ALASKA LEGISLATURE COMMITTEE FILES 1987-1988 8672
4546 HHES HB 277 (FILE 2)

118

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
35918 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 <u>acute</u> 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.).

(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/cm

CORRECTION

THIS DOCUMENT
HAS BEEN REPHOTOGRAPHED
TO ASSURE LEGIBILITY

(1)

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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)

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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.

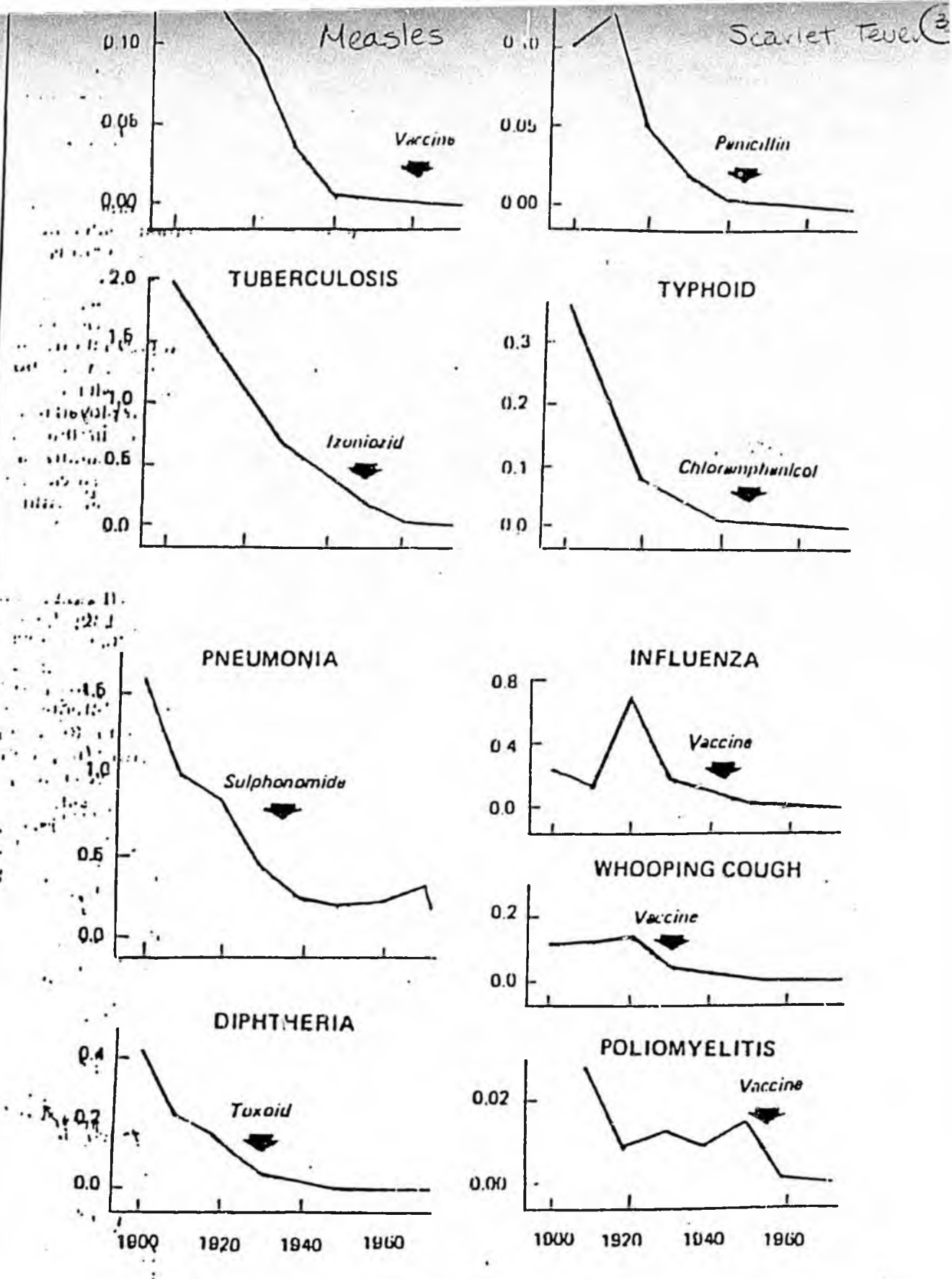
However, two of the scientists whose papers were cited by Rifkin expressed doubt in interviews that the cattle viruses played any role in causing AIDS.

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).

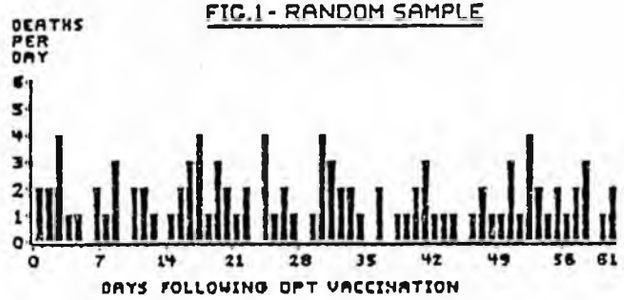
Physicians for Study of Pertussis Vaccines found evidence in documents received from the USPHS(CDC) that indicate 1 in 15,000 children are permanently damaged, and 1 in 35,000 die from DPT. PSPV has called the current "P" a "brain poison," and is calling for emergency efforts toward a safer vaccine.

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.

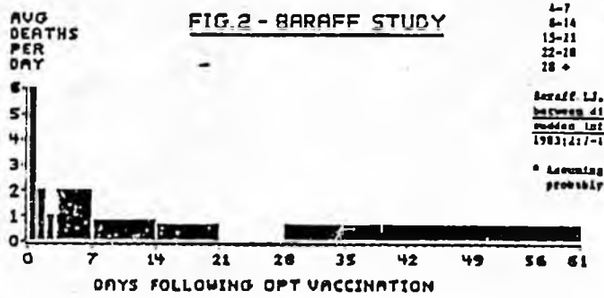


FIG.2 - BARAFF STUDY

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.

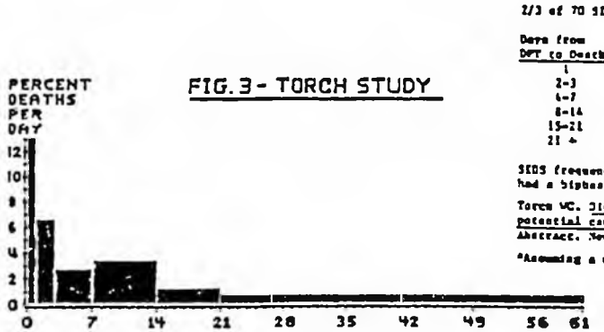


FIG.3 - TORCH STUDY

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:

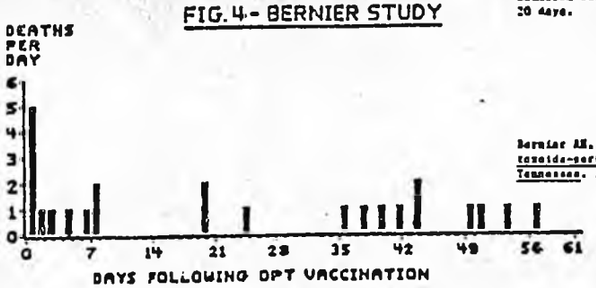
RECOGNIZED SEVERE REACTIONS (by CDC, AAP, and/or vaccine manufacturers):

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

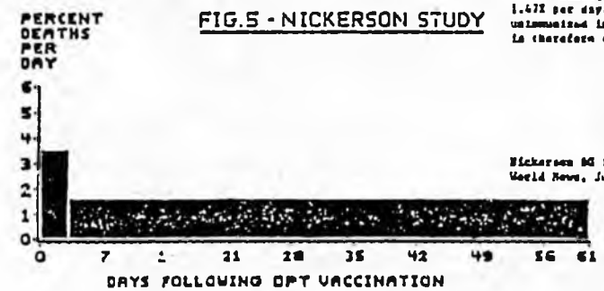
33 of 35 SIDS victims had received DPT; the number of deaths as shown were recorded on a per day basis. An additional 9 deaths occurred between 61 and 240 days, or on the average 1 every 20 days.



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?

d

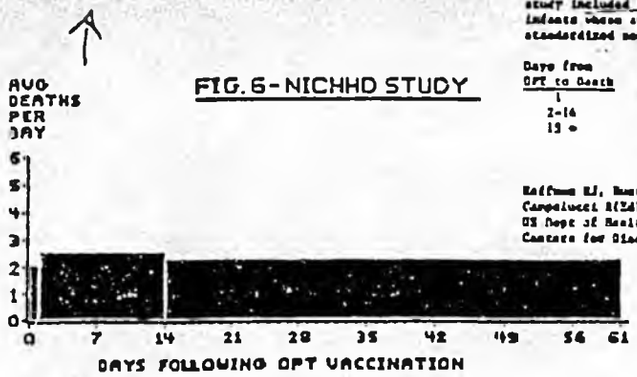


FIG. 6 - NICHHD STUDY

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

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.

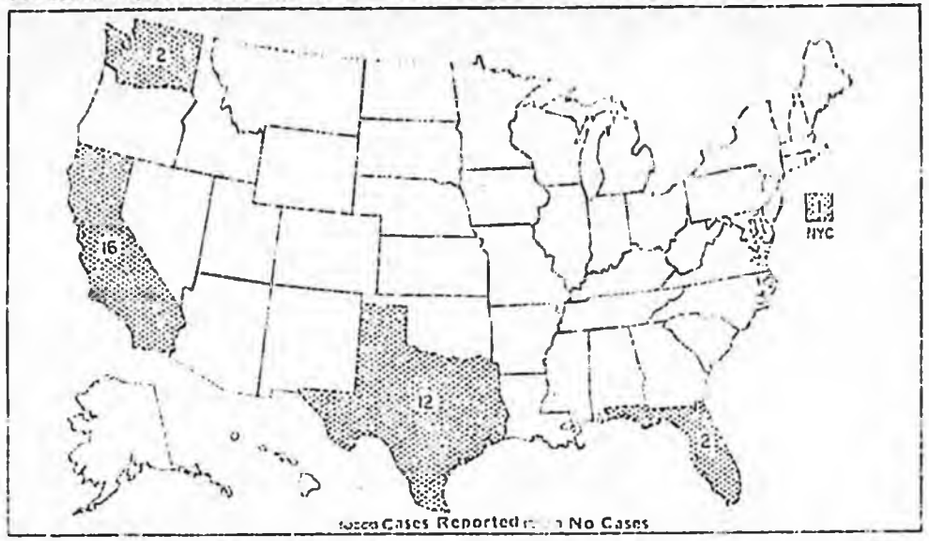
Our eighth baby was a little girl. A cold was clearing up when she got her first DPT at 3 months. She reacted with limpness and terrible screaming, and was found dead 4 hours after DPT. The coroner ruled SIDS.

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



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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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CENTERS FOR DISEASE CONTROL

MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT

January 10, 1986 / Vol. 35 / No. 1

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

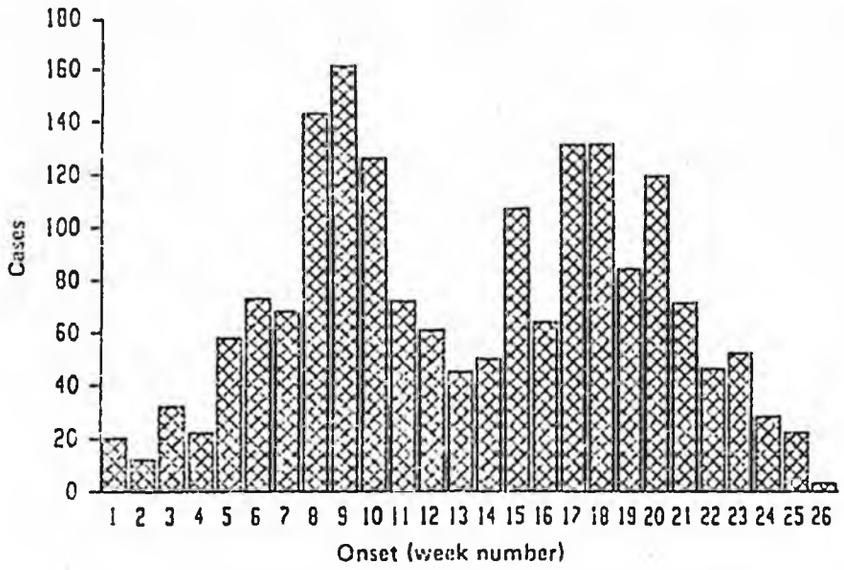

TABLE 1. Age distribution and estimated incidence rates of measles — United States, first 26 weeks, 1984 and 1985*

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.

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STATE OF ALASKA
OFFICE OF THE GOVERNOR
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	▨	▨	▨
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	▨	▨	

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

DIVISION OF PUBLIC HEALTH
SECTION OF COMMUNICABLE DISEASE CONTROL

3601 "C" STREET, SUITE 576
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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.

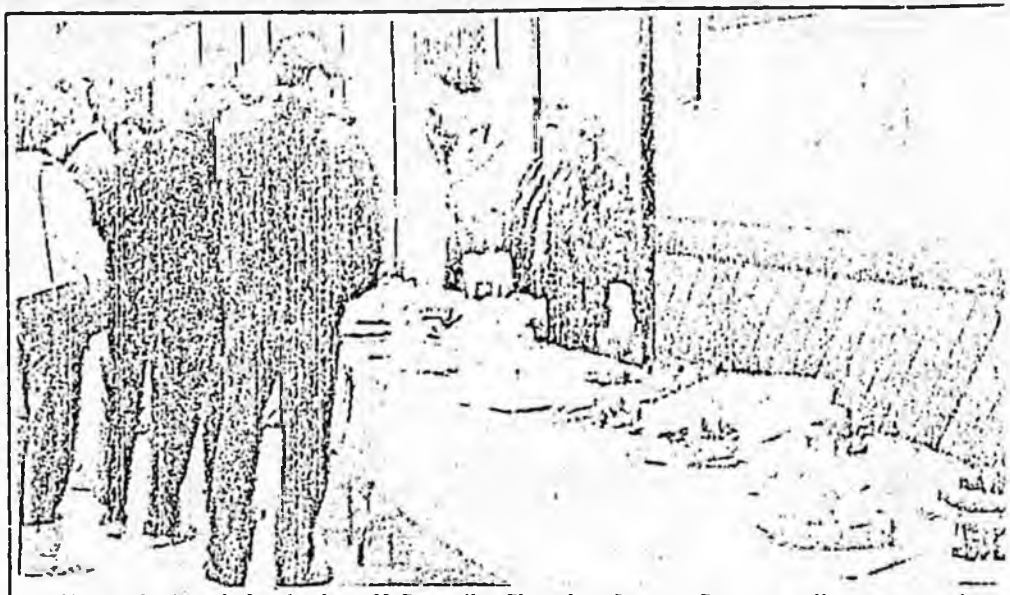
He acknowledges that the reaction reporting system hasn't been effective in the past, and that many parents may not have associated illnesses occurring after a vaccination as related to the vaccine. "I have no doubt that the adverse reactions were under-reported," Klatt said.

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

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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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CENTERS FOR DISEASE CONTROL

MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT

January 10, 1986 / Vol. 35 / No. 1

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.

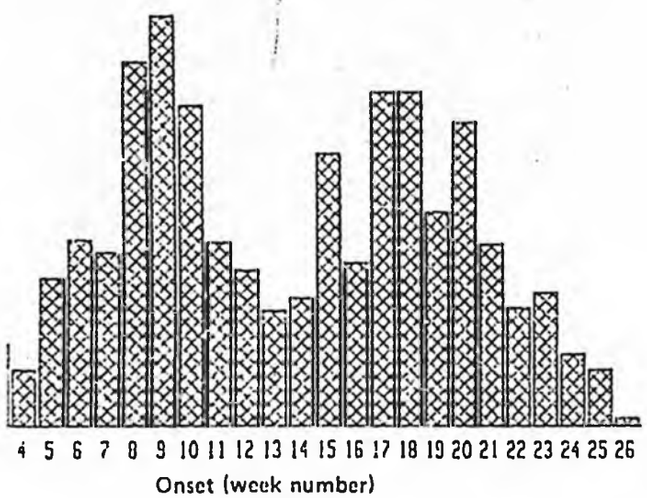
Seventy cases (3.9%) were international importations. An additional 128 (7.1%) cases

*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.