVE,[10] COCHLEAR LESION,[11] BRACHIAL PLEXUS NEUROPATHY,[12,13] AND A CASE OF DIFFICULTY IN SWALLOWING, ACCOMMODATION PARESIS, AND EEG DISTURBANCES[14] HAVE BEEN REPORTED IN THE DIFFERENTIAL DIAGNOSIS OF POLYRADICULONEUROPATHIES FOLLOWING ADMINISTRATION OF TETANUS TOXOID. TETANUS TOXOID SHOULD BE CONSIDERED AS A POSSIBLE ETIOLOGY.[15]

CONTRAINDICATIONS

IMMUNIZATION SHOULD BE DEFERRED DURING THE COURSE OF ANY ACUTE ILLNESS. THE OCCURRENCE OF ANY TYPE OF NEUROLOGICAL SYMPTOMS OR SIGNS, INCLUDING ONE OR MORE CONVULSIONS (SEIZURES) FOLLOWING ADMINISTRATION OF THIS PRODUCT IS A CONTRAINDICATION TO FURTHER USE. USE OF THIS PRODUCT IS ALSO CONTRAINDICATED IF THE CHILD HAS A PERSONAL OR FAMILY HISTORY OF CENTRAL NERVOUS SYSTEM DISORDERS.

THE PRESENCE OF ANY EVOLVING OR CHANGING DISORDER AFFECTING THE CENTRAL NERVOUS SYSTEM IS A CONTRAINDICATION TO ADMINISTRATION OF DTP REGARDLESS OF WHETHER THE SUSPECTED NEUROLOGICAL DISORDER IS ASSOCIATED WITH OCCURRENCE OF SEIZURE ACTIVITY OF ANY TYPE.

The Committee on Infectious Diseases of the American Academy of Pediatrics recommends that pertussis vaccine should be withheld when a previous dose has been followed by convulsion, encephalitis, focal neurological signs or collapse. Nor should infants who experience excessive somnolence, excessive screaming (persistent crying or screaming for three or more hours duration) or temperature more than 105° F (40.5° C) receive additional doses of the vaccine.[16]

The Immunization Practices Advisory Committee (ACIP) of the U.S. Public Health Service recommends that hypersensitivity to vaccine components, presence of an evolving neurologic disorder, or a history of a severe reaction (usually within 48 hours) following a previous dose all remain definitive contraindications to the receipt of pertussis vaccine. Severe reactions include collapse or shock, persistent screaming episode, temperature 40.5° C (105° F) or greater, convulsion(s) with or without accompanying fever, severe alterations of consciousness, generalized and/or focal neurologic signs, or systemic allergic reactions.[17]

Immunosuppressive therapy, including irradiation, corticosteroids, antimetabolites, alkylating agents, and cytotoxic agents may result in aberrant responses to active immunization procedures. Administration should be deferred in individuals receiving such therapy.

The clinical judgement of the attending physician should prevail at all times.

Elective immunization of patients over the age of 6 months should be deferred during an outbreak of poliomyelitis.

PARTIAL LIST OF POSSIBLE SEVERE LONG-TERM ADVERSE REACTIONS TO DPT VACCINE (USUALLY PERTUSSIS COMPONENT IMPLICATED)

* article available from Alaska Dissatisfied Parents Together

*1) **Cervical lymphadenopathy** . Omokoku, B: "Post DPT inoculation caused lymphadenitis in children." N.Y. State Journal Medicine 81:1667, 1981

2)**Thrombocytopenia** (blood disease). Connaught manufacturer's insert*. Pertussis. Report of Committee on Infectious Diseases. AAP, Evanston, Illinois, p. 205, 1977

*3) **hemolytic anemia** (blood disease). Haneberg B.; "Acute hemolytic anemia related to DPT vaccination": ACTA Pae diatr. Scand. 67:347-350, 1978

*4) **death, encephalopathy, Reyes syndrome, tracheo bronchitis. convulsions with and without residual brain damage** . Griffith A.H: "Reactions after Pertussis vaccine; a manufacturer's experiences and difficulties since 1964", British Medical Journal: April 1, 1978, pg. 809-814

*5) **destructive encephalopathys, convulsions, hypsarrhythmia, shock, serious meningitis** . Incidence of neurological reactions 1:3,600 children. Strom, Justus M.D., "Further Experience of Reactions, Especially of a Cerebral Nature, in Conjunction w/Triple Vaccine: Swedish Study, 1959-1965", British Medical Journal, 1967, 320-323

*6) **recurrent seizures, severe developmental delays** . Murphy, Jerome. "Recurrent Seizures after DPT Vaccine Immunization", AJDC, Vol 138, Oct. 1984

*7) **blindness, cerebral palsy, death, mental retardation, chronic convulsions** . Byers, Randolph. "Encephalopathies Following Prophylactic Pertussis Vaccine", Pediatrics, Vol. 1, #4, April 1948.

*8) **recurring convulsions, paralysis, mental retardation, allergies** . Berg, J.M. "Neurological Complications of Pertussis Immunization", British Medical Journal, July 5, 1958

*9) **death, sudden death, convulsions, paresis, rhinopharyngitis, rapid mental deterioration, coma, cerebral palsy, deafness, epilepsy** . Neurological reactions after vaccination- 1 in 6,000 children; death or permanent defect- 1 in 17,000. "Is Universal Vaccination Against Pertussis Always Justified?" Justus Strom, M.D., British Medical Journal. Oct. 22, 1960.

*10) **allergic form of encephalopathy, death** . "Encephalopathy Following Pertussis Vaccine Prophylaxis", Joseph H. Globus, M.D., J.A.M.A., October 22, 1949

*11) **cerebral degeneration, blindness** . "Neurological Complications of Pertussis Inoculation", M. Kulenkanpff, Archives of Disease in Children, 1974, pg. 46, 49

*12) **sudden death, seizures, convulsions, respiratory infection** . John A. Toomey, "Reactions to Pertussis Vaccine", J.A.M.A., February

13)"**Post vaccinal lymphadenitis developing intc Hodgkins Disease**". Bichel, J. ACTA Med. Scand., 199:523, 1976

*14) **anaphylaxis** (extreme, sometimes fatal allergic reaction). Howard Orens, M.D. "Anaphylaxis due to vaccination in the Office". Can. Med. Assoc. Journal

*15) **paroxysmal supra ventricular tachycardia** . Joon M. Park, M.D. "Paroxysmal Supra ventricular tachycerdia precipitated by pertussis vaccine". Journal of Pediatrics, June 1983

SIDS AND DPT VACCINATION

STUDIES THAT SHOW CORRELATION BETWEEN SIDS/DPT

*1) BARAFF GRAPH. "Possible Temporal Association between DPT Vaccination and Sudden Infant Death". Pediatric Infectious Disease, 1983, 2,7-11

*2) TORCH STUDY summary & graph "DPT Immunization: a Potential Cause of the Sudden Infant Death Syndrome." Neurology 1982, 32 A 169

(20)

*3) BERNIER STUDY GRAPH. "DTP Vaccination and SIDS in Tennessee." Journal of Pediatrics, 1982, 101:419-421
*4) "DTP Immunization and Sudden Infant Death Syndrome." Alexander M. Walker, et. al., AJPH, August 1987, Vol. 77, #8

TETANUS VACCINE REACTIONS (PARTIAL LIST)

1) "Abnormal T-Lymphocyte Subpopulations in Healthy Subjects After Tetanus Booster Immunization." Martha Eibe, New England Journal of Medicine, 310(3) 1307-1313, November 26, 1981. Report pointed out that similar drops in helper/suppressor ratio of T-lymphcytes are characteristic of AIDS.
2) neuralgic amyotophy . J. Neurology, Neurosurgy & Psych, Vol. 47; 320, March 1984
3) transverse myelitis. Br. Med Journal 1977; 1: 1430-1431
4) demyelinating neuropathy . J Neur. Sci. 1978; 37: 113-125
5) peripheral neuropathy . Arch Phys Med Rehab Vol 63, July 1982, 332-334. (detailing many cases)
6) calcifying dermatomyositis . Arch Int Med Vol 143, July 1983, 1457-8
7) mono and polyneuritis (22 cases). Int. Symoos. on Imm. Dev. Biol Stands, Vol. 43, pg. 25-32, 1979
8) Guillain Barre Syndrome . N.Z. Med J., Nov 11, 1981., Akt. Neurol 1980: 7;195-200
9) hemolytic anemia . Acta Pediatric Scand, May 1978
10) anaphylactic shock . Harefuah, Nov 1975 - Dtsch Med Wochenschr, Jan 1973 - Annals of Allergy, Vol 49, August 1982, pg 107
11) nerve damage, inner ear. Munch Med. Wochen Schr, Nov 1965
12) foreign body granuloma . Rocky Mountain Medical Journal, Jan, 1966
13) seizure activity . Neurol Neurochir Pol. Sept 1981
14) recurrent abscess formetio n. Pediatric, May 1985
15) brachial plexus neuropathy . Archives of Neurology, 1972
(which can lead to paralysis of the arm)

DIPTHERIA VACCINE REACTIONS

(all from Center of Disease Control Manual: "Vaccine Preventable Diseases; Epedemiology, Prevention and Control", pg 38-39.)

1) local reactions, abscess at the site of injection
2) arthus-type hypersensitivity reactions, characterized by severe local reactions
3) severe systemic reactions such as generalized urticaria (allergic rash and hives), anaphylaxis, neurological complications

DPT VACCINE INGREDIENTS

*data available from Alaska Dissatisfied Parents Together

FORMALDEHYDE

"Formaldehyde (ingredient in Lederle DPT vaccine) is also mutagenic in bacteria, viruses, fungi, insects and mouse lymphoma cells with or without metabolic activation. It induces chromosomal recombination in yeast, insects, and cultured mammalian cells, as well as cellular transformation in mouse Balb/C 3T3 cells (Griesemer, et al., 1980). These results indicate that formaldehyde is capable of binding to, and altering, genetic material."
Formaldehyde: Review of Scientific Basis of EPA's Carcinogenic Risk Assessment Peter W. Preuss Ph. D., May 20, 1983., page 91

"Immunologic. (physiological effect): The characteristics of an allergic mechanism are that the response can be evoked in sensitized individuals with very small amounts of formaldehyde. Symptoms usually develop some time after the initial exposure rather than on initial contact. Usually only a proportion of the exposed will be affected. In the documented cases there is typically a delayed response, although there may be a brief immediate reaction as well (dual response), and the late reaction may be prolonged." Formaldehyde Toxicity, James E. Gibson, 1983*

"Carcinogenic Effect: Of additional concern is the carcinogenic potential of formaldehyde in humans. This concern is based on metabolism, mutagenicity, and carcinogenicity studies which were reviewed in the Report of the Federal Panel on Formaldehyde, Griesemer, et. al., 1980. In brief, the panel reported that these studies showed that formaldehyde reacts readily with biological chemical, including proteins and nucleic acids." page 395, Formaldehyde: Review of Scientific Basis of EPA's Carcinogenic Risk Assessment, May 20, 1982*

Aluminum

(another ingredient in all DPT vaccines)

"...In Canada (researchers) found that after a latent period of 10 to 20 days, animals receiving a single intracerabral injection of aluminum incurred a progressive decline in learning and memory." Physiol Behav, Crapper DR, Dalton AJ, 1973

"Crapper also found that aluminum accumulates preferentially on the chromatin of various cell nuclei, including brain cell nuclei from patients with SDAT... (Senile Dementia of the Alaheimer's Type)." Frontiers in Neurology and Neuroscience Research, "Dementia: Recent observations on Alzheimer's disease and experimental aluminum encephalopathy." Crapper, Dr., 1974

Thimerosal (mercury derivative)

definition: prepared by reacting ethylmercuric chloride (or ethymercuric hydroxide) with thiosalicylic acid. The Merck Index, 1983*

ethylmercuric chloride: caution: Highly toxic. causes skin burns, is absorbed through the skin, chronic exposure has caused permanent injury to brain, applied at 2% strength as a fungicide for treating seeds. The Merck Index, 1983*

the following from: "Epidemiology & Toxicology of Mercury" The Environmental Mercury Problem*

"Furthermore, the vast majority of the organomercurial poisonings are due to alkylmercurials such as methyl or ethylmercury."

"Therefore while it is important to recognize that all forms of mercury are powerful poisons, the akylmercurials are many times more effective poisons than either the inorganic or arylmercurials."

"...the organic mercury compounds, especially the alkymercurials (ethymercury) are more toxic than the other kinds of mercury compounds because the human body absorbs more and excretes less of them."

"Several alkylmercury poisoning epidemics have been recorded." Guatamala, Pakistan, Iraq: "In 1960 many farmers were poisoned and 221 patients were admitted to hospital in Baghdad, Iraq. Other patients were known to have been stricken by ETHYLMERCURIC CHLORIDE

POLIO

definition : a viral disease marked by inflammation of the nerve cells of the spinal cord, deformity, and paralysis. 95% of all polio infliction are inapparent or subclinical, but may still be able to transmit infection to others (CDC Manual)

diagnosis : A) 4%-8% nonspecific illness of influenza-like illness B) 1%-2% of polio infections result in major illness w/complete recovery C) 0.1%-0.2% of all polio infections result in flaccid paralysis. Many persons w/paralytic polio recover completely. Deathrate: 2-5% in children 15-30% in adults

treatment : 1) early ambulation 2) muscular relaxation 3) controlled and prolonged medical observation 4) special nutrition program Virginia Medical Monthly, June 1956, Nutrition, "Nutrition as Treatment for Polio Victims", Prevention, November 1960

complications: See diagnosis

POLIOVIRUS VACCINE

all information from manufacturer's product insert unless specified

Ingredients: mixture of 3 types of attenuated polioviruses propagated in cercopithecus MONKEY KIDNEY CELLS, amino acids, antibiotics, CALF SERUM, sorbitol, streptomycin, NEOMYCIN

CONTRAINDICATION : MUST NOT BE ADMINISTERED TO PATIENTS WITH IMMUNE DEFICIENCY.

Question: Since no mechanisms are employed by health care providers to determine immune deficiency (especially public health providers who have never seen 2 month old infants before vaccine clinics), how is this to be determined?

ALL PERSONS WITH ALTERED IMMUNE STATUS SHOULD AVOID CLOSE HOUSEHOLD-TYPE CONTACT WITH RECIPIENTS FOR AT LEAST 6-8 WEEKS.

Question: Most people aren't aware of the health status of everyone their child comes in contact with (especially other infants in day care), so how is this to be accomplished and what are the other health implications?

Adverse Reactions: 1) paralytic disease, vaccine associated paralysis in healthy vaccines, susceptible family members, and other close personal contacts 2) transverse myletis (inflammation of spinal cord or bone marrow) "Transverse myletis after diptheria, tetanus, and polio immunization." case history British Medical Journal, June 4, 1977

NOTES:

1) "Many physicians and health workers will be surprised to learn that the Sabin vaccine is now the chief cause of polio in the world today and that it was introduced without any controlled field trials." J. and D. Salk, Science 4/4/77

2) Current Trends: Average of 10 cases per year reported 1980-1985, no wild virus cases since 1979; one imported case per year: REMAINING CASES IN VACCINE RECIPIENTS OR CONTACTS. page 88, CDC manual Note: speaker at seminar, Neil Livengood stated that no "natural cases" of polio have occurred in U.S. since 1979

3) "A defect either in the humoral (B-cell) mediated (T-cell) system appears to increase the risk of vaccine associated polio myelitis. T-cell dysjunction from any cause must therefore be assumed to confer greater risk for vaccine related poliomyelitis." Elena Nightengale, Ph. D, et. al, Committee for the Study of Poliomyelitis Vaccines, Institute of Medicine. Correspondence New England Journal of Medicine, Dec. 8, 1977

4) "The poliovirus isolated from a patient with paralytic disease may not always be the virus causing the patients disease." Lancet, Dec. 8, 1984, pg. 1315

*5) "The DBS (Division of Biological Sciences) requires monkey kidney cells used in growing polio vaccine be held for only 28 days in order to ensure that they contain no SV 40 virus According to A. Girandi of the Wistar Institute SV 40 may remain latent for up to 35 days. Nor does the DBS require monkey kidney cells to be screened for chromosomal abnormalities - a possible indicator of cancerous tendencies - a test they would probably fail in large numbers." "The Boat That Never Rocked", Science, March 17, 1977

CONTRAINDICATIONS

Under no circumstances should this vaccine be administered parenterally

Administration of the vaccine should be postponed or avoided in those experiencing an acute illness and in those with any advanced debilitated condition or persistent vomiting or diarrhea

ORIMUNE *must not* be administered to patients with immune deficiency diseases such as combined immunodeficiency, hypogammaglobulinemia and agammaglobulinemia. It would also be prudent to withhold ORIMUNE from siblings of a child known to have an immunodeficiency syndrome. Further, ORIMUNE *must not* be administered to patients with altered immune states such as those occurring in thymic abnormalities, leukemia, lymphoma or generalized malignancy or by lowered resistance from therapy with corticosteroids, alkylating drugs, antimetabolites or radiation. All persons with altered immune status should avoid close household-type contact with recipients of the vaccine for at least 6-8 weeks. IPV is preferred for immunizing all persons in this setting.[2,3,4,6,7]

PRECAUTIONS

Other viruses (including poliovirus and other enterovirus) may interfere with the desired response to this vaccine, since their presence in the intestinal tract may interfere with the replication of the attenuated strains of poliovirus in the vaccine

It would seem prudent not to administer TOPV shortly after Immune Serum Globulin (ISG) unless such a procedure is unavoidable, for example, with unexpected travel to or contact with epidemic areas or endemic areas. If TOPV is given with or shortly after ISG, the dose probably should be repeated after three months if immunization is still indicated.[8] However, ISG may not interfere with immunization with TOPV.[9]

The vaccine is not effective in modifying or preventing cases of existing and/or incubating poliomyelitis

ADVERSE REACTIONS

Paralytic disease following the ingestion of live poliovirus vaccines has been, on rare occasion, reported in individuals receiving the vaccine, (see for example CONTRAINDICATIONS) and in persons who were in close contact with vaccinees.[2,3,4,10,11,12,13] The vaccine viruses are shed in the vaccinee's stools for at least 6 to 8 weeks as well as via the pharyngeal route. Most reports of paralytic disease following ingestion of the vaccine or contact with a recent vaccinee are based on epidemiological analysis and temporal association between vaccination or contact and the onset of symptoms. Most authorities believe that a causal relationship exists.[2,10,14,15]

The risk of vaccine-associated paralysis is extremely small for vaccinees, susceptible family members and other close personal contacts.[2] However, prior to administration of the vaccine, the attending physician should warn or specifically direct personnel acting under his authority to convey the warnings to the vaccinee, parent, guardian or other responsible person of the possibility of vaccine-associated paralysis. The Centers for Disease Control report that during the years 1969 through 1980 approximately 290 million doses of TOPV were distributed in the United States. In the same 12 years, 25 "vaccine-associated" and 55 "contact vaccine-associated" paralytic cases were reported. Twelve other "vaccine-associated" cases have been reported in persons (recipients or contacts) with immune deficiency conditions.[3] These statistics do not provide a satisfactory basis for estimating these risks on a per person basis.[14]

When the attenuated vaccine strains are to be introduced into a household with adults who have not been adequately vaccinated or whose immune status cannot be determined, the risk of vaccine-associated paralysis can be minimized by giving these adults three doses of IPV a month apart before the children receive ORIMUNE.[2] The CDC reports that no paralytic reactions to IPV are known to have occurred since the 1955 cluster of poliomyelitis cases caused by vaccine that contained live polioviruses that had escaped inactivation.[2]

The Immunization Practices Advisory Committee of the U.S. Public Health Service states:

"Because of the overriding importance of ensuring prompt and complete immunization of the child and the extreme rarity of OPV-associated disease in contacts, the Committee recommends the administration of OPV to a child regardless of the poliovirus-vaccine status of adult household contacts. This is the usual practice in the United States. The responsible adult should be informed of the small risk involved. An acceptable alternative, if there is strong assurance that ultimate, full immunization of the child will not be jeopardized or unduly delayed, is to immunize adults according to the schedule outlined above before giving OPV to the child."[2]

The Immunization Practices Advisory Committee has concluded that "Oral polio vaccine remains the vaccine of choice for primary immunization of Children.

from: How to Raise a Healthy Child in Spite of Your Doctor, Dr. Robert Mendelsohn

MUMPS

definition and diagnosis: relatively innocous viral disease, usually experienced in childhood, causes swelling of one or both of the salivary glands. Symptoms; temp of 100-104 degrees, appetite loss, headache, back pain. Infection confers lifetime immunity.

treatment: does not require medical treatment - bed rest, lots of fluids, ice packs to reduce swelling.

complications: very rarely in adult males with mumps infection, orchitis (mumps condition that affects testicles) may occur. Orchitis rarely causes sterility and when it does usually only one testicle is affected

In 1981, 1,491 cases in U.S..; 1 death (MMWR 1983 summary)

MEASLES

definition and diagnosis: rubeola, contagious viral disease that can be contracted by touching an object used by infected person, slight fever at first to high (103-104 degrees) in few days-sometimes small white spots occur inside mouth - rash occurs below hairline and spreads downward to cover body in about 36 hours

treatment: bedrest, fluids, Calamine lotion or cornstarch to relieve itching, may be light sensitive (darken room), Vitamin A supplements in malnourished. "Vitamin A Supplements and Mortality Related to Measles: A Randemised Clinical Trial", Andrew J.G. Barclay, British Medical Journal, Jan. 31, 1987, Volume 294

RUBELLA

definition and diagnosis: non-threatening disease in children that does not require medical treatment- fever, slight cold w/sore throat - rash appears on face and spreads to body, spot do not run together (as in measles), confers lifetime immunity

treatment: rest and fluids

complications: none to child. Threat posed by rubella is the possibility it may cause damage to fetus if a women contracts disease during first three months of pregnancy

In 1981, 2,077 cases of rubella in U.S.; 5 deaths (MMWR 1983 Summary)

(26)

MEASLES, MUMPS, RUBELLA (MMR)
VACCINE INFORMATION AND ADVERSE REACTIONS

NOTE: Since all three vaccines in combined shot, it's difficult to ascertain what vaccine causes what reaction. Any live virus vaccine is capable of producing the same syptoms, reactions, etc. as the virus.

Ingredients: CELL CULTURES OF CHICK EMBRYO (measles and mumps), HUMAN DIPLOID CELL culture (rubella), neomycin, sorbitol, hydorlized gelatin.
Adverse Reactions: (from Manufacturer's insert)

CONTRAINDICATIONS

Do not give M-M-R II to pregnant females; the possible effects of the vaccine on fetal development are unknown at this time. If vaccination of postpubertal females is undertaken, pregnancy must be avoided for three months following vaccination.

Hypersensitivity to neomycin (each dose of reconstituted vaccine contains approximately 25 mcg of neomycin).

Any febrile respiratory illness or other active febrile infection.

Active untreated tuberculosis.

Patients receiving therapy with ACTH, corticosteroids, irradiation, alkylating agents or antimetabolites. This contraindication does not apply to patients who are receiving corticosteroids as replacement therapy, e.g., for Addison's disease.

Individuals with blood dyscrasias, leukemia, lymphomas of any type, or other malignant neoplasms affecting the bone marrow or lymphatic systems.

Primary immuno-deficiency states, including cellular immune deficiencies, hypogammaglobulinemic and dysgammaglobulinemic states.

HYPERSENSITIVITY TO EGGS, CHICKEN, OR CHICKEN FEATHERS

This vaccine is essentially devoid of potentially allergenic substances derived from host tissues (chick embryos).* However, because the attenuated measles and mumps viruses in this vaccine are propagated in cell cultures of chick embryo, there is a potential risk of hypersensitivity reactions in patients allergic to eggs, chicken or chicken feathers. Widespread use of the vaccine for more than a decade has resulted in only rare, isolated reports of minor allergic reactions attributed to allergens of this kind, possibly related to the vaccine. Significantly, when children with known allergies to eggs, chicken and chicken feathers were given a similarly prepared vaccine in a clinical study,[20] none experienced reactions other than those reactions previously observed in non-allergic children.

PRECAUTIONS

Administer M-M-R II subcutaneously; *do not give intravenously.*

Epinephrine should be available for immediate use in case an anaphylactoid reaction occurs.

M-M-R II may be given simultaneously with monovalent or trivalent poliovirus vaccine, live, oral. M-M-R II should not be given less than one month before or after administration of other live virus vaccines.

Due caution should be employed in administration of M-M-R II to children with a history of febrile convulsions, cerebral injury or any other condition in which stress due to fever should be avoided. The physician should be alert to the temperature elevation which may occur 5 to 12 days following vaccination.

Vaccination should be deferred for at least 3 months following blood or plasma transfusions, or administration of human immune serum globulin.

Excretion of small amounts of the live attenuated rubella virus from the nose or throat has occurred in the majority of susceptible individuals 7-28 days after vaccination. There is no confirmed evidence to indicate that such virus is transmitted to susceptible persons who are in contact with the vaccinated individuals. Consequently, transmission, while accepted as a theoretical possibility, is not regarded as a significant risk.**

There are no reports of transmission of live attenuated measles or mumps viruses from vaccinees to susceptible contacts.

It has been reported that live attenuated measles, mumps and rubella virus vaccines given individually may result in a temporary depression of tuberculin skin sensitivity. Therefore, if a tuberculin test is to be done, it should be administered either before or simultaneously with M-M-R II.

As for any vaccine, vaccination with M-M-R II may not result in seroconversion in 100% of susceptible subjects given the vaccine.

ADVERSE REACTIONS

Because of the slightly acidic pH (6.2-6.6) of the vaccine, patients may complain of burning and/or stinging of short duration at the injection site.

The adverse clinical reactions associated with the use of M-M-R II are those expected to follow administration of the monovalent vaccines given separately. These may include malaise, sore throat, headache, fever, and rash, mild local reactions such as erythema, induration, tenderness and regional lymphadenopathy; parotitis; orchitis; thrombocytopenia and purpura; allergic reactions such as wheal and flare at the injection site or urticaria; and arthritis, arthralgia and polyneuritis.

Moderate fever [101-102.9°F (38.3-39.4°C)] occurs occasionally, and high fever (above 103°F (39.4°C)) occurs less commonly. On rare occasions, children developing fever may exhibit febrile convulsions. Rash occurs infrequently and is usually minimal, but rarely may be generalized.

Clinical experience with live attenuated measles, mumps and rubella virus vaccines given individually indicates that encephalitis and other nervous system reactions have occurred very rarely. These might occur also with M-M-R II.

Experience from more than 80 million doses of all live measles vaccines given in the U.S. through 1975 indicates that significant central nervous system reactions such as encephalitis and encephalopathy, occurring within 30 days after vaccination, have been temporally associated with measles vaccine approximately once for every million doses. In no case has it been shown that reactions were actually caused by vaccine. The Center for Disease Control has pointed out that "a certain number of cases of encephalitis may be expected to occur in a large childhood population in a defined period of time even when no vaccines are administered". However, the data suggest the possibility that some of these cases may have been caused by measles vaccines. The risk of such serious neurological disorders following live measles virus vaccine administration remains far less than that for encephalitis and encephalopathy with natural measles (one per thousand reported cases).

There have been isolated reports of ocular palsies and Guillain-Barre syndrome occurring after immunization with vaccines containing live attenuated measles virus. The ocular palsies have occurred approximately 3-24 days following vaccination. No definite causal relationship has been established between either of these events and vaccination.

There have been reports of subacute sclerosing panencephalitis (SSPE) in children who did not have a history of natural measles but did receive measles vaccine. Some of these cases may have resulted from unrecognized measles in the first year of life or possibly from the measles vaccination. Based on estimated nationwide measles vaccine distribution, the association of SSPE cases to measles vaccination is about one case per million vaccine doses distributed. This is far less than the association with natural measles, 5-10 cases of SSPE per million cases of measles. The results of a retrospective case-controlled study conducted by the Center for Disease Control suggest that the overall effect of measles vaccine has been to protect against SSPE by preventing measles with its inherent higher risk of SSPE.

Local reactions characterized by marked swelling, redness and vesiculation at the injection site of attenuated live measles virus vaccines have occurred in children who received killed measles vaccine previously. M-M-R II was not given under this condition in clinical trials.

Transient arthritis, arthralgia and polyneuritis are features of natural rubella and vary in frequency and severity with age and sex, being greatest in adult females and least in prepubertal children. This type of involvement has also been reported following administration of MERUVAX II (Rubella Virus Vaccine, Live, MSD). In children, joint reactions are rare and of brief duration if they do occur. In women, incidence rates for arthritis and arthralgia are generally higher than those seen in children (children: 0-3%; women: 12-20%),[21] and the reactions tend to be more marked and of longer duration. Rarely, symptoms may persist for a matter of months. In adolescent girls, the reactions appear to be intermediate in incidence between those seen in children and in adult women. Even in older women (35-45 years), these reactions are generally well tolerated and rarely interfere with normal activities.

NOTES:

MEASLES

1) subacute scleros panencephalitis "SSPE" (fatal hardening of brain) Modern Medicine, 1/7/74 and "Occurence of Measles in Previously Vaccinated Individuals, 1979", American Society for Microbiology meeting at Ft. Detrick, Md., April 27, 1987

*2) toxic epidermal nercrolysis (dying of skin "scalded skin") also reported to occur secondary to polio, diptheria, and tetanus vaccinations. "Toxic Epidermal Nercrolysis Following Measles Vaccination", Robert G. Shoss, M.D., Arch. Dermatol, Vol 110, Nov. 1974

*3) ataxia (inability to coordinate muscle movements), mental retardation, aseptic meningitis, seizure disorders, hemiparesis (paralysis affecting one side of body), multiple sclerosis, Reyes syndrome, juvenile-onset diabetes. How to Raise a Healthy Child In Spite of Your Doctor, Robert S. Mendelsohn, M.D., 1984, Contemporary Books, Inc.

RUBELLA

*1) thrombocytopenia (blood clotting problem) "Thrombocytopenia Associated With Rubella Vaccination", Henry R. Bartos M.D., F.A.C.P; New York State Journal of Medicine, Feb. 15, 1972

2) arthritis and arthralgia. In United States, 87 cases of congenital rubella syndrome were reported, 12 in New Jersey. 17% of all children vaccinated in N. Jersey developed arthritis and arthralgia. Science, March 26, 1977

(29)

Boffins claim the cure can kill

By HARRY NELSON

ST PETERSBURG, (Florida).— New findings about the way viruses ehave once more point to their possible role in causing cancer — and perhaps diseases such as arthritis and multiple sclerosis.

The findings, reported here at a seminar for science writers spnsored by the American Cancer Society, raise questions about the possible harmful effects of immunization programmes to prevent influenza, measles and polio.

The new findings came from Dr Robert W, Simpson, of Rutgers University in New Jersey, and Dr Wendell D. Winters, a University of California at Los Angeles virologist now working at the University of Texas in San Antonio.

Last year, the Nobel Prize for medicine was given to David Baltimore and Howard Temin for discovering that viruses that cause cancer in animals are equipped with a very special enzyme called reverse transcriptase.

The viruse that carry the enzyme are called RNA viruses. Possession of the enzyme allows the RNZ viruses to form strands of DNA, thus enabling them to become cfegrated with the DNA of the cells they infect.

It is this integration of the DNA transcribed by the virus with the cell's DNA that somehow triggers cancer, at least in animals.

(The genetic material of all living things, includin viruses, is either RNA (ribonucleic acid) or DNA (deoxyribonucleic acid). Before the discovery of reverse transcriptase, which enables RNA viruses to transcribe their genetic material into a DNA form, scientists had trouble understanding how RNA cancer viruses could transform DNA cells.)

in cells without expressing themselves in any way.

Simpson raised the question whether immunization programmes against flu, measles, mumps and polio may actually be seeding humans with RNA to form proviruses which will then becme latent in cells throughout the body.

He said some of these latent proviruses could be "molecules in search of disease" which under proper conditions become activated and cause a variety of diseases.

Of diseases that could be caused in this manner, the chief possibilities are rheumatoid arthritis, multiple sclerosis, lupus erythematosus, Parkinson's disease and perhaps cancer.

Winters, the UCLA virologist, has added a new dimension to the subject of viruses being a possible cause of human cancer.

Cells grown

He has been working in the laboratory with tumour cells removed frm UCLA surgery patients. The cells were then grown in dishes.

When he added a common respiratory virus known as Adenovirus 5 to the cells, the Adenovirus caused large numbers of latent RNA particles to be released.

"It is possible but not proven that the RNA particles were the cause of the human tumours. Perhaps they are also the seeds released into the bloodstream which float to other parts of the body where they infect cells and start cancer viruses into action.— Los Angeles Times service.

More recently, Simpson has found that RNA viruses which do not cause cancer also can form DNA, even though they lack reverse transcriptase.

DNA formed in this way from an RNA virus is called a provirus.

No effect

It is known from earlier work that some non-cancerous viruses have a tendency to exist as proviruses for long periods of time in cells without causing any apparent disease.

Some examples of common RNA viruses that do not cause cancer but may have the capacity to form proviruses are influenza, measles, mumps and polio viruses.

Simpson showed in laboratory experiments that proviruses derived from the measles virus and the respiratory syncytial virus (a cause of respiratory disease in newborn babies) can exist

(31)

Expert links AIDS to bovine viruses

By PHILIP M. BOFFEY
New York Times

WASHINGTON — Jeremy Rifkin, an outspoken critic of genetic engineering and other biotechnologies, Monday asked three federal agencies to determine whether cattle viruses play a role in causing AIDS.

In a petition submitted to the Agriculture Department, the Federal Centers for Disease Control and the National Institutes of Health, Rifkin called the cattle viruses "an extraordinary potential threat to public health."

Rifkin speculated in an interview that the AIDS virus might have evolved from cattle viruses, or that the cattle viruses might themselves play a role in the development of acquired immune deficiency syndrome in humans.

The petition cited scientific papers indicating a "close correlation" between the HIV, or human immunodeficiency virus, that causes AIDS in humans, and a virus found in cattle called bovine visna-like virus or bovine immunodeficiency-like virus. The petition warned that a range of viruses "exist in domestic animal herds in the U.S. and thus could pose a potential health hazard."

It also speculated that the cattle virus, BIV, might have infected cell cultures used to make some human vaccines, perhaps thereby contributing to the global spread of AIDS.

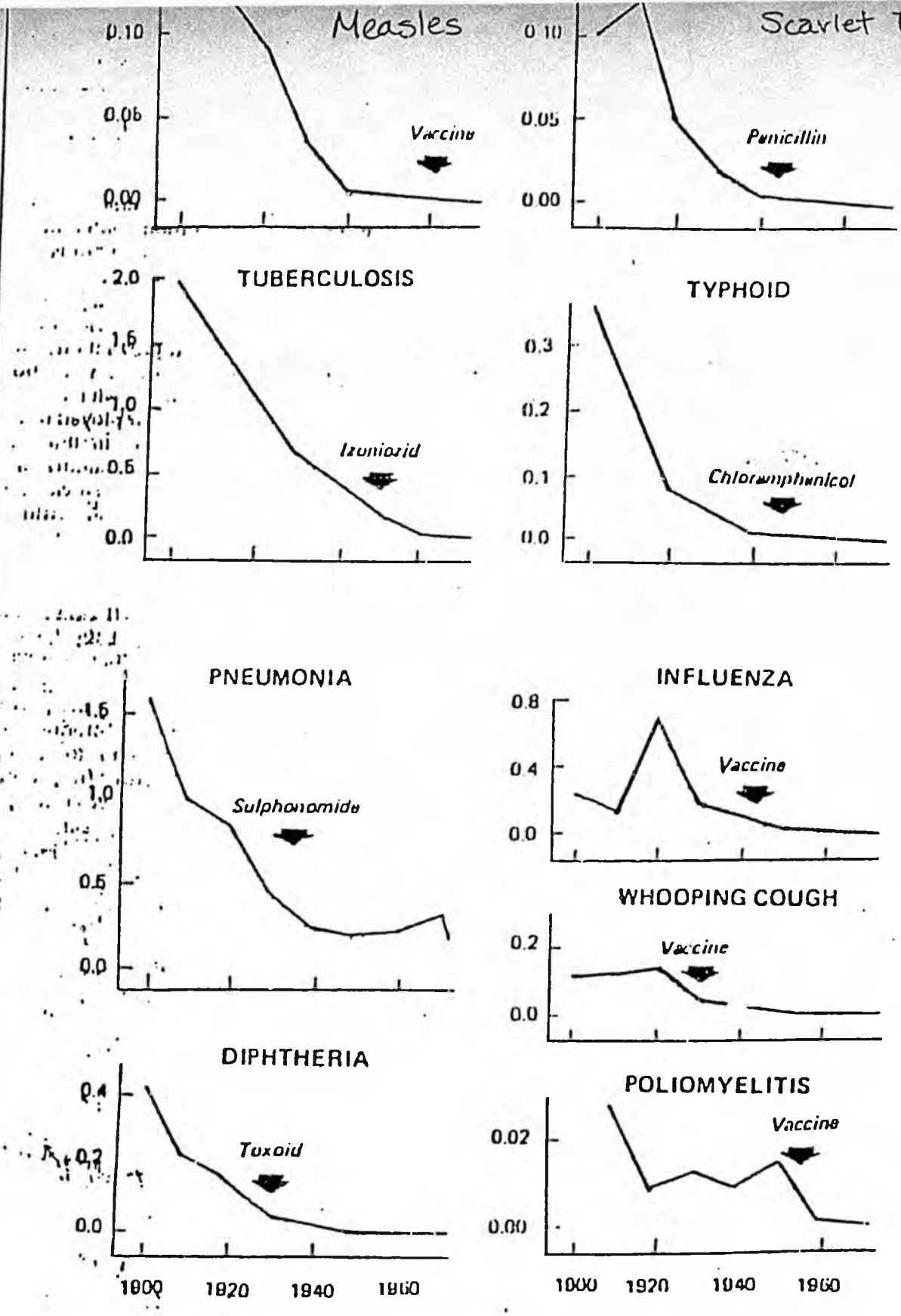
However, two of the scientists whose papers were cited by Rifkin expressed doubt in interviews that the cattle viruses played any role in causing AIDS.

One of them, Dr. Matthew A. Gonda, a virus expert who has performed detailed studies of the structural and genetic makeup of BIV as compared to the AIDS virus, said that the two were close enough to be considered members of the same family of viruses, called lentiviruses.

In fact, Gonda and his colleagues at Program Resources, Inc., which conducts research for the National Cancer Institute in Frederick, Md., have proposed that the cattle virus be used as a model for studying the AIDS virus. But the cattle virus is not close enough to be considered the progenitor of the AIDS virus or the cause of AIDS, Gonda said.

"I don't think that BIV could cause AIDS in humans," he said. "I don't want people to say this is an AIDS virus. It's not something that somebody should be afraid will jump into humans or that should make people fear cows."

The second expert, Dr. Martin J. Van der Maaten, of the Agriculture Department's National Animal Disease Laboratory in Ames, Iowa., who first isolated BIV from cattle, said he believed there was "very little chance of it infecting humans."



The Fall in the Standardized Death Rate (per 1,000 Population) for Nine Common Infectious Diseases in Relation to Specific Medical Measures, for the United States, 1900-1977.

From "Contribution of Medical Measures to Mortality Decline", by John B. McKinlay and Sonja M. McKinlay

(For Adult Use) is recommended.[1-4]

Parenteral drug products should be inspected visually for particulate matter and discoloration prior to administration whenever solution and container permit.

HOW SUPPLIED

Diphtheria and Tetanus Toxoids and Pertussis Vaccine Adsorbed, Aluminum Phosphate Adsorbed, is available in vials of 7.5 ml. Product 1548-33

STORAGE

Keep between 2 and 8° C (35-46° F). DO NOT FREEZE.

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DX12

DIPHTHERIA AND TETANUS TOXOIDS AND PERTUSSIS VACCINE ADSORBED TRI-IMMUNOL®

Diphtheria and Tetanus Toxoids and Pertussis Vaccine Adsorbed, TRI-IMMUNOL®, Lederle, is a combination of Purogenated Diphtheria Toxoid Aluminum Phosphate-Adsorbed, Purogenated Tetanus Toxoid Aluminum Phosphate-Adsorbed, and Pertussis Vaccine.

DESCRIPTION

The diphtheria toxin is produced according to the method of Mueller and Miller and is detoxified by use of formaldehyde. The tetanus toxin is produced by the method of Mueller and Miller and is detoxified by the use of formaldehyde. The toxoids are refined by the Pillemer alcohol fractionation method and are diluted with a solution containing potassium phosphate monobasic, sodium phosphate dibasic, glycine, and thimerosal (mercury derivative) as a preservative. Pertussis Vaccine is prepared by growing Phase I *B. pertussis* in a modified Cohen-Wheeler broth containing acid hydrolysate of casein. The *B. pertussis* culture is harvested, inactivated, and then suspended in a solution containing potassium phosphate monobasic, sodium phosphate dibasic, sodium chloride, and thimerosal (mercury derivative) as a preservative and is then combined with the refined Diphtheria and Tetanus Toxoids in physiological saline (NaCl) diluent containing thimerosal (mercury derivative) as a preservative. The final concentration of thimerosal (mercury derivative) in the combined vaccine is 1:10,000. The aluminum content of the final product does not exceed 0.80 mg per 0.5 ml dose.

The total immunizing dose contains 12 units of pertussis vaccine.

The primary immunization against diphtheria, tetanus, and pertussis consists of four 0.5 ml doses when administered as recommended.[1-4]

CLINICAL PHARMACOLOGY

Simultaneous immunization against diphtheria, tetanus, and pertussis during infancy and childhood has been a routine practice in the United States since the late 1940's. It has played a major role in markedly reducing the incidence of cases and deaths from each of these diseases.

Diphtheria is primarily a localized and generalized intoxication caused by diphtheria toxin, an extracellular protein metabolic of toxinogenic strains of *Corynebacterium diphtheriae*. While the incidence of diphtheria has decreased from about 20 cases per 100,000 population before the general use of diphtheria toxoid[1-3] to about 55 cases reported between 1978 and 1981, the ratio of fatalities to attack rate has remained constant at about 5%-10%. The highest case fatality rates are in the very young and the elderly. Diphtheria toxoid induces antitoxin. Following adequate immunization with diphtheria toxoid is thought to protect for at least 10 years.[1]

It significantly reduces both the risk of developing diphtheria and the severity of clinical illness. It does not, however, eliminate carriage of *C. diphtheriae* in the pharynx or on the skin.[1] A serum level ≥0.01 toxin neutralization units/ml is generally considered protective.[4]

Tetanus is an intoxication manifested primarily by neuromuscular dysfunction, caused by a potent exotoxin elaborated by *Clostridium tetani*. The incidence of tetanus has dropped dramatically with the routine use of tetanus toxoid, remaining relatively constant over the last decade at about 100 cases reported annually. Spores of *C. tetani* are ubiquitous, and there is essentially no natural immunity to tetanus toxin. Thus, universal primary immunization with tetanus toxoid with subsequent maintenance of adequate antitoxin levels by means of timed boosters is necessary to protect all age groups.[1] Tetanus toxoid is highly effective, with a failure rate in fully immunized persons of less than 4 per 100 million.[5] Protective levels of serum antitoxin (≥0.01 toxin neutralization units/ml)[4] are achieved which persist for at least 10 years after full immunization.[1]

Pertussis is a disease of the respiratory tract caused by *Bordetella pertussis*. This gram negative coccobacillus produces an array of biologically active components that escape from the site of infection and produce systemic effects, including an endotoxin-related febrile response, attenuation of the host's febrile and inflammatory responses, lymphocytosis, leukocytosis, effects on glucose homeostasis, and possible neurotoxicity. The role of each of the different components in the pathogenesis of and immunity to pertussis is not well understood.

Pertussis is a highly communicable disease, which, unique for a bacterial disease, has an attack rate in unimmunized populations of over 90%.[6] As a result of immunization with pertussis vaccine, the number of reported cases and associated mortality has de-

cined from about 120,000 cases and 1,100 deaths in 1950[6] to an annual average of about 2,300 cases and 10 fatalities over the last 10 years.[7] Accurate data do not exist as bacteriological confirmation of pertussis can be obtained in less than half of the cases. Most reported deaths occur in children less than one year old. Older children and adults, in whom classic signs are often absent, may go undiagnosed and serve as reservoirs of disease.[8]

Evidence of the efficacy of pertussis vaccine can be provided by the recent British experience, where a reduction in the number of immunized individuals from 79% in 1973, to 31% in 1978 resulted in an epidemic of 102,500 pertussis cases and 36 deaths between late 1977 and 1980, and 1,440 cases per week reported during the winter of 1981-82. A similar situation occurred in Japan.[9]

Because the incidence and severity of pertussis decrease with age, routine pertussis immunization is not recommended for persons 7 years of age or older.[1]

INDICATION AND USAGE

Diphtheria and Tetanus Toxoids and Pertussis Vaccine Adsorbed is indicated for active immunization of infants and children through 6 years of age against diphtheria, tetanus, and pertussis.[1,10]

CONTRAINDICATIONS

IMMUNIZATION SHOULD BE DEFERRED DURING THE COURSE OF ANY ACUTE ILLNESS.

THE OCCURRENCE OF ANY TYPE OF NEUROLOGICAL SYMPTOMS OR SIGNS, INCLUDING ONE OR MORE CONVULSIONS (SEIZURES) FOLLOWING ADMINISTRATION OF THIS PRODUCT IS A CONTRAINDICATION TO FURTHER USE. USE OF THIS PRODUCT IS ALSO CONTRAINDICATED IF THE CHILD HAS A PERSONAL OR FAMILY HISTORY OF CENTRAL NERVOUS SYSTEM DISORDERS.

THE PRESENCE OF ANY EVOLVING OR CHANGING DISORDER AFFECTING THE CENTRAL NERVOUS SYSTEM IS A CONTRAINDICATION TO ADMINISTRATION OF DTP REGARDLESS OF WHETHER THE SUSPECTED NEUROLOGICAL DISORDER IS ASSOCIATED WITH OCCURRENCE OF SEIZURE ACTIVITY OF ANY TYPE.

The Committee on Infectious Diseases of the American Academy of Pediatrics recommends that pertussis vaccine should be withheld when a previous dose has been followed by convulsion, encephalitis, focal neurological signs or collapse. Nor should infants who experience excessive somnolence, excessive screaming (persistent crying or screaming for three or more hours duration) or temperature more than 105° F (40.5° C) receive additional doses of the vaccine.[4]

The Immunization Practices Advisory Committee (ACIP) of the U.S. Public Health Service recommends that hypersensitivity to vaccine components, presence of an evolving neurologic disorder, or a history of a severe reaction (usually within 48 hours) following a previous dose all remain definitive contraindications to the receipt of pertussis vaccine. Severe reactions include collapse or shock, persistent screaming episode, temperature 40.5° C (105° F) or greater, convulsion(s) with or without accompanying fever, severe alterations of consciousness, generalized and/or local neurologic signs, or systemic allergic reactions.[5]

Immunosuppressive therapy, including irradiation, corticosteroids antimetabolites, alkylating agents and cytotoxic agents may result in aberrant responses to active immunization procedures. Administration should be deferred in individuals receiving such therapy.

The clinical judgement of the attending physician should prevail at all times.

Elective immunization of patients over the age of 6 months should be deferred during an outbreak of poliomyelitis.

WARNING

THIS PRODUCT IS NOT RECOMMENDED FOR IMMUNIZING PERSONS AFTER THEIR SEVENTH BIRTHDAY. DO NOT ATTEMPT ROUTINE IMMUNIZATION IF THE CHILD HAS A PERSONAL OR FAMILY HISTORY OF CENTRAL NERVOUS SYSTEM DISORDERS. SHOULD ANY SYMPTOMATOLOGY RELATED TO NEUROLOGICAL DISORDERS DEVELOP FOLLOWING ADMINISTRATION, DO NOT ATTEMPT FURTHER ADMINISTRATION OF PERTUSSIS VACCINE. CONVULSION, ENCEPHALITIS, FOCAL NEUROLOGIC SIGNS, COLLAPSE, SHOCK, EXCESSIVE SCREAMING (PERSISTENT CRYING OR SCREAMING FOR THREE OR MORE HOURS DURATION), EXCESSIVE SOMNOLENCE, SEVERE ALTERATION OF CONSCIOUSNESS, SYSTEMIC ALLERGIC REACTIONS OR TEMPERATURE MORE THAN 105° F (40.5° C) ARE CONTRAINDICATIONS FOR ANY FURTHER USE OF PERTUSSIS VACCINE.

If such disorders are found, the infants or children should be given diphtheria and tetanus toxoids (DT) instead of DTP. If DT is used, three doses at least 4 weeks apart, followed by a fourth dose 6-12 months later, are recommended for infants. For children 1 year of age or older, two doses of DT at least 4 weeks apart followed by a third dose 6-12 months later, are recommended.[1]

The occurrence of sudden-infant-death syndrome (SIDS) has been reported following administration of DTP.[11,12,13] A causal relationship between DTP immunization and the syndrome has not been established.[12,14]

Prior to administration of this vaccine, health care personnel should inform the parent, guardian, or other responsible adult of the benefits and risks to the child of DTP vaccine. For recent information about the estimated range of risks of severe reactions following DTP administration, consult references 1, 15, 16, 17, 18, and 21.

DTP should not be given to infants or children with thrombocytopenia or any coagulation disorder that would contraindicate intramuscular injection unless the potential benefit clearly outweighs the risk of administration.

If the vaccine is used in persons receiving immunosuppressive therapy, the expected antigenic response may not be obtained.

Special care should be taken so the injection is not made into a blood vessel.

PRECAUTIONS

A. *General*

1. This product should be used for the age group between 2 months and the 7th birthday.
2. A separate sterile syringe and needle or a sterile disposable unit should be used for each individual patient to prevent transmission of hepatitis or other infectious agents from one person to another.
3. *Since this product contains both a bacterial suspension and an adjuvant, shake vigorously before withdrawing each dose from multiple dose vials.*
4. Before the injection of any biological, the physician should take all precautions known for prevention of allergic or any other side reactions. This should include: A review of the patient's history regarding possible sensitivity, the ready availability of epinephrine 1:1000 and other appropriate agents used for control of immediate allergic reactions; and a knowledge of the recent literature pertaining to use of the biological concerned, including the nature of side effects and adverse reactions that may follow its use.

B. *Information for Parent*

1. Prior to administration of any dose of DTP, the parent or guardian should be asked about the recent health status of the infant or child to be injected.
2. WHEN AN INFANT OR CHILD IS RETURNED FOR THE NEXT DOSE IN THE SERIES, THE PARENT SHOULD BE QUESTIONED CONCERNING OCCURRENCE OF ANY SYMPTOM AND/OR SIGNS OF AN ADVERSE REACTION AFTER THE PREVIOUS DOSE (SEE CONTRAINDICATIONS; ADVERSE REACTIONS).

ADVERSE REACTIONS

Local reactions, manifested by erythema and induration with or without tenderness, are common after administration of DTP. Such local reactions are usually self-limited and require no therapy. A nodule may be palpable at the injection site for a few weeks.

Abscess formation at the site of injection has been reported.[19,20,21] Cervical lymphadenopathy has been reported following DTP injections into the arm.[19]

Mild to moderate temperature elevations frequently follow DTP administration and are often accompanied by fretfulness, drowsiness, vomiting, and anorexia.[8,19,20] Approximately 50% of DTP recipients will develop temperature elevations > 38° C (100.4° F) after one or more doses of the series; approximately 6% > 39° C (102.2° F); and approximately 1.5% > 40° C (104° F). Some data suggest that febrile reactions are more likely to occur in those who have experienced such responses after prior doses.[19]

SIGNIFICANT REACTIONS ATTRIBUTED TO THE PERTUSSIS VACCINE COMPONENT HAVE BEEN: HIGH FEVER OF 40.5° C (105° F), A TRANSIENT SHOCK-LIKE EPISODE, EXCESSIVE SCREAMING (PERSISTENT CRYING OR SCREAMING FOR THREE OR MORE HOURS DURATION), SOMNOLENCE, CONVULSIONS, AND ENCEPHALOPATHY. THESE REACTIONS HAVE BEEN REPORTED TO OCCUR RARELY FOLLOWING THE INJECTION OF THIS PRODUCT AND THEY MAY BE FATAL OR RESULT IN PERMANENT DAMAGE TO THE CENTRAL NERVOUS SYSTEM. PERTUSSIS VACCINE HAS BEEN ASSOCIATED WITH A GREATER PROPORTION OF ADVERSE REACTIONS THAN MANY OTHER CHILDHOOD IMMUNIZATIONS.[19,20] SHOULD SYMPTOMATOLOGY REFERABLE TO THE CENTRAL NERVOUS SYSTEM DEVELOP FOLLOWING ADMINISTRATION, FURTHER IMMUNIZATION WITH THIS PRODUCT IS CONTRAINDICATED (SEE CONTRAINDICATIONS). SUCH REACTIONS ALMOST ALWAYS APPEAR WITHIN 24 TO 48 HOURS AFTER INJECTION, BUT HAVE BEEN THOUGHT TO OCCUR AFTER AN INTERVAL AS LONG AS SEVEN DAYS.

NEUROLOGICAL COMPLICATIONS FOLLOWING TETANUS TOXOID ADMINISTRATION, SUCH AS PARALYSIS OF THE RADIAL NERVE,[22] RECURRENT PHARYNGEAL NERVE,[23] COCHLEAR LESION,[24] BRACHIAL PLEXUS NEUROPATHY[25,26] AND A CASE OF DIFFICULTY IN SWALLOWING, ACCOMMODATION PARESIS, AND EEG DISTURBANCES[27] HAVE BEEN REPORTED. IN THE DIFFERENTIAL DIAGNOSIS OF POLYRADICULONEUROPATHIES FOLLOWING ADMINISTRATION OF TETANUS TOXOID, TETANUS TOXOID SHOULD BE CONSIDERED AS A POSSIBLE ETIOLOGY.[28]

DOSAGE AND ADMINISTRATION

Shake vigorously before withdrawing each dose from the multiple dose vials.

Before injection, the skin over the site to be injected should be cleansed and prepared with a suitable germicide. After insertion of the needle, aspirate to help avoid inadvertent injection into a blood vessel. Expel the dose slowly and terminate the dose with a small bubble of air (0.1 to 0.2 ml).

The basic immunizing course for infants and children through 6 years of age consists of three doses of 0.5 ml each at 4- to 8-week intervals, followed by a fourth dose of 0.5 ml approximately one year after the third dose.

It is recommended that active immunization against diphtheria, tetanus, and pertussis be started at 2 months of age.[1] All doses should be injected intramuscularly, preferably into the mid-lateral muscles of the thigh or deltoid, with care to avoid major peripheral nerve trunks.

Interruption of the recommended schedule with a delay between doses does not interfere with the final immunity achieved; nor does it necessitate starting the series over again, regardless of the length of time elapsed between doses.[1]

A recall (booster) dose of 0.5 ml is indicated at age 4-6 years, preferably prior to entrance into kindergarten or elementary school. However, if the fourth dose of the basic immunizing series was administered after the fourth birthday, a recall (booster) of DTP prior to school entry is not considered necessary.[1]

For either basic or recall (booster) immunization against tetanus and diphtheria of individuals 7 years of age and older, the use of Tetanus and Diphtheria Toxoids Adsorbed

CONNAUGHT

DIPHTHERIA AND TETANUS TOXOIDS AND PERTUSSIS VACCINE ADSORBED USP

FOR PEDIATRIC USE

SPECIAL NOTICE: *EXPOSURE OF THIS VACCINE TO TEMPERATURES BELOW 2°C (35°F) OR ABOVE 25°C (77°F) FOR AS LITTLE AS 24 HOURS RESULTS IN CONDITIONS WHICH MAKE RESUSPENSION OF THE VACCINE DIFFICULT.*

CARE SHOULD BE TAKEN NOT TO STORE THIS PRODUCT NEAR FREEZING SURFACES. ALWAYS RETURN UNUSED PORTION TO REFRIGERATION, 2°C TO 8°C (35°F to 46°F), IMMEDIATELY AFTER USE.

DO NOT USE IF RESUSPENSION CANNOT BE ACHIEVED BY VIGOROUS SHAKING.

DESCRIPTION

This product combines diphtheria and tetanus toxoids, adsorbed with pertussis vaccine in a sterile isotonic sodium chloride solution containing sodium phosphate to control pH; each 0.5 ml injection contains not more than 0.25 mg of aluminum added in the form of aluminum potassium sulfate. Thimerosal (mercury derivative) 1:10,000 is added as a preservative. The mixture provides an immunizing dose of each component in the total dosage prescribed below. Each single dose contains 4 protective units of Pertussis Vaccine based on the U.S. Standard Pertussis Vaccine.

INDICATIONS

For active immunization of infants and young children against diphtheria, tetanus and pertussis simultaneously. Injections should be started at 2 to 3 months of age and be completed no later than the age of 6 years. Immunization should always be started at once if whooping cough or diphtheria is present in the community.

CONTRAINDICATIONS

Persons 7 years of age and older should not be immunized with Pertussis Vaccine. Immunization should be deferred during the course of any acute illness, however, a minor illness not associated with fever such as a mild upper respiratory infection need not preclude vaccination. The benefit/risk ratio of routine immunization with this product should be carefully considered by the responsible physician if the child has a personal or family history of central nervous system disease or convulsions.[2] The occurrence of a severe reaction following administration of this product, consisting of high fever (39°C or above), somnolence, screaming, shock, convulsions, encephalopathy or thrombocytopenia, is a contraindication to further use of this vaccine. Anaphylactoid and/or allergic reactions, immunosuppressive therapy, recent gammaglobulin, plasma, or blood transfusions, immunodeficiency disorders, leukemia, lymphoma, or generalized malignancy are also contraindications.[2] Simultaneous administration of DTP with another vaccine should be avoided unless they have been shown to be effective when used together. The clinical judgment of the responsible physician should prevail at all times.

The occurrence of any type of neurological symptoms or signs following administration of this product is an absolute contraindication to further use.

Elective immunization of patients over the age of six months should be deferred during an outbreak of poliomyelitis.

WARNING

This product is not recommended for immunizing persons 7 years of age and older.

The benefit/risk ratio of routine immunization with this product should be carefully considered by the responsible physician if the child has a personal or family history of central nervous system disorders or convulsions.[2] Should any symptomatology related to neurological disorders develop following administration, do not attempt further administration of pertussis antigen. The development of "excessive screaming syndrome" is an absolute contraindication for any further use of pertussis vaccine.

If the vaccine is used in persons receiving immunosuppressive therapy, a recent injection of immune globulin or having an immunodeficiency disorder, the expected antibody response may not be obtained.[2]

Special care should be taken so the injection is not made into a blood vessel.

ADVERSE REACTIONS

Adverse reactions may be local and include pain, erythema, tenderness, heat, edema and induration at the site of injection. Significant reactions attributed to the pertussis vaccine component have been high fever (greater than 39°C), a transient shocklike episode, excessive screaming, somnolence, convulsions, encephalopathy, thrombocytopenia, and hemolytic anemia.[3,4] Such reactions almost always appear within 24 to 48 hours after injection but have been thought to occur after an interval as long as seven days. A small nodule may develop at the site of injection and remain for a few weeks before being completely absorbed. Sterile abscesses have been reported. Systemic reactions include mild to moderate transient fever, chills, malaise, and irritability.

Neurological disorders such as encephalopathy, possibly due to the pertussis component, have been reported to occur rarely following the injection of this product and they may be fatal or result in permanent damage to the central nervous system.

There have been rare reports of Sudden Infant Death Syndrome (crib death) after the administration of DTP Vaccine. However, available data indicate no association between DTP vaccination, in general, and sudden infant death, in particular.[5]

Neurological complications have been reported. These include cochlear lesion,[6] brachial plexus neuropathies,[7,8] paralysis of the radial nerve,[9] paralysis of the recurrent nerve,[10] accommodation paresis, EEG disturbances, and one reported case of swallowing difficulty.[11] In the differential diagnosis of polyradiculoneuropathies following administration of tetanus toxoid, tetanus toxoid should be considered as a possible etiology.[12]

STORAGE

To maintain potency it is necessary to store this vaccine at a temperature which will maintain ice continuously in a solid state. This vaccine may remain fluid at temperatures above -14° C (+7° F) because of its sorbitol content. If frozen, the vaccine must be completely thawed prior to use. An *unopened* container of vaccine that has been frozen and then is thawed may be carried through a maximum of 10 freeze-thaw cycles, provided the temperature does not exceed 8° C (46° F) during the periods of thaw, and provided the total cumulative duration of thaw does not exceed 24 hours. If the 24-hour period is exceeded, the vaccine then must be used within 30 days, during which time it must be stored at a temperature between 2-8° C (36-46° F).

DISCLAIMER OF REPRESENTATIONS AND WARRANTIES

This vaccine has been produced and tested in accordance with the regulations of the United States Food and Drug Administration for the production of Poliovirus Vaccine, Live, Oral Trivalent. The manufacturer makes no representation or warranty, expressed or implied, with respect to the merchantability or fitness for use of this vaccine other than that the vaccine has been produced in accordance with the standards for its production prescribed by the United States Food and Drug Administration and applicable thereto at the time of its release by the manufacturer. While the use of this preparation and other measures described herein are consistent with accepted standards of medical practice, their use as described cannot be expected necessarily to assure a specific result.

HOW SUPPLIED

2084-08 - 10 (0.5 ml) DISPETTES® Disposable Pipettes
2084-12 - 50 (0.5 ml) DISPETTES®

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REV. 12/83

80:12

POLIOVIRUS VACCINE, LIVE, ORAL TRIVALENT ORIMUNE®

0.5 ml Dose

Contains Sorbitol

SABIN STRAINS TYPES 1, 2 and 3

FOR ORAL ADMINISTRATION - NOT FOR INJECTION

DESCRIPTION

Manufacture and Composition: ORIMUNE® TRIVALENT VACCINE is a mixture of three types of attenuated polioviruses which have been propagated in cercopithecus monkey kidney cell culture. The cells are grown in the presence of Eagle's Basal Medium consisting of Earle's Balanced Salt Solution containing amino acids, antibiotics and calf serum. After cell growth, the medium is removed and replaced with fresh medium containing the inoculating virus but no calf serum. The final vaccine is diluted with a modified cell culture maintenance medium containing sorbitol. Each dose (0.5 ml) contains less than 25 micrograms of each of the antibiotics, streptomycin and neomycin.

The potency is expressed in terms of the amount of virus contained in the recommended dose as tissue culture infective doses ($TCID_{50}$). The human dose of vaccine containing all three virus types shall be constituted to have infectivity titers in the final container material of $10^{5.4}$ to $10^{9.4}$ for Type 1, $10^{4.5}$ to $10^{8.5}$ for Type 2 and $10^{5.2}$ to $10^{9.2}$ for Type 3.[1]

Color Change: This vaccine contains phenol red as a pH indicator. The usual color of the vaccine is pink, although some containers of vaccine, shipped or stored in dry ice, may exhibit a yellow coloration due to the very low temperature or possible absorption of carbon dioxide. The color of the vaccine prior to use (red -pink - yellow) has no effect on the virus or efficacy of the vaccine.

INDICATIONS AND USAGE

The purpose of administering any attenuated, live, virus vaccine is to stimulate the body mechanism to produce an active immunity by simulating the natural infection without producing untoward symptoms of the disease. To accomplish this with live poliovirus vaccine, it is necessary for the virus to multiply in the intestinal tract. A primary series of this vaccine is designed to produce an antibody response to poliovirus Types 1, 2 and 3. This response is comparable to the immunity induced by the natural disease. The antibodies thus formed help protect the individual against clinical poliomyelitis infection by any of the three types of poliovirus. When used in the prescribed manner for primary immunization, type specific neutralizing antibodies will be induced in 90% or more of susceptibles.

This vaccine is indicated for use in the prevention of poliomyelitis caused by poliovirus Types 1, 2 and 3.

Infants starting at six to twelve weeks of age, *all unimmunized children* and *adolescents* through age 18 are the usual candidates for routine prophylaxis.

The Immunization Practices Advisory Committee (IPAC) of the Public Health Service states that trivalent oral poliovirus vaccine (TOPV) and inactivated poliovirus vaccine (IPV) are both effective in preventing poliomyelitis. TOPV is the vaccine of choice for primary immunization of children in the United States when the benefits and risks for the entire population are considered. TOPV is preferred because it induces intestinal immunity, is simple to administer, is well accepted by patients, results in immunization of some contacts of vaccinated persons, and has a record of having essentially eliminated disease associated with wild poliovirus in this country.[2] The choice of TOPV as the preferred poliovirus vaccine in the United States has also been made by the Committee on Infectious Diseases of the American Academy of Pediatrics and a special expert committee of the Institute of Medicine, National Academy of Science.[3,4] TOPV is also recommended for control of epidemic poliomyelitis.[2,3]

Past history of clinical poliomyelitis or prior vaccination with IPV in otherwise healthy individuals does not preclude the administration of TOPV when otherwise indicated.

Serologic evidence indicates that measles and rubella vaccines or combinations (measles-mumps-rubella vaccine) given simultaneously with trivalent oral poliovirus vaccine can be expected to give adequate antibody response.[5]

Routine poliomyelitis immunization for adults residing in the continental United States is not necessary because of extreme unlikelihood of exposure. However, primary immunization with IPV is recommended whenever feasible for those unimmunized adults subject to *increased risk* of exposure, as by travel to or contact

with epidemic or endemic areas and for those employed in hospitals, medical laboratories, clinics or sanitation facilities. If less than 4 weeks are available before protection is needed, a single dose of TOPV is recommended, with IPV given later if the person remains at increased risk. Immunization with IPV may be indicated for unimmunized parents and those in other special situations where, in the judgement of the attending physician, protection may be needed.[2] (see CONTRAINDICATIONS and ADVERSE REACTIONS.)

CONTRAINDICATIONS

Under no circumstances should this vaccine be administered parenterally.

Administration of the vaccine should be postponed or avoided in those experiencing any acute illness and in those with any advanced debilitated condition or persistent vomiting or diarrhea.

ORIMUNE *must not* be administered to patients with immune deficiency diseases such as combined immunodeficiency, hypogammaglobulinemia and agammaglobulinemia. It would also be prudent to withhold ORIMUNE from siblings of a child known to have an immunodeficiency syndrome. Further, ORIMUNE *must not* be administered to patients with altered immune states such as those occurring in thymic abnormalities, leukemia, lymphoma or generalized malignancy or by lowered resistance from therapy with corticosteroids, alkylating drugs, antimetabolites or radiation. All persons with altered immune status should avoid close household-type contact with recipients of the vaccine for at least 6-8 weeks. IPV is preferred for immunizing all persons in this setting.[2,3,4,8,7]

PRECAUTIONS

Other viruses (including poliovirus and other enterovirus) may interfere with the desired response to this vaccine, since their presence in the intestinal tract may interfere with the replication of the attenuated strains of poliovirus in the vaccine.

It would seem prudent not to administer TOPV shortly after Immune Serum Globulin (ISG) unless such a procedure is unavoidable, for example, with unexpected travel to or contact with epidemic areas or endemic areas. If TOPV is given with or shortly after ISG, the dose probably should be repeated after three months, if immunization is still indicated.[8] However, ISG may not interfere with immunization with TOPV.[9]

The vaccine is not effective in modifying or preventing cases of existing and/or incubating poliomyelitis.

Use in Pregnancy:

Although there is no convincing evidence documenting adverse effects of either TOPV or IPV on the developing fetus or pregnant woman, it is prudent on theoretical grounds to avoid vaccinating pregnant women. However, if immediate protection against poliomyelitis is needed, TOPV is recommended.[2] (See CONTRAINDICATIONS and ADVERSE REACTIONS.)

ADVERSE REACTIONS

Paralytic disease following the ingestion of live poliovirus vaccines has been, on rare occasion, reported in individuals receiving the vaccine, (see for example CONTRAINDICATIONS) and in persons who were in close contact with vaccinees.[2,3,4,10,11,12,13] The vaccine viruses are shed in the vaccinee's stools for at least 6 to 8 weeks as well as via the pharyngeal route. Most reports of paralytic disease following ingestion of the vaccine or contact with a recent vaccinee are based on epidemiological analysis and temporal association between vaccination or contact and the onset of symptoms. Most authorities believe that a causal relationship exists.[2,10,14,15]

The risk of vaccine-associated paralysis is extremely small for vaccinees, susceptible family members and other close personal contacts.[2] However, prior to administration of the vaccine, the attending physician should warn or specifically direct personnel acting under his authority to convey the warnings to the vaccinee, parent, guardian or other responsible person of the possibility of vaccine-associated paralysis. The Centers for Disease Control report that during the years 1969 through 1980 approximately 290 million doses of TOPV were distributed in the United States. In the same 12 years, 25 "vaccine-associated" and 55 "contact vaccine-associated" paralytic cases were reported. Twelve other "vaccine-associated" cases have been reported in persons (recipients or contacts) with immune deficiency conditions.[2] These statistics do not provide a satisfactory basis for estimating these risks on a per person basis.[14]

When the attenuated vaccine strains are to be introduced into a household with adults who have not been adequately vaccinated or whose immune status cannot be determined, the risk of vaccine-associated paralysis can be minimized by giving these adults three doses of IPV a month apart before the children receive ORIMUNE.[2] The CDC reports that no paralytic reactions to IPV are known to have occurred since the 1955 cluster of poliomyelitis cases caused by vaccine that contained live polioviruses that had escaped inactivation.[2]

The Immunization Practices Advisory Committee of the U.S. Public Health Service states:

"Because of the overriding importance of ensuring prompt and complete immunization of the child and the extreme rarity of OPV-associated disease in contacts, the Committee recommends the administration of OPV to a child regardless of the poliovirus-vaccine status of adult household contacts. This is the usual practice in the United States. The responsible adult should be informed of the small risk involved. An acceptable alternative, if there is strong assurance that ultimate, full immunization of the child will not be jeopardized or unduly delayed, is to immunize adults according to the schedule outlined above before giving OPV to the child."[2]

The Immunization Practices Advisory Committee has concluded that "Oral polio vaccine remains the vaccine of choice for primary immunization of Children."[2]

ADMINISTRATION

ORIMUNE is to be administered *orally, under the supervision of a physician. Under no circumstances should this vaccine by administered parenterally.* For convenience, the vaccine is supplied in a disposable pipette containing a single dose of 0.5 ml. The vaccine can be administered directly or mixed with distilled water, tap water free of chlorine, simple syrup USP or milk. Alternatively, it may be adsorbed on any one of a number of foods such as bread, cake or cube sugar.

Community Programs:

Poliovirus Vaccine, Live, Oral Trivalent has been recommended for epidemic control. Within an epidemic area, TOPV should be provided for all persons over 6 weeks of age who have not been completely immunized or whose immunization status is unknown, with the exceptions noted under immunodeficiency.[2,3]

DOSAGE

Dose: Each single dose consists of 0.5 ml of Poliovirus Vaccine, Live, Oral Trivalent ORIMUNE.

Initial Administration (Primary Series)

Infants: The primary series is three doses. The Immunization Practices Advisory Committee (Public Health Service) recommends that the three dose immunization series be started at 6 to 12 weeks of age, commonly with the first DTP inoculation. The second dose should be given not less than 6 and preferably 8 weeks later. The third dose is an integral part of the primary immunization and should be administered 8 to 12 months after the second dose.[2]

The American Academy of Pediatrics recommends that the vaccine be administered at 2 months, 4 months, and at approximately 18 months of age. An optional dose of TOPV may be given at 6 months in areas where poliomyelitis is endemic.[3]

Administration to the newborn (under 6 weeks) is not generally recommended because of the varying persistence of maternal antibodies. However, in certain tropical endemic areas, where poliomyelitis has been increasing in recent years, the physician may wish to administer TOPV to the infant at birth, and complete the basic course during the first six months of life.[3] If the physician chooses to immunize the infant at birth, it may be wise to wait until the child is three days old, and it may be prudent to recommend abstention from breast-feeding for two to three hours before and after oral vaccination to permit establishment of the vaccine viruses in the gut.[14]

Older Children and Adolescents (through age 18): Two doses, given not less than 6 and preferably 8 weeks apart and the third dose 6 to 12 months after the second dose.[2,3]

Adults: See INDICATIONS and ADVERSE REACTIONS. Where ORIMUNE is given to unimmunized adults, the dosage is as indicated for children and adolescents.

Booster Doses - School Entrance: On entering elementary school, all children who have completed the primary series should be given a single follow-up dose of trivalent oral poliovirus vaccine.[2,3] All others should complete the primary series.

The Public Health Service Advisory Committee does not recommend routine booster doses of vaccine on the basis of current information, beyond that given at the time of entering school.[2] Recent data indicates that over 95% of children studied five years after full immunization with oral poliovirus vaccine had protective antibodies to all three types of polinvirus.[17]

Increased risk: If an individual who has completed a primary series is subjected to a substantially increased risk by virtue of contact, travel or occupation, a single dose of TOPV has been suggested.[2]

syringe to be used for reconstitution. Inject all the diluent in the syringe into the vial of lyophilized vaccine, and agitate to mix thoroughly. Withdraw the entire contents into a syringe and inject the total volume of restored vaccine subcutaneously.

It is important to use a separate sterile syringe and needle for each individual patient to prevent transmission of hepatitis B and other infectious agents from one person to another.

10 Dose Vial (available only to government agencies/institutions)

Withdraw the entire contents (7 mL) of the diluent vial into the sterile syringe to be used for reconstitution, and introduce into the 10 dose vial of lyophilized vaccine. Agitate to ensure thorough mixing. The outer labeling suggests "For Jet Injector or Syringe Use". Use with separate sterile syringes is permitted for containers of 10 doses or less. The vaccine and diluent do not contain preservatives; therefore, the user must recognize the potential contamination hazards and exercise special precautions to protect the sterility and potency of the product. The use of aseptic techniques and proper storage prior to and after restoration of the vaccine and subsequent withdrawal of the individual doses is essential. Use 0.5 mL of the reconstituted vaccine for subcutaneous injection.

It is important to use a separate sterile syringe and needle for each individual patient to prevent transmission of hepatitis B and other infectious agents from one person to another.

Each dose contains not less than the equivalent of 1,000 $TCID_{50}$ of the U.S. Reference Measles Virus, 5,000 $TCID_{50}$ of the U.S. Reference Mumps Virus and 1,000 $TCID_{50}$ of the U.S. Reference Rubella Virus.

Parenteral drug products should be inspected visually for particulate matter and discoloration prior to administration. M-M-R II, when reconstituted, is clear yellow.

HOW SUPPLIED

No. 4749 — M-M-R II is supplied as a single-dose vial of lyophilized vaccine, NDC 0006-4749-00, and a vial of diluent.

No. 4681/4309 — M-M-R II is supplied as follows: (1) a box of 10 single-dose vials of lyophilized vaccine (package A), NDC 0006-4681-00; and (2) a box of 10 vials of diluent (package B). To conserve refrigerator space, the diluent may be stored separately at room temperature.

Available only to government agencies/institutions:

No. 4682X — M-M-R II is supplied as one 10 dose vial of lyophilized vaccine.

NDC 0006-4682-00, and one 7 mL vial of diluent.

Storage

It is recommended that the vaccine be used as soon as possible after reconstitution. Protect vaccine from light at all times, since such exposure may inactivate the virus. Store reconstituted vaccine in the vaccine vial in a dark place at 2 - 8°C (35.6 - 46.4°F) and discard if not used within 8 hours.

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Issued January 1986 Printed In USA

MSD | M-M-R® II (MEASLES, MUMPS, and RUBELLA VIRUS VACCINE LIVE, MSD)

M-M-R® II
(Measles, Mumps, and Rubella Virus Vaccine Live, MSD)

DESCRIPTION

M-M-R® II (Measles, Mumps, and Rubella Virus Vaccine Live, MSD) is a live virus vaccine for immunization against measles (rubeola), mumps and rubella (German measles).

M-M-R II is a sterile lyophilized preparation of (1) ATTENUVAX® (Measles Virus Vaccine Live, MSD), a more attenuated line of measles virus, derived from Enders' attenuated Edmonston strain and grown in cell cultures of chick embryo; (2) MUMPSVAX® (Mumps Virus Vaccine Live, MSD), the Jeryl Lynn (B level) strain of mumps virus grown in cell cultures of chick embryo; and (3) MERUVAX® II (Rubella Virus Vaccine Live, MSD), the Wistar RA 27/3 strain of live attenuated rubella virus grown in human diploid cell (WI-38) culture.[1,2] The vaccine viruses are the same as those used in the manufacture of ATTENUVAX (Measles Virus Vaccine Live, MSD), MUMPSVAX (Mumps Virus Vaccine Live, MSD) and MERUVAX II (Rubella Virus Vaccine Live, MSD). The three viruses are mixed before being lyophilized. The product contains no preservative.

The reconstituted vaccine is for subcutaneous administration. When reconstituted as directed, the dose for injection is 0.5 mL and contains not less than the equivalent of 1,000 $TCID_{50}$ (tissue culture infectious doses) of the U.S. Reference Measles Virus; 5,000 $TCID_{50}$ of the U.S. Reference Mumps Virus; and 1,000 $TCID_{50}$ of the U.S. Reference Rubella Virus. Each dose contains approximately 25 mcg of neomycin. The product contains no preservative. Sorbitol and hydrolized gelatin are added as stabilizers.

CLINICAL PHARMACOLOGY

Clinical studies of 279 triple seronegative children, 11 months to 7 years of age, demonstrated that M-M-R II is highly immunogenic and generally well tolerated. In these studies, a single injection of the vaccine induced measles hemagglutination inhibition (HI) antibodies in 95 percent, mumps neutralizing antibodies in 96 percent, and rubella HI antibodies in 99 percent of susceptible persons.

The RA 27/3 rubella strain in M-M-R II elicits higher immediate post-vaccination HI, complement-fixing and neutralizing antibody levels than other strains of rubella vaccine[3-9] and has been shown to induce a broader profile of circulating antibodies including anti-theta and anti-iota precipitating antibodies.[10,11] The RA 27/3 rubella strain immunologically simulates natural infection more closely than other rubella vaccine viruses.[11-13] The increased levels and broader profile of antibodies produced by RA 27/3 strain rubella virus vaccine appear to correlate with greater resistance to subclinical reinfection with the wild virus,[11,12,13] and provide greater confidence for lasting immunity.

Vaccine induced antibody levels following administration of M-M-R II have been shown to persist for at least two years without substantial decline.[15] Antibody levels after immunization with M-M-R (Measles, Mumps, and Rubella Virus Vaccine Live, MSD), containing the HPV-77 strain of rubella, have persisted for 10.5 years without substantial decline.[17] If the present pattern continues, it will provide a basis for the expectation that immunity following vaccination will be permanent. However, continued surveillance will be required to demonstrate this point.

INDICATIONS AND USAGE

M-M-R II is indicated for simultaneous immunization against measles, mumps, and rubella in persons 15 months of age or older. A booster is not needed.

Infants who are less than 15 months of age may fail to respond to the measles component of the vaccine due to presence in the circulation of residual measles antibody of maternal origin, the younger the infant, the lower the likelihood of seroconversion. In geographically isolated or other relatively inaccessible populations for whom immunization programs are logistically difficult, and in population groups in which natural measles infection may occur in a significant proportion of infants before 15 months of age, it may be desirable to give the vaccine to infants at an earlier age. Infants vaccinated under these conditions at less than 12 months of age should be revaccinated after reaching 15 months of age. There is some evidence to suggest that infants immunized at less than one year of age may not develop sustained antibody levels when later reimmunized. The advantage of early protection must be weighed against the chance for failure to respond adequately on reimmunization.[18]

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Previously unimmunized children of susceptible pregnant women should receive live attenuated rubella vaccine, because an immunized child will be less likely to acquire natural rubella and introduce the virus into the household.

Non Pregnant Adolescent and Adult Females

Immunization of susceptible non pregnant adolescent and adult females of childbearing age with live attenuated rubella virus vaccine is indicated if certain precautions are observed (see below and PRECAUTIONS). Vaccinating susceptible postpubertal females confers individual protection against subsequently acquiring rubella infection during pregnancy, which in turn prevents infection of the fetus and consequent congenital rubella injury.[19]

Women of childbearing age should be advised not to become pregnant for three months after vaccination and should be informed of the reasons for this precaution.*

It is recommended that rubella susceptibility be determined by serologic testing prior to immunization.** If immune, as evidenced by a specific rubella antibody titer of 1:8 or greater (hemagglutination-inhibition test), vaccination is unnecessary. Congenital malformations do occur in up to seven percent of all live births.[20] Their chance appearance after vaccination could lead to misinterpretation of the cause, particularly if the prior rubella-immune status of vaccinees is unknown.

Postpubertal females should be informed of the frequent occurrence of self limited arthralgia and possible arthritis beginning 2 to 4 weeks after vaccination (see ADVERSE REACTIONS).

Postpartum Women

It has been found convenient in many instances to vaccinate rubella-susceptible women in the immediate postpartum period (See *Nursing Mothers*.)

Revaccination: Children vaccinated when younger than 12 months of age should be revaccinated. Based on available evidence, there is no reason to routinely revaccinate persons who were vaccinated originally when 12 months of age or older. However, persons should be revaccinated if there is evidence to suggest that initial immunization was ineffective.

Use with other Vaccines

Routine administration of DTP (diphtheria, tetanus, pertussis) and/or OPV (oral poliovirus vaccine) concomitantly with measles, mumps and rubella vaccines is not recommended because there are insufficient data relating to the simultaneous administration of these antigens. However, the American Academy of Pediatrics has noted that in some circumstances, particularly when the patient may not return, some practitioners prefer to administer all these antigens on a single day. If done, separate sites and syringes should be used for DTP and M-M-R II.[21]

M-M-R II should not be given less than one month before or after administration of other virus vaccines.

CONTRAINDICATIONS

Do not give M-M-R II to pregnant females; the possible effects of the vaccine on fetal development are unknown at this time. If vaccination of postpubertal females is undertaken, pregnancy should be avoided for three months following vaccination. (See PRECAUTIONS, *Pregnancy*.)

Anaphylactoid reaction to neomycin (each dose of reconstituted vaccine contains approximately 25 mcg of neomycin).

History of anaphylactoid reaction to eggs (see HYPERSENSITIVITY TO EGGS below).

Any febrile respiratory illness or other active febrile infection.

Active untreated tuberculosis.

Patients receiving immunosuppressive therapy. This contraindication does not apply to patients who are receiving corticosteroids as replacement therapy, e.g., for Addison's disease.

Individuals with blood dyscrasias, leukemia, lymphomas of any type, or other malignant neoplasms affecting the bone marrow or lymphatic systems.

Primary immunodeficiency states, including cellular immune deficiencies, hypogammaglobulinemic and dysgammaglobulinemic states.

Individuals with a family history of congenital or hereditary immunodeficiency, until the immune competence of the potential vaccine recipient is demonstrated.[22]

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*NOTE: The Immunization Practices Advisory Committee (ACIP) has recommended "In view of the importance of protecting this age group against rubella, reasonable precautions in a rubella immunization program include asking females if they are pregnant, excluding those who say they are, and explaining the theoretical risks to the others."[13]

**NOTE: The Immunization Practices Advisory Committee (ACIP) has stated "When practical, and when reliable laboratory services are available, potential vaccinees of childbearing age can have serologic tests to determine susceptibility to rubella.... However, routinely performing serologic tests for all females of childbearing age to determine susceptibility so that vaccine is given only to proven susceptibles is expensive and has been ineffective in some areas. Accordingly, the ACIP believes that rubella vaccination of a woman who is not known to be pregnant and has no history of vaccination is justifiable without serologic testing."[19]

7416509

M M R® II
(Measles, Mumps, and Rubella Virus Vaccine Live, MSD)

HYPERSENSITIVITY TO EGGS

Live measles vaccine and live mumps vaccine are produced in chick embryo cell culture. Persons with a history of anaphylactic or other immediate reactions (e.g., hives, swelling of the mouth and throat, difficulty breathing, hypotension, or shock) subsequent to egg ingestion should not be vaccinated. Evidence indicates that persons are not at increased risk if they have egg allergies that are not anaphylactic in nature. Such persons may be vaccinated in the usual manner. There is no evidence to indicate that persons with allergies to chickens or feathers are at increased risk of reaction to the vaccine.[18]

PRECAUTIONS

General

Adequate treatment provisions including epinephrine, should be available for immediate use should an anaphylactoid reaction occur.

Due caution should be employed in administration of M-M-R II to persons with a history of febrile convulsions, cerebral injury or any other condition in which stress due to fever should be avoided. The physician should be alert to the temperature elevation which may occur following vaccination. (See ADVERSE REACTIONS.)

Vaccination should be deferred for at least 3 months following blood or plasma transfusions, or administration of human immune serum globulin.

Excretion of small amounts of the live attenuated rubella virus from the nose or throat has occurred in the majority of susceptible individuals 7-28 days after vaccination. There is no confirmed evidence to indicate that such virus is transmitted to susceptible persons who are in contact with the vaccinated individuals. Consequently, transmission through close personal contact, while accepted as a theoretical possibility, is not regarded as a significant risk.[13] However, transmission of the rubella vaccine virus to infants via breast milk has been documented (see *Nursing Mothers*).

There are no reports of transmission of live attenuated measles or mumps viruses from vaccinees to susceptible contacts.

It has been reported that live attenuated measles, mumps and rubella virus vaccines given individually may result in a temporary depression of tuberculin skin sensitivity. Therefore, if a tuberculin test is to be done, it should be administered either before or simultaneously with M-M-R II.

As for any vaccine, vaccination with M-M-R II may not result in seroconversion in 100% of susceptible persons given the vaccine.

Pregnancy

Pregnancy Category C

Animal reproduction studies have not been conducted with M-M-R II. It is also not known whether M-M-R II can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Therefore, the vaccine should not be administered to pregnant females; furthermore, pregnancy should be avoided for three months following vaccination (see CONTRAINDICATIONS).

In counseling women who are inadvertently vaccinated when pregnant or who become pregnant within 3 months of vaccination, the physician should be aware of the following: (1) In a 10 year survey involving over 700 pregnant women who received rubella vaccine within 3 months before or after conception (of whom 189 received the Wistar RA 27/3 strain), none of the newborns had abnormalities compatible with congenital rubella syndrome;[23] (2) Although mumps virus is capable of infecting the placenta and fetus, there is no good evidence that it causes congenital malformations in humans. Mumps vaccine virus also has been shown to infect the placenta, but the virus has not been isolated from the fetal tissues from susceptible women who were vaccinated and underwent elective abortions;[24] and (3) Reports have indicated that contracting of natural measles during pregnancy enhances fetal risk. Increased rates of spontaneous abortion, stillbirth, congenital defects and prematurity have been observed subsequent to natural measles during pregnancy. There are no adequate studies of the attenuated (vaccine) strain of measles virus in pregnancy. However, it would be prudent to assume that the vaccine strain of virus is also capable of inducing adverse fetal effects.

Nursing Mothers

It is not known whether measles or mumps vaccine virus is secreted in human milk. Recent studies have shown that lactating postpartum women immunized with live attenuated rubella vaccine may secrete the virus in breast milk and transmit it to breast-fed infants.[25] In the infants with serological evidence of rubella infection, none exhibited severe disease; however, one exhibited mild clinical illness typical of acquired rubella.[26,27] Caution should be exercised when M-M-R II is administered to a nursing woman.

ADVERSE REACTIONS

Because of the slightly acidic pH (6.2-6.6) of the vaccine, patients may complain of burning and/or stinging of short duration at the injection site.

The adverse clinical reactions associated with the use of M-M-R II are those expected to follow administration of the munos alent vaccines given separately. These may include malaise, sore throat, headache, fever, and rash, mild local reactions such as erythema, induration, tenderness and regional lymphadenopathy; parotitis; orchitis; nerve deafness; thrombocytopenia and purpura; allergic reactions such as wheal and flare at the injection site or urticaria; and arthritis, arthralgia and polyneuritis.

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(Measles, Mumps, and Rubella Virus Vaccine Live, MSD)

Moderate fever [101-102.9°F (38.3-39.4°C)] occurs occasionally, and high fever [above 103°F (39.4°C)] occurs less commonly. On rare occasions, children developing fever may exhibit febrile convulsions. Rash occurs infrequently and is usually minimal, but rarely may be generalized.

Forms of optic neuritis, including retrobulbar neuritis, papillitis, and retinitis may infrequently follow viral infections, and have been reported to occur 1 to 3 weeks following inoculation with some live virus vaccines.

Clinical experience with live attenuated measles, mumps and rubella virus vaccines given individually indicates that encephalitis and other nervous system reactions have occurred very rarely. These might occur also with M-M-R II.

Experience from more than 80 million doses of all live measles vaccines given in the U.S. through 1975 indicates that significant central nervous system reactions such as encephalitis and encephalopathy, occurring within 30 days after vaccination, have been temporally associated with measles vaccine approximately once for every million doses. In no case has it been shown that reactions were actually caused by vaccine. The Center for Disease Control has pointed out that "a certain number of cases of encephalitis may be expected to occur in a large childhood population in a defined period of time even when no vaccines are administered". However, the data suggest the possibility that some of these cases may have been caused by measles vaccines. The risk of such serious neurological disorders following live measles virus vaccine administration remains far less than that for encephalitis and encephalopathy with natural measles (one per two thousand reported cases).

There have been isolated reports of ocular palsies and Guillain-Barré syndrome occurring after immunization with vaccines containing live attenuated measles virus. The ocular palsies have occurred approximately 3-24 days following vaccination. No definite causal relationship has been established between either of these events and vaccination. Isolated reports of polyneuropathy including Guillain-Barré syndrome have also been reported after immunization with rubella containing vaccines.

There have been reports of subacute sclerosing panencephalitis (SSPE) in children who did not have a history of natural measles but did receive measles vaccine. Some of these cases may have resulted from unrecognized measles in the first year of life or possibly from the measles vaccination. Based on estimated nationwide measles vaccine distribution, the association of SSPE cases to measles vaccination is about one case per million vaccine doses distributed. This is far less than the association with natural measles, 6-22 cases of SSPE per million cases of measles. The results of a retrospective case-controlled study conducted by the Center for Disease Control suggest that the overall effect of measles vaccine has been to protect against SSPE by preventing measles with its inherent higher risk of SSPE.[28]

Local reactions characterized by marked swelling, redness and vesiculation at the injection site of attenuated live measles virus vaccines, and systemic reactions including atypical measles, have occurred in persons who received killed measles vaccine previously. M-M-R II was not given under this condition in clinical trials. Rarely, more severe reactions that require hospitalization, including prolonged high fevers and extensive local reactions, have been reported.[29] Panniculitis has been reported rarely following administration of measles vaccine.[30]

Transient arthritis, arthralgia and polyneuritis are features of natural rubella and vary in frequency and severity with age and sex, being greatest in adult females and least in prepubertal children. This type of involvement as well as myalgia have also been reported following administration of MERUVAX II (Rubella Virus Vaccine Live, MSD). In children, joint reactions are rare and of brief duration if they do occur. In women, incidence rates for arthritis and arthralgia are generally higher than those seen in children (children: 0-3%; women: 12-20%),[31] and the reactions tend to be more marked and of longer duration. Symptoms may persist for a matter of months or on rare occasions for years. In adolescent girls, the reactions appear to be intermediate in incidence between those seen in children and in adult women. Even in older women (35-45 years), these reactions are generally well tolerated and rarely interfere with normal activities.

DOSAGE AND ADMINISTRATION

FOR SUBCUTANEOUS ADMINISTRATION

Do not inject intravenously

The dosage of vaccine is the same for all persons. Inject the total volume of the single dose vial (about 0.5 mL) or 0.5 mL of the 10 dose vial of reconstituted vaccine subcutaneously, preferably into the outer aspect of upper arm. *Do not give immune globulin (IG) concurrently with* M-M-R II.

During shipment, to insure that there is no loss of potency, the vaccine must be maintained at a temperature of 10°C (50°F) or less.

Before reconstitution, store M-M-R II at 2 - 8°C (35.6 - 46.4°F). *Protect from light.*

CAUTION: A sterile syringe free of preservatives, antiseptics, and detergents should be used for each injection and/or reconstitution of the vaccine because these substances may inactivate the live virus vaccine. A 25 gauge, 5/8" needle is recommended.

To reconstitute, use only the diluent supplied, since it is free of preservatives or other antiviral substances which might inactivate the vaccine.

Single Dose Vial — First withdraw the entire volume of diluent into the

Letters to the editor

DPT parent responds to report on interview of health official

To the editor:

This is in regard to the article, "Klatt urges parents to immunize children," by Janet Hevly, Jan. 18.

I am president of the Alaska chapter of Dissatisfied Parents Together (DPT), parents concerned with vaccine safety, efficacy and awareness. We are not anti-vaccine, but stress that each parent should be educated as to all the risks as well as the benefits of any vaccine to be administered to their child. We also stress that each parent should be allowed to choose what vaccines their child is to receive without threat of exclusion from public school.

I wish to clarify and comment on several of the misleading statemets made by Mr. Klatt, so that local parents will not fall prey to the scare tactics so willingly employed by our public health department.

As it is true that the pertussis disease can be fatal, the high death rate (600,000 yearly worldwide) does not exist in developed countries. In Sweden and West Germany, where mandatory pertussis vaccinations have been discontinued due to high reaction rates, the death rate is virtually nonexistent. According to the official Annual Summary 1983 of Morbidity and Mortality Weekly Report, distributed by the U.S. Department of Health and Human Services, only six fatalities due to the pertussis disease occurred in the U.S. in 1981. According to this publication, six deaths per year due to pertussis is the average in our country. An interesting note: the only part of Europe where pertussis vaccination is universally imposed is in the communist countries, such as the Soviet Union, East Germany, Poland and Czechoslovakia.

In regards to the 1985 whooping cough epidemic, I have correspondence from Michael Klatt stating that only 9 of the 30 reported whooping cough cases were actually confirmed pertussis. Approximately half had received pertussis vaccinations. There were no deaths. According to this letter and future correspondence, Mr. Klatt stated that he "was unable to ascertain the immunization histories, because immunization histories were not gotten (for whatever reasons) for all reported cases." How did he manage to come up with the in-depth information then for his interview with Ms. Hevly?

While our group of concerned parents is glad to see that the health department is finally allowing that their adverse-reaction reporting system is inefficient and has been underreporting both immediate severe reactions and long-term illnesses suffered from vaccinations, it is not heartening to realize that this same health department expects parents to disregard these facts and keep on injecting our children with this highly reactive pertussis vaccine. Also, Mr. Klatt failed to mention that his office does not accept an adverse-reaction form unless it meets minimum criteria. One of these is that the reaction must have been severe enough to require a visit to a doctor, health-care facility or hospital. None of these places are required to report any reaction, however.

If a report form does not include this visit, it is shredded. According to the 1987 Goals and Objectives, published by our health department, this criteria is not scheduled to change.

In regard to the statistics Mr. Klatt quoted in relation to reported adverse reactions, they are not only questionable, because they are admittedly underreported, but they do not begin to address the long-term damage associated with many immediate adverse reactions; epilepsy, chronic blood diseases, deafness, blindness, cerebral palsy, severe retardation, death, etc.

Our organization finds it amazing that though there have been four studies published in the 1980s in the Unites States showing a direct causal relationship between DPT vaccinations and SIDS, our government and public officials (e.g., Mr. Klatt) have chosen to disregard these findings in favor of another study that shows only a temporal relation. I have correspondence from our Alaska Health Department that states that no vaccine information is collected on SIDS victims, supposedly because such information is too hard to analyze!

Also, Mr. Klatt failed to mention that the DPT vaccination series is not effective until all three shots of that first series are completed at the age of six months (if the vaccination schedule is strictly adhered to), so by the time a child is "protected," he's already out of the danger zone. "Whooping cough is most fatal to children under six months of age," Klatt, quoted from Clarion article.

As a last comment, I'd like to let Alaskan parents know that there is legislation being drafted to require mandatory adverse-reaction reporting by all sectors, to require accurate parent information, extensive long-term followup and to allow Alaskan parents to object to any or all state mandated vaccines without exclusion from public school as is allowed in 22 other states.

Shannon Kohler
Soldotna

People

Klatt urges parents to immunize children

By JANET HEVLY
Staff Writer

Parents who aren't immunizing their children because of concern about the safety of the pertussis vaccine are encouraged to consider the risks of the disease, says Michael Klatt, manager of the Alaska Immunization Program.

"The real risks of the pertussis disease far outweigh the theoretical risks of the pertussis vaccine," Klatt said in a recent interview. "The best way to protect your child and society from the disease is to immunize your child on schedule."

Pertussis, also called whooping cough, can be a fatal disease for children. According to information Klatt provided from various medical journals, the disease claims an estimated 600,000 lives a year throughout the world. The vast majority of these fatalities are children under six months of age.

For children, whooping cough is characterized by a distinctive wheezing gasp for air in coughing episodes that can last several minutes. The gasp is coupled by a choking build-up of thick mucus — appearing as a froth from the nose and mouth — that restricts the child's ability to breathe. Children may turn blue from lack of oxygen.

Several epidemics of whooping cough were reported in 1985, resulting in 30 reported cases of the disease in Alaska. During that year, 18 cases were reported in the Kenai-Soldotna area, with 13 of those cases occurring in children under the age of five, Klatt said.

Of the 13 preschoolers, four of the children were less than six months old, four were between the ages of six and 12 months, and five were reported in children between one and five years of age.

Klatt said 11 of the 13 children afflicted with the disease had not been properly immunized. Those children either hadn't received any immunizations, or hadn't been immunized according to the mandated immunization schedule. State and federal laws require children in public schools, in state day-care centers and in the federally funded Headstart program to be immunized at two, four and six months, and between 15 and 18 months of age. A booster shot is also recommended before entering school.

Klatt said five cases of whooping cough were reported in 1986, and three cases have been reported so far this year.

Many of the parents who aren't immunizing their children are worried about the adverse effects of the pertussis vaccine. Klatt said 15 adverse reactions were reported in Alaska in 1985. An adverse reaction is defined as anything more than a fever or minor reaction at the site of the injection.

He acknowledges that the reaction reporting system hasn't been effective in the past, and that many parents may not have associated illnesses occurring after a vaccination as related to the vaccine. "I have no doubt that the adverse reactions were under-reported," Klatt said.

As of mid-1986, Klatt said the state is using vaccines purchased from the federal government which require parents to receive written information about the potential hazards of the vaccines. Parents must sign a form stating they understand the possible adverse reactions, and that any adverse reactions should be reported to the health-care provider.

Prior to the written warnings, parents having their children immunized only received verbal warnings about the potential adverse reactions to the shots, Klatt said.

"I anticipate an increase in reported adverse reactions," Klatt said, "And that's good because we want accurate reporting."

According to information from Klatt's medical journals, whooping cough is an extremely contagious disease. The odds indicate that if one of your children brings it home, the rest of the kids will get it. Recovery takes weeks; the Japanese name for whooping cough is translated to "the hundred-days cough."

Children have about a 50-50 chance of developing minor redness, swelling and pain at the site of the DTP injection. Fever, vomiting and drowsiness after a DTP vaccination occur about one in five times. One in 310,000 vaccinated children suffers brain damage, according to information supplied by Klatt. Despite the alarming number of side affects, he emphasized that a study in the United States indicates that SIDS victims were no more likely than non victims to have received a DTP vaccine.

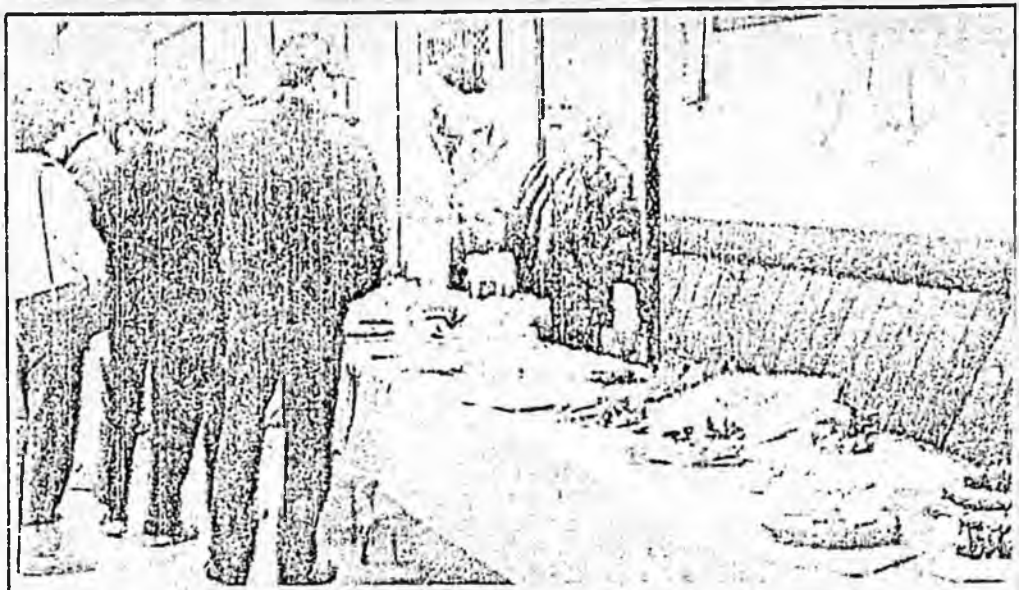
Parents who delay having their children immunized until after six months of age are actually missing their prime opportunity to immunize against pertussis when it is most effective, Klatt said. Whooping cough is most fatal to children under six months of age.

Klatt said public health nurses are receiving an increasing number of requests for just a DT vaccine, without the "P" for pertussis. "They won't honor that request unless they have a written request from a physician," Klatt said. Only a private physician will give just a DT vaccine because a parent philosophically objects to the pertussis vaccine.

A more safe pertussis vaccine may be introduced in the near future, Klatt said. The United States is currently helping finance a study being conducted in Sweden on an acellular pertussis vaccine. The pertussis vaccine administered here is a whole cell vaccine, using all parts of the pertussis bacteria. Klatt said. The acellular vaccine separates the bacteria, attempting to use just the immune qualities of the bacteria and eliminate the other ingredients that may be causing the adverse reactions, he explained.

"The study should be done by the end of the summer, and the results written up by the end of the year," Klatt said. "If it is determined to be as effective at protecting against pertussis with less side affects, I would assume the U.S. would go for that vaccine."

Klatt said he obtained his information from articles on pertussis in Public Health Reports, Journal of the American Medical Association, the American Journal of Diseases of Children, the John Hopkins University School of Hygiene and Public Health and Mothers Today.



Neva Black, a judge in the 4-H Council's Chocolate Lovers Contest, talks to passersby who were looking at entries to the contest this weekend at the Kenai Mall. (Photo by Nicky Donald)

BRIEFING PAPER

H.B. 277: A Bill relating to the immunization of minors
proposed by Alaska DPT and sponsored by Rep. Mike Navarre

The following is an outline of the main components of H.B. 277, evidence that supports the need for each of these goals, and sources of this supporting information. Any item referred to can be obtained from Rep. Mike Navarre's office or by contacting Alaska DPT office at the address listed at the end of this paper.

I. Parental Choice: To allow philosophical objection (parental discretion) on administration of immunizations without threat of exclusion from a school, preschool, or day care in this state.

A. Twenty-two states in the United States allow this exemption. See attachment #1.

B. No studies have been conducted by the Center of Disease control to correlate use of this exception and greater rates of disease. Due to the small numbers that invoke this exemption, they state it would be difficult to make meaningful comparisons. (from AK State Legislature House of Representatives Research Agency request: Laws concerning Mandatory Immunization, #87.065)

C. Questionable effectiveness of vaccines*

1. Approximately half of the cases of whooping cough (pertussis) in 1984/1985 epidemic had received pertussis vaccine at some point in their life. (from correspondence of May 1, 1986 , Ak. Public Health Dept.)
2. Nationally, of the 1,051 affected with measles who were between 16 months and 28 years of age, 842 (80.1%) had been vaccinated on or after their first birthday which is the currently recommended timetable for measles vaccination. (from Morbidity and Mortality Weekly Report, Jan. 10, 1986 Vol. 35, #1)

D. Questionable safety of vaccines*

1. All short term and long term possible adverse reactions recognized by National Center of Disease Control that may result from vaccinations (see official MSAEFI report form, attachment #2)
2. All of the above and more also listed in manufacturers inserts from vaccines

*See bibliography for additional information regarding safety and effectiveness

II. Parent Immunization Information: To mandate

that each parent receive extensive written information as to the risks as well as the benefits of each vaccine before vaccination and with immunization information provided by Public Health at birth. This information would include:

A. Manufacturer's product insert from each vaccine which includes ingredients of product, adverse reactions that may occur from use of product, and contraindications to warrant discontinuing use of product
   1. DPT vaccine: Lederle Lab Division, American Cyanamid Co., Pearl River N.Y., 10965, or from Public Health Dept.
   2. Polio; Live Oral: same as DPT. Please note that this insert contains a "Disclaimer of Representations and Warranties".
   3. MMR: (measles, mumps, rubella): Merck, Sharp & Dohme, Div. of Merck & Co., Inc., Westpoint PA., 19486 or from Public Health Dept.

III. Adverse Reaction Reports: To mandate that all

health care providers (physicians, nurses, etc.) report to the Public Health Dept., all occurences of serious adverse reactions resulting from immunizations, and that long-term follow-up investigations be included

A. From correspondence with Public Health Dept: "The State does not have any specific regulations regarding the reporting of adverse reactions following immunizations. Health care providers who administer vaccines are encouraged to report possible adverse reactions to this office. This is a passive surveillance system which relies on the integrity of the health care providers to comply." (from letter dated November 14, 1986)

B. Paragraph excerpt from newspaper interview with Michael Klatt, manager Ak. Immunization program: "He acknowledges that the reaction reporting system hasn't been effective in the past and that many parents may not have associated illnesses occurring after a vaccine as related to the vaccine. 'I have no doubt that the adverse reactions were under-reported.'" (from Peninsula Clarion, Feb. 18, 1987)

C. Interviews with Alaska parents and adverse reaction report forms on file with AK. DPT--all fit the criteria of severe adverse reactions, several contacted doctors, hospitals or health centers about reaction; none were reported until contact with AK. DPT, few still reported. Includes: one child partially paralyzed, 2 cases of 105 degree fever with development of cerebral palsy, one child with nerve damage deafness, one case of SIDS, developmental delay, convulsions, etc.

D. Alaska DPT stresses the importance of mandatory adverse reaction reporting with follow-up so that parents may be able to accurately ascertain the benefit/risk ratio when determining whether to immunize.

IV. Immunization Records:

to insure that the vaccination manufacturer and lot # be kept on file for at least three years and to insure that reaction be recorded in minors permanent medical record so that no further doses of questionable vaccine be administered to minor, even if location of administration varies.

This briefing paper was prepared by:
Alaskan Chapter
Dissatisfied Parents Together
Box 1746
Soldotna, Alaska 99669
(907) 262-3825

Founded in 1982, Dissatisfied Parents Together is a National non-profit educational organization concerned with protecting children from death and injury from whooping cough (pertussis) and the pertussis vaccine, the "P" component of the DPT shot.

The Alaskan Chapter of DPT has expanded their concerns to all diseases and all State mandated vaccines. We are not anti-vaccine, but stress that parents have the right to be educated about all the aspects of any vaccine to be administered to our children. We also stress that Alaskan parents should have the right to decide which if any vaccines are to be administered to our children without threat of exclusion from State schooling or liscensed day care.

REPORT OF ADVERSE EVENT FOLLOWING IMMUNIZATION

DEPARTMENT OF HEALTH & HUMAN SERVICES, PUBLIC HEALTH SERVICE, Centers for Disease Control, Atlanta, Georgia 30333

PATIENT ID

Immunization Project Area _____ | State Code ☐☐ | Seq. No. ☐☐☐☐ | County Where Administered: _____ County Code ☐☐☐ | MSAEFI REPORT NO. FOR CDC USE ONLY

Date of Birth ☐☐ Mo. ☐☐ Day ☐☐ Yr. | Sex M ☐ F ☐ | Date of Initial Report ☐☐ Mo. ☐☐ Day ☐☐ Yr. | Source of Information MD/DO ☐ Nurse ☐ Family ☐ Other ☐ _____

VACCINE HISTORY

Date of Immunization ☐☐ Mo. ☐☐ Day ☐☐ Yr.

Vaccine Administered By: Pub. ☐ Pvt. ☐ Mil. ☐ Other ☐

Vaccine Purchased By: Pub. ☐ Pvt. ☐ Mil. ☐ Other ☐

Enter Below All Vaccines Given on the Date of Immunization:

	Vaccine Type	Mfgr.	Lot Number	Route	Site	No. Prior Doses
A						
B						
C						
D						

CLINICAL DESCRIPTION OF PRESENT ILLNESS

SIGNS AND SYMPTOMS OF PRESENT ILLNESS

Onset of 1st Sign or Symptom: ☐☐ Mo. ☐☐ Day ☐☐ Yr.

	Yes	No	Unk
1. Fever: Temp ≥(100°F (37.8°C) (7806)	☐	☐	☐
Felt Hot, But Temperature Not Measured: (7806)	☐		
Highest Measured Temperature ☐☐☐.☐ F/C			
2. Local Reaction: Site _____			
Pain, Swelling, Increased Warmth, Induration or Lump Without Abscess (9993)	☐	☐	☐
Abscess Formation — Required Drainage or Drained Spontaneously (6829)+(9993)	☐	☐	☐
Results of Culture _____			
3. Rash: Other Than at Injection Site (7821)	☐	☐	☐
4. Adenopathy:			
Local (Injection Site Area) (7856)	☐	☐	☐
Generalized (7856)	☐	☐	☐
5. Allergic Event: (9995)	☐	☐	☐
Hives (7080)	☐	☐	☐
Angioneurotic Edema (9951)	☐	☐	☐
Wheezing/Asthma (4939)	☐	☐	☐
Anaphylaxis (9994)	☐	☐	☐
If "Yes," Interval from Vaccination to Onset: < 30 min ☐ 30 min-6 hrs ☐ > 6 hrs ☐			
Was Blood Pressure Measured?	☐	☐	☐
If "Yes," Lowest B.P. ☐☐☐/☐☐☐			
6. Arthralgia/Arthritis:			
Pain in Joints (7194)	☐	☐	☐
Inflammation of Joints (Redness, Swelling, Tenderness) (7169)	☐	☐	☐
7. Convulsions: (7803)	☐	☐	☐
If "Yes," How many Episodes Following Immunization ☐☐			
8. Encephalitis and/or Encephalopathy: (3483)	☐	☐	☐
Abnormal Lumbar Puncture (Enter Results in Laboratory subsection) (7920)	☐	☐	☐
Signs of Increased Intracranial Pressure (3482)	☐	☐	☐
Focal Neurologic Signs (3499)	☐	☐	☐
Coma or Marked Alteration in Level of Consciousness (7800)	☐	☐	☐

	Yes	No	Unk
9. Guillain–Barré Syndrome: (3570)	☐	☐	☐
10. Reye's Syndrome: (3318)	☐	☐	☐
11. Polio: (0459)	☐	☐	☐
12. Paralysis other than GBS, Reye's Syndrome or Polio: (3449)	☐	☐	☐
13. Other Neurologic Symptoms and Diagnoses:			
Aseptic Meningitis (0479)	☐	☐	☐
Infantile Spasms (Hypsarrhythmia, drop seizures) (3456)	☐	☐	☐
Bell's Palsy (3510)	☐	☐	☐
Hearing Loss (3899)	☐	☐	☐
Neuritis, Neuralgia (7292)	☐	☐	☐
Paresthesias (7820)	☐	☐	☐
Screaming Episode (High Pitched Abnormal Cry or Screaming Lasting ≥ 3 Hours) (7998)	☐	☐	☐
Neurologic Symptoms not cited above (specify) _____	☐	☐	☐
14. Miscellaneous:			
Hypotonic, Hyporesponsive Episode (7859)	☐	☐	☐
Idiopathic Thrombocytopenic Purpura	☐	☐	☐
If "Yes," Lowest Platelet count (2873) ☐☐☐☐☐			
Pancreatitis (5770)	☐	☐	☐
Parotitis (5272)	☐	☐	☐
15. Death:			
Sudden Infant Death Syndrome (SIDS) (7980)	☐	☐	☐
Non–SIDS Death (7981)	☐	☐	☐
If "Yes," Cause(s): _____			

LABORATORY:

	Performed Yes	Performed No	Performed Unk	Results Normal	Results Abnormal
EEG	☐	☐	☐	☐	☐ (7940)
BRAIN SCAN	☐	☐	☐	☐	☐ (7940)
LUMBAR PUNCTURE	☐	☐	☐	☐	☐ (7920)

Results if Abnormal:

WBC's _____ Opening Pressure _____

Lymphs (%) _____ Culture Results _____

Glucose _____ Other _____

Total Protein _____

Other Pertinent Information:

Signature of MSAEFI Coordinator:

Seen by Health Care Provider: ☐ Yes ☐ No ☐ Unk ☐ Number of Visits | Hospitalized ☐ Yes ☐ No ☐ Unk ☐☐ Number of Days

PAST HISTORY

Previous Illness Following Immunization: Yes ☐ No ☐ If "Yes," Date: ☐☐ Mo. ☐☐ Day ☐☐ Yr.

Vaccine _____

Describe Illness _____

Previous Convulsions in Patient: Yes ☐ No ☐ Unk. ☐

If "Yes," ☐ With Fever ☐ Without Fever

History of Convulsions in Siblings or Parents: Yes ☐ No ☐ Unk. ☐

If "Yes," ☐ With Fever ☐ Without Fever

FOLLOWUP

SEVEN DAY FOLLOWUP: If recovered, send to State Office — ☐☐ Mo. ☐☐ Day ☐☐ Yr. — Duration of Illness ☐ Days

30 DAY FOLLOWUP: If not recovered at 7 days, carry out 30 Day Followup and send to State Office — ☐☐ Mo. ☐☐ Day ☐☐ Yr. — ☐☐ Days

	Recovered	Partially Recovered*	Not Recovered*	Not Located	Dead
SEVEN DAY FOLLOWUP	☐	☐	☐	☐	☐
30 DAY FOLLOWUP	☐	☐	☐	☐	☐

* Comments _____

Reviewed By Immunization Project Physician (Items 7 - 15 and Anaphylaxis): ☐ Yes ☐ No ☐ Unk — Signature of Reviewing M.D. _____

CDC USE

Results of One-Year Followup: Recovered ☐ Partially Recovered* ☐ Not Recovered* ☐ Dead ☐ Not Located ☐ *Comments _____

This report is authorized by law (42 USC 247b; 42 CFR 51 b). Its submission is [illegible] questions to vaccination and is voluntary except when required as a condition of immunization grant awards.

Exemptions from Immunization Requirements (K-12)

▨ Allowed ☐ Not Allowed

State	Medical	Religious	Philosophical
Alabama	▨	▨	
Alaska	▨	▨	
Arizona	▨	▨	▨
Arkansas	▨	▨	
California	▨	▨	▨
Colorado	▨	▨	▨
Connecticut	▨	▨	
Delaware	▨	▨	▨
Dist. of Col.	▨	▨	
Florida	▨	▨	
Georgia	▨	▨	
Hawaii	▨	▨	
Idaho	▨	▨	▨
Illinois	▨	▨	
Indiana	▨	▨	▨
Iowa	▨	▨	
Kansas	▨	▨	
Kentucky	▨	▨	
Louisiana	▨	▨	▨
Maine	▨	▨	▨
Maryland	▨	▨	
Massachusetts	▨	▨	
Michigan	▨	▨	▨
Minnesota	▨	▨	▨
Mississippi	▨		
Missouri	▨	▨	▨
Montana	▨	▨	▨
Nebraska	▨	▨	▨
Nevada	▨	▨	
New Hampshire	▨	▨	
New Jersey	▨	▨	
New Mexico	▨	▨	
New York	▨	▨	
North Carolina	▨	▨	
North Dakota	▨	▨	▨
Ohio	▨	▨	▨
Oklahoma	▨	▨	▨
Oregon	▨	▨	
Pennsylvania	▨	▨	▨
Puerto Rico	▨	▨	
Rhode Island	▨	▨	▨
South Carolina	▨	▨	
South Dakota	▨	▨	
Tennessee	▨	▨	
Texas	▨	▨	
Utah	▨	▨	▨
Vermont	▨	▨	▨
Virginia	▨	▨	
Washington	▨	▨	▨
West Virginia	▨		
Wisconsin	▨	▨	▨
Wyoming	▨	▨	

Shannon Kohler, President
Dissatisfied Parents Together
Alaska Chapter
Box 1746
Soldotna, Alaska 99669
262-3825

Representative Niilo Koponen
Box V (MS 3100)
Juneau, Alaska 99811

November 12, 1987

Dear Representative Koponen,

Enclosed is the video, "Vaccine Roulette", that I mentioned I would send to you in earlier correspondence. It was taped from the original television broadcast that was aired on April 19, 1982 by WKC-TV, Washington D.C. I hope that you can take the time to view it and also arrange to have the other H.E.S.S. committee members view it.

Given your concern as to the high death rate of Alaska's infants, I've enclosed some sudden infant death/DPT vaccine information compiled by our national DPT group. When I received these booklets last winter, I then wrote to our health dept. to ascertain their statistic gathering in regards to SIDS and vaccinations. To quote David A. Spence, M.D., Medical Officer with Alaska Public Health in charge of SIDS statistics and information gathering: "Regarding your question about the time of vaccination and SIDS occurance, our office does not collect those statistics."

I feel confident that you will be able to see the need to gather vaccine information in regards to sudden infant deaths. I hope that you will be able to set the machinery in motion to begin collecting those statistics and remedy this information gap.

Also enclosed is a chart of data received by AK-DPT from 10 states that allow a philosophical objection to immunizations in their statutes. We sent questionnaires to all 22 in early October, but to date only 10 have responded. We shall add to the chart as more states respond. This data consistently shows that even with the allowance of parental choice, the vast majority of parents choose to immunize and cases of disease are rare.

Representative Navarre recently told me that he will try to arrange with the H.E.S.S. committee to hear HB 277 in early January. AK-DPT and I are eagerly awaiting the chance to present our bill and supporting material to your committee. I look forward to meeting you at that time.

Sincerely,

Shannon Kohler

Shannon Kohler

the People's Doctor
A MEDICAL NEWSLETTER FOR CONSUMERS by Robert S. Mendelsohn, MD

VOL. 8 NO. 12

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IN THIS ISSUE:

More Anti-Vaccine Arguments



Dr. Robert Mendelsohn

Older folks sometimes question why I devote so much space to immunizations (this is the seventh People's Doctor Newsletter on the subject in the past eight years). There are at least four reasons:

1) Those who are grandparents and great-grandparents share some responsibility for the health of their grandchildren.

2) Older folks who have certain diseases which usually are attributed by doctors to the aging process may be interested in such other possible causes for their conditions as immunizations given to them decades earlier.

3) The scientific, political, and economic insights gained from the controversies surrounding immunizations may further one's understanding of other controversial issues in medicine.

4) Some of you may be participating directly--as judges, lawyers, and jurors--in present and future legal battles on behalf of parents who are fighting to keep their children from being immunized, as well as legal battles to compensate children (and some adults) who were damaged by immunizations.

Q

Ever since my daughter was born almost three years ago, I have been compiling an extensive file on the pros and cons of vaccinations. So far, she remains unimmunized, but one serious worry remains in my mind. Should she be immunized against tetanus? Most anti-vaccination people seem to feel that the tetanus shot is the lesser of two evils--I am told that tetanus germs are everywhere.

I realize you have changed your advice from pro-tetanus for everyone to only for farm dwellers, and we do not live on a farm. If I choose not to vaccinate my child, what if she winds up in a hospital emergency room badly cut or with a puncture wound?--M.H.

A

Are tetanus shots necessary?

You have every right to closely question me on the tetanus vaccine, since that was the last vaccine I abandoned. It wasn't hard for me to give up vaccines for whooping cough, measles, and rubella because of their disabling and sometimes deadly side effects. The mumps vaccine, a high-risk, low-benefit product, struck me and plenty of other doctors as silly from the moment it was introduced. Arguments for the diphtheria vaccine were vitiated by epidemics during the past 15 years which showed the same death rate and the same severity of illness in those who were vaccinated vs. those who were not vaccinated. As for smallpox, even the government finally gave up that vaccine in 1970, and I gave up on the polio vaccine when Jonas Salk showed that the best way to catch polio in the United States was to be near a child who recently had taken the Sabin vaccine. But the tetanus vaccine exercised a hold on me for a much longer time.

As you point out, I gave up belief in this vaccine in stages. For a while, I still held onto the notion that farm families and people who work around stables should continue to take tetanus shots. But in spite of my early indoctrination with fear of "rusty nails," in recent years, I have developed a greater fear of the hypodermic needle. My reasons are:

1) Scientific evidence shows that too-frequent tetanus boosters actually may interfere with the immune reaction.

2) There has been a gradual retreat of even the most conservative authorities from giving tetanus boosters every one year to every two years to every five years to every 10 years (as now recommended by the American Academy of Pediatrics), and according to some, every 20 years. All these numbers are based on guesses rather than on hard scientific evidence.

3) There has been a growing recognition that no controlled scientific study (in which half the patients were given the vaccine and the other half were given injections of sterile water) has ever been carried out to prove the safety and effectiveness of the tetanus vaccine. Evidence for the vaccine comes from epidemiologic studies which are by nature controversial and which do not satisfy the criteria for scientific proof.

4) The tetanus vaccine over the decades has been progressively weakened in order to reduce the considerable reaction (fever and swelling) it used to cause. Accompanying this reduction in reactivity has been a concomitant reduction in antigenicity (the ability to confer protection). Therefore, there is a good chance that today's tetanus vaccine is about as effective as tap water.

5) Until the last few years, government statistics admitted that 40 percent of the child population of the U.S. was not immunized. For all those decades, where were the tetanus cases from all those rusty nails?

6) There now exists a growing theoretical concern which links immunizations to the huge increase in recent decades of auto-immune diseases, e.g., rheumatoid arthritis, multiple sclerosis, lupus erythematosus, lymphoma, and leukemia. In one case, Guillain-Barre paralysis from swine flu vaccine, the relationship turned out to be more than just theoretical.

Risks of tetanus vaccine

In preparing my courtroom testimony on behalf of a child who allegedly was brain-damaged as a result of the DPT (diphtheria, pertussis, tetanus) vaccine, I reviewed the prescribing information (package insert) for the Connaught Laboratories product which was administered to this child. The 1975 and 1977 package insert information which measured seven-and-a-half inches long listed three scientific references in support of the indications, contraindications, warnings, cautions, and adverse reactions to this vaccine. By 1978, the length of the insert had grown to 13 1/2 inches, and the number of scientific references had increased to 11. By 1980, the package insert was 18 inches long, and the references numbered 14. Of those newly-added references, seven (three from U.S. medical journals and four from foreign medical journals) dealt specifically with reactions to the tetanus DPT portion of the (toxoid) vaccine.

An article in the Archives of Neurology (1972) described brachial plexus neuropathy (which can lead to paralysis of the arm) from tetanus toxoid Four patients who received only tetanus toxoid noticed the onset of limb weakness from six to 21 days after the inoculation. A 1966 article published in the Journal of the American Medical Association reports the first case of "Peripheral Neuropathy following Tetanus Toxoid Administration." A 23-year-old white medical student received an injection of tetanus toxoid into his right upper arm after an abrasion of the right knee while playing tennis. Several hours later, he developed a wrist drop of his right hand. He later suffered from complete motor and sensory paralysis over the distribution of the right radial nerve (one of the major nerves innervating the arm and hand). One month later, no residual motor or sensory deficit could be found.

Reference is made to an article in the Journal of Neurology, 1977, entitled "Unusual Neurological Complication following Tetanus Toxoid Administration." The author reports a 36-year-old female who received tetanus toxoid in her left upper arm following a wound to her finger. Five days later, she noticed a weakness first of the right, and then of the left arm and later of both legs. She complained of dizziness, instability, lethargy. chest discomfort, difficulty in swallowing, and inarticulate speech. She staggered when she walked, and she could take only a few steps. Her EEG showed some abnormalities. After a month, she was discharged without neurologic disturbance, but she continued to feel weak and anxious. Examinations during the next 11 months showed continued emotional instability and some paresthesias (numbness and tingling) in the extremities. The medical diagnosis was "a rapidly progressing neuropathy with involvement of cranial nerves, myelopathy, and encephalopathy."

The Journal of Allergy and Clinical Immunology, 1973, carried an article entitled "Hypersensitivity to Tetanus Toxoid," and in a volume entitled "Proceedings of the II International Conference on Tetanus" (published by Hans Huber, Bern, Switzerland, 1967), an article appeared entitled "Clinical Reactions to Tetanus Toxoid."

A 44-year-old article in the Journal of the American Medical Association (1940) was entitled "Allergy Induced by Immunization with Tetanus Toxoid." That same year, an article in the British Medical Journal reported on "Anaphylaxis (a form of shock) following Administration of Tetanus Toxoid." In 1969, a German medical journal reported a case of paralysis of the recurrent laryngeal nerve (the nerve to the voicebox) after a booster injection of tetanus toxoid. The patient developed hoarseness and was unable to speak loudly, but the nerve paralysis subsided completely after approximately two months.

Should your doctor reassure you that tetanus vaccine is completely safe, or that "the benefits outweigh the risks," or that you should have a shot "just in case," why not share these citations with him?

DPT and SIDS

A study from UCLA's School of Medicine linking DPT vaccine to sudden infant death appeared in the journal Pediatric Infectious Disease (January 1983). Conducted by Larry Baraff, M.D., and co-workers, this is the third major research project which links childhood immunizations, and more specifically, the whooping cough (pertussis) component, to crib deaths.

As far as the other two studies are concerned, in 1979 I reported to you the work of Robert Hutcheson, Director of Epidemiology of Tennessee's State Department of Public Health. Dr. Hutcheson statistically associated Wyeth's DPT vaccine with sudden infant death. In June 1982, I reported to you the work of Nevada's William Torch, M.D., which established the same relationship.

The latest study of Dr. Baraff, carried out together with the Los Angeles County Health Department, found that 53 of 145 SIDS (Sudden Infant Death Syndrome) victims whose families were interviewed, had received a DPT immunization. Of these 53, 27 had received this immunization within 28 days of death. Six of these 27 deaths occurred within 24 hours of DPT immunization, and 17 occurred within one week of immunization. The most striking finding of this study was that no deaths occurred in the fourth week following immunization. The authors conclude that "The excess of deaths in the 24 hours and first week following immunization and the absence of deaths in the fourth week following immunizations were all statistically significant." They call for more studies to substantiate their findings, despite the fact that this is already the third investigation, and all three have pointed in the same direction.

Since sudden infant death is one of the major causes of mortality in the pediatric age group (approximately one in 600 live births), every parent must take immediate action to protect his own child from becoming a DPT/SIDS statistic. Therefore, when your doctor tells you it's time for your baby to get a DPT shot, ask him if he has carefully read the studies of Hutcheson, Torch, and Baraff. Ask him what he thinks of the last sentence in the Baraff study which suggests that "If further studies substantiate our findings, it seems prudent to consider rescheduling DPT immunization until after the period of highest risk of SIDS, i.e., the latter half of the first year of life." Ask your doctor if he might even go as far as Dr. Mendelsohn and junk DPT altogether. Or more significantly, ask him if he's giving DPT shots to members of his own family. Finally, if you have friends or relatives who have lost a baby to SIDS and who were told by their doctors that the cause of SIDS is "unknown," encourage them to get a copy of their doctor's records in order to determine the exact time relationship between DPT immunization and death.

Pennsylvania doesn't require pertussis vaccine

The laws requiring mandatory immunization for school entry are becoming curiouser and curiouser. When I recently appeared on a Pittsburgh TV station to discuss the hazards of immunizations, a list was displayed which gave the vaccines required before a child can enter school in the State of Pennsylvania. Surprisingly, whooping cough (pertussis) was not on the list.

On my return to Chicago, my editor, Vera Chatz, telephoned the State of Pennsylvania Department of Public Health in Harrisburg to check out this information. She confirmed that, while the whooping cough vaccine is "recommended" for children at earlier ages, it is not required for school entry.

Mrs. Chatz then called out own Illinois State Department of Public Health and discovered that the pertussis vaccine is required for school entry, but is not required after the age of six because everyone agrees that this vaccine is too dangerous to use after age six. She therefore logically asked, "If my child has never received the whooping cough vaccine, why not wait until his sixth birthday to start him in school?" The man at the other end laughed and replied, "I guess you're right."

What do we learn from this? First, we learn there is apparently quite a significant variation from one state to the next, even in those 28 states which have no shots/no school laws. Therefore, if a dispute should arise about vaccinations between you and the school your child attends, you must immediately contact your own state department of public health and ask (in writing, if necessary) for their exact rules.

Second, if your doctor insists that your little infant must receive the DPT vaccine or he will be unable to enter school later in life, ask him (if you live in Pennsylvania, or other states with similar regulations) whether he is aware that the pertussis component of DPT vaccine is not, repeat not, required for school entry.

Your doctor then may retreat to a fallback position on DPT (since there is general agreement among doctors that the whooping cough component is certainly the vaccine most likely to cause severe neurological damage such as epilepsy, cerebral palsy, and mental retardation), telling you that he will give your child only DT vaccine. At that point, instead of quietly acquiescing, take this opportunity to ask your doctor for the readily available information (e.g., included in the package insert of Connaught Laboratories vaccine) which documents the short- and long-term risks of the tetanus component.

Q When our seven-month-old daughter received her first DPT shot three months ago, she ran a fever that peaked at 100.8. She became very fussy and cried off and on, sleeping between her cries. She would wake and cry and jump at the slightest touch or movement. Occasionally, she jumped and cried without any known cause. On the next day, she was her usual self.

After hearing about her reaction, the doctor wants to divide the next DPT shot, giving half the dosage one week and the other half two weeks later. What do you think is best for our baby?--Mr. & Mrs. J.C.

Dividing DPT dosage

A Your doctor was wise to withhold the next full DPT shot after you reported your child's reaction to the first shot. Although quite a few doctors recommend divided doses of DPT vaccine, there never has been a scientific study which proves that divided doses are less likely to result in catastrophic neurological reactions (cerebral palsy, mental retardation, convulsions, sudden infant death, etc.) than are full doses. So return to your doctor, and ask him to provide the evidence which supports his advice.

$10 million polio vaccine judgement

Those of you who still are enthusiastic about the polio vaccine should know that a Wichita, Kansas, jury awarded $10 million to a father who contracted polio after his infant daughter was vaccinated against the disease with Orimune, the live oral polio vaccine manufactured by Lederle Laboratories. This verdict, reported in the National Law Journal, June 18, 1984, is the largest verdict thus far in the product liability suits involving Orimune.

The father, Emil Johnson, first showed symptoms of polio 10 to 12 days after his child was immunized. Since then, he has suffered from irreversible bulbar poliomyelitis paralyzing his lungs. He can barely walk across a room before he keels over.

The jury found that Orimune was marketed without adequate warnings of its risks and found Lederle negligent in failing to warn that non-immunized people (Johnson had never been immunized) faced an increased risk of contracting polio by coming into contact with anyone who had received the oral vaccine.

Johnson's lawyers based their case on an interoffice memo written by a Lederle doctor that discussed "the possibility of reduced Orimune sales if the company took steps to inform doctors of the risks associated with administering the drug."

The son of polio vaccine developer Jonas Salk, Dr. Darrell Salk of the University of Washington Medical School, testified on behalf of Johnson. The younger Salk advocated a return to his father's vaccine, a killed virus vaccine given by injection. Dr. Salk said he is aware of 16 pending lawsuits involving Orimune, but Lederle declined to reveal how many cases have been brought against them.

We now have the opportunity to watch the Doctors Salk attack the Sabin vaccine. In previous years, Doctor Sabin attacked the Salk vaccine. I think they're both right.

Pediatricians attack DPT

More pediatricians have joined in attacking DPT vaccine. First, pediatrician-immunologist Kevin Geraghty, M.D., of El Cerrito, California, conducted a major study which linked that immunization to Sudden Infant Death Syndrome.

Now pediatrician Mark Thoman, M.D., head of the American Academy of Clinical Toxicology reports (Veterinary and Human Toxicology, August, 1984) that we are seeing more reactions from DPT today than a few years ago. He states: "The reason for this is that until almost 15 years ago, there was a

pharmaceutical manufacturer that had approximately 50 percent of the market with fewer reactions." The preparation of this manufacturer yielded a purer vaccine (known as a split-cell vaccine) with fewer reactions, both mild and serious.

This company wanted to get out of the vaccine business, and its rights and patents were picked up by another manufacturer who had been using the older "whole-cell" method of preparation. According to information obtained by Dr. Thoman (1426 Woodland, Des Moines, IA 50309), "The newer, safer vaccine was never used! Instead, the older reactogenic form was continued."

Dr. Thoman gives a very careful checklist of contraindications to DPT including neurological history, previous reactions (yes, even mild ones), strong history of convulsions or SIDS in the family, etc. He points out that the split-cell vaccine is being used in different parts of the world but is not available in the United States. He asks: "Isn't is ironic that we require or recommend immunizations in order to start school only to, in some cases, compromise some of the children by the very method we are using to supposedly protect them?"

Speaking to his fellow doctors, he concludes, "Perhaps we could be reminded of the concept that many of us learned during our training... primum non nocere...Above all, let's do no harm!"

Add this safer whooping cough vaccine to the growing list of medications (Laetrile included) that can only be obtained by crossing a border or an ocean.

Another M.D.'s opinion

As the immunization controversy heats up, many pediatricians have lined up in support of vaccines. On the other hand, critics of immunizations now have been joined by one of the giants in American medicine, the Cleveland Clinic's eminent surgeon, George Crile, Jr., M.D.

In a letter he wrote me after he participated with me and eight other medical authorities in a conference on "Dissent in Medicine," Dr. Crile commented: "I was very much interested in your Newsletter [Vol. 2, No. 4]. In the first paragraph, you state that some of these viruses could be molecules in search of diseases, and I absolutely agree. I think that the live vaccines in all are very dangerous. I remember Dr. Owen Wangensteen [the Mayo Clinic's renowned surgeon], who was an old man when he had his, nearly died as the result of neurological complications from that immunization. I would never have one. I think you are completely right about the whooping cough vaccine. The symptoms it produces seem to be more serious than the disease, and I am very much interested in whether the current epidemic of hyperactivity in children could have its origin in the measles vaccine. Certainly that should be looked into. I think that vaccinating with living viruses is almost by definition dangerous... Do you remember when the polio vaccine first came out? They had been using the live vaccine abroad for two or three years, but it was held up and was not allowed to be imported here until Salk could perfect his killed vaccine, and then we went right back and used the live one. Well, I think that the Salk vaccine, being a killed vaccine is safe, and now that the incidence of disease is way down, we could go back to that."

It will be interesting to see how other medical authorities, in fields other than pediatrics, now line up on the immunization issue.

Wyeth halts DPT manufacture

In June, 1984, Wyeth Laboratories, one of the most distinguished pharmaceutical companies in the country, gave up the manufacture and distribution of DPT vaccine. This then left only two commercial producers

(of the original 17) of this injection designed to prevent diphtheria, whooping cough and tetanus--Lederle Laboratories here in the U.S., and Connaught Laboratories from Canada.

My first reaction to the Wyeth decision was delight that the American system of free enterprise was working. Faced with the loss of millions of dollars as a result of legal action by parents of vaccine-damaged children, the drug manufacturers had increased the price of the vaccine tenfold. As judges and juries throughout the country have had the opportunity to carefully listen to and deliberate on the vaccine controversy, increasing numbers of children who suffer from convulsions, epilepsy, mental retardation, cerebral palsy, and other forms of neurologic damage are receiving the financial compensation to which they are justly entitled. Now, the true cost of vaccines is becoming known not only to the manufacturers, but to the American public at large.

I could hardly wait for Connaught and Lederle to follow Wyeth's example so that the DPT controversy would be clearly settled by the law of supply and demand: No vaccine available because no one wants it.

However, on second--and more sober--thought, another, more sinister scenario seems possible. What if Connaught and Lederle do indeed throw in the towel, leaving the U.S. without a supply of DPT? (Connaught Laboratories has withdrawn from manufacturing DPT vaccine--and then there was one.) Won't the top vaccine cheerleaders--the Centers for Disease Control and the American Academy of Pediatrics--immediately predict the return of those diseases?

Indeed, an epidemic of whooping cough in this country had already been invented. But, thanks to former top government virologist J. Anthony Morris, Ph.D. (and the honest editors of the Maryland State Journal who in 1983 published his analysis), the so-called "epidemic" turned out to consist almost exclusively of three categories:

1) bacteriologically unproven cases

2) children under two months of age and thus not even eligible for DPT and

3) cases in children who were completely immunized.

This kind of careful analysis conceivably should scotch such episodes of "creative diagnosis' in the future.

But if this strategy of vaccine-pushers were to go into operation, the American public might well panic and put enough pressure on Congress to rush through legislation which immunizes the manufacturers, just as they did with the ill-fated swine flu vaccine program of the mid-70's. For those of you who don't remember, the vaccine manufacturers refused to produce that material unless the government assumed liability for damage. The doctors, especially those at the Centers for Disease Control, whipped the public into a frenzy of fear, and the government caved in. Of the 80 million people (led by President Gerald Ford) who rolled up their sleeves to receive shots for an epidemic which never occurred, thousands now are paralyzed by Guillain-Barre syndrome. It is you and I, as taxpayers, and not the vaccine manufacturers, who are paying the cost.

I recommend that every reader of this Newsletter:

1) Learn about whooping cough, a very difficult disease to definitely diagnose and one which is easy to confuse with other diseases. Pertussis may look like little more than the common cold, or it may show the full-blown picture of whooping, vomiting and respiratory distress.

2) Learn about the contraindications and adverse reactions to the vaccine.

3) If your doctor claims that you or your child has whooping cough, make sure that he carries out the proper laboratory tests, including special culturing techniques and blood tests.

American physicians, as well as drug manufacturers, have been enraged at the failure of a bill proposed by Florida Senator Paula Hawkins which is piously described as "compensation for vaccine-damaged children." If that were indeed the case, why haven't doctors pushed such legislation during the past 40 years? Why did it take media disclosures

educating members of the public (who legitimately responded by going to the courts) to spur doctors to belatedly run to government? No, the real motivating force behind the Hawkins bill is to protect the doctors and the manufacturers. Indeed, that bill may well limit the compensation to damaged children.

If your local newspapers are not carrying details of this latest attempt to shift to the taxpayers a responsibility which traditionally has been assumed by business, you may contact former top government virologist J. Anthony Morris, Ph.D. (P.O. Box 40, College Park, MD 20740), who together with attorney Robert Kaufman of Gaylord, Michigan, is spearheading the effort to keep the liability for this vaccine, whose dangers are increasingly being recognized, right where it belongs--with the companies who make the vaccine and the doctors who administer it.

Until 1983, pediatricians did not inform parents of the risks of immunization. Then, as a result of media exposure, they admitted that one in a million children might be damaged by the vaccines. And what are their latest statistics? United Press quotes James Strain, M.D., president of the American Academy of Pediatrics: "Our main concern is with the pertussis (whooping cough) vaccine. One in 3,000 doses causes permanent injury to a child." Quite a precipitous drop from one in a million!

Also, until recently, the Academy showed little concern about vaccine-damaged children, regarding such cases as the inevitable price that must be paid (by the damaged child and his parents) for the protection of the entire population. Now, the Academy is showing some concern, and it wants tax dollars rather than vaccine manufacturers' insurance or profits to be used to compensate parents for death, loss of income, and medical care of the child. The benevolent pediatricians even are somewhat concerned with the child's pain and suffering, recommending that compensation for this item be granted "to a limited extent."

In the same UPI article, another Academy priority was noted--their fight against the "Baby Doe" rules that forbid hospitals and doctors to withhold food or medical care from handicapped infants. Dr. Strain said the Academy proposed a "bioethical committee representing society, disabled people, perhaps clergy." (Emphasis mine.)

He continues, "The government should not involve itself in the ethical dilemma..."

I can understand the traditional resentment pediatricians feel towards government, but one wonders why pediatricians hesitate to involve clergy in a committee that deals with ethical questions.

Rubella update

The latest recommendations from the Centers for Disease Control (Journal of the American Medical Association, July 12, 1984) contain a few interesting lines. First let me tell you the bad news and then the good news about rubella vaccine-induced arthritis. The bad news is that up to 40 percent of those vaccinated in the large-scale field trials suffered joint pain (arthralgia). The good news is that less than two percent developed frank arthritis.

Second, in its zeal to completely eliminate rubella, the CDC now recommends that "proof of rubella immunity for attendance at day care centers should be required and enforced. Licensure should depend on such requirements...Vaccination should be extended to include all post-abortion settings...Should become routine before discharge from a hospital for any reason...Vaccines should be offered to adults any time contact is made with the medical system...Consideration should be given for making rubella immunity a condition of employment...Immunity should be required for

attendance for both male and female (college) students."

The CDC explains its drive for enforcement by saying, "Less rigorous approaches, such as voluntary appeals for vaccination, have not been effective..."

Tough guys, those government docs. Perhaps they should be transferred to the State Department to conduct diplomatic relations with the Russians.

Q What is your opinion of the increasing number of vaccines being required for dogs and cats? Our 30-year-old son has never had a shot, and he is healthy. I want the same for my pets, yet the powers that be make that very difficult.--E.W.

A *Vaccine for animals*

My good friend Tom Brewer, M.D., author of "What Every Pregnant Woman Should Know" (Random House, $8.95), is fond of pointing out that animals often get better medical care than do human beings. For example, a dairy farmer never would restrict the salt intake or arbitrarily limit the weight gain of a pregnant cow the way obstetricians have been carrying out such practices in pregnant humans.

While I believe that modern doctors have a lot to learn from veterinarians, perhaps when it comes to immunizations, veterinarians can learn something from such doctors as Richard Moskowitz, M.D. In recent years, Dr. Moskowitz, who specializes in homeopathic medicine, has publicly raised the possibility that the increasing number of vaccines (particularly live virus vaccines) decades later may be responsible for the production of such auto-immune diseases as rheumatoid arthritis, multiple sclerosis, Guillain-Barre paralysis and certain tumors.

Since animals have immune systems that are not too different from those of humans, ask your verterinarian if any research has been done on the danger of vaccines to pets, comparable to the research showing the dangers of vaccines to humans.

Another View

by Marian Tompson
Executive Director,
Alternative Birth Crisis Coalition



Richard Moskowitz, M.D., graduated Phi Beta Kappa from Harvard University, received his M.D. from New York University's medical school, and teaches homeopathic medicine at the National Center for Homeopathy in Washington, D.C. Although the lecture he recently gave on immunizations will be published in its entirety in the "Dissent in Medicine" volume (Spring, 1985, Contemporary Books), let me now share with you Dr. Moskowitz's lucid explanations between the difference in naturally acquired immunities and what he (and others) suspects happens when we try to provide that immunity with a vaccine.

"For the last 10 years or so," began Dr. Moskowitz, "I have really felt a deep and growing compunction against giving routine immunizations to children. At first, I basically believed, and still believe, that people have the right to choose for themselves. But soon I discovered I just was not able to give the shots, even when the parents wished me to

"We all know that measles is a disease of the respiratory tract, primarily. It is inhaled primarily by the susceptible person on contact with the infected droplets produced by coughing and sneezing of the person with the disease. Once inhaled, it undergoes a long period of silent multiplication inside the tonsils, the adenoids, the accessory lymphoid tissues, the pharynx. Then it goes to the regional lymph nodes of the head and neck and eventually, several days later, into the blood, entering the spleen, liver, the thymus and the bone marrow--what you might call the visceral organs of the immune system. This incubation period lasts 10 to 14 days, and by the time the first symptoms of the measles appear, you begin to see circulating antibodies in the blood. At the height of the illness, when the child is sneezing and coughing

and his eyes are running, we have the peak of the antibody response. In other words the 'illness' that we see is precisely the definitive effort of the immune system to clear the virus from the blood, which it does by sending it out exactly the same way that it came in. When a child recovers from the measles, you have true immunity. That child will never, never again get the measles no matter how many epidemics he is exposed to. [Earlier in the speech, Dr. Moskowitz cited repeated findings that booster shots have no effect on someone who has been vaccinated against measles and is no longer immune. Such a booster shot, he says, does not restimulate the immunity.] Furthermore you have the sense that that person will respond vigorously and dramatically to whatever infectious agents he is exposed to. The side benefit of that disease is a nonspecific immunity that charges or primes his immune system so that it can better respond to the subsequent challenges that it is going to meet in the future.

"Now by contrast, when you take an artificially attenuated measles vaccine and introduce it directly into the blood and bypass the portal of entry, there is no period of sensitization of the portal of entry tissues. There is no silent period of incubation in the lymph nodes. Furthermore the virus itself has been artificially weakened in such a way that there is no generalized inflammatory response. By tricking the body in this way, it seems to me that we have done what the entire evolution of the immune system seems to be designed to prevent. We have placed the virus directly and immediately into the blood and given it free and immediate access to the major immune organs and tissues without any obvious way of getting rid of it. The result of this, of course, is the production of circulating antibodies which can be measured in the blood. But that antibody response occurs purely as an isolated technical feat, without any generalized inflammatory response or any noticeable improvement in the general health of the organism. Quite the contrary, in fact. I believe that the price we pay for those antibodies is the persistence of virus elements in the blood for long periods of time, perhaps permanently, which in turn presupposes a systematic weakening of our ability to mount an effective response not only to measles but also to other infections. So, far from producing a genuine immunity, if what I am saying is correct, the vaccine may act by actually interfering with or suppressing the immune response as a whole in much the same way as radiation and chemotherapy, corticosteroids and other anti-inflammatory drugs do.

"We already have adequate models from our study of experimental virology to show us what sorts of chronic disease are likely to result from chronic long-term persistence of viruses and other proteins within cells of the immune system. We know that live viruses are capable of surviving or remaining latent within host cells for years without continually provoking acute disease. They do this by attaching their own genetic material to the cell, an extra piece of genetic material. They replicate along with the cell. That allows the host cell to continue its normal functioning but continuing to synthesize the viral protein. Latent viruses produce various kinds of diseases. Because the virus is now permanently incorporated within the genetic material of the cell, the only appropriate immunological response is to make antibodies against the cell, no longer against the virus.

"So it is my feeling," concludes Dr. Moskowitz, "that immunizations promote certain types of chronic diseases. And far from providing a genuine immunity, the vaccines are actually a form of immunosuppression."

The People's Doctor Newsletter
P.O. Box 982
Evanston, Illinois 60204

Published monthly. Subscription rate: $24.00 annually.
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Another View

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Did you know that the so-called "herd immunity" theory, which assumes that if enough members of the population are vaccinated everyone will be protected, has been proved false in epidemiological studies? In 1971 in Casper, Wyoming, a rubella epidemic occurred one year after 83 percent of the city's schoolchildren had been vaccinated against rubella. (Ninety-one of the 125 cases occurred in vaccinated children.) Several years after the smallpox vaccine was introduced into the Philippines (it was first given in 1910) and after 95 percent of the population--8 million people--had been given 24,500,000 doses of vaccine, the Philippines experienced its worst smallpox epidemic in history.

Did you know that the incidence of measles actually has been declining steadily for the past 100 years? This certainly leads one to question the drug industry's claim that this drop is due to vaccinations. From 1958 to 1966, the number of measles cases reported each year dropped from 800,000 to 200,000. But it wasn't until 1967 that the live vaccine which is presently used was introduced, this after the killed virus vaccine which came out in 1963 was found to be ineffective and potentially harmful. Besides this cyclical decline, we must question the reliability of the numbers of cases now being reported. A survey of pediatricians in New York City revealed that only 3.2 percent of pediatricians actually were reporting measles cases to the health department. In 1974, the Centers for Disease Control determined that there were 36 cases of measles in Georgia, but the Georgia state surveillance system reported 660 cases that same year.

Did you know that, while there was a reported sharp decline in the incidence of polio after the introduction of the oral polio vaccine, the definition of polio was changed at the same time? The definition no longer included aseptic meningitis cases, thus hardly leaving a basis for comparison.

Did you know that when immunity to a disease is acquired naturally, the possibility of reinfection is only 3.2 percent? If the immunity comes from a vaccination, the chance of reinfection is 80 percent. Studies from the Faroe Islands have shown that adults who had acquired measles immunity naturally still were protected 65 years later.

Did you know that the article "Nature and Rates of Adverse Reactions Associated with DTP and DT Immunizations in Infants and Children" (Pediatrics, Nov. 1981, Vol. 68, No. 5) reported only 18 serious reactions in children who had been given 15,752 shots? But if you read the article closely, you found that each child in the study received 5 shots adding up to 3,150 series. Thus, more than one out of every 175 children who received the full DPT series suffered severe reactions.

This information was given to me by Keith Block, M.D., a family physician from Evanston, Illinois, who has spent years collecting data in the medical literature on immunizations. He is alarmed at the potential hazards of vaccinations which artificially introduce a foreign protein as well as a "slow virus" into the human body which doesn't belong there and which can create serious health hazards such as the Guillain-Barre Syndrome which was linked to the swine flu vaccine. Vaccinations, Dr. Block explains, plant a seed which may be triggered months or years later by a variety of situations such as life stresses, medication, refined sugar, etc. "Living as we do, in a well-fed, hygienic society," Dr. Block points out, we end up trading off what would usually be a relatively minor illness for a potentially serious disease. Instead of taking personal responsibility for our body's immunological system, we try to handle everything with a vaccine, insulting our bodies and creating a sicker more endangered species. We are, literally, walking time bombs!" Those are strong words, I'll admit, but they're certainly worth pondering.

the People's Doctor
A MEDICAL NEWSLETTER FOR CONSUMERS by Robert S. Mendelsohn, MD
VOL. 6, NO. 12
BULK RATE
U S POSTAGE
PAID
PERMIT NO. 9323
CHICAGO, IL
P.O. Box 982 Evanston, Illinois 60204

IN THIS ISSUE:

Recent Immunization Research



Dr. Robert Mendelsohn

When I first went public with my syndicated column and The People's Doctor Newsletter, it was almost taboo to mention the risks of immunizations, except, of course, if that mention were safely tucked away within the pages of medical journals. But as the years went by, the information began to trickle out to the public.

This year, as a result of Lea Thompson's NBC-TV documentary, "Vaccine Roulette," immunization has become one of the most hotly-discussed subjects in the country. Requests for the documentation of the hazards of immunizations presented in my Newsletters pour in from M.D.'s, chiropractors, nurses, journalists and just plain people.

This is my fourth Newsletter on this subject. Something tells me it won't be the last.

Other criticisms of compulsory immunization

Just so that you know I am not alone in my criticism of compulsory immunization laws, Dr. F. M. White, Director of Communicable Disease Control and Epidemiology with the Alberta, Canada, Health Department and more recently with the British Columbia Ministry of Health, also is concerned about the ethical considerations of immunizing in view of "the present lack of precise knowledge of the field." Connaught Laboratories' "Biolines" quotes Dr. White as saying, "There is an important ethical distinction between treatment and preventive programs...Are all immunizations of proven value and do we really know what we are doing?"

Fifteen years before Dr. White voiced his concerns, Sir Graham Wilson in his book "The Hazards of Immunizations" showed a good grasp of the ethical problems which accompany immunization. "Once a vaccine has been introduced, with apparently good results, it becomes extremely difficult ever to find out its real value," wrote Wilson. "Moral objections may be too strong to permit a properly-controlled trial."

Ask your own doctor whether the vaccine he wants to inject into your child ever has been scientifically proven by controlled studies. Or does he just "believe" in the vaccine?

Government admits vaccine dangers

While I was preparing to give testimony as an expert witness in some upcoming law cases which deal with children who are alleged to have been damaged by immunizations, I reviewed some government documents which never before had come to my attention.

The November 20-21, 1975 minutes of the 15th meeting of the Panel on Review of Bacterial Vaccines and Toxoids with Standards of Potency, presented by the Bureau of Biologics and the Food and Drug Administration, contain a remarkably complete analysis of vaccines which are currently in use. While the overall conclusion is that vaccines are worthwhile and good, I thought you might like to read part of the darker side of immunizations described by the eminent scientists on this committee, a side which rarely reaches the public eye.

The section on diphtheria immunization contains the sentence: "For several reasons, diphtheria toxoid, fluid or absorbed, is not as effective an immunizing agent as might be anticipated. Clinical (symptomatic) diphtheria may occur occasionally in immunized individuals--even those whose immunization is reported as complete by recommended regimens." The panel claims that when diphtheria does occur in such an individual, "It appears to be milder." The report continues with "...the permanence of immunity induced by toxoid...is open to question."

Regarding the combination diphtheria/tetanus vaccine used in adults, the panel stated that this substance has never been shown conclusively to be an adequate primary immunizing agent. Furthermore, the intervals between booster doses of TD (diphtheria/tetanus) in adults sufficient to maintain diphtheria immunity have not been established. Efforts by producers to reduce the reactions of the toxoid by increasing purification "may have resulted in diminished immunogenicity."

In other words, as the diphtheria/tetanus vaccine is made safer in order to cut the severity of reactions to it, it gives less protection against the disease. Since no controlled studies have recently been carried out on this vaccine, maybe now it's just plain old water.

While giving tetanus toxoid generally high marks, the scientists from the Bureau of Biologics and the Food and Drug Administration point out, "The antigenicity [degree of potency] of tetanus toxoid can vary considerably from preparation to preparation." Furthermore, "Recent changes in manufacturing procedures may have resulted in lowering of the immunizing potency of tetanus toxoid in some products; hence there is a need for re-evaluating the primary antigenicity of current preparations."

The panel continued: "Most of the local and febrile [fever] reactions that are seen appear to be related to more frequent inoculations than are necessary."

Now, on to whooping cough. While noting the reduction in this disease over several decades, the panel concedes that "Not all of this remarkable decline can be attributed to widespread use of the vaccine for the reason that some decline in morbidity [illness] and mortality from pertussis was observed in the United States and other Western countries prior to the institution of vaccination."

On one hand, the scientists claim the incidence of whooping cough is low, yet they qualify this statement: "The exact rates, however, are unknown for several reasons. Cases are frequently unreported or not recognized." Since many laboratories are not equipped to routinely test for whooping cough germs, "The infection may go undiagnosed...Infection in immunized persons may cause bronchitis but without typical whooping."

In one of the most important admissions in the entire document, the panel concluded: "Therefore, reports of pertussis obtained by the Center for Disease Control probably represent only a fraction of all pertussis infections occurring throughout the country."

How pure is the whooping cough vaccine? The panel stated, "In contrast to some other immunizing agents, such as diphtheria and tetanus toxoids, pertussis vaccine is a relatively crude preparation that con-

tains the majority of the bacterial constituents, most of which are probably not relevant to the induction of immunity to the disease."

Has your doctor told you the kind of reactions which are due to the whooping cough vaccine? The panel described them as follows: "Significant reactions that have been attributed to pertussis vaccine have included high fever...a transient shock-like episode, excessive screaming, somnolence, convulsions, encephalopathy, and extremely rarely, thrombocytopenia [deficiency of clotting elements in the blood]. Such reactions almost always appear within 24 to 48 hours after injection, but have been thought to occur after an interval as long as seven days."

How common are these complications? The panel first used the word "rare," but immediately thereafter confessed that the rates (of complications) are "difficult to define precisely at least in part because they are often not reported." The report further points out that vaccine of higher potency may produce more reactions.

Panel members admitted that the whooping cough vaccines pose a special problem since they "do not exhibit the effe tiveness and safety which have been achieved with certain other immunizing agents." The report conceded that "Without adequate surveillance of disease rates, the effectiveness of current vaccines and immunization programs cannot be monitored."

How long does immunity last? According to the panel, "Experience with modern pertussis immunization is not of sufficient duration to predict whether childhood immunization may in some instances postpone natural infection until a later age."

Should your child receive whooping cough vaccine before starting school? The panel reported: "The usefulness of the currently recommended booster dose at school entrance has never been fully documented." The panel admitted that the ultimate significance, if any, in terms of permanent results of vaccine-induced somnolence, excessive screaming, and high fever is unknown. Without such knowledge, satisfactory recommendations for further immunizations when any of these reactions occurs cannot be made.

How often do complications occur? In the understatement of the decade, the panel states, "Physicians are expected to report complications of immunization to manufacturers, in the United States, but compliance with this expectation is less than optimum." The panel further points out, "Many physicians are not cognizant of their clinical features. Further, both physicians and manufacturers have been held liable for damage suits by patients who may suffer adverse effects from established vaccines. All these factors undoubtedly discourage reporting; without maximum reporting or some other form of surveillance, definition of the rates and significance of untoward reactions to current and future vaccines cannot be ascertained."

The panel criticized the laboratory procedures used in the production and testing of pertussis vaccine and, not surprisingly, recommended increased public support for more research studies. "Without such basic studies, a more effective and safer pertussis vaccine cannot be developed." I agree, and I further suggest that all pertussis immunization be suspended while such research is being conducted on this obviously low-quality vaccine.

The panel actually recommends that "The vaccine label should warn that if shock, encephalopathic [brain damage] symptoms, convulsions, or thrombocytopenia [a clotting disorder] follow a vaccine injection, no additional injections with pertussis antigens should be given....The label should also include a cautionary statement about fever, excessive screaming, and somnolence." (Wouldn't it be wise to ask your doctor for a peek at the label the next time he tries to immunize your child?)

The panel's final recommendation is for legislation providing federal compensation for "the few individuals" injured and disabled by participating "in a meritorious" public health program. The panel members frankly admit, "Such legislation would protect manufacturers and physicians against liability...." (Does everyone remember the swine flu vaccine? Its manufacturers did succeed in passing the buck of liability to the federal government so that you and I now are paying for the many cases of paralysis and other damage which resulted from that immunization--for a disease that never materialized.)

The panel's criticism of other vaccines--typhoid (TAB vaccine which is the now-discontinued typhoid-paratyphoid vaccine received by all who served in the armed forces during World War II), cholera, plague--is required reading for anyone whose travel agent tells him he needs these shots in order to travel abroad.

On the very last page of the minutes, the government panel mentions its "careful note" of a report on the potential for oncogenic (tumor-producing) action of aluminum and oil adjuvants, substances which were added to increase the action of many vaccines: "There is little doubt that some of the material containing aluminum as adjuvant appears to be carcinogenic [cancer-producing] in a strain of Swiss mice."

The panel also is investigating the possibility of retrospectively examining the human experience with the incidence of fibrosarcomas [malignant tumors of connective tissue] at the usual sites of injections of vaccines."

Immunizations as seeds of long-term damage

Six months ago, NBC-TV did an expose on the risks of whooping cough vaccine (a component of the DPT triple immunization recommended for all U.S. infants), and Channel 5 in Chicago ran a feature on its nightly news entitled "DPT: Vaccine Roulette." Channel 5 heralded this feature in Chicago newspapers with full-page ads headlined: "Will this child be a victim of vaccine roulette?"

Of course, for the past six years, my readers have been exposed to information about the dangers of immunization. Now, I bring to your attention further revelations by eminent scientist Robert W. Simpson, Ph.D., Professor of Virology, Waksman Institute of Microbiology, Rutgers University.

The Simpson saga began in March, 1976 when, at a Science Writers Seminar sponsored by the American Cancer Society, Dr. Simpson presented a paper which was widely quoted in the press. Press reports stated that Simpson's paper pointed out that "immunization programs against flu, measles, mumps, polio, etc. actually may be seeding humans with RNA to form proviruses which will then become latent cells throughout the body. Some of these latent proviruses could be molecules in search of diseases which under proper conditions become activated and cause a variety of diseases including rheumatoid arthritis, multiple sclerosis, lupus erythematosus, Parkinson's disease and perhaps cancer."

In Chapter II of the Simpson saga, Mrs. Sue Schieler of Milford, Indiana wrote Dr. Simpson, inquiring about links between immunization procedures and multiple sclerosis. Mrs. Schieler sent me Dr. Simpson's response of September 25, 1981 in which he wrote "...I regret to inform you that our earlier studies (1976) at Rutgers University on related work were totally misquoted by the media. We have never obtained any evidence that would implicate vaccination as a cause or contributing factor for such human diseases [as multiple sclerosis]."

In February 1982, I asked Dr. Simpson for his complete paper. I wrote: "Since your (misquoted) statement was so widely publicized, your

complete statement should enable me to correct any misconceptions by the readers of my books, subscription newsletter and syndicated column."

I promptly received a copy of Dr. Simpson's five-page paper entitled "RNA-Containing Viruses of Humans Can Be Transcribed Into DNA Proviruses." While I am sure Dr. Simpson will be happy to supply full copies of this paper to those of you who are interested, let me now share with you some quotes from it which are admittedly out of context.

Discussing the result of studies conducted in his laboratory, Dr. Simpson states: "This finding holds important implications regarding the potential of common RNA viruses (e.g., influenza, measles, mumps, etc.) to persist in human populations in a latent or masked form following either natural acute infection or active immunization with live virus vaccines." (Emphasis mine.)

Dr. Simpson continues, "...the disease potential of such DNA proviruses and their possible existence in human populations needs to be determined in light of ongoing, large scale vaccination programs with live viruses and also with a view to understanding the underlying etiology of human cancer as well as various types of chronic degenerative disease such as multiple sclerosis, Parkinson's disease and rheumatoid arthritis."

Referring to these proviruses (known as molecular intermediates), Dr. Simpson speculates: "Are these molecular intermediates a natural product of acute virus infection or live virus vaccination with common riboviruses?" (Emphasis mine.) He continues, "Regarding the latter point, animal studies now in progress in our laboratory suggest that RS virus can persist in a latent form in lung tissue many months after initial infection...This preliminary finding presents the intriguing possibility that persistence of such riboviruses at the molecular level may not only be a common feature of viral infections but a necessary event for the maintenance of long-lasting immunity...conceivably, some of these latent agents could represent potential 'molecules in search of disease' which under appropriate conditions of environmental stress might infrequently be reactivated as complete or defective viruses capable of evoking a pathological response to their resident host."

Dr. Simpson's scientific paper concludes with this statement: "Finally, the question of the risks associated with the use of live virus vaccines of human RNA viruses that may possibly be transcribed into DNA proviruses must be considered...it is still necessary that public health scientists intensify and improve their surveillance efforts for detecting infrequent complications associated with the large-scale use of such live virus vaccines for immunizing human populations. Such complications might gradually manifest themselves over a very long time course measured in years and might assume a disease course that one would not ordinarily relate to the original vaccine virus."

You now are in a good position to judge whether Dr. Simpson was originally misquoted! But the Simpson saga does not end here. The most bizarre aspect of the entire affair is Dr. Simpson's red-penned note to me on the top of his paper: "This work could not be repeated in our laboratories after the investigator who originally made these observations left."

While I leave it to each of your fertile imaginations to figure out the implications of that cryptic statement, I can assure you that the deeper I delve into research on immunizations, the curiouser and curiouser it gets.

Where to get information on DPT vaccine

The issue of whether or not to immunize is heating up all over the world. In Australia, Drs. Archie Kalokerinos and Glen Dettman, Ph.D., have published their findings on the dangers of DPT vaccine in an excellent booklet entitled "The Dangers of Immunization" (The Humanitarian Society, Box 77, Quakertown, Pennsylvania 18951).

Attorney Robert Kaufman of Gaylord, Michigan has brought legal action against Merck Sharp & Dohme on behalf of a child who is suffering from severe neurologic damage which began after a measles shot. And Chicago attorney Allen McDowell, in his case involving a child who developed mental retardation after a DPT shot, has gathered testimony from medical experts in England (Dr. Gordon Stewart and Dr. John Wilson) and in Germany (Dr. Wolfgang Ehrengut).

Dr. Ehrengut, Director of the Hamburg (Germany) Vaccination Institute, stated in deposition (further information may be obtained from Allen McDowell, Suite 1313, 127 N. Dearborn, Chicago, Illinois 60602) that in Germany, the state pays for vaccine-damaged children "even if the doctor is responsible from some stupidity which they have done, if they have made a mistake, in every case to protect the individual, our state pays. This is paragraph 51 of our so-called Infectious Disease Law. By this law, this individual gets for his whole life some compensation. In this way, this is the best law in the world."

Referring to the United States, Ehrengut said, "To be very frank, your doctors hide complications. They don't tell the truth if they have done something incorrect."

Both these lawsuits and the above-mentioned publication are required reading for anyone whose child may have been damaged by routine immunization as well as for all parents who are concerned about the negative effect of immunizations.

In addition, if you would like to read the testimony J. Anthony Morris, Ph.D., one of the leading vaccine experts in the United States, gave before the Senate Investigating Committee (June 30, 1982), write Dr. Morris at P.O.B. 40, College Park, Maryland 20740 for a copy of his 11-page statement. In this statement, Dr. Morris concludes that "The thrust of the testimony given by Drs. Foege, Fulginiti, Parrott, and Fannin [the chief proponents of mandatory immunization] before the Subcommittee at this hearing on immunization and preventive medicine was either misleading, self-serving, or both, and careful efforts by the public to understand the thrust of their statements will only erode further the public's confidence in vaccines."

Monitoring adverse reactions

Your doctor should know about the September 1979 statement of the Office of Technology Assessment reporting to the U.S. Congress on vaccine and immunization policies. Referring to the Center for Disease Control's system for monitoring adverse reactions to vaccines, the report begins, "The system will not generate data that will permit calculation of incidence rates of adverse reactions among defined populations." In other words, U.S. government doctors, in contrast to those in foreign countries, never have worked out a method for finding out what percent of children suffer damage from vaccines.

The report points out, "Vaccinations are recommended and administered to millions of children and other individuals each year on the presumption [emphasis mine] that the benefits far outweigh the risks. The benefit side of the equation is straightforward: Vaccinations can prevent serious disease. The risk side is not so straightforward since it includes factors that are known that may exist but have not yet been discovered."

Arthritis from rubella vaccine

Now that you are aware, through recent extensive media coverage, that whooping cough (pertussis) vaccine can cause brain damage, I wouldn't want you to fear giving your children whooping cough vaccine while believing that all other vaccines are perfectly safe. That is why I am bringing to your attention the latest research on the German measles (rubella) vaccine.

Six years ago, Dr. Aubrey Tingle, a pediatric immunologist at Children's Hospital in Vancouver, British Columbia, and his co-workers discovered that 30 percent of adults who had been exposed to rubella vaccine suffered arthritis two to four weeks after vaccination, ranging from mildly aching joints to severe crippling. Recently (as reported in Maclean's Magazine, February 8, 1982), these same researchers found live rubella virus in one-third of patients--both children and adults--with rheumatoid arthritis. (Rheumatoid arthritis, of course, is a much more severe degenerative and crippling disease than is rubella arthritis.) In one patient, rubella arthritis developed into rheumatoid arthritis. Ten percent of adults who have the symptoms of arthritis resulting from rubella immunization will suffer extreme pain.

Dr. Tingle pointed out that when the rubella vaccine was first introduced, its promoters said that "all the symptoms disappear in three months." Dr. Tingle soberly reflected, "But that's not correct. We've had patients that we followed for 10 years who are still having recurrent episodes.

"One such victim is Anita Willson, a 32-year-old teacher. In 1975, when she applied for a marriage license in Calgary, she was required to undergo a rubella vaccination. She complied. About two weeks later, she began to experience swelling of her big toe, and the pain soon spread to her fingers and wrists. The diagnosis: arthritis. 'I was so disabled that I couldn't shift gears on my car or open a jar,' Willson recalls. 'Here I was, newly married and with a new job. My whole world came crashing down. It was terrifying.' Willson's arthritis, which now appears to be in abeyance, lasted for five years."

For children who receive rubella immunizations, Dr. Tingle wisely warns, "The longterm effects are the major unresolved issue that we have to face."

Medical News

On sexual freedom

From the British medical journal Lancet comes the following excellent analysis in an article entitled "Biological Effects of Sexual Freedom": "There are something on the order of 250 million new cases of gonorrhea and 50 million new cases of syphilis annually. Other sexually communicable conditions may be even more common... The adverse biological effects of sexual freedom on women and their babies are a disappointing development in the second half of the 20th century."

"MalePractice: How Doctors Manipulate Women," Dr. Mendelsohn's latest book, is now available in paperback from Contemporary Books ($6.95).

"Confessions of a Medical Heretic" is available from WarnerBooks ($3.25).

From the time we began publication seven years ago, the annual subscription price of The People's Doctor Newsletter has remained at $18.00. Since rising costs make it impossible for us to continue publishing at that price, the new annual subscription rate will be $24.00. Individual back issues will now be priced at $2.50.

The People's Doctor Newsletter
P.O. Box 982
Evanston, Illinois 60204

Published monthly. Subscription rate: $24.00 annually.
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the People's Doctor
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VOL. 11, NO. 10

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IN THIS ISSUE: IMMUNIZATION CONTROVERSIES CONTINUE: Vaccines Implicated in AIDS . . . DPT Seizure Hazards . . . Futility and Risks of Measles, Flu and Pneumonia Shots

This is my eleventh Newsletter on immunizations, and the revelations about the damage they cause continue to appear in the public press.



Dr. Robert Mendelsohn

A hard-hitting salvo against infant vaccines appeared this year in a five-part 16-page newspaper series in the Rochester (New York) Democrat and Chronicle. Entitled "Children at Risk--DPT Dilemma," this special report by reporter Jennifer Hyman represents five months of research, complete with photos of brain-damaged children, graphic depictions of reaction estimates and interviews with doctors on both sides of the vaccine issue.

Hyman discovered what I have been reporting to you for the last several years--doctors who won't give the vaccine to their own children. For example, Dr. Kevin Geraghty, a specialist in pediatric immunology, told Hyman, "You could put a gun to my head, and I wouldn't use the American [DPT] vaccine. No power on earth could make me do it."

According to Hyman, many pediatric neurologists--some say a majority--will not allow their own children to have the vaccination. Hyman learned that doctors still are not informing parents about the vaccine's side effects. Nor were most parents and doctors aware that nine states, including New York, do not require the DPT shot. Of greatest importance are Hyman's revelations that DPT is not the only childhood vaccine with side effects. She tells about adults who develop polio after they have contact with children who recently have been immunized with that vaccine; more fevers have been reported to the Centers for Disease Control after the MMR (measles, mumps, rubella) than after the DPT shot.

Rochester, New York, is not exactly a hotbed of radicalism. And the appearance of this important series indicates that word about vaccine dangers is entering the consciousness of middle America. The Democrat and Chronicle, after receiving thousands of requests from around the country for copies of this series, has made special reprints available.

Q I am enclosing an article from the Denver paper advocating immunizations. I am against immunizations, and so is my daughter, but my son-in-law disagrees with us. In my opinion, the newspaper's statement about increases in some childhood diseases simply is not true. The article seems intended to panic people into getting unnecessary shots for their children. I'd love to know where those statistics came from!--Mrs. E.J.

Vaccine proponents defend themselves

A Thanks for sending me that clipping from your Denver newspaper which blames the increase on the cost of vaccines, as well as the public disputes over vaccine safety and liability and the alleged shortages of some vaccines.

All the above is true. Because of jury awards to children who have been brain-damaged by vaccine, vaccine costs have skyrocketed. As more and more parents begin to recognize the link between vaccines and their child's condition (epilepsy, convulsions, mental retardation, cerebral palsy, Sudden Infant Death, etc.), lawsuits have become commonplace. As drug companies exit the vaccine field, public health authorities worry about vaccine shortages.

Therefore, whenever you read one of the ever-increasing number of articles which try to panic people into vaccinating their children, you also must read about the other side of this most controversial issue. Read about doctors who are concerned about the damage that may appear decades later as a result of immunizations intended to protect children against relatively innocuous diseases. Read about doctors who are concerned about damage to the immune system from immunizations. Read about the sorry record of public health authorities in other preventive matters--the swine flu vaccine included. Read about the many fully-immunized children who nevertheless are getting measles and mumps and whooping cough.

While I share your misgivings about the kind of scare tactic exemplified by this article, at the same time I admit a certain sense of satisfaction. The fact that our public health authorities feel compelled to thus defend themselves indicates that they are being hard hit by vaccine opponents, myself included.

Before 1982 (when the vaccine controversy became a public issue), public health authorities never had to resort to this kind of scare strategy. But now, the public health people know that lots of parents don't believe them anymore. Lots of parents are asking lots of questions of their own doctors before they let their children receive those shots.

By bringing you documented information on the darker side of immunizations, this Newsletter will continue its tradition of opposing the blind acceptance of routine immunizations. But you have to do your part too. Denver is your home town. The Denver newspaper is your newspaper. While I am flattered that you chose to write to me, I urge you to also write to the editor of that newspaper. Tell him how you feel about immunizations and why you feel that way. In case you want to send the editor some medical references which oppose immunizations, send him a copy of this Newsletter.

Can immunizations trigger AIDS?

With increased public awareness of the dangers of immunizations, I repeatedly have been asked about future vaccines, particularly the new genetically-engineered recombinant vaccines. People ask, "Will such vaccines be safer than the present pertussis vaccine? Will such vaccines, because they are not derived from human blood, obviate the danger of catching AIDS from the shot?"

Until now, I have had to answer such questions by invoking some of Mendelsohn's Laws. For example, "Look for quick use of the new vaccines because doctors try to use a new remedy as rapidly as possible before its side effects become known." Or, I reply with another of Mendelsohn's Laws, "Doctors never give up one dangerous remedy until they have an even more dangerous one waiting in the wings."

But now, concerns about genetically-engineered vaccines are surfacing in the highest circles of medicine. Buried deep within the New England Journal of Medicine (December 3, 1986) are three important sentences: "Extensive research is being conducted on recombinant live-virus vaccines in which vaccinia [the smallpox organism] is used as a biologic carrier. Recently, several groups have developed candidate recombinant HIV vaccines. Our case report raises provocative questions concerning the ultimate safety of such vaccines."

Now for the background of those admittedly technically complex, but obviously frightening, sentences. The NEJM article entitled, "Disseminated Vaccinia in a Military Recruit with Human Immunodeficiency Virus (HIV) Disease," was sent to me by Simon Delarue, head of the Paris-based French League Against Vaccinations. The article describes a healthy 19-year-old U.S. Army recruit who began basic training in April, 1984. Within the first three days of basic training, he received multiple immunizations (adenoviruses 4 and 7, measles, rubella, bivalent influenza, trivalent poliomyelitis, tetravalent meningococcus, tetanus, and diphtheria, followed

by a smallpox vaccination at the end of the first week of basic training). Two-and-a-half weeks later, he developed fever, headache and a stiff neck. A spinal tap showed him to be suffering from cryptococcal meningitis. HIV (the AIDS virus) was isolated from his blood.

Interviews conducted by trained investigators with the patient and family members failed to reveal evidence of homosexual activity or intravenous drug use. Four weeks after vaccination, during his hospitalization for the treatment of the meningitis, the patient developed an ulcer at the site of the smallpox vaccination. Within the next few days, 80 to 100 pustular lesions appeared on the buttocks and legs, rapidly progressing to ulcerations. When these lesions were cultured, vaccinia was found. The young soldier died in December, 1985.

Live-virus vaccines (such as smallpox, polio, mumps, rubella and measles) have been well-recognized as a cause of severe complications when they are given to patients who have impaired functioning of their immunologic systems. In an attempt to minimize the occurrence of this complication, the U.S. Armed Forces now require screening for HIV antibodies before immunizations are given. And the U.S. Public Health Service has stated that live vaccines are not recommended for use in patients with "clinically apparent HIV-associated immunodeficiency."

The U.S. Army is not waiting for "clinically apparent" AIDS. Instead, on the basis of pre-vaccination AIDS screening, they are excluding recruits with evidence of HIV infection from receiving live virus vaccines.

This article raises a series of important questions:

1) Should your child receive a blood test to see whether he has HIV (AIDS) infection before you allow your doctor to give the live-virus vaccine

2) What about killed viruses?

3) Did you know that Army recruits receive so many vaccines, all within such a short period of time? While the general population no longer is vaccinated against smallpox, military populations are immunized against smallpox "because of strategic defensive military and anti-terrorist considerations."

4) Since we now know that the production of gentically-engineered recombinant vaccines involves the use of smallpox (vaccinia), how safe are any of these new vaccines?

And why are these admittedly provocative questions buried so deeply within the pages of medical journals instead of being headlined on the front pages of your newspapers?

My Newsletter, "AIDS: Linkage to Smallpox Vaccine" (Vol. 11, No. 8), brought you information gleaned from foreign newspapers which linked the AIDS epidemic in Africa to previous smallpox vaccination campaigns.

A perfect correlation exists between the number of AIDS cases, mostly heterosexual, in various Central African countries and the number of people vaccinated in that country. The method of vaccination had the vaccinators using the same needle on 40 to 60 people, passing the needle through a flame as the only means of sterilization.

The only South American country that has a significant number of AIDS cases is Brazil, which happens to be the only South American country that had a recent smallpox vaccination campaign. The relationship between smallpox eradication efforts and AIDS cases could explain the equal distribution of the disease between the two sexes in Africa, in contrast to the United States, where the disease seems to be primarily spread by homosexual sex and intravenous drug use.

I just learned that Harold E. Buttram, M.D., wrote about the relationship between smallpox vaccine and AIDS in the December 1986 issue of Health Report (Clymer Health Clinic, Quakertown, Pa.). The lead article was entitled, "A Theory on the Origin of AIDS: Cross-cultural Immunizations and Immune Malfunction."

Dr. Buttram and researcher John Chriss Hoffmann wrote: "There are grounds for believing that Western vaccines, introduced since World War II into native populations, may have catalyzed the change of the AIDS virus from latent to active states." They quote Dr. Robert Gallo, chief AIDS researcher at the National Cancer Institute, who told the Washington Post on February 2, 1986 that vaccines "trick the immune system into manufacturing antibodies and can be a risk for infected persons."

In other words, Buttram and Hoffmann explain that immunizations may mimic the effects of multiple infections in the healthy carrier of the AIDS virus, possibly activating infection from its latent state. If the present AIDS epidemic did begin in Africa (as is thought), according to Buttram and Hoffman it probably is due to the weakening of the immune system of native Africans from multiple causes, of which immunization is one. They conclude, "There is a great need to study the possible immunosuppressive effects of vaccine."

Another doctor has spoken out on the possible relationship between the AIDS epidemic and vaccinations. Thanks to Santa Monica, California subscriber Johanna Amschl, I have before me the August 7, 1987 issue of the Los Angeles Reader which details Pasadena internist Robert Strecker's belief that AIDS is transmitted through vaccines.

In addition, Jeremy Rifkin, a medical activist in Washington, D.C., has asked the National Institutes of Health to examine world-wide stocks of human vaccines to see if they might be contaminated with animal viruses which could be central in causing AIDS.

How might animal viruses get into vaccines? The Reader describes how smallpox vaccine is manufactured: "A young calf has his belly shaved. Many slashes are made in the skin. A prior batch of smallpox vaccine is dropped into the slashes and allowed to fester over a period of days. During this time, the calf stands in a headstock so that he can't lick his belly. The calf then is led out of the stock to a table where he is strapped down. His belly scabs and pus are scraped off and ground into a power. That powder is the next batch of smallpox vaccine."

Reader reporter Jon Rappaport asked the veterinarian who gave the above description whether incidental viruses which the calf was carrying might be contained in these scabs and, hence, appear in the vaccine. "Reluctantly, he [the vet] said yes."

And don't think that smallpox vaccine, which largely has been abandoned in the United States, is the only vaccine under suspicion. Ten years ago, William Bennett, medical editor of the Harvard University Press, wrote in The Atlantic Monthly (February, 1976) that the SV40 virus (which comes from monkeys--SV stands for Simian Virus) was used, along with its host monkey kidney, during the 1950s and 1960s in the manufacture of polio vaccines and "cold shots."

In 1985, Dr. Jacob Rachlin, head of a group of University of Chicago researchers, reported a study to the American Association of Neurologic Surgeons which turned up SV40 in human cancers. In Rachlin's study, three children with brain tumors were born of mothers who had received polio shots during their pregnancies.

One of Mendelsohn's laws is, "When it comes to medicine, whenever you think things are bad, they usually are worse." These new revelations are powerful evidence that vaccines are more horrible than even I would have imagined.

The last time you took your child (or grandchild) to the doctor for an infant vaccine, did he ask you whether any member of your family ever had a

convulsion? If not, he is in violation of government standards.

As reported by the Centers for Disease Control in its MMWR report (May 15, 1987), the Immunization Practices Advisory Committee (ACIP) recommends that parents of infants and children who have family histories of convulsions should be informed of their children's increased risk of seizure after DPT vaccinations.

"In particular, they should be told, before the child is vaccinated, to seek immediate medical evaluation in the unlikely event of a seizure," says the ACIP.

Doctors like to use words such as "event" or "incident" when something they do leads to trouble. For example, if a mistake is made in prescribing medication in a hospital, an "incident" report is filled out. Similarly, the CDC refers to the risk of neurologic "events" after DPT vaccination. Do these words "incident" and "event" serve to obscure responsibility and make the patient's damage appear to be an act of God Himself?

According to the CDC, studies now show that infants and children with a history of convulsions whose parents, brothers and sisters have a history of convulsions have a "3.2-fold increased risk for neurologic events compared to those without such histories."

So, parents and grandparents, see whether your doctor asks you if anybody in the family has had convulsions before he injects your child. (Approximately five to seven percent of all children have a family history of convulsions.) If there is a family history, see whether he warns you of the increased chance that your child will convulse following the shot. Then see whether he tells you, before he gives the shot, to seek medical care if your child has a convulsive "event." See whether he follows the CDC recommendations to document in your child's medical record that "the small risk of postvaccination seizure and the benefits of pertussis vaccination have been discussed." (That documentation is just in case you later decide to sue for any damage your child may have incurred because the shot was given without affording you the opportunity for informed consent.)

Finally, see whether the doctor talks to you about using acetaminophen, Tylenol included, after the DPT shot to decrease the risk of febrile convulsions. If so, tell him that the CDC confesses that "there are no data on whether the prophylactic use of antipyretics [which may be able to reduce the incidence of postvaccination fever] following the DPT vaccine can decrease the risk of febrile convulsions."

Now watch the language of this next sentence. "Thus, it is reasonable to consider administering antipyretics (such as acetaminophen) at age-appropriate doses at the time of vaccination and every 4 to 6 hours for 48 to 72 hours to children at higher risk for seizures then the general population." Note how carefully the CDC pussyfoots around the issue of acetaminophen. They don't say it is reasonable to give this antipyretic. Instead, they say it is reasonable to consider giving this drug, which they know can be toxic to both the kidneys and liver.

This latest revelation doesn't add very much to our store of knowledge about DPT's safety and efficacy. But it certainly gives us some insights into the byzantine thought processes of government doctors who are supported by your tax dollars and mine.

Japanese pertussis vaccine no panacea

If your doctor says the Japanese whooping cough vaccine (not available in the U.S.) is a more effective vaccine and is a safe substitute for the dangerous U.S. vaccine, ask if he has read the November 1986 issue of the American Academy of Pediatrics Newsletter.

Since the development of this new acellular pertussis vaccine in Japan late in 1981, there has been a continuing decrease of the incidence

of pertussis from the epidemic peak in 1979. But surprisingly, in spite of higher vaccination coverage, the incidence of whooping cough in 1984 was above the levels of the early 1970s.

While you legitimately may be amazed that the incidence of whooping cough in Japan actually was higher after this new vaccine was introduced than it had been a decade previously, this news will not surprise epidemiologists and others who specialize in tracing disease patterns. A long time ago, when smallpox vaccine first was introduced, medical journals carried quite a few reports of an increased incidence of the disease in the years after introduction of the vaccine; the same thing happened initially with the polio vaccine. And, as I inform you below, some communities in the U.S. are reporting an increase in measles cases following introduction of the measles vaccine.

What does it all mean? Does the vaccine paradoxically cause the disease it is intended to prevent, or do the doctors change their criteria for reporting a disease after the vaccine is introduced? While experts continue to ponder these and other hypotheses, you have to be informed about this strange pattern which perplexes scientists.

If your pediatrician tells you that the serious neurological reactions (convulsions, epilepsy, mental retardation, cerebral palsy, sudden infant death, etc.) associated with the original pertussis vaccine have decreased with use of the Japanese vaccine, please remind him that the Japanese do not start routine pertussis vaccination until two years of age. In contrast, the U.S. vaccine is started at two months, and it is given during the high-risk months for Sudden Infant Death Syndrome. In addition, serious neurologic reactions following pertussis vaccination in Japan had already fallen significantly after 1975 when the age of administration of the vaccine was raised to two years. But the rate of whooping cough in children ages two and below is higher than it was before 1975.

All these variables make it impossible to say the Japanese vaccine is any more safe or effective. The lesson to parents is clear. They must ask the same questions about the Japanese vaccine which they have been asking about the U.S. vaccine.

Measles updates

If your doctor has been singing the praises of the measles vaccine, you may want to get a second opinion.

The federal government reports (Morbidity and Mortality Weekly Report, June 6, 1986) that during 1985, out of 1,984 non-preventable cases of measles, 20 percent (395) occurred in children under 16 months of age who were too young for routine vaccination and 3.6 percent (71 persons) were born before the vaccine became available. Of the 1,518 who were between 16 months and 28 years of age, 80 percent (1,207) had been vaccinated on or after their first birthday; one percent (14) had previously had a physician diagnose them as having measles; three percent (48) were non-U.S. citizens, and 16 percent (248) had medical contraindications or exemptions under state law. Please note that 80 percent of these so-called "non-preventable cases" occurred in people who had been properly vaccinated.

So if your doctor tries to remind you of all those cases of measles that would have occurred if no one had been vaccinated (a guess on his part), you might remind him of all those for-sure cases of measles that occurred in spite of the shot.

After there had been no reported cases of measles in the state of Iowa since 1979, 125 cases occurred last year (Waterloo Courier, July 10, 1986).

Most of the cases occurred in children who had received the measles

vaccine. Iowa health officials consulted with the Centers for Disease Control which reported that a number of other communities in the United States had experienced similar problems.

As reported in Science News September 13, 1986, "The war against measles isn't going according to plan." In the first half of 1986, more than twice as many cases were reported as in the first half of 1985 and nearly four times as many as were reported in the first six months of 1986 according to the Centers for Disease Control's Bulletin of August 22, 1986. Half the measles patients had been vaccinated.

Great stuff, that measles vaccine!

Q Should I get a flu shot this year? I'm 66 years old and in good health. My doctor has told me about the pneumonia vaccine and I wonder if I should get that as well.--C.C.

Risks of flu shots and pneumonia shots

A Even though it is almost now winter and these shots are to be given before the flu season begins, plenty of people still are under pressure to be vaccinated against influenza and against pneumonia. That pressure to immunize emanates from at least three sources--one's own doctor, public health doctors, vaccine manufacturers and their public relations firms.

This triad (triumvirate? troika?) will, of course, try its best to frighten people about the dangers of the diseases. Just take a look at the very name of last year's flu--Taiwan flu. Haven't you ever wondered why doctors name flu strains after Asiatic countries? Do you remember the Hong Kong flu? The Singapore flu? The Bangkok flu? The Asian flu? The Russian flu, etc.?

Did you note that, when a strain finally originated in the U.S., doctors didn't call it the New Jersey flu? Instead, they named it after an animal that has a thick, bristly skin and a long, mobile snout--swine flu.

When the scare campaign heads in your direction, don't panic. Instead, keep in mind the fact that the doctor's treatment may be even more dangerous than the disease. Before your doctor fills the syringe, ask him to hand you the prescribing information for the vaccine. When you carefully read the four columns describing Merck Sharp & Dohme's pneumococcal vaccine, Pneumovax, you will learn that, while this vaccine is particularly recommended for older folks who are more likely to be ill, the manufacturer warns that caution should be exercised in giving Pneumovax to individuals "with severely compromised cardiac and/or pulmonary function in whom a systemic reaction would pose a significant risk." Thus, the very people for whom the vaccine is recommended may be the same ones for whom it is the most dangerous!

You also will learn that, in addition to the more common reactions--soreness, redness, fever--neurologic disorders including Guillain-Barre paralysis have been associated with the penumococcal vaccine.

After you have read the small print on the pneumococcal vaccine, read the small print on Fluzone, Squibb-Connaught's influenza virus vaccine. Under the section on warnings, you will learn that this vaccine interacts with anticoagulants, theophylline and anti-convulsants. You will learn that if jet injection is used, special precautions must be taken during sterilization to prevent the transmission of hepatitis or other infectious agents. You will learn that neurologic disorders such as encephalopathy (brain damage) have been linked to this vaccine. These reactions can begin as soon as a few hours and as late as two weeks after vaccination. You also will learn that, when the doctor or his nurse brings in the tray

for your injection, the tray should be carrying two syringes--the second containing adrenalin, in case you go into shock from the vaccine.

Writing for Scripps-Howard News Service, Dr. William Froschauer reports (November 5, 1986) that healthy people under age 65 should not take the flu vaccine because "the risk of suffering serious complications from the vaccine is far greater than that of having serious effects from the flu."

Maybe after you read all this information, you will lean toward rejecting the vaccine. If you still need a clinching argument to help you make up your mind, ask your doctor if he himself has taken those shots.

Q I am a physician who is interested in side effects and risks of vaccinations. In the November 21, 1986, issue of the Journal of the American Medical Association, I read that the most common cause of death in Air Force recruits during basic training is myocarditis. This appears to be caused in some cases by vaccinations given to the recruits. The article refers also to the Annals of Clinical Research (1978) which showed that post-vaccination EKG changes of myocarditis were seen in three percent of asymptomatic recruits in Finland.

Keep up the good work.--Van Alan Valenta, M.D.

Vaccine dangers to recruits

A Thank you for sending me that important and authoritative article which gives a 20-year review of sudden cardiac deaths in Air Force recruits (from the Department of Cardiology, Wilford Hall Medical Center, Lackland Air Force Base, San Antonio, Texas, and the Department of Cardiovascular Pathology, Armed Forces Institute of Pathology, Washington, D.C.).

All the airmen had received meningococcus, influenza and tetanus-diphtheria inoculations on the fourth day of training. On the eighth day, adenovirus, rubella and rubecla inoculations were administered. Vaccinia (smallpox) vaccinations were administered on the third day of the training during the period from 1965 through 1968, but were discontinued thereafter. On the 30th day of the training, oral polio and tetanus-diphtheria boosters were given.

In the Finnish study you refer to in your letter, smallpox and diphtheria immunizations were identified as the most common agents of EKG changes of myocarditis (inflammation of the heart muscle). In another reference from the New England Journal of Medicine, a fatal case of myocarditis occurred after a smallpox vaccination. In the JAMA study, a recruit who died of vaccinia myocarditis was immunized two weeks before.

This study proves one thing: For Air Force recruits, a shot from the doctor may be more tragic than a shot from the enemy.

Potpourri

What's in a name?

Arcadia. Have you noticed that Arcadia is the name of both towns (one in Florida and one in Indiana) in which controversy surrounds AIDS-affected schoolchildren? In Florida, the three hemophiliac Ray children and their parents fled from Arcadia after a mysterious fire destroyed their home. In Indiana, AIDS patient Ryan White and his family found sanctuary in Arcadia after encountering turmoil when he attempted to enter Kokomo's public schools.

Webster defines Arcadia as "a region or scene of simple pleasure and quiet," from the region of ancient Greece which frequently was chosen as a background for pastoral poetry.

There are Arcadias, and then there are Arcadias.

The People's Doctor Newsletter
P.O. Box 982
Evanston, Illinois 60204

Published monthly. Subscription rate: $24.00 annually.
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Vera Chatz, Managing Editor

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Another View

by Marian Tompson



How do you get your non-immunized child into school when you live in a state in which immunizations are required? Well, let me tell you how Rose dealt with this situation this year when her oldest child, Lara, was ready to enter kindergarten.

Wanting to make this transition as smooth as possible for Lara, Rose contacted the state health department months before school was to begin and asked how she might go about getting an exemption from immunizations for her daughter. "All you have to do is write a note to the school stating why Lara doesn't have shots," she was told.

But when Rose tried to register Lara for school, she sensed there was going to be trouble. The school nurse was most unfriendly, declaring that no unimmunized child had ever been registered at that school. Even with a letter of exemption, it still was up to the principal to decide if Lara could enter school. "And if anyone in the school catches a disease," she warned, "you could be sued by the parent of that child!"

The week before school began, the school secretary phoned Rose with the urgent message that the exemption letter was needed right away so it could be presented to the school lawyer before the school committee meeting. The letter, which both Rose and her husband signed, was headed Legal Immunization Exemption Per Compliance With State Statute Provisions. Underneath, the name of the school, the city and Lara's name were listed. The text read as follows: "As legal parents of Lara _____ we hereby withdraw our consent to have our child immunized since one or two of the immunizing agents could manifest an allergic reaction. Also whereas; Vaccines are contrary to our beliefs and practices, which violates the free exercise of our religious principles. As legal and responsible parents of the above child we hereby release the school from its responsibility. This legal request to be filed with student's school health record as legal proof of our objection."

Rose accompanied Lara to her first day of school only to be told by the nurse that she had conferred with the school principal and he said the exemption letter wasn't specific enough to allow Lara to enter school. "And what if Lara should cut herself on the swing set?" the nurse demanded. "If she got lockjaw, she would just die because it's a fatal disease. So then, how are you going to live with that?"

The nurse next handed Rose a handwritten note containing the following points which she claimed the school's lawyer required be added to the letter: The name of the religion, an agreement to exempt the school and all of its personnel from any and all liability now and in the future, willingness to allow first aid to be given to the child as stated in the school department protocol, a list of the beliefs and practices specifically violated by immunizations given to the child, specific allergic reactions referred to and why, and the understanding that copies of the objection would be filed with the state health department. The letter was to be completed, signed and notarized before Lara would be allowed in school. Rose's objection that none of the points was required by law was met by the nurse's reiteration that the school's lawyer required them.

During the next 24 hours, Rose got a copy of the state's general laws on immunization from the library. Next she got a notebook, writing in it everything pertinent to the issue, including the names of everyone she had talked to and exactly what they had said. By making one long-distance phone call, Rose learned that the U.S. Supreme Court had ruled that an individual's personal religious beliefs do not necessarily have to be tied to or affiliated with any external manifestation of religious practice through any organized religious organization. She called the Attorney General's office in the role of an irate mother whose child was being kept out of school. ("I had been told that if you're too nice, they just put you on the back burner," Rose explained.) An assistant to the Attorney General told her that while they couldn't make a formal decision unless it was in writing, he personally felt that Rose and her husband had complied with the law in their original letter, and he suggested that Rose have the school lawyer call him.

When she telephoned the principal to get the lawyer's phone number, Rose learned that the principal never had seen the original letter. He also claimed to know nothing about the added demands made on Rose by the school nurse. A call to the school's lawyer produced the added revelation that he knew nothing about those demands. In the end, the principal prepared a statement which contained one single agreement which would allow first aid to be given. Rose signed the statement, and Lara started school, only one day late!

Getting her daughter into school became an educational experience for Rose as well. She learned to check out the claims of people in authority because they might be lying. She learned to check out the actual laws and use them. And she learned that, with persistence, even a young mother holding a nursing baby in her arms can challenge the system and win. And I think she deserves a medal!

the People's Doctor
A MEDICAL NEWSLETTER FOR CONSUMERS by Robert S. Mendelsohn, MD

VOL. 9, NO. 6

BULK RATE
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CHICAGO, IL

P.O. Box 982 Evanston, Illinois 60204

IN THIS ISSUE:

More on Immunizations



Dr. Robert Mendelsohn

As the vaccine machine prepares to roll out new products--chicken pox vaccine, H. influenza meningitis vaccine, AIDS vaccine, malaria vaccine--all of us must be alerted to the proven risks and unproven effectiveness of those vaccines which are already available.

Only this kind of information can immunize us from the latest voodoo curses of doctors ("If you are not immunized, you and your children will die from foreign travel") and from their irrational attempts to create guilt ("You unpatriotic people are depending on your immunized neighbors to keep you healthy").

Thus--this eighth People's Doctor Newsletter on the risks of immunizations.

Q My eight-year-old daughter was immunized when she was a baby. I let her have the standard shots, something which I would never do today. So what now? Is there something I can do to balance out what was put into her body?--Mrs. C.L.

A *Can shots be undone?*

Here are my recommendations for you and for the many other parents who have written me after changing their minds about immunizations:

1) Don't let your doctor give your child any more immunizations. Even if you are in the middle of a series, stop now.

2) In the future, don't accept any of the immunizations which are now on the drawing board, e.g , chicken pox, meningitis, gonorrhea, etc.

3) Since your child has already received, in addition to the weakened bacteria and viruses, a host of chemical agents in those shots, do your best to reduce her chemical intake in the future. Pay close attention to food and water, medicine, etc.

4) Most important, remember that in order to have your child immunized, you had to take her to the doctor when she was healthy. In the future, keep her away from doctors unless she is sick. That's what my latest book "How to Raise a Healthy Child in Spite of Your Doctor" (Contemporary Books, $13.95) is all about.

5) Remember, when your doctor gave your child those immunizations, he did not tell you about their possibly disastrous side effects. In the future, ask him plenty of questions, and then check up on his answers.

DPT on last legs

Since three major charges recently have been exploded in the DPT controversy, no parent should take his child to the doctor's office for that triple vaccine without carefully reading the following documents:

1) If you did not see ABC-TV's April 1985 "20/20" program dealing with the DPT shot (or even if you did) write ABC for a transcript. Incidentally, one of the doctors on that program, Mark Thoman, M.D., a pediatrician and editor-in-chief of the Journal of the American Academy of Clinical Toxicology (1426 Woodland, Des Moines, IA 50309), will send you the warnings issued by his organization on the DPT vaccine.

2) A new book, "DPT: A Shot In The Dark" (Harcourt, Brace, Jovanovich, $19.95), provides in easily readable form the most comprehensive documentation on DPT damage. The authors are renowned historian Harris Coulter and Barbara Fisher, founder of the parents' organization of vaccine-damaged children known as Dissatisfied Parents Together (DPT). The book includes scientific evidence and case reports.

3) A report on DPT by a group of lawyers, "Advocates for a Safe Vaccine," has been presented to members of Congress. This report, which provides scientific evidence and internal memos from vaccine manufacturers and public officials presumably responsible for vaccine safety, may be obtained through the offices of Congressman Henry Waxman of California and Senator Paula Hawkins of Florida.

Now that the vaccine issue is national news, every responsible parent must be sure to get all the latest information in order to avoid future guilt feelings. These three documents will enable parents to make up their minds. I hope you will ask your own doctor if he has done his homework, since I predict that any practicing physician who carefully reads this information will find his hands shaking every time he reaches for his DPT-filled syringe.



On the eve of our daughter's first birthday, I am writing to ask you a few questions about vaccinations. We have been afraid to give them to Heather because we are concerned that they contain dreadful toxic things, that they would not contribute to her health and might cause harm to her immune system.

Our daughter was born at home and still is on breast milk, although she has eaten fruits, vegetables, cheese and butter. She was given the oral polio vaccine, and we have been thinking about giving her the tetanus shots. We are convinced not to give her pertussis, but are 50/50 on diphtheria. Would we be doing her harm or jeopardizing her health if we gave her the rest of the polio shots as well as the tetanus shot?

As you can imagine, our children's health is of the utmost importance. We are looking into home schooling for the kids and are planning to move out of Los Angeles; my husband has lived in Chicago and Wisconsin.--L.S.



You may not have to worry too much longer about the diphtheria shot. In early 1984, stung by the multi-million dollar judgments awarded to vaccine-damaged children, Wyeth Laboratories and Connaught Laboratories stopped the manufacture and distribution of DPT (production has since been resumed). Lederle, while still in the field, has raised the cost of the vaccine sharply.

As the country and the manufacturers--and even the doctors--are learning finally the true cost of the DPT vaccine, all the vaccine's manufacturers may permanently throw in the towel. When this happens, the vaccine issue will have been settled by my favorite method--the American free enterprise system.

When you consider where to re-locate, keep in mind that while Illinois laws mandate immunization (no shots equal no school), moves are afoot to change that law (see page 4). Since you are interested in home schooling, you have joined many other parents who have told me that if they are smart enough not to immunize their children, they also are smart enough not to

send them to school. You should know that Wisconsin is one of the 22 "loophole states" (your present state, California, is another) in which parents can exempt their children from immunization on the grounds of personal conviction.

Measles outbreak raises questions

On the day after newspaper headlines told of two students who died from measles at Principia College, a Christian Science Church school in Southern Illinois, TV pictures showed anxious students on the campus lining up for immunizations. Those pictures were enough to scare any parent into taking his child on an emergency visit to the doctor's office for a measles shot.

If you should take this route, be sure to broach some subjects to your doctor before he fills the syringe for your baby, your college-age son/daughter or for you:

1) How sure were the Principia doctors of their diagnosis? After all, most doctors today see few cases of measles, and they may not even recognize the characteristic signs (e.g., white spots in the mouth) of the disease. Did the doctors confirm the diagnosis by virus isolation from the throat or blood, or by certain blood tests (e.g., complement-fixation) on those two victims, or in the other 79 cases diagnosed as measles since January 1985 in that school? Did they exclude other diseases sometimes confused with measles, including scarlet fever, drug rashes, meningococcal infections, infectious mononucleosis, Rocky Mountain spotted fever, etc.?

2) Even though these students came from families which reject vaccines, perhaps their parents felt differently years ago and had them inoculated with the killed measles vaccine when they were babies. This dangerous immunization (which is no longer available) was given to a million children in the U.S. and Canada between 1963 and 1970. Recipients of this vaccine, if later exposed to natural measles, may develop an especially virulent condition known medically as "atypical measles," characterized by severe pneumonia and other life-threatening conditions. Atypical measles has also occurred after inoculation with the live measles vaccine, perhaps as a result of inadvertent inactivation due to improper storage.

3) Ask your doctor to give you the government-mandated form or the manufacturer's prescribing information or the articles from the Journal of the American Medical Association which describe the adverse effects of the vaccine, including thrombocytopenia (a clotting deficiency leading to abnormal bleeding into body organs), hyperactivity, learning disabilities, polyneuritis, Guillain-Barre syndrome, ocular palsy (paralysis of the eye muscles), arthralgia (painful joints), arthritis, convulsions and a mysterious "slow virus" form of mental retardation named SSPE which leads to death.

4) Were all female Principia College students informed that the prescribing information for the vaccine clearly states, "Subjects should be considered for vaccination only if they agree they will not become pregnant within three months following vaccine and if they are informed of the reason for this precaution [fetal damage]"?

5) Were those college students warned that, in addition to pregnancy, other contraindications to the vaccine include illness with fever; allergy to eggs, chickens and chicken feathers, because of a potential risk of hypersensitivity reactions, and (of particular interest to college-age students) the use of cortisone, a drug present in many anti-acne medications

6) Before the doctor plunges that measles vaccine needle under the skin, you might be well-advised to ask to see his bottle of adrenalin. The prescribing information warns that "epinephrine (adrenalin) should be available for immediate use in case an anaphylactoid (shock) reaction occurs

7) Even if doctors are right in claiming that the measles vaccine reduces the death rate from measles, how, in the absence of any controlled studies, can we be sure that the vaccine does not increase deaths from other causes? For example, cholestyramine, a popular cholesterol-lowering drug, reduces the death rate from heart attack. But patients on this drug have a higher death rate from violent causes (suicides, homicides, accidents). Thus, the "funeral rate" of cholestyramine takers is the same. Why hasn't a study of this nature been carried out on the measles (or any other) vaccine?

Perhaps the heads of Principia College and their Church should have insisted on a full investigation by a panel of experts representing both sides--vaccine enthusiasts and vaccine critics--so that they could have learned the real truth. If that had been the case, college students and parents would not have been panicked into moving hastily only to regret at leisure.

Salk vs. Sabin polio vaccine

Many of you have been justifiably frightened of the Sabin polio vaccine which has been linked to every case of polio in the U.S. during the past three years, and so you have asked me whether you should not be taking the Salk vaccine instead. Even though the Salk vaccine has not been shown to cause polio, I have been skeptical of it for other reasons (e.g., its ability to produce tumors in experimental animals).

Now, an outbreak of five cases of polio in Finland (reported in American Medical News, February 8, 1985) reveals problems with the Salk vaccine. A 17-year-old male developed paralytic polio, even though he previously had received five doses of inactivated (Salk) polio vaccine. A 12-year-old boy, who also had received five doses of Salk vaccine, developed paralytic polio. A 33-year-old man, who had not been completely immunized and who had Hodgkin's disease, developed paralytic polio.

Can you guess what the Finnish doctors have recommended? You guessed it--a campaign to immunize all adults with oral (Sabin) vaccine!

Religious exemptions for vaccines

For more than a year, Penny and Stanley Heard of Hot Springs, Arkansas have been fighting to exempt their healthy children from state-mandated inoculations. At the beginning of the 1984 school year, the State granted the Heards a six-month exemption based on religious grounds. As reported in attorney Mark Huberman's column (Vegetarian Health Science, November/December 1984), the Heards furnished evidence of membership in the Universal Life Church, based in Modesto, California. Individual branches of that church, including the one to which they belong, oppose vaccines.

Illinois reconsidering mandatory vaccinations

The Illinois State Board of Education and the Superintendent of Education have recommended the elimination of financial penalties for schools which permit non-immunized students to attend classes (Illinois Medical Journal, September 1984).

The Board also adopted a recommendation to eliminate the fifth- and ninth-grade mandatory physical examination. As you might expect, the Illinois State Medical Society opposes these two brave actions by the State's education officials who feel that the purpose of schools is to educate, not medicate.

I will keep you informed on the legislative fate of these proposals.

Flu shots discredited

Thanks to former top government virologist, J. Anthony Morris, PhD, I can pass on to you scientific data which discredits the flu vaccine.

At a meeting on January 24 and 25, 1985, a government group known as the Vaccines and Related Biological Products Advisory Committee (Centers for Disease Control, Influenza Branch, Atlanta, Georgia) presented studies showing the failure of the vaccine to protect against influenza B illness. Nursing home patients in seven states were studied over four successive influenza seasons. In an analysis of studies to measure protection afforded by the influenza vaccine against influenza illness in aged patients in two New York/New Jersey hospitals, it was shown that improper controls were used. Thus, the test results were meaningless.

In addition to these important disclosures at meetings attended by scientists and doctors, this bad news about the flu vaccine was distributed to the public through the Gannett News Service in an article (January 30, 1985) by ace reporters Chris Collins and John Hanchette headlined "Flu shot benefit questioned in new studies."

In case your doctor points that needle in your direction and tells you that flu shots are good for old folks, be sure to ask him whether he is aware of these important studies.

Many older patients who suffer from asthma are advised by their doctors to have flu shots. I hope their doctors know that "immunization procedures should not be undertaken in patients who are on corticosteroids (Medrol and prednisone both belong to this group)...because of possible hazards of neurologic complications and a lack of antibody response." That means that any kind of immunization given to a patient who is taking Medrol can cause vertigo, convulsions, increased intracranial pressure, and death. At the same time, as measured by blood tests, the shot doesn't work.

The drive to immunize adults

While no one knows for sure whether routine childhood immunizations benefit children, no one questions that such shots certainly benefit pediatricians. Compulsory immunizations have produced a captive population for pediatric service, a captive population which must return at regular intervals for pediatric service. This round-up of child patients by pediatricians has not gone unnoticed by doctors who treat adults. So not surprisingly, the 60,000-member American College of Physicians has launched a major campaign to make sure that "adult Americans are as well protected by vaccines as their children..."

Since the good doctors are recommending seven vaccines for adults, you must be prepared to ask your doctor some questions if he tries to convince you of the safety and value of these shots:

1) If your doctor suggests a tetanus shot, ask him to hand you the prescribing information that the manufacturer has shared with him so you can discover the references describing neurological damage from that vaccination.

2) Should your doctor recommend diphtheria shots, ask him about the evidence from diphtheria outbreaks (including that reported by the Chicago Board of Health) which show that neither the incidence of the disease nor the outcome were different in those who were vaccinated and those who were not.

3) If the doctor advises you to have the measles vaccine, be sure to ask him for the printed prescribing information so that you can learn the severe neurological complications associated with this immunization.

4) If the doctor recommends the rubella (German measles) vaccine, ask him about the much higher incidence of arthritis in adults who use this product.

5) If the doctor advises the hepatitis vaccine, ask him why two-thirds of medical personnel who are considered to be at risk of developing this serious liver disease have refused this vaccine, even when it is offered without charge. Because the hepatitis vaccine is a human blood product, health professionals fear it may harbor the agent that transmits AIDS--even though not a single case of AIDS has thus far been traced back to that vaccine.

6) If the doctor offers you the influenza vaccine, ask him if he remembers the hundreds of cases of paralysis that resulted from the swine flu vaccine, a condition which can develop with any kind of flu vaccine.

7) If the doctor suggests the pneumococcal vaccine, ask him if he knows that a variety of neurological disorders, including paralysis, have been associated with this substance. Furthermore, make sure you have not received pneumococcal vaccine in the past, since re-vaccination of adults is not recommended.

When your doctor recommends the seven vaccines, be sure he doesn't accidently throw in the polio vaccine (not to be given to adults) or pertussis, the whooping cough vaccine (not to be given to anyone over five years of age).

After you have done your homework, you may decide to reject your doctor's recommendations. He then may remind you of the danger of tetanus. He may luridly describe the risk of a rusty nail leading to lockjaw, paralysis, convulsions and painful death. If so, you might point out to him that, according to the Federal Centers for Disease Control, 40 percent of adults in this country have not had the booster tetanus injections which are needed to protect them against this disease. In view of those statistics, where are all the cases of tetanus from all those rusty nails?

Will this adult vaccination drive succeed? I predict that these well-intentioned doctors will not be able to corral their adult patients with nearly the same success rate achieved by their pediatric colleagues. After all, most parents fear more for their children then they do for themselves. So support your commonsense with a little homework. Before your doctor aims the needle in your direction, ask him to give you the reading material on vaccines recommended by this Newsletter.

With the stepped-up drive to vaccinate U.S. adults (now that more than 90 percent of children have been forced to receive immunizations because of the no shots/no school laws), the government doctors at the Centers for Disease Control are trying to figure out how to accomplish their new goal. The front page of the AMA News (February 1, 1985) bore the headline, "Is a 'Gimmick' the Answer?"

The government doctors complain that 40 percent of U.S. adults lack protection from tetanus, 30 percent have no antibodies against diphtheria, and 10 to 15 percent of women are still susceptible to German measles. The government doctors tell us that, with regard to the flu vaccine, things are getting worse. The popularity of flu vaccinations peaked at 38 percent of the high-risk population in 1977, but since then, it has declined to between 25 percent and 35 percent (sounds as though people learned something from the swine flu fiasco).

Because of this sorry state of affairs, the AMA advises, "Adult vaccines need a gimmick--something catchy, yet sophisticated, designed to capture the imagination of a populace that embraces bottled water, running shoes, and Pritikin diets, yet balks at the thought of a simple inoculation." (Imagine comparing my sneakers to a "simple" inoculation!)

The CDC's well-intentioned physicians then proceed to speculate on the reasons for the "abysmal" acceptance rate of vaccines. Reason #1 is: "Patients don't want vaccines." The doctors answer: "There are lingering

doubts about safety. In the minds of many patients, the hepatitis vaccine still is linked to acquired immune deficiency syndrome (AIDS); the flu vaccine, to paralysis, and the diphtheria/pertussis/tetanus vaccine to brain damage." (The CDC doctors fail to mention that two-thirds of physicians eligible for the hepatitis vaccine have refused to take it, and Guillain-Barre paralysis from the flu vaccine and cerebral palsy from the whooping cough-pertussis vaccine exist not in the minds of patients, but rather in their paralyzed limbs.)

Another reason given by government doctors is, "Physicians do not encourage vaccination." (Maybe physicians who have flesh-and-blood patients know something the CDC theoreticians don't.) A recent poll revealed that 50 percent of elderly people who requested a flu vaccine were dissuaded by their physicians--let's hear it for those doctors!

The government doctors complain about other forces which oppose immunizations, e.g., "Resistance from civil libertarians who assert that you cannot force healthy individuals to be vaccinated..." And they conclude, "The biggest obstacle, however, is physician and public ignorance."

"Consumers aren't sold on the idea," bemoans the director of marketing for Merck Sharp & Dohme. (What would you expect a director of marketing for a vaccine manufacturer to bemoan?) He continues, "We're asking them to do something they don't want to do and aren't required to do. We're asking them to spend money and cause pain to prevent themselves from disease they'll probably never get." (Can't argue with that!)

The vaccine enthusiasts have solutions which even they concede "range from the sublime to the ridiculous." They describe a "vaccine voucher" which is "just like the discount cards people use to get bargains at dry cleaners or win prizes from cereal boxes. These government-provided vouchers could be traded in by patients for a free vaccination at the physician's office of their choice." They propose, "A vaccine superstar could do for infectious disease what Michael Jackson did for drug abuse or Mary Tyler Moore did for diabetes." (I assume this falls in the "sublime" category of recommendations.)

CDC physicians suggest a catchy slogan, such as "Vaccines are not just kid stuff" or "Vaccines: The adult thing to do!" In case the above marketing techniques don't do the trick, the government doctors are ready to unfurl their crepe-hanging techniques, using TV spots to stir up memories of the 1918 flu epidemic (precious few of us have memories that go back that far), iron lungs and crippled limbs from polio, etc. Magazine ads could warn high-risk groups; for example, the hepatitis vaccine has been plugged in 73 gay magazines.

The CDC doctors recognize that, for child vaccines, the school system is the "gatekeeper" of immunizations. They complain, "But adults have no common institution through which they all pass."

Perhaps your own doctor, if he belongs to the AMA, will share this entire AMA News article with you. Then, you can read in detail the government doctors' game plan for this new shooting war in which you are the target.

Dr. Mendelsohn's latest book, "How to Raise a Healthy Child in Spite of Your Doctor," has been published by Contemporary Books ($13.95).

"Confessions of a Medical Heretic" is available from WarnerBooks ($3.25).

The People's Doctor Newsletter
P.O. Box 982
Evanston, Illinois 60204

Published monthly. Subscription rate $24.00 annually.
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Vera Chatz, Managing Editor

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Another View

by Marian Tompson
Executive Director,
Alternative Birth Crisis Coalition



My immunization file originally was put together to help my daughters and their husbands decide what to do about immunizing their children. But in recent years it's been shared with a lot of other families. If you're looking for information, documentation, or help with a vaccine damaged child, here are some of the published resources now available:

1) "DPT: A Shot In the Dark," by medical historian Harris L. Coulter and Barbara Loe Fisher (Harcourt Brace Jovanovich, $19.95). While it's hard to get through the heart-wrenching interviews with parents whose children developed serious reactions to the DPT shot, this comprehensive report also gives us the background on pertussis and the development of the DPT vaccine with all the political, economic and social forces involved in shaping our vaccination policy. It includes a guide for parents on vaccine reactions, medical conditions that put a child at high risk of a reaction, and the dangers of the disease itself.

2) "Dangers of Compulsory Immunizations--How To Avoid Them Legally," by attorney Tom Finn (Family Fitness Press, P.O. Box 1658, New Port Richey, FL 33552, $5.95). A nationally-known trial attorney, Tom Finn has litigated cases dealing with health freedom issues, including compulsory immunizations. Brief and to the point, the book gives readers the background of immunizations, the status of the law, and alternatives to inoculating their children.

3) "Immunization Booklet" (Mothering Publications, P.O.Box 8410, Santa Fe, NM 87504, $5.00). Reprints of the best articles on immunization that have appeared in Mothering magazine are presented in this newly revised edition with an updated resource section.

4) "The Vaccine Machine" (Gannett News Service, Box 7858, Washington, DC 20044, 1984). A 24-page special report available free of charge.

5) "DPT" (Fresno Bee, Features Dept., 1626 E. Street, Fresno, CA 93786). Twelve-page reprint of a multiple-part series that appeared in the Fresno Bee.

6) "How We Beat the School System--One Family's Lengthy Struggle to Avoid Compulsory Immunizations at School," by Robert Allanson, plus "The Medical Time Bomb of Immunization Against Disease" (from "How To Raise a Healthy Child in Spite of Your Doctor") by Robert S. Mendelsohn, M.D., in East/West Journal, November, 1984. Available from East/West Journal, Back Issues Dept 144B, 17 Station St., P.O.Box 1200, Brookline, MA 02147, $2.00.

The following organizations have excellent resources on vaccines:

1) DPTSHOT (Determined Parents to Stop Hurting Our Tots), P.O. Box 543, Beaver Dam, WI 53916. When Marge Grant, the founder, appeared on the Donahue Show with her vaccine-damaged son, Scott, she asked viewers to send her information on other vaccine-damaged children in an attempt to start a central record keeping agency. Everyone who writes to DPTSHOT receives a newsletter.

2) DPT (Dissatisfied Parents Together), 128 Branch Road, Vienna, VA 22180. The goals of this non-profit organization include in-depth research and study of the pertussis portion of DTP; effecting mandatory reporting of adverse reactions; promoting public debate on whether or not the vaccine should be a requirement for attending school, and assuring treatment and compensation for persons damaged by the vaccine. A copy of the first vaccine reform bill to be signed into law in Maryland in 1984 is available for $2.00. The group also sells a 16-page information booklet, "Pertussis and Pertussis Vaccine," for $3.00.

3) Advocates for a Safe Vaccine (Andrew W. Dodd, Esq., Ward, Dodd, Gaunt & Denver, 21525 Hawthorne Blvd., Pavillion A, Torrence, CA 90503) is a group of lawyers who have extensive experience representing plaintiffs allegedly suffering the effects of whooping cough vaccine injuries. They have prepared an impressive interim report on DPT vaccine for the use of professionals engaged in similar litigation.

4) Physicians for Study of Pertussis Vaccines (Box 345, 11072 San Pablo Ave., El Cerrito, CA 94530) is a small, but rapidly growing, group of physicians, scientists and nurses committed to the continued development, improvement and availability of safe and effective vaccines. This group recently initiated legislation introduced in the California Assembly which would require true labeling of DPT vaccines sold in California as to their actual assayed potencies.

5) And last but not least, there's this Newsletter. While most other resources have only been available for a few years, since April of 1978, The People's Doctor has devoted eight issues to informing readers on the risks and confusion surrounding immunizations.

the People's Doctor
A MEDICAL NEWSLETTER FOR CONSUMERS
by Robert S. Mendelsohn, M.D.
P.O. Box 982 Evanston, Illinois 60204
VOL. 2, NO. 4

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IN THIS ISSUE:

The Truth About Immunizations



Dr. Robert Mendelsohn

As the government drumbeating in favor of immunizations grows ever louder, I've decided to devote a large part of this issue of my Newsletter to a discussion of the risks of inoculating against certain diseases. You've had ample opportunity to read all the "pros," so now is your chance to find out why immunizations, like all of medicine, are a mixed blessing.

Historically, immunizations were designed for very serious, life-threatening diseases such as smallpox, tetanus, and diphtheria. The risks of getting these illnesses were great, and so were the mortality rates. As the incidence of once-sweeping disease outbreaks (such as the smallpox epidemic which decimated the Aztec and Inca populations in the 16th century) has declined, the risks of immunizations have begun to take on a greater importance. In fact, with some immunizations, the risks of taking the shots may outweigh their benefits. For example, in 1976, while addressing science writers at a seminar of the American Cancer Society, Dr. Robert Simpson of Rutgers University pointed out that "immunization programs against flu, measles, mumps, polio, etc. actually may be seeding humans with RNA to form pro-viruses which will then become latent cells throughout the body. Some of these latent pro-viruses could be molecules in search of diseases which under proper conditions become activated and cause a variety of diseases including rheumatoid arthritis, multiple sclerosis, lupus erythematosus, Parkinson's disease and perhaps cancer."

Smallpox

The United States finally has abandoned smallpox immunization because the risk of serious complications, leading to death in one per million vaccinations, was higher from the vaccine than from the risk of smallpox itself. The risks of a person being hospitalized with encephalitis or with conditions known as eczema vaccinatum and progressive vaccinia was about 10 per million vaccinations. The risk of a serious complication including eczema vaccinatum, accidental implantation of vaccinia on the eye, or superinfection of a variety of skin conditions approached 1,000 cases per million primary vaccinations.

Diphtheria

Diphtheria, once an important cause of disease and death, has largely disappeared, but immunizations continue. Even when a rare outbreak of diphtheria does occur, this form of immunization often is of questionable value. For example, during a 1969 outbreak of diphtheria in Chicago, four of the 16 victims (according to a Chicago Board of Health report) had been fully immunized against the disease, and five

others had received one or more doses of the vaccine, two of these showing evidence of full immunity. In another report of three fatal diphtheria cases, one individual who died and 14 of 23 carriers had been fully immunized.

Whooping Cough

Whooping cough (pertussis) vaccine is hotly debated in many places in the world, both because its effectiveness rate is only about 50 per cent and because it may cause high fevers and convulsions as well as a form of encephalopathy (brain damage). This vaccine is regarded as so dangerous that most public health authorities prohibit its use after age six. Meanwhile, whooping cough itself has almost completely disappeared (less than 1,000 reported cases in 1976), and it shouldn't be too long before the whooping cough vaccine goes the route of the smallpox vaccine.

Measles

In recent years, vaccines have been developed and introduced for measles, mumps, and German measles, conditions which certainly do not have the dread implications of smallpox, tetanus, and diphtheria. (Incidentally, contrary to popular belief, measles cannot cause blindness; it can cause a condition known as photophobia which parents years ago treated by simply pulling down the windowshades.)

Measles vaccine is designed primarily to prevent measles encephalitis which is said to occur in one out of one thousand cases of measles. Any of us who has had decades of experience with measles must question this statistic: The incidence of 1/1000 may be accurate for children who live in conditions of poverty and malnutrition, but in the middle and upper classes, if one excluded simple sleepiness from the measles itself, the incidence of true encephalitis probably is more like 1/10,000 or 1/100,000. Meanwhile, the vaccine itself is associated with encephalopathy in one case per million and with a series of other complications such as SSPE (subacute sclerosing panencephalitis). Other neurologic and sometimes fatal conditions associated with the measles vaccine include ataxia (inability to coordinate muscle movements), retardation, learning disability or hyperactivity, aseptic meningitis, seizure disorders and hemiparesis (paralysis affecting one side of the body). I wonder whether the current epidemic of hyperactivity in children may have its origin, at least in part, in the measles vaccine.

Mumps

Mumps vaccine is extremely questionable. While it obviously decreases the incidence of mumps in the children to whom it is given, it does so at a possible risk of exposing them to the dangers of mumps later, if the effects of the mumps vaccine prove to last less than a lifetime. The chance of sterility from mumps is overrated since in practically every case of mumps orchitis (inflammation of the testes), only one testis is affected, and a man could repopulate the entire world with the other one.

German Measles

The German measles (rubella) vaccine remains controversial throughout the Western world, and there is little consensus regarding the age of the population which should be immunized and when the immunization should be given. Meanwhile, the risk of arthritis, usually temporary

but not uncommonly lasting for many months, from the rubella vaccine raises the question of whether it causes more damage than it prevents. It also is debatable whether immunization of children does anything to protect the one who is at the greatest risk if struck by German measles --namely, an unborn fetus. In the United States, rubella vaccine is administered routinely to children, rather than to women who are contemplating pregnancy. It is doubtful whether this kind of immunization can be validated scientifically, particularly since the rate of defective babies born to mothers with obvious, diagnosed rubella varies widely from one year to the next, from one epidemic to the next, and from one study to the next.

Polio

Immunization is not the sole factor in determining whether or not one contracts a disease. Numerous other factors such as nutrition, housing, and sanitation all figure in determining whether a person will contract a disease against which he has been immunized. As a matter of fact, one of the determinants in whether or not a person comes down with a disease may be whether he has been immunized against the disease! In September 1977, Jonas Salk, developer of the killed polio virus vaccine, testified along with some other scientists that most of the handful of polio cases which had occurred in the U.S. since the early 1970's probably were the byproduct of the live polio vaccine which is in standard use here. In Finland and Sweden, there have been no cases of polio in more than 10 years, but in those countries, the killed virus vaccine is used almost exclusively.

No one who lived through the 1940's and saw pictures of children in iron lungs, saw a President confined to his wheelchair by this dread disease, and was forbidden to use public beaches for fear of catching polio, can forget the frightening spectre it raised in all minds. But today, when the man who is credited with stamping out polio points to the vaccine as the source of the handful of cases which do exist, it's high time to question what we are gaining by vaccinating an entire population against that disease.

Influenza

I never can think about flu shots without remembering a wedding I once attended. Strangely enough, no grandparents were among the participants, and no one who was present seemed to be over 60. When I asked where all the older folks were, I was told they had all received their flu shots a few days before, and they all were at home, recovering from the ill effects of the shots!

The flu vaccine's efficacy and potency still are subjects of great debate, particularly since the strains covered by one year's vaccine often fail to correspond to whatever strains are causing flu at that particular time. The entire effort resembles a game of roulette in which, in any given year, the numbers may or may not match the strains.

We were all afforded a peek into the real dangers of the flu vaccine in 1976 when close governmental surveillance of one strain, the swine flu vaccine, disclosed that 565 cases of Guillain-Barre paralysis were associated with this vaccine, as were the unexplained deaths of 30 elderly persons. One wonders how much more would be known about the ill effects of flu shots if this kind of surveillance had been exercised over everyone who had received other forms of flu vaccine over the years.

What's ahead for the future? A vaccine has been developed for Russian flu which Dr. John Seal of the National Institute of Allergy and

Infectious Disease says may cause the same paralyzing Guillain-Barre syndrome. "We have to go on the basis that any and all flu vaccines are capable of causing Guillain-Barre," Dr. Seal says. Again, we are quick to pull the immunization trigger, but we are slow to examine the consequences of our actions.

Q My son will be going away to camp next summer. Will he need a tetanus booster shot?--W.M.

A Not if he's had one during the past 10 years.

Tetanus boosters

Q Please help me with this problem. We apparently are going to be required by law to immunize our school-age children. I have put off getting rubella and mumps shots for our 12-year-old daughter in the hope that she would get these illnesses naturally, but she has not. I read that rubella immunization is not very long-lasting, with 25 per cent of those immunized losing protection within five years after inoculation.

When my daughter was immunized against red measles at the age of 18 months, she became very ill, and her eyes were crossed for years afterwards because of the high fever she had developed. The daughter of a friend of mine suffered from arthritis after being immunized against German measles, and she still has the condition 10 years later. I looked this up in the Physicians' Desk Reference and discovered that in my daughter's age group, there is a 5 to 10 per cent chance of joint pain, swelling, stiffness, and, rarely, encephalitis after rubella immunization.

Is it best to get these shots or not?--Mrs. B.C.

Q What is your view of all the various shots that children are supposed to have? I'm afraid of complications which might develop if our son is exposed to all these immunizations. We have been careful to give him the very best start in life--he's 13 months old, still nurses, and received no solids until he was six months old. He has received no immunizations. Are there certain ones he should get and others he could do without? Our present doctor says we are relatively safe in what we've done, but other doctors have thrown us out of their offices for questioning their training. Please answer--we will accept your advice.--Mrs. K.B.

Q I distrust drugs and try to avoid them as much as possible. When my daughter was born, I found myself confronted by the question of immunizations. I've read articles that questioned the injection of germs into a healthy body, and I've read articles about how the number of certain diseases has dropped drastically since vaccines against them came into use. When the pediatricians I spoke to recommended immunizing my daughter, I finally decided to do it. The day she got her first DPT shot [diphtheria, tetanus, whooping cough], she cried all night, and her reaction to the second DPT was a nightmare: her entire thigh became red and swollen, and she ran a high fever. She screamed all night, cried most of the next day, refused to nurse, and had an unusually large number of bowel movements.

Doctor, how can anything that makes a child so sick be good for her? Is the agony worth it? Of course, if need be, I'd rather have the baby suffer for a couple of days rather than for a week or two with one of the diseases, but what is the percentage rate of vaccine effectiveness?

What are her changes of contracting an immunizable disease these days if she's unvaccinated? What effect do immunizations have on her overall health? If we don't get the third DPT shot, will the two she's already had provide protection? Christian Scientists don't immunize--I wonder if their disease rate is higher than anyone else's. Many other young parents share our concern.--K.P.

Should children be immunized?

Your three letters, as well as many others I have received in recent months, reflect the growing suspicions that the average American is beginning to feel and express about the ever-growing number of immunizations. In many cases, these vaccines are for diseases which have all but disappeared--in 1976 there were 9 reported cases of polio, 146 cases of diphtheria, 927 of whooping cough, and 68 of tetanus. Smallpox vaccine already has been discontinued in this country, since while the disease itself had disappeared, deaths and illnesses from the smallpox vaccine had not.

Even though medical societies, the pharmaceutical industry, and government agencies are pushing these shots, each mother and father still has the ultimate responsibility of examining both sides of the story in order to decide whether to place their child in the line forming for immunizations.

Of course, vaccine enthusiasts advocate their product on the grounds that, while they certainly produce complications, they are safer than the disease itself. Nevertheless, the adverse reactions listed in the prescribing information for measles vaccine include encephalitis and encephalopathy occurring within 30 days after vaccination, as well as sub-acute sclerosing panencephalitis in children who had no history of natural measles but who did receive measles vaccine.

Listed under adverse reactions for rubella vaccine are arthritis, arthralgia (painful joints) and polyneuritis. "Symptoms relating to joints (pain, swelling, stiffness, etc.) and to peripheral nerves (pain, numbness, tingling, etc.) occurring within approximately two months after vaccination should be considered as possibly vaccine related."

The Journal of the American Medical Association, January 23, 1978, reported that, of the 18 cases of polio in 1977, three of the patients were persons who were in the United States but who were not residents, and two of the other 15 victims apparently contracted the disease abroad. Three cases occurred in recent vaccine recipients, and 10 cases had been in close contact with recently immunized people. Only three cases occurred in persons "without known vaccine associations."

As far as the whooping cough vaccine (a component of the triple DPT baby shots) is concerned, Dr. Edward B. Shaw, a distinguished University of California physician, has stated (JAMA, March 1975): "I doubt that the decrease in pertussis (whooping cough) is due to the vaccine, which is a very poor antigen and an extremely dangerous one, with many very serious complications...the decline in pertussis began long before the widespread use of vaccine." Dr. Shaw then proceeds to question the controversial view that the decrease in polio is a result of the polio vaccine.

As far as your query about Christian Scientists, I am not aware of statistics on individual diseases, but as a group, they have one of the best life expectancy records in our country.

The information you have already gathered on the pros and cons of current immunizations will also help you when you are faced with the vaccines currently being developed for chicken pox and venereal disease.

From the letters reaching me from all parts of the country, I am aware that many school authorities have decided to exclude unimmunized

children from classes. Thus, vaccination, once a medical matter, now has become a political issue.

As a case in point, some Alaskan chiropractors had sought to excuse healthy children in their practices from compulsory immunization. A Superior Court ruling that only M.D.s and D.O.s have the right to decide when a child's health will be harmed by a vaccination was appealed to the Alaska Supreme Court.

As with all political issues, the question of immunization will be resolved by lawyers, by elected representatives, and, ultimately, by informed public opinion.

More on diphtheria immunization

I was recently preparing to give testimony as an expert witness in some upcoming law cases which deal with children who are alleged to have been damaged by immunizations. During that preparation, I reviewed a government document which had never before come to my attention.

The November 20-21, 1975, minutes of the 15th meeting of the Panel of Review of Bacterial Vaccines and Toxoids with Standards and Potency (presented by the Bureau of Biologics and the Food and Drug Administration) contained a remarkably complete analysis of vaccines which are currently in use. While the panel's overall conclusion is that vaccines are good and worthwhile, let me pass on to you part of the darker side of immunizations as described by the eminent scientists on this panel.

The section on diphtheria immunization contains the sentence: "For several reasons, diphtheria toxoid, fluid or absorbed, is not as effective an immunizing agent as might be anticipated. Clinical [symptomatic] diphtheria may occur occasionally in immunized individuals--even those whose immunization is reported as complete by recommended regimens." The panel members claim that when diphtheria does occur in such an individual, "It appears to be milder." The report continues that "...the permanence of immunity induced by the toxoid...is open to question."

Combination diphtheria-tetanus vaccine

Regarding the combination diphtheria/tetanus vaccine used in adults, the panel stated that this substance "has never been shown conclusively to be an adequate primary immunizing agent. Furthermore, the intervals between booster doses of Td [diphtheria/tetanus] in adults sufficient to maintain diphtheria immunity have not been established."

Finally, "efforts by producers to reduce the [reactions] of the toxoid by increasing purification may have resulted in diminished immunogenicity." In other words, as the vaccine is made safer in order to cut the severity of reactions to it, it gives less protection against the disease.

Tetanus toxoid only

Now, for tetanus toxoid itself. The government panel pointed out, "The antigenicity [degree of potency] of tetanus toxoid can vary considerably from preparation to preparation." Furthermore, "recent changes in manufacturing procedures may have resulted in lowering of the immunizing potency of tetanus toxoid in some products; hence there is a need for re-evaluating the primary antigenicity of current preparations....Most of the local and febrile [fever] reactions that are seen appear to be related to more frequent inoculations than are necessary."

Whooping Cough

On to whooping cough.

While noting the reduction in this disease over several decades, the panel concedes that "not all of this remarkable decline can be attributed to widespread use of the vaccine for the reason that some decline in morbidity [illness] and mortality from pertussis [whooping cough] was observed in the United States and other Western countries prior to the institution of vaccination."

On one hand, the scientists claim the incidence of whooping cough is low, yet they qualify this statement with: "The exact rates, however, are

unknown for several reasons. Cases are frequently unreported or not recognized." Since many laboratories are not equipped to routinely test for the whooping cough germ, "the infection may go undiagnosed....Infection in immunized persons may cause bronchitis but without typical whooping."

In one of the most important admissions in the entire document, the panel concludes, "Therefore, reports of pertussis obtained by The Center for Disease Control probably represent only a fraction of all pertussis infections occurring throughout the country."

How pure is the whooping cough vaccine? The panel stated, " In contrast to some other immunizing agents, such as diphtheria and tetanus toxoids, pertussis vaccine is a relatively crude preparation that contains the majority of the bacterial constituents, most of which are probably not relevant to the induction of immunity to the disease."

Complications of whooping cough vaccination

Has your doctor told you the kind of reactions which are due to the whooping cough vaccine? The panel described them as follows, "Significant reactions that have been attributed to pertussis vaccine have included high fever..., a transient shock-like episode, excessive screaming, somnolence, convulsions, encephalopathy, and extremely rarely, thrombocytopenia [deficiency of clotting elements in the blood]. Such reactions almost always appear within 24 to 48 hours after injection, but have been thought to occur after an interval as long as seven days."

How common are these complications? The panel first used the word "rare," but immediately thereafter confessed that the rates [of complications] are "difficult to define precisely at least in part because they are often not reported." The report further points out that vaccines of higher potency may produce more reactions.

Panel members admitted that the whooping cough vaccines pose a special problem since they "do not exhibit the effectiveness and safety which have been achieved with certain other immunizing agents." The report concedes that "without adequate surveillance of disease rates, the effectiveness of current vaccines and immunization programs cannot be monitored."

How long does immunity last? According the the panel, "Experience with modern pertussis immunization is not of sufficient duration to predict whether childhood immunization may in some instances postpone natural infection until a later age."

Should your child receive whooping cough vaccine before starting school? The panel stated, "...the usefulness of the currently recommended booster dose at school entrance has never been fully documented."

Having described the reactions to pertussis vaccine, the panel admitted that the ultimate significance, if any, in terms of permanent results of vaccine-induced somnolence, excessive screaming, and high fever is unknown. Without such knowledge, satisfactory recommendations for further immunizations when any of these reactions occurs cannot be made.

How often do complications occur? In the understatement of the decade, the panel says: "Physicians are expected to report complications of immunizations to manufacturers in the United States, but compliance with this expectation is less than optimum."

Occurrence of complications

The panel adds, "Many physicians are not cognizant of the importance of reporting untoward reactions or may be unaware of their clinical features. Further, both physicians and manufacturers have been held liable for damage suits by patients who may suffer adverse effects from established vaccines. All these factors undoubtedly discourage reporting; without maximum reporting or some other form of surveillance, definition of the rates and significance of untoward reactions to current and future vaccines cannot be ascertained."

More research needed

The panel next criticized the laboratory procedures used in the production and testing of pertussis vaccine. Not surprisingly, increased

public support for more research was recommended because "Without such basic studies, a more effective and safer pertussis vaccine cannot be developed." I suggest that all pertussis immunization be suspended while such research is being conducted on this obviously low-quality vaccine.

The panel actually recommends that "The vaccine label should warn that if shock, encephalopathic [brain damage] symptoms, convulsions, or thrombocytopenia [a clotting disorder] follow a vaccine injection, no additional injections with pertussis antigens should be given....The label should also include a cautionary statement about fever, excessive screaming, and somnolence." (Wouldn't it be wise to ask your doctor for a peek at the label the next time he tries to immunize your child?)

The panel's final recommendation is for legislation providing federal compensation for "the few individuals" injured and disabled by participating "in a meritorious" public health program. The panel members frankly admit, "Such legislation would protect manufacturers and physicians against liability...." Does everyone remember the swine flu vaccine? Its manufacturers did succeed in passing the buck of liability to the federal government so that you and I now are paying for the many cases of paralysis and other damage which resulted from that immunization--for a disease that never materialized.

The panel's criticism of other vaccines (typhoid; TAB vaccine, which is the now-discontinued typhoid-paratyphoid vaccine given to all members of the armed forces who served in World War II; cholera, plague) is required reading for anyone whose travel agent tells him he needs these shots to travel abroad.

Tumor-causing substances

On the very last page of its minutes, the government panel mentions its "careful note" of a report on the potential for oncogenic (tumor-producing) action of aluminum and oil adjuvants, substances which are added to increase the action of many vaccines: "There is little doubt that some of the material containing aluminum as adjuvant appears to be carcinogenic [cancer-producing] in a strain of Swiss mice.

"The panel is also investigating the possibility of retrospectively examining the human experience with the incidence of fibrosarcomas (malignant tumors of the connective tissue) at the usual sites of injections of vaccines."

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Another View

by Marian Tompson
Executive Director,
Alternative Birth Crisis Coalition



Philip, our youngest, is in high school now, so while we weren't personally involved in the dilemma facing parents of grammar-school children in our town, we could sympathize with them. The problem was immunization. Parents just weren't signing the consent forms, so finally the superintendent announced that, if a larger percentage of parents did not have their children inoculated, ALL children would have to be immunized in order to attend school. My first thought was, "Who will sacrifice their children to appease the Board of Education?"

Parents are having second thoughts about all immunizations. And it isn't happening just in the United States. Headlines from Europe show the same concern. Doctors are troubled because children are not being immunized. Parents are worried about possible reactions if they are immunized. To combat this reluctance, the American Academy of Pediatrics released a film, "A Gift, An Obligation," which stresses the importance of childhood immunizations. The fact that the film was produced with financial assistance from a drug company does, I think, strain some of its credibility. During a trip to India, I noticed that, in one town, there were posters everywhere urging parents to have their children immunized. When I asked my host why this city had been singled out for a campaign, he laughed, "It's because the vaccine is manufactured here."

When I was a child attending kindergarten in Illinois, there were no consent forms to sign. The doctor came to school, you got your shot, and your parents found out about it when you got home. Today, after 40 years of progress, the child still gets a shot, but the parents sign a paper agreeing not to sue if their child suffers complications.

This isn't so in California, where the state legislature passed a law--the first of its kind--which provides up to $15,000 for medical expenses for children who suffer catastrophic reactions (how bad is catastrophic?) to required immunizations. The fact that this law was enacted makes me feel that such reactions can't be all that rare!

But we need more than insurance. We need reliable, objective information. It was reported in the January 23, 1978 issue of the Journal of the American Medical Association that out of the 18 cases of paralytic polio and two deaths from polio reported in the United States in 1977, three of the victims had received polio vaccine, and ten had been in close contact with recently immunized people. This revelation only heightens suspicions that immunizations not only do not guarantee protection from disease, but might actually cause them.

Where do we find a health official or school official who will address our concerns, and acknowledge their validity? We want to protect the health of our children, but we want to do it safely and sensibly. Researchers tell us that it soon may be possible to immunize babies against disease before they are even born by inoculating the pregnant mother. Is this good news, or should it be making us just a little more uneasy?

"MalePractice: How Doctors Manipulate Women," Dr. Mendelsohn's latest book, is now available in paperback from Contemporary Books ($6.95).

"Confessions of a Medical Heretic" is available from WarnerBook. ($3.25).

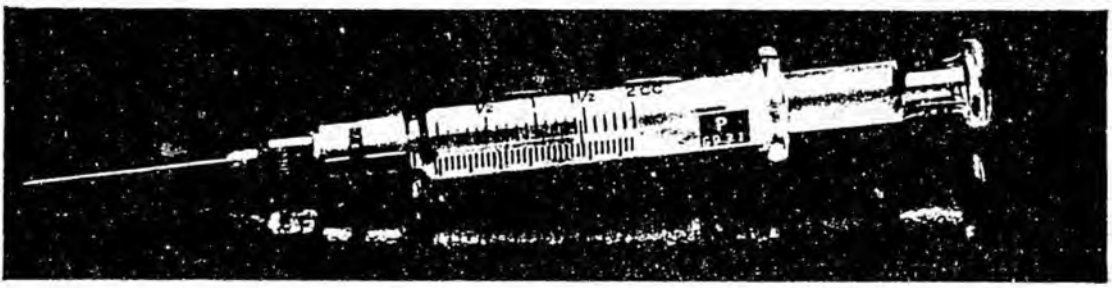
The People's Doctor Newsletter
P.O. Box 982
Evanston, Illinois 60204

Published monthly. Subscription rate: $24.00 annually.
Robert S. Mendelsohn, MD, Editor
Vera Chatz, Associate Editor

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DPT

A SHOT IN THE DARK



HARRIS L. COULTER
AND BARBARA LOE FISHER

imaged child drew a parallel to what
he spoke of her son, who cannot speak.
t it could have been avoided. I thought
ive him that shot. If I had known about
option, I might have taken my chances
't know. But I do know that God gave
happy when he was born. He was so
n fingers. God gave me a perfect child
imaged God's perfect work."

about—parents grieving for their chil-
ew are broken, many with futures too
rs, we miraculously conceive our babies
while we eat the right foods and read
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our child. As mothers, we breastfeed to
life, and we sit up nights rocking them
parents, we work long hours and make
their future secure.

e to our children. They are part of
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ot risk for them. They are our children.
ildren. We fight with all our strength
from harm. The time has come to edu-

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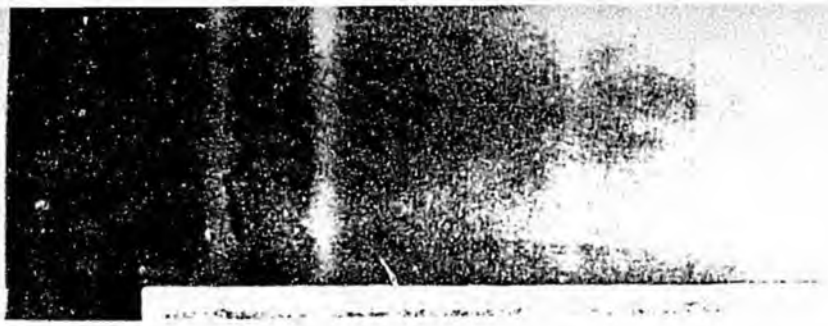
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