1-1

No evidence face masks protected vulnerable from Covid, health officials admit

Joe Pinkstone, April 12, 2023

Critics say authorities are failing to prepare for any future pandemics by not examining the effectiveness of masks

There is not enough evidence to suggest medical-grade face masks protect vulnerable people from Covid, health officials have admitted.

A rapid review report published by the UK Health Security Agency (UKHSA) investigated if high-quality masks, such as the N95, KN95 and FFP2 coverings, protect clinically vulnerable people in the community from catching Covid.

However, the report was unable to find a single piece of scientific research which had usable data.

"The review did not identify any studies for inclusion, and so could provide no evidence to answer the research question," the authors state. "No studies matching the inclusion criteria were found, so no evidence could be presented."

The rapid review looked at 4,371 studies specifically about Covid but there were none that examined the effectiveness of N95 and equivalent face masks as wearer protection against Covid-19 when used in the community by people at higher risk of becoming seriously ill.

The government scientists collected data up until September 2022 and the at-risk groups included people with Down's Syndrome, some cancer patients and people with immune system disorders.

Contentious debate

Throughout the pandemic there has been a contentious debate about the pros and cons of wearing face coverings among scientists with little decisive evidence either way.

Various studies have purportedly shown masks to reduce transmission and disease, while others have shown them to be ineffective.

Some vocal academics entrenched in scientific politicking have vociferously defended their own position for the last three years while other scientists calling for more research have often been met with criticism.

Now, health officials are struggling with a lack of data which experts warn leave us just as in the dark now as we were three years ago about whether masks work or not.

Prof Carl Heneghan, professor of evidence-based medicine at the University of Oxford, told The Telegraph it is "a significant failing" that there has not been high quality trials done on the effectiveness of masks.

"I do not understand why there's been a lack of will to do high quality trials in this area," he said. "We have completely failed to address this issue and I actually consider that to be an issue that the [Covid] inquiry needs to look at.

1-2

"For those people at low risk these questions don't necessarily matter too much, but if you're at high risk, you really want this question to be addressed. You want to know the answer."

He added that the scientific field's inability to conduct good clinical trials that gather robust data leaves us exposed and at risk of making the same mistakes in the next pandemic as we did in the last one.

"If there's another pandemic around the corner, we still haven't addressed any of these issues. We've not learned anything," Prof Heneghan said.

A previous UKHSA which was wider in scope concluded that all types of face coverings are effective in reducing transmission of SARS-CoV-2 to some extent in both healthcare and community settings. In this review it was noted that N95 respirators are likely to be the most effective.

However, a Cochrane review published last month found insufficient evidence to inform on the effectiveness of masks. It is impossible to say if masks work or not, because there is not enough good data, the review found.

Prof Paul Hunter, Professor in Medicine at the Norwich School of Medicine, led a study at the end of 2020 looking at how effective masks were and used data on flu, as well as other viruses.

"Masks did reduce risk of transmission by about 20 per cent and in the early days of the pandemic that was really important," Prof Hunter told The Telegraph. "But they were never the cast-iron guarantee that some people seem to have been saying. However, since the appearance of omicron masks no longer provide much if any value.

"The exception is people who remain particularly vulnerable to severe disease as there is some evidence that if you catch Covid whilst wearing a mask you generally get a less severe infection.

'No good evidence'

"In my view there is no good evidence that N95 masks work any better than surgical masks."

Dr Aodhán Breathnach, a Consultant Global Health Microbiologist at UKHSA and a Consultant Medical Microbiologist at St George's University Hospitals, recently published a study which found masks in hospitals had little impact on Covid transmission in the omicron wave.

He told The Telegraph that conducting randomised clinical trials for mask wearing would be very difficult to do in practice.

"It is maybe surprising that there is no conclusive evidence one way or another [as to whether masks work], given that SARS-CoV-2 is perhaps the most studied virus ever, and masking was always a debated topic," Dr Breathnach said.

"Nonetheless, the fact that the studies that do exist (including our own late addition) fail to show convincing evidence of benefit from masking suggests that, if there is a benefit, it is a rather modest one, i.e. masks may reduce the risk slightly but do not guarantee you won't get infected."

2-1

Explosive New Study Finds Face Masks May Increase Stillbirths, Testicular Dysfunction, Cognitive Decline IN KIDS

24 April, 2023 Steve Watson

Research finds that face coverings can cause carbon dioxide poisoning, leading to serious health issues

A new study by German researchers has concluded that face masks can cause carbon dioxide poisoning when worn even for short periods and may have contributed significantly to stillbirths when worn by pregnant women, as well as testicular dysfunction and cognitive decline in children, among other destructive health issues.

As reported by the Daily Mail, the research, published in the journal Heliyon, comprises a review of 43 previously published studies on exposure to CO2, mask-wearing, and pregnancy.

The study notes that even short-term exposure to concentrations of CO2 as low as 0.3% caused brain damage, increased anxiety, and impaired memory in both pregnant rats and young mice in one study.

In another, when male mice were exposed to 2.5 percent CO2 for four hours, testicular cells and sperm were destroyed. The equivalent amount for humans would be 0.5 percent of CO2 over the same time period.

Yet another experiment discovered that stillbirth and birth defects occurred in pregnant rats that were exposed to just 3 percent CO2, which would be equal to 0.8 percent for humans.

The study also points to research that found just five minutes of mask wearing resulted in CO2 levels increasing to between 1.4 percent and 3.2 percent.

While they note that the review provides 'circumstantial evidence' only, the researchers allude to a surge in stillbirths during the pandemic, saying that masks could have contributed.
Swedish researchers previously found that the stillbirth rate increased from seven per 1000 births to 21 per 1000 births after the pandemic, while a leading UK hospital saw a four-fold increase in its stillbirth rate.

"Circumstantial evidence exists that popular mask use may be related to current observations of a **significant rise of 28 percent to 33 percent in stillbirths worldwide,**" the German researchers asserted.

They also note that research indicates "reduced verbal, motor, and overall cognitive performance of two full standard deviations in scores in children born during the pandemic."

Dr Kevin Bass, cell and molecular biology PhD, has a detailed thread on the study, which can be linked through to below:

The findings dovetail with a report published by the UK Health Security Agency (UKHSA) that concluded "no evidence could be presented" to prove medical-grade face masks protected vulnerable people from COVID at all.

Study Finds "No Evidence" Face Masks Protect Vulnerable Against COVID
Scores of studies have come to the same conclusion, yet people are still wearing masks despite all of this, some schools are still forcing children to wear masks, and some airlines and travel companies are still enforcing mask wearing.

It's been common knowledge since the very start of the pandemic that masks do practically nothing. Those who resisted, even doctors, were punished and banned from publicly voicing their concerns.

This goes hand in hand with the massively harmful lockdowns.
When will enough be enough?

3-1

Masks Had No Effect On COVID Cases Among Children: Study

APR 29, 2023

Naveen Athrappully via The Epoch Times

The imposition of mask mandates among school children during the pandemic did not affect the incidence of COVID-19 infection, according to research conducted in Finland.

The study, published in the journal BMC Public Health on April 21, was conducted in three Finnish cities—Helsinki, Turku, and Tampere. These cities had similar baseline incidences of COVID-19 between August and September 2021. At the time, the federal government had recommended using masks in schools for children aged 12 years and above. In Helsinki and Tampere, the national recommendation was imposed as mandates at schools while in Turku, the mandate was levied on kids aged 10 and above.

The research team looked at the effects of masks on two groups of children—those between seven and nine years and those between 10 and 12. While the seven to 10-year-olds were not subject to mask mandates, 10-12 years olds had to wear masks.

*"**According to our analysis, no additional effect was gained from mandating masks**, based on comparisons between the cities and between the age groups of the unvaccinated children (10–12 years versus 7–9 years)," the study said.*

*"**Face mask recommendations in schools did not reduce COVID-19 incidence among 10–12-year-olds in Finland**. This may indicate that COVID-19 cases in schools merely reflect community infections than school outbreaks*

Ineffective Masks

The Finnish study cited Spanish research on mask mandates in schools which found that masking was not associated with lower COVID-19 incidence or transmission. The transmission risk in schools was found to be lower than in households.

It also cited a late 2022 study from the United States which found that lifting mask requirements was associated with an increase in COVID-19 cases among students and staff.

"However, this study aggregated data from all age groups, making it difficult to determine how the effects of mask recommendations might vary by age," the Finnish study stated.

Multiple other studies have also suggested that masks may be ineffective when it comes to controlling COVID-19.

On April 13, the UK Health Security Agency (UKHSA) said that **it could not find evidence as to whether N95 or similar medical-grade masks protect clinically vulnerable people from getting seriously ill from the disease.**

A review by the UKHSA of thousands of primary studies about the effectiveness of face coverings could not find anything on whether wearing N75 or similar respirators could protect people or not. This is quite significant given that N95 respirators are considered to be very efficient in filtering airborne particles.

Mask Harms

In addition to being ineffective, wearing masks also turns out to be harmful. A systematic review of 2,168 studies that looked at the adverse effects of wearing masks during COVID-19 found that many people suffered from health consequences like headaches and itching as a result.

*Read more **here**...*

4-1

Unravelling the role of the mandatory use of face covering masks for the control of SARS-CoV-2 in schools: a quasi-experimental study nested in a population-based cohort in Catalonia (Spain)

British Medical Journal August 23, 2022

Ermengol Coma, Martí Català, Leonardo Méndez-Boo, Sergio Alonso, Eduardo Hermosilla, Enric Alvarez-Lacalle, David Pino, Manuel Medina, Laia Asso, Anna Gatell, Quique Bassat, Ariadna Mas, Antoni Soriano-Arandes, Francesc Fina Avilés, Clara Prats

Abstract

Objective To assess the effectiveness of mandatory use of face covering masks (FCMs) in schools during the first term of the 2021–2022 academic year.

Design A retrospective population-based study.

Setting Schools in Catalonia (Spain).

Population 599 314 children aged 3–11 years attending preschool (3–5 years, without FCM mandate) and primary education (6–11 years, with FCM mandate).

Study period From 13 September to 22 December 2021 (before Omicron variant).

Interventions A quasi-experimental comparison between children in the last grade of preschool (5 years old), as a control group, and children in year 1 of primary education (6 years old), as an interventional group.

Main outcome measures Incidence of SARS-CoV-2, secondary attack rates (SARs) and effective reproductive number (R*).

Results SARS-CoV-2 incidence was significantly lower in preschool than in primary education, and an increasing trend with age was observed. Six-year-old children showed higher incidence than 5 year olds (3.54% vs 3.1%; OR 1.15 (95% CI 1.08 to 1.22)) and slightly lower but not statistically significant SAR (4.36% vs 4.59%; incidence risk ratio 0.96 (95% CI 0.82 to 1.11)) and R* (0.9 vs 0.93; OR 0.96 (95% CI 0.87 to 1.09)). Results remained consistent using a regression discontinuity design and linear regression extrapolation approaches.

Conclusions We found no significant differences in SARS-CoV-2 transmission due to FCM mandates in Catalonian schools. Instead, age was the most important factor in explaining the transmission risk for children attending school.

Full document:

https://adc.bmj.com/content/archdischild/108/2/131.full.pdf

5-1

Australian COVID-19 pandemic: A Bradford Hill analysis of iatrogenic excess mortality

Wilson Sy Preprint February 2023

Abstract Australian official mortality data show no clear evidence of significant excess deaths in 2020, implying from an older WHO definition that there was no COVID-19 pandemic. A seasonality analysis suggests that COVID-19 deaths in 2020 were likely misclassifications of influenza and pneumonia deaths. Australian excess mortality became significant only since 2021 when the level was high enough to justify calling a pandemic. Significant excess mortality was strongly correlated (+74%) with COVID-19 mass injections five months earlier. Strength of correlation, consistency, specificity, temporality, and dose-response relationship are foremost Bradford Hill criteria which are satisfied by the data to suggest the iatrogenesis of the Australian pandemic, where excess deaths were largely caused by COVID-19 injections. Therefore, a strong case has been presented for the iatrogenic origins of the Australian COVID-19 pandemic and therefore, the associated mortality risk/benefit ratio for COVID injections is very high. 1. Introduction On 11 March 2020, the World Health Organization (WHO) declared [1] the COVID-19 pandemic based on 4,291 deaths, by 118,000 cases in 114 countries, with an average of about 1,000 cases in each country. Based on this very small sample, the WHO assumed that the COVID-19 disease is highly infectious and has an infection fatality rate (IFR) of at least 0.4 percent. Therefore, the COVID-19 pandemic was declared based on expectation and not on fact, as the WHO had previously defined for an influenza pandemic [2]: An influenza pandemic occurs when a new influenza virus appears against which the human population has no immunity, resulting in several, simultaneous epidemics worldwide with enormous numbers of deaths and illness. Emphasis added. A pandemic should be justifiably declared only if there are "enormous numbers of deaths", for otherwise seasonal influenza or even the common cold of the Rhinovirus could be declared as pandemics, i.e., just based on numbers of cases of infection. By now, it is abundantly clear that the number of cases defined by the PCR tests may be grossly inflated (see section 2). By assuming "cases" would lead to "enormous deaths", the WHO declared a pandemic based on supposition, not on scientific fact. The presumption of sound science by governments has *Revised 27 March 2023, PhD, Director, Biotechnology Unit, Investment Analytics Research. Lex Stewart and Jeremy Beck are thanked for useful comments. The author has no financial or political conflicts of interest and is not funded by external sources. Paper to appear in the Journal of Clinical and Experimental Immunology.

10.Conclusion

Australian health policy has been based on misinformation from flawed COVID-19 data which are scientifically unsound. Based on sound mortality data, the Australian COVID-19 pandemic did not begin until the advent of mass mRNA injections in 2021. It is ironic that mass injections which were introduced to mitigate a non-existent pandemic, created a real iatrogenic pandemic. This study, backed by a Bradford Hill analysis, has shown that more injections administered to reduce the pandemic, had the opposite effect of causing more excess deaths to increase the pandemic. The very large excess deaths observed from the data imply that the mortality risk/benefit ratio from COVID injections is very high. That is, the harm or risk realized has far outweighed any benefit from COVID injections. This study has introduced a very simple, but robust, methodology, which should be used by other countries, particularly those in Figure 10 which appear to have adequate data, to replicate and investigate the likely iatrogenic origins of their own pandemics. Billions of lives in the world are at stake from the potential findings of the research.

Full 23 page document:
file:///C:/Users/mibro/Downloads/AustralianIatrogenicCOVIDPandemicRevisedFinal.pdf

6-1

ISSN: 2475-6296

Review Article

Journal of Clinical & Experimental Immunology

COVID-19 vaccines – An Australian Review

Conny Turni[1] and Astrid Lefringhausen[2]

[1]*Queensland Alliance for Agriculture and Food Innovation, the University of Queensland, St Lucia, Queensland 4067, Australia.*

[2]*Albany Creek, Queensland 4035*

Corresponding author
Conny Turni, Queensland Alliance for Agriculture and Food Innovation, the University of Queensland, St Lucia, Queensland 4067, Australia.

Submitted: 10 Sep 2022; **Accepted**: 12 Sep 2022; **Published**: 21 Sep 2022

Citation: *Conny Turni and Astrid Lefringhausen (2022) COVID-19 vaccines – An Australian Review. Journal of Clinical & Experimental Immunology. 7(3):491-508.*

Abstract

After millions of people have been vaccinated as often as four times within a year, the effects of these vaccinations are slowly becoming apparent. This review has been written from an Australian perspective with the main focus on the COVID-19 mRNA vaccines. We will look at the promises/predictions originally made and the actual facts. We will evaluate the safety and efficacy by looking at the literature and the data from government agencies. The literature review will be summed up in a table listing the so far reported side effects of which many are very serious including death, with this data coming from 1011 case reports. Long term side effects will also be covered and the risk benefit ratio will be explored. The review is ending with some very critical question that need further discussion.

Introduction

This review is written from an Australian perspective and will concentrate on the COVID-19 mRNA vaccines. In Australia the COVID vaccination is still heavily promoted. Until April 2022 only the mRNA vaccines Comirnaty (Pfizer) and Spikevax (Moderna), as well as the vector vaccines Vaxzevria (AstraZeneca) and COVID-19 Vaccine Janssen (Janssen) were preliminarily registered for use. Every one of these vaccines forces the vaccinees body to produce the spike protein for which the genetic code is delivered into the cells as mRNA via a nanoparticle or as double stranded DNA via a viral vector. (https://www.tga.gov.au/international-covid-19-vaccines-recognised-australia).

In April 2022 yet another vaccine, Nuvaxovid (Biocelect on behalf of Novavax, based on a new concept) received preliminary approval in Australian. Nuvaxoid contains a modified spike derived from moth cells cultured after transfection using Baculovirus, which express the spike protein on their cell membrane. This spike protein is harvested and assembled onto a synthetic lipid nanoparticle, which displays 14 spike proteins each. (https://www.precisionvaccinations.com/vaccines/novavax-covid-19-vaccine). The vaccine is registered for 18 years of age and older.

The government continues to push particularly the mRNA vaccinations by encouraging a fourth vaccination and recommending the vaccine for pregnant women as well as children 5 to 11 years old. The official public message is that the mRNA vaccines are safe. However, the Therapeutic Goods Administration (TGA), the medicine and therapeutic regulatory agency of the Australian Government, states quite clearly on their website that the large-scale trials are still progressing and no full data package has been received from any company. The TGA is currently getting rolling data and safety and effectiveness are still being assessed (https://www.tga.gov.au/covid-19-vaccines-undergoing-evaluation).

Initial information

The mRNA vaccines were supposed to remain at the injection site and be taken up by the lymphatic system. This assumption proved to be wrong. During an autopsy of a vaccinated person that had died after mRNA vaccination it was found that the vaccine disperses rapidly from the injection site and can be found in nearly all parts of the body [1]. The mRNA is enveloped in liquid nano particles (LNP) containing a mixture of phospholipids, cholesterol, PEGylated lipids and cationic or ionizable lipids [2]. Research has shown that such nanoparticles can cross the blood-brain barrier [3] and the blood-placenta barrier [4], so it came as no surprise that the European Medicines Agency assessment report for the Moderna vaccine on page 47 (https://www.ema.europa.eu/en/documents/assessment-report/spikevax-previously-covid-19-vaccine-moderna-epar-public-assessment-report_en.pdf) also noted that mRNA could be detected in the brain following intramuscular administration at about 2% of the level found in plasma. In 2021 researchers from Japan reported a disproportionately high mortality due to cerebral venous sinus thrombosis and intracranial haemorrhage. Despite not being able to prove a causal link with vaccines, as no autopsies were performed, they still believed that a link with vaccination is possible and further analysis is warranted [5].

It was furthermore stated that the mRNA will degrade quickly. Normally, mRNA breaks down within a few minutes to hours, however, the mRNA in these vaccines is nucleoside-modified to reduce potential innate immune recognition [6, 7] and it has been shown that production of the spike protein in some vaccines is kept up for an extraordinarily long time. A study by Röltgen et al. [8] found that the vaccine mRNA persists in the body up to 60 days, with 60 days being the end point of their study. It is thus unknown and impossible to define how much of the spike protein is actually produced in the vaccinated. It is a standard requirement for vaccine producers to define the amount of antigen in each injection. For a "so called "vaccine that is using the human body as the production facility there is no possible quantification of antigen. This is highly variable and dependant on the amount and stability of nanoparticles in the injection, age and fitness of the vaccinee, their immune status and the injection technique – if a blood vessel is directly injected, the nanoparticles will travel in minutes to all major organs including the brain. It is therefore impossible to assess how much spike protein any individual vaccinee produces following an inoculation. In summary, it is unknown where exactly the vaccine travels once it is injected, and how much spike protein is produced in which (and how many) cells.

Prominent cardiologist Dr Peter McCullough stated that the spike protein - a cytotoxin solely responsible for the severity of the respiratory infection - makes the use of it as immunizing agent dangerous. The spike protein in itself can produce COVID- 19 symptoms as shown in animal experiments. The S1 subunit of the SARS-CoV-2 spike protein when injected into transgenic mice overexpressing human ACE-2 caused a COVID-19 like response (a decline in body weight, dramatically increased white blood cells and protein concentrations in bronchoalveolar lavage fluid (BALF), upregulation of multiple inflammatory cytokines in BALF and serum, histological evidence of lung injury, and activation of signal transducer and activator of transcription 3 (STAT3) and nuclear factor kappa-light-chain-enhancer of activated B cells (NF-κB) pathways in the lung [9].

It was further shown that the spike protein S1 subunit, when added to red blood cells in vitro, could induce clotting by binding fibrinogen and ACE2 on platelets, thus triggering their aggregation [10]. The S protein also increases human cell syncytium formation, removes lipids from model membranes and interferes with the capacity of high-density lipoprotein to exchange lipids [11, 12]. Another in silico study showed that the spike protein S2 subunit specifically interacts with BRCA-1/2 and 53BP1 [13]. BRCA-1 is frequently mutated in breast cancer in women and prostate cancer in men, while 53BP1 is a well-established tumor suppressor protein.

A paper published by Liu et al. conducted single-cell mRNA sequencing of peripheral blood mononuclear cells (PBMCs) harvested from patients before and 28 days after the first injection of a COVID-19 vaccine [14]. While this vaccine was based on an attenuated virus and not a mRNA vaccine, it also is injected directly into the deltoid muscle, bypassing the mucosal and vascular barriers.

The authors found consistent alteration of gene expression following vaccination in many different immune cell types. One housekeeping gene of high importance is RNA polymerase I (POL I) which transcribes ribosomal DNA into RNA and monitors rDNA integrity in the process. Many of the downregulated genes identified by Liu et al. (2021) were linked to the cell cycle, telomere maintenance, and both promoter opening and transcription of POL I, indicative of impaired DNA repair processes [14].

Seneff et al (2022) describe another mechanism by which the mRNA vaccines could interfere with DNA repair [15]. The microRNA miR-148 has been shown to downregulate homologous recombination in the G1 phase of the cell cycle. MiR-148 is one of two microRNAs found in exosomes released by human cells following SARS-CoV-2 spike protein synthesis in the experiments by Mishra and Banerjea [16].

Natural immunity ignored

It is an amazing fact that natural immunity is completely disregarded by health authorities around the world. We know from SARS-CoV-1 that natural immunity is durable and persists for at least 12-17 years [17]. Immunologists have suggested that immunity to SARS-Cov-2 is no different. The human population has encountered and co-existed with a great number of coronaviruses throughout evolution. Most of us have cross-reacting T-cells, B cells and antibodies derived from encounters with common cold coronaviruses that can recognise SARS-CoV-2 [18-20]. A survey of more than 100 immunologists, infectious-disease researchers and virologists working on the coronavirus, who were asked whether the virus could be eradicated, showed that almost 90% of respondents believe that the coronavirus will become endemic [21]. The four human coronaviruses that cause common colds are also endemic, without there ever having been a vaccine for any of them. The existence of related viruses might explain that approximately 40% to 45% of COVID infected people are asymptomatic and about 80% of COVID cases are mild infections. In some cohorts, the asymptomatic infection figure jumps as high as 96% depending on the age and cross-immunity imparted by other viruses such as beta coronaviruses HCoV-OC43 and HCoV-HKU1, which have been proposed as a mitigating factor in the spread of SARS-CoV-2 [22-23].

The Brownstone institute has established the most updated and comprehensive library list of 150 of the highest-quality, complete, and robust scientific studies and evidence reports/position statements on natural immunity as compared to the COVID-19 vaccine-induced immunity. The consensus of these studies is that immunity induced by COVID infection is robust and long lasting (https://brownstone.org/articles/79-research-studies-affirm-naturally-acquired-immunity-to-covid-19-documented-linked-and-quoted/).

(AstraZeneca) and coronary myocarditis (Pfizer).

Pregnancy and Vaccination

Some concerns about vaccinating pregnant women were voiced by Anand and Stahel [83]. Walsh et al. [89]. reported that the results of the Pfizer vaccine demonstrate a broad immune response to vaccination with stimulation of neutralizing antibody responses, stimulation of CD4+ cells and growth of effector memory CD8+T cells in men and women. Anand and Stahel [83] hypothesised that one could assume this would also happen in pregnant women. This would not be favourable for a perinatal outcome and might lead to preterm birth and fetal loss, as a good outcome relies on amplifcation of helper T cell type 2 and regulatory T cell activity coupled with decreased Th1 response [90]. Evidence has suggested that mothers with variant CD4+ T cell responses give birth to babies that may suffer enduring adverse consequences [91].

Side Effects Acknowledged but Played Down as Extremely Small Risk

The TGA report in Australia on a weekly basis and the report of the 2nd of September 2021 mentioned nine more blood clots and low platelet counts, confirmed as probably Thrombocytopenia syndrome linked to the AstraZeneca vaccine with two connected deaths during that week, one from Queensland and one from NSW. An assessment of the 125 cases of thrombosis with thrombocytopenia syndrome (TTS) showed that women in the younger age groups were slightly more likely to develop TTS in more unusual places such as brain and abdomen with more serious outcomes projected (TGA).

Another rare side effect is Guillian-Barre syndrome (GBS), which affects the nerves. Up to the 29 August 99 reports of GBS after vaccination have been received. Further 61 reports of immune thrombocytopenia were lodged after AstraZeneca vaccination. For the Pfzer vaccine the TGA reports 293 instances of suspected myocarditis and/or pericarditis following vaccination to the 29 August 2021. Nine of these reports were from children 16 to 17 years of age. A study concluded that observations of increased thrombosis, cardiomyopathy and other vascular events following vaccination might be caused by the mRNA vaccines dramatically increasing inflammation of the endothelium and T cell infiltration of cardiac muscle [92].

Whistleblowers

At a parliament enquiry by US senator Ron Johnson lawyer Thomas Renz presented three US military doctors, Drs. Samuel Sigoloff, Peter Chambers, and Theresa Long, whose declarations he planned to use in federal court under penalty of perjury. These doctors revealed a 300% increase in miscarriages in the military above the five-year average in 2021 with the five-year average being 1,499 miscarriages per year while in the first 10 months of 2021 the registered miscarriages were 4,182. Other diseases went up in a similar fashion such as an almost 300% increase in cancer diagnoses (from a five-year average of 38,700 per year to 114,645 in the first 11 months of 2021). Neurological issues increased by 1000% from a baseline average of 82,000 to 863,000 in 2021. Some other increased conditions were:

- 269% increase of myocardial infarction
- 291% increase of Bell's palsy
- 156% increase of children's congenital malformations of military personnel
- 471% increase of female infertility
- 467% increase of pulmonary embolisms

https://newlifenarrabri.wordpress.com/2022/02/01/jo-nova-huge-spike-in-us-military-injuries-from-covid-vaccinations/ and https://www.ronjohnson.senate.gov/2022/2/sen-johnson-to-secretary-austin-has-dod-seen-an-increase-in-medical-diagnoses-among-military-personnel

According to an interview in February 2022 with Julian Gillespie, who is currently fighting in court against the vaccine mandates, an evaluation of the TGA reports revealed that Australia's average of adverse events after vaccination since 1971 up to 2020 is recorded as 2.4 death per year and up to 3,500 adverse events per annum. Since the rollout of the COVID vaccines there have been 755 deaths and 105,000 adverse events in a year with these figures likely to be underreported. https://rumble.com/vtv5pe-julian-gillespie-update-on-avn-judicial-review-to-stop-vaccines-in-australi.html?fbclid=IwAR34RTAAYX_nf9eTe1LOJSxuZ0-TbUFasXPQ37qhPEqrQI9wNe8Yig4ZwQ8

The question is how many deaths and side effects are we accepting as normal for vaccines and where do we draw the line to say more investigations need to be done before any further vaccines are distributed?

Conclusion

Never in Vaccine history have 57 leading scientists and policy experts released a report questioning the safety and efficacy of a vaccine [93]. They not only questioned the safety of the current Covid-19 injections, but were calling for an immediate end to all vaccination. Many doctors and scientists around the world have voiced similar misgivings and warned of consequences due to long-term side effects. Yet there is no discussion or even mention of studies that do not follow the narrative on safety and efficacy of Covid-19 vaccination.

In the USA, as Blaylock [94] states it very nicely, federal bureaucrats have forced the acceptance of special forms of care and prevention, which includes experimental mRNA vaccines [93]. Medical experts that have questioned the safety of these vaccines have been attacked and demonised, called conspiracy theorists and have been threatened to be de-registered if they go against the narrative. Alternative treatments were prohibited and people who never practised medicine are telling experienced doctors how to do their job. AHPRA is doing the same here in Australia to the detriment and in ignorance of science. When Adjunct Professor John Skerritt, who is currently the Deputy Secretary and directly responsibility for both the Therapeutic Goods Administration and the Office of Drug Control, was asked why the registration process for vaccines was shortened he wrote: "It is nonsense to assert that vaccines typically take 10 years to licence. The standard regulatory process for vaccines is about 10-12 calendar

months and in the case of COVID-19 vaccines this period was shortened by accepting data on a rolling basis, teams reviewing different parts of the dossier in parallel, working collaboratively with international regulators, and by many members of the teams working long hours" (personal e-mail communication). One has to wonder how they propose to assess long-term side effects. Can we really trust any pharmaceutical drug approval by the TGA after this statement?

Pfizer never planned to reveal its clinical trial data and had to be ordered by a judge in the USA to release the data to the public. Even then they and the CDC tried to limit the number of pages published per month which would have made the full study data public knowledge sometime in the 2070ies. The reason given was that some proprietary information had to be blacked out before release to the public. Again, it is inconceivable why it would be impossible to go through the study data in a few months, when it took the CDC less than 4 weeks to give the injections emergency use authorization - unless you want to entertain the idea that the study data were never actually read and scrutinised, a frightening perspective.

As scientists we put up hypotheses and test them using experiments. If a hypothesis is proven to be true according to current knowledge it might still change over time when new evidence comes to light. Hence, sharing and accumulating knowledge is the most important part of science. The question arises when and why this process of science has been changed. No discussion of new knowledge disputing the safety of the COVID-19 vaccines is allowed. Who gave bureaucrats the means to destroy the fundaments of science and tell scientists not to argue the science?

References

1. Hansen, T., Titze, U., Kulamadayil-Heidenreich, N. S. A., Glombitza, S., Tebbe, J. J., Röcken, C., ... & Wilkens, L. (2021). First case of postmortem study in a patient vaccinated against SARS-CoV-2. International Journal of Infectious Diseases, 107, 172-175.
2. Ndeupen, S., Qin, Z., Jacobsen, S., Bouteau, A., Estanbouli, H., & Igyártó, B. Z. (2021). The mRNA-LNP platform's lipid nanoparticle component used in preclinical vaccine studies is highly inflammatory. Iscience, 24(12), 103479.
3. Zhou, Y., Peng, Z., Seven, E. S., & Leblanc, R. M. (2018). Crossing the blood-brain barrier with nanoparticles. Journal of controlled release, 270, 290-303.
4. Wick, P., Malek, A., Manser, P., Meili, D., Maeder-Althaus, X., Diener, L., ... & von Mandach, U. (2010). Barrier capacity of human placenta for nanosized materials. Environmental health perspectives, 118(3), 432-436.
5. Shimazawa, R., & Ikeda, M. (2021). Potential adverse events in Japanese women who received tozinameran (BNT162b2, Pfizer-BioNTech). Journal of Pharmaceutical Policy and Practice, 14(1), 1-3.
6. Karikó, K., Buckstein, M., Ni, H., & Weissman, D. (2005). Suppression of RNA recognition by Toll-like receptors: the impact of nucleoside modification and the evolutionary origin of RNA. Immunity, 23(2), 165-175.
7. Karikó, K., Muramatsu, H., Welsh, F. A., Ludwig, J., Kato, H., Akira, S., & Weissman, D. (2008). Incorporation of pseudouridine into mRNA yields superior nonimmunogenic vector with increased translational capacity and biological stability. Molecular therapy, 16(11), 1833-1840.
8. Röltgen, K., Nielsen, S.C.A., Silv,a O., Younes, S.F. et al. (2022). Immune imprinting, breadth of variant recognition, and germinal center response in human SARS-CoV-2 infection and vaccination. Cell, 185, 1025 – 1040. DOI: https://doi.org/10.1016/j.cell.2022.01.018
9. Biancatelli, R. M. C., Solopov, P. A., Sharlow, E. R., Lazo, J. S., Marik, P. E., & Catravas, J. D. (2021). The SARS-CoV-2 spike protein subunit S1 induces COVID-19-like acute lung injury in K18-hACE2 transgenic mice and barrier dysfunction in human endothelial cells. American Journal of Physiology-Lung Cellular and Molecular Physiology.
10. Zhang, S., Liu, Y., Wang, X., Yang, L., Li, H., Wang, Y., ... & Hu, L. (2020). SARS-CoV-2 binds platelet ACE2 to enhance thrombosis in COVID-19. Journal of hematology & oncology, 13(1), 1-22.
11. Cattin-Ortolá, J., Welch, L. G., Maslen, S. L., Papa, G., James, L. C., & Munro, S. (2021). Sequences in the cytoplasmic tail of SARS-CoV-2 Spike facilitate expression at the cell surface and syncytia formation. Nature communications, 12(1), 1-11.
12. Cheng, Y. W., Chao, T. L., Li, C. L., Wang, S. H., Kao, H. C., Tsai, Y. M., ... & Yeh, S. H. (2021). D614G substitution of SARS-CoV-2 spike protein increases syncytium formation and virus titer via enhanced furin-mediated spike cleavage. Mbio, 12(4), e00587-21.
13. Singh, N., & Singh, A. B. (2020). S2 subunit of SARS-nCoV-2 interacts with tumor suppressor protein p53 and BRCA: an in silico study. Translational Oncology, 13(10), 100814.
14. Liu, J., Wang, J., Xu, J., Xia, H., Wang, Y., Zhang, C., ... & Liu, Z. (2021). Comprehensive investigations revealed consistent pathophysiological alterations after vaccination with COVID-19 vaccines. Cell discovery, 7(1), 1-15.
15. Seneff, S., Nigh, G., Kyriakopoulos, A. M., & McCullough, P. A. (2022). Innate immune suppression by SARS-CoV-2 mRNA vaccinations: The role of G-quadruplexes, exosomes, and MicroRNAs. Food and Chemical Toxicology, 164, 113008.
16. Mishra, R., Banerjea, A.C. (2021) SARS-CoV-2 Spike Targets USP33-IRF9 Axis via Exosomal miR-148a to Activate Human Microglia. Frontiers in Immunology, 12. DOI=10.3389/fimmu.2021.656700
17. Reiss, K., & Bhakdi, S. (2020). Corona, False Alarm?: Facts and Figures. Chelsea Green Publishing.
18. Doshi, P. (2020). Covid-19: Do many people have pre-existing immunity?. Bmj, 370.
19. Ng, K. W., Faulkner, N., Cornish, G. H., Rosa, A., Harvey, R., Hussain, S., ... & Kassiotis, G. (2020). Preexisting and de novo humoral immunity to SARS-CoV-2 in humans. Science, 370(6522), 1339-1343.
20. King, E. M. (2020). T-cells Are the Superstars in Fighting COVID-19. But Why are some People So Poor at Making Them?. bmj, 370.
21. Phillips, N. (2021). The corona virus will become endemic.

7-1

Immune imprinting, breadth of variant recognition, and germinal center response in human SARS-CoV-2 infection and vaccination

Katharina Röltgen, Sandra C.A. Nielsen, Oscar Silva, Benjamin A. Pinsky, Kari C. Nadeau, Scott D. Boyd
January 24, 2022 – *Cell*

Highlights

- Vaccination confers broader IgG binding of variant RBDs than SARS-CoV-2 infection
- Imprinting from initial antigen exposures alters IgG responses to viral variants
- Histology of mRNA vaccinee lymph nodes shows abundant GCs
- Vaccine spike antigen and mRNA persist for weeks in lymph node GCs

Summary

During the SARS-CoV-2 pandemic, novel and traditional vaccine strategies have been deployed globally. We investigated whether antibodies stimulated by mRNA vaccination (BNT162b2), including third-dose boosting, differ from those generated by infection or adenoviral (ChAdOx1-S and Gam-COVID-Vac) or inactivated viral (BBIBP-CorV) vaccines. We analyzed human lymph nodes after infection or mRNA vaccination for correlates of serological differences. Antibody breadth against viral variants is lower after infection compared with all vaccines evaluated but improves over several months. Viral variant infection elicits variant-specific antibodies, but prior mRNA vaccination imprints serological responses toward Wuhan-Hu-1 rather than variant antigens. In contrast to disrupted germinal centers (GCs) in lymph nodes during infection, mRNA vaccination stimulates robust GCs containing vaccine mRNA and spike antigen up to 8 weeks postvaccination in some cases. SARS-CoV-2 antibody specificity, breadth, and maturation are affected by imprinting from exposure history and distinct histological and antigenic contexts in infection compared with vaccination.

Introduction

The urgent need for countermeasures against the coronavirus disease 2019 (COVID-19) pandemic has spurred the rapid development of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) vaccines of diverse formulations. mRNA vaccines BNT162b2 (BioNTech-Pfizer) and mRNA-1273 (Moderna/NIAID) have demonstrated high efficacy and safety in clinical trials for COVID-19 prevention (Baden et al., 2021, Polack et al., 2020, Walsh et al., 2020). Additional COVID-19 vaccines including adenoviral vectored vaccines ChAdOx1-S (Astra Zeneca) (Voysey et al., 2021), Ad26.COV2.S (Johnson & Johnson) (Sadoff et al., 2021), and Gam-COVID-Vac (Sputnik V) and inactivated viral vaccines such as BBIBP-CorV (Sinopharm) also have reported efficacy. Correlates of vaccine-elicited protection from COVID-19 are the titers of neutralizing antibodies to SARS-CoV-2, and the concentration of antibodies binding to spike or receptor-binding domain (RBD) (Earle et al., 2021, Gilbert et al., 2022, Khoury et al., 2021, Röltgen and Boyd, 2021). Most neutralizing antibodies target the RBD and prevent

Full 44 page document: https://www.cell.com/cell/fulltext/S0092-8674(22)00076-9?rss=yes#relatedArticles

8-1

FDA confirms Graphene Oxide is in the mRNA COVID-19 Vaccines after being forced to publish Confidential Pfizer Documents by order of the US Federal Court

THE EXPOSÉ APRIL 2, 2023

The Covid-19 vaccines have been at the centre of a heated debate since their introduction, with many questions and concerns raised about their safety and effectiveness.

Speculation has also been rife that the Covid-19 injections may contain traces of Graphene Oxide, a highly toxic and conductive substance.

Medicine regulators, with the support of the Mainstream Media, have repeatedly denied these claims.

But they were lying to you.

Because recent evidence has emerged that confirms the presence of Graphene Oxide, a highly toxic and conductive substance, in the Pfizer vaccine. And it has come from the US Food and Drug Administration (FDA) which has been forced to publish the confidential Pfizer documents by order of the Federal Court in the USA.

The FDA had initially attempted to delay the release of Pfizer's Covid-19 vaccine safety data for 75 years, despite approving the injection after only 108 days of a safety review on December 11th, 2020.

However, a group of scientists and medical researchers sued the FDA under FOIA to force the release of hundreds of thousands of documents related to the licensing of the Pfizer-BioNTech Covid-19 vaccine.

In early January 2022, Federal Judge Mark Pittman ordered the FDA to release 55,000 pages per month, and since then, PHMPT has posted all of the documents on its website as they have been published.

One of the most recent documents published by the FDA saved as 125742_S1_M4_4.2.1 vr vtr 10741.pdf, confirms the use of Graphene Oxide in the manufacturing process of the Pfizer Covid-19 vaccine.

The document is a description of a study carried out by Pfizer between April 7th 2020 and 19th August 2020, with the objective being "to express and characterize the vaccine antigen encoded by BNT162b2."

The study conclusion is as follows-

9-1

Secret Documents published by order of the U.S. Federal Court prove Pfizer, the FDA & Fact Checkers lied when they said Toxic Graphene Oxide was not inside the Covid-19 Vaccines

THE EXPOSÉ APRIL 9, 2023

Graphene Oxide is a fairly new substance not yet well understood. But what we do know is that studies have proven it can be toxic to cells and tissues in the body. And further studies have shown Graphene Oxide to have toxic effects on blood cells, inducing oxidative stress and inflammation.

This is why it's concerning to find Graphene Oxide (GO) has been in and out of the news for the past two years in relation to the COVID-19 vaccines developed by Pfizer-BioNTech and Moderna.

Several independent studies conducted by doctors and scientists have confirmed that Graphene Oxide is in fact present in these vaccines. But the manufacturers, medicine regulators and so called Fact-Checkers have refuted these claims, most likely due to the known toxic effects it has on the body.

For instance, Reuters, which essentially supplies the news to the entire Western world without most people realising it, stated in a fact-check article published July 23rd 2021, that it is impossible for the Covid vaccines to contain Graphene Oxide because they would be either dark brown or black in colour, instead of the clear/yellowish colour they are.

But what Reuter's Fact Checkers failed to mention is that when Graphene Oxide is combined with other ingredients, such as Sucrose, a listed ingredient of the Pfizer Covid-19 vaccine, it's perfectly possible to produce a clear or yellowish liquid.

But at the time of writing, Reuters did not have access to a document published in February 2023 by the U.S. Food & Drug Administration (FDA) by order of the U.S. Federal Court.

A document that was submitted to the FDA by Pfizer to gain Emergency Use Authorization (EUA).

A document that confirms it is perfectly possible for toxic Graphene Oxide to end up in the Covid-19 vaccines due to the manufacturing process.

Full 12 page document with microscope photos at: https://expose-news.com/2023/04/09/pfizer-fda-lied-graphene-oxide-is-inside-covid-vaccines/

10-1

Vaccine Shedding & Graphene Oxide: Secret Pfizer Documents & Studies prove Graphene is in the COVID Vaccines & Shedding is sadly occurring with Deadly Consequences

THE EXPOSÉ APRIL 5, 2023

For over two years, concerned citizens around the world have been voicing their concerns about the safety of the novel Covid-19 mRNA vaccines. Yet, time and time again, they have been dismissed and labelled as conspiracy theorists by the mainstream media and medical establishment.

However, recent developments have proven that these so-called conspiracy theories were, in fact, true all along.

Because confidential Pfizer documents, that the US Food and Drug Administration (FDA) attempted to delay the release of for 75 years, but were subsequently forced to publish by order of the US Federal Court; and various scientific studies have confirmed that the Pfizer Covid-19 vaccine does in fact contain a highly toxic substance known as Graphene Oxide.

A substance that is so toxic that it has and still is destroying red blood cells and forming strange blood clots.

Unfortunately, the same confidential Pfizer documents and various scientific studies also confirm that 'vaccine shedding' has been occurring. A process in which individuals who received the Covid-19 vaccine unintentionally shed the contents of it to others.

This means the not-vaccinated population have also suffered and is continuing to suffer the highly toxic effects of Graphene Oxide entering the body alongside other serious adverse events induced by the Covid-19 vaccines.

One of the studies confirming the vast majority of humanity has had absolutely no choice in the matter of whether they wish to get the Covid-19 injection or not because the vaccinated have been transmitting antibodies generated by the injections through aerosol was by conducted by scientists at the University of Colorado

The findings came as no surprise however, because a confidential Pfizer document given to the FDA had already confirmed shedding and exposure to the Covid-19 mRNA injections was perfectly possible by skin-to-skin contact and breathing the same air as someone who had been injected with the Covid-19 "vaccine".

Evidence for Aerosol Transfer of SARS-CoV2-specific Humoral Immunity

Ross M. Kedl, Elena Hsieh, Thomas E. Morrison, Gabriela Samayoa-Reyes, Siobhan Flaherty, Conner L. Jackson, Rosemary Rochford

doi: https://doi.org/10.1101/2022.04.28.22274443

The abstract of the study reads as follows –

Despite the obvious knowledge that infectious particles can be shared through respiration, whether other constituents of the nasal/oral fluids can be passed between hosts has surprisingly never even been postulated, let alone investigated.

The circumstances of the present pandemic facilitated a unique opportunity to fully examine this provocative idea. The data we show provides evidence for a new mechanism by which herd immunity may be manifested, the aerosol transfer of antibodies between immune and non-immune hosts.

And here are the study authors' main findings –

10-2

The extended mandates for mask wearing in both social and work environments provided a unique opportunity to evaluate the possibility of aerosolized antibody expiration from vaccinated individuals.

*Utilizing a flow cytometry-based Multiplex Microsphere Immunoassay (MMIA) to detect SARS-CoV-2-specific antibodies (**Fig 1A and B**)* [4,5] *and a method previously used to elute antibody from rehydrated dried blood spots (DBS), we identified anti-SARS-CoV-2 specific antibodies eluted from surgical face masks worn by vaccinated lab members donated at the end of one workday.*

*Consistent with the results reported by others, we identified both IgG and IgA in saliva from vaccinated individuals (**Fig 1C and D**). It was therefore not surprising to detect both IgG and IgA following elution of antibody from face masks (**Fig 1C and D**).*

Given these observations, we hypothesized that droplet/aerosolized antibody transfer might occur between individuals, much like droplet/aerosolized virus particles can be exchanged by the same route.

exchanged by the same route. To evaluate this hypothesis, we obtained nasal swabs from children living in households in which parents or family members had varying degrees of SARS-CoV2-specific immunity, including those unvaccinated, vaccinated and COVID-19+. Initial comparison of nasal swabs acquired from children living in vaccinated households revealed readily detectable SARS-CoV-2-specific IgG (Fig 1E), especially when compared to the complete deficit of SARS-CoV-2-specific antibody detected in the few nasal swabs we obtained from children in non-vaccinated households. We then used the variation in parents' levels of intranasal IgG as the basis of stratification across all children's samples. Log transformation of the data from thirty-four adult-child pairs established antibody cut-offs for high vs low parental intranasal antibody levels. Evaluation of samples in this fashion revealed that high intranasal IgG in vaccinated parents was significantly associated (p-value = 0.01) with a 0.38 increase in the log transformed intranasal IgG gMFIs within a child from the same household (Fig 1F). This significant positive relationship was observed using either parametric or non-parametric analysis, and adjustments for the correlation within household did not alter the conclusion. Though not statistically significant, a similar trend of elevated IgA was found in the same samples.

This proves Covid-19 vaccine shedding is perfectly possible when we take into account a study performed on behalf of Pfizer in Japan.

The study observed the distribution of the Covid-19 injection in the bodies of Wister Rats over a period of 48 hours. One of the most concerning findings from the study is the fact that the Pfizer injection accumulates in the ovaries over time.

The highest concentration was noted in the liver. But it also accumulates in the salivary glands on the skin.

10-3

2.6.5.5B PHARMACOKINETICS: ORGAN DISTRIBUTION CONTINUED Test Art

Sample	Total Lipid concentration (µg lipid equivalent/g [or mL]) (males and females combined)						
	0.25 h	1 h	2 h	4 h	8 h	24 h	48 h
Lymph (mandibular)	0.064	0.189	0.290	0.408	0.534	0.554	0.727
Lymph node (mesenteric)	0.050	0.146	0.530	0.489	0.689	0.985	1.32
Muscle	0.021	0.061	0.084	0.103	0.096	0.095	0.192
Ovaries (females)	0.104	1.34	1.64	2.34	3.09	5.24	12.3
Pancreas	0.081	0.207	0.414	0.380	0.294	0.358	0.599
Pituitary gland	0.339	0.645	0.868	0.854	0.405	0.478	0.694
Prostate (males)	0.061	0.091	0.128	0.157	0.150	0.183	0.170
Salivary glands	0.084	0.193	0.255	0.220	0.135	0.170	0.264
Skin	0.013	0.208	0.159	0.145	0.119	0.157	0.253
Small intestine	0.030	0.221	0.476	0.879	1.28	1.30	1.47
Spinal cord	0.043	0.097	0.169	0.250	0.106	0.085	0.112
Spleen	0.334	2.47	7.73	10.3	22.1	20.1	23.4
Stomach	0.017	0.065	0.115	0.144	0.268	0.152	0.215
Tests (Males)	0.031	0.042	0.079	0.129	0.146	0.304	0.320
Thymus	0.088	0.243	0.340	0.335	0.196	0.207	0.331
Thyroid	0.155	0.536	0.842	0.851	0.544	0.578	1.00
Uterus (females)	0.043	0.203	0.305	0.140	0.287	0.289	0.456
Whole blood	1.97	4.37	5.40	3.05	1.31	0.909	0.420
Plasma	3.97	8.13	8.90	6.50	2.36	1.78	0.805
Blood: plasma ratio	0.815	0.515	0.550	0.510	0.555	0.530	0.540

It is not known if the injection continues to accumulate after 48 hours due to observations being curiously halted after this amount of time in the study.

But these results, coupled with the first study above, tell us that for a minimum of 48 hours, an unvaccinated person is at risk of being exposed to the Covid-19 injection if they breathe the same air as or touch the skin of a person who has been vaccinated.

This should however come as no surprise because Pfizer admitted as much in their 'A PHASE 1/2/3, PLACEBO-CONTROLLED, RANDOMIZED, OBSERVER-BLIND, DOSE-FINDING STUDY TO EVALUATE THE SAFETY, TOLERABILITY, IMMUNOGENICITY, AND EFFICACY OF SARS-COV-2 RNA VACCINE CANDIDATES AGAINST COVID-19 IN HEALTHY INDIVIDUALS' document.

The document contains a whole section covering the possibility of 'mRNA vaccine shedding' in which it is possible for those who have been in close proximity to someone who has had the Pfizer mRNA jab to suffer an adverse reaction.

Section 8.3.5 of the document, describes how exposure during pregnancy or breastfeeding to the Pfizer mRNA jab during the trials should be reported to Pfizer Safety within 24 hours of investigator awareness.

This is strange because pregnant women / new mothers were and are not part of the safety trials.

So how can they be exposed?

10-4

8.3.5. Exposure During Pregnancy or Breastfeeding, and Occupational Exposure

Exposure to the study intervention under study during pregnancy or breastfeeding and occupational exposure are reportable to Pfizer Safety within 24 hours of investigator awareness.

Well, Pfizer confirms that exposure during pregnancy can occur if a female is found to be pregnant and is environmentally exposed to the mRNA Covid-19 vaccine.

The document states that environmental exposure during pregnancy can occur if a female family member or healthcare provider reports that she is pregnant after having been exposed to the study intervention by inhalation or skin contact.

Or if a male family member of a healthcare provider who has been exposed to the study intervention by inhalation or skin contact then exposes his female partner prior to or around the time of conception.

8.3.5.1. Exposure During Pregnancy

An EDP occurs if:

- **A female participant is found to be pregnant while receiving or after discontinuing study intervention.**
- **A male participant who is receiving or has discontinued study intervention exposes a female partner prior to or around the time of conception.**
- **A female is found to be pregnant while being exposed or having been exposed to study intervention due to environmental exposure. Below are examples of environmental exposure during pregnancy:**
  - **A female family member or healthcare provider reports that she is pregnant after having been exposed to the study intervention by inhalation or skin contact.**
  - **A male family member or healthcare provider who has been exposed to the study intervention by inhalation or skin contact then exposes his female partner prior to or around the time of conception.**

In layman's terms, Pfizer is admitting in this document that it is possible to expose another human to the mRNA Covid vaccine just by breathing the same air or touching the skin of the person who has been vaccinated.

All of this makes the findings in a study conducted by Dr Philippe van Welbergen all the more concerning.

Findings that are now supported as fact by the publication of a confidential Pfizer Document in February 2023.

A document that the US Food and Drug Administration (FDA) has been forced to publish by order of the Federal Court in the USA. after arguing they wanted to delay the release of the documents for 75 years.

Dr Philippe van Welbergen ("Dr Philippe"), Medical Director of Biomedical Clinics, was one of the first to warn the public of the damage being caused to people's blood by Covid injections by releasing images last year of blood samples under the microscope.

At the beginning of July 2021, Dr Philippe was interviewed and explained that when his patients started complaining about chronic fatigue, dizziness, memory issues, even sometimes paralysis and late onset of heavy menstruation (women in their 60s upwards), he took blood samples.

Their blood had unusual tube-like structures, some particles which lit up and many damaged cells. Few healthy cells were visible. Until three months earlier, he had never seen these formations in blood.

10-5

Then in February 2022, Dr Philippe presented images of his latest blood slides and explained what the images show. His slides showed that vaccine-free patients have been "infected" with vaccine toxins through shedding, including what was claimed to be at the time, but is now known to definitely be graphene thanks to the US Federal Court.

A full review of his slides can be viewed here. But here's a short clip of his presentation –

What Dr Philippe van Welbergen demonstrated is that the graphene being injected into people is organising and growing into larger fibres and structures, gaining magnetic properties or an electrical charge.

And the fibres are showing indications of more complex structures with striations.

He also demonstrated that "shards" of graphene are being transmitted from "vaccinated" to vaccine-free or unvaccinated people, sadly destroying their red blood cells and causing strange blood clots.

Below is an image of typical healthy red blood cells as seen with a microscope, what blood should look like. There is no coagulation or foreign objects in it.

The next image is of a person who has been injected with the experimental Covid drug. The blood is coagulated, and the misshapen red blood cells are clumped together.

The cell encircled in the image is a healthy red blood cell, one of the few in the image, sitting alongside the graphene fibres.

You can see the size of the graphene fibres in relation to the size of a red blood cell. Fibres of this size will block capillaries.

You can also see the graphene fibres are hollow and contain red blood cells.

Below is the image of a blood sample from an eight-year-old unvaccinated child whose blood has been contaminated and destroyed by the transmission of graphene from those around him/her who had been given a Covid injection.

The child's right arm and upper right leg are basically paralysed, the child is unable to lift his/her right arm and the thigh is not functioning properly.

Dr Philippe's presentation is truly eye-opening and horrifying – a must-watch, especially for those who proclaim Covid injections are "safe" and are insisting people be injected. And the findings of Dr Phillippe's study have now been proven as fact by the FDA being forced to publish confidential Pfizer documents.

The FDA had initially attempted to delay the release of Pfizer's Covid-19 vaccine safety data for 75 years, despite approving the injection after only 108 days of a safety review on December 11th, 2020.

However, a group of scientists and medical researchers sued the FDA under FOIA to force the release of hundreds of thousands of documents related to the licensing of the Pfizer-BioNTech Covid-19 vaccine.

In early January 2022, Federal Judge Mark Pittman ordered the FDA to release 55,000 pages per month, and since then, PHMPT has posted all of the documents on its website as they have been published.

One of the most recent documents published by the FDA saved as 125742_S1_M4_4.2.1 vr vtr 10741.pdf, confirms the use of Graphene Oxide in the manufacturing process of the Pfizer Covid-19 vaccine.

The document is a description of a study carried out by Pfizer between April 7th 2020 and 19th August 2020, with the objective being "to express and characterize the vaccine antigen encoded by BNT162b2."

What is most interesting about the study is that it confirms on page 7 that reduced Graphene Oxide is required to manufacture the Pfizer Covid-19 vaccine because it is needed as a base for the lipid nanoparticles.

Pfizer states on page 7 of the study in section 3.4 the following –

10-6

3.4. Cryo-EM of P2 S

For TwinStrep-tagged P2 S, 4 µL purified protein at 0.5 mg/mL were applied to gold Quantifoil R1.2/1.3 300 mesh grids freshly overlaid with graphene oxide. The sample was blotted using a Vitrobot Mark IV for 4 seconds with a force of -2 before being plunged into liquid ethane cooled by liquid nitrogen. 27,701 micrographs were collected from two identically prepared grids. Data were collected from each grid over a defocus range of -1.2 to -3.4 µm with a total electron dose of 50.32 and 50.12 $e^-/Å^2$, respectively, fractionated into 40 frames over a 6-second exposure for 1.26 and 1.25 $e^-/Å^2$/frame. On-the-fly motion

Source – Page 7

A full investigation of the document can be read here. But this document proves that Graphene Oxide is indeed used in the manufacturing process of the Pfizer mRNA Covid-19 vaccine because it is vital in helping to make the vaccine's lipid nanoparticles stable.

Therefore, trace amounts or large amounts, depending on the batch of vaccine manufactured, of reduced Graphene Oxide inevitably make their way into the Pfizer Covid-19 injections.

The use of Graphene Oxide in the Pfizer Covid-19 vaccine has been a source of controversy and concern from the outset, with many individuals claiming that regulators and media outlets were deliberately misleading the public about its inclusion.

Despite initial denials, the documents released by the FDA, which they were forced to publish by order of the Federal Court in the USA. have confirmed the use of Graphene Oxide in the manufacturing process of the Pfizer vaccine, raising questions about who we can trust.

But the Pfizer documents and studies also confirm Covid-19 vaccine shedding has been and still is occurring, destroying red blood cells and forming strange blood clots.

Therefore, it would appear there was never any need to waste an extortionate amount of taxpayers' money on propaganda to coerce the public into getting the Covid-19 injections.

Because the taxpayer never had a choice in the matter.

All they had to do was breathe.

11-1

Senior Embalmer's Shocking Discovery: 'Dirty Blood' and Parasitic Fibre Masses in Covid 'Vaccinated' Patients (Video)

April 8, 2023 **VIDEO - https://rumble.com/v2fnr48-to-all-funeral-directors-and-embalmers-worldwide-.html**
Funeral Director and embalmer Laura Jeffery recently testified at the National Citizens Inquiry in Toronto, Ontario, shedding light on a disturbing phenomenon she has observed since the rollout of the experimental Covid vaccines. During her testimony, Jeffery detailed aspects of her profession as a primary method of ensuring that people who have died are well-represented in their appearance. Embalmers use a technique that drains the circulatory system of deceased patients and fills it with preservation fluids, allowing them to present a person that is reasonable to how their appearance should be.

However, Jeffery has been noticing alarming anomalies in the embalming process of individuals who have received the vaccines. She described the return blood as stickier, thicker, and darker with little tiny pieces of clot-like polka dots, calling it 'dirty blood.' Furthermore, Jeffery started discovering white fibrous masses in the veins of the deceased individuals in her care.

"It's an anomaly that I have never seen before in 27 years as an embalmer and funeral director. I started seeing them in the Spring of 2021," Jeffery said.

"The fibre mass clots are solid. They are an exact cast of what the circulatory system looks like inside of our bodies. They often have a current jelly clot incorporated into the tentacles of the white fibre masses. Hence, it almost seems as though the masses are feeding off our blood," Jeffery continued, referring to the findings as appearing more parasitic than clot-like. Jeffery said that the masses were getting bigger over time.

Jeffery has observed that the embalming process for individuals who have received the Covid vaccine differs from those who have not. Jeffery has noticed that these individuals often have more swelling and discoloration in their limbs, particularly in the area where the vaccine was administered. These new findings have only been observed since the spring of 2021 and have never been seen before in all her years in the industry.

"I was shocked that the people that I was seeing were living with that amount of that material in their circulatory system; it shows that something is wrong – very wrong. I don't understand why, as a funeral director, I'm the one blowing the whistle because we have a system that is supposed to take care of us, and it hasn't, so here I am," said Jeffery.

Jeffery was disturbed by her findings and has set up an e-mail address, ConcernedFDs@gmail.com, to receive communication and facilitate a discussion around these findings. She has also connected with other Canadian embalmers who share her concerns.

The implications of Jeffery's findings are concerning and uncover more startling consequences of the Covid vacciTherefore, its. It is critical that Jeffery's testimony is thoroughly investigated to determine the full extent of the issue and whether there is cause for alarm. As Jeffery, herself stated, "something is wrong – very wrong." The public deserves answers, and it is essential that the healthcare industry takes responsibility and provides them.

National Citizens Inquiry

The National Citizens Inquiry (NCI) is an initiative by a group of concerned Canadians seeking to uncover the truth about the Canadian government's handling of the Covid pandemic. A panel of experts is conducting the inquiry and aims to provide a platform for individuals to share their experiences and insights related to the pandemic. In addition, the NCI is intended to gather evidence and information that can be used to hold government officials accountable for their actions during the pandemic.

Chris, a member of Police On Guard for Thee, provided information about the NCI and the importance of citizen participation in holding government officials accountable.

124

IgG4 Antibodies Induced by Repeated Vaccination May Generate Immune Tolerance to the SARS-CoV-2 Spike Protein

Vladimir N. Uversky, Elrashdy M. Redwan, William Makis, Alberto Rubio-Casillas

Vaccines **2023**, *11*(5), 991; **https://doi.org/10.3390/vaccines11050991**

Published: 17 May 2023

Abstract

Less than a year after the global emergence of the coronavirus SARS-CoV-2, a novel vaccine platform based on mRNA technology was introduced to the market. Globally, around 13.38 billion COVID-19 vaccine doses of diverse platforms have been administered. To date, 72.3% of the total population has been injected at least once with a COVID-19 vaccine. As the immunity provided by these vaccines rapidly wanes, their ability to prevent hospitalization and severe disease in individuals with comorbidities has recently been questioned, and increasing evidence has shown that, as with many other vaccines, they do not produce sterilizing immunity, allowing people to suffer frequent re-infections. Additionally, recent investigations have found abnormally high levels of IgG4 in people who were administered two or more injections of the mRNA vaccines. HIV, Malaria, and Pertussis vaccines have also been reported to induce higher-than-normal IgG4 synthesis. Overall, there are three critical factors determining the class switch to IgG4 antibodies: excessive antigen concentration, repeated vaccination, and the type of vaccine used. It has been suggested that an increase in IgG4 levels could have a protecting role by preventing immune over-activation, similar to that occurring during successful allergen-specific immunotherapy by inhibiting IgE-induced effects. However, emerging evidence suggests that the reported increase in IgG4 levels detected after repeated vaccination with the mRNA vaccines may not be a protective mechanism; rather, it constitutes an immune tolerance mechanism to the spike protein that could promote unopposed SARS-CoV2 infection and replication by suppressing natural antiviral responses. Increased IgG4 synthesis due to repeated mRNA vaccination with high antigen concentrations may also cause autoimmune diseases, and promote cancer growth and autoimmune myocarditis in susceptible individuals.

1. Introduction

In a relatively short period after the beginning of the COVID-19 pandemic, two mRNA vaccines, BNT162b2 (Pfizer-BioNTech, New York, NY, USA) and mRNA-1273 (Moderna, Cambridge, MA, USA), were granted the first-ever emergency use authorization. These mRNA vaccines represented a new type of vaccine that comprises synthetic mRNA molecules that contain the coding sequence necessary to build the SARS-CoV-2 Spike protein, which is encased in the lipid nanoparticles (LNPs) to allow for the delivery of mRNA to cells. The main characteristic of the mRNA vaccine platform is that the proteins are synthesized within the host cells, mimicking a natural infection with SARS-CoV-2 [1].

Contemporary investigations have contrasted the seriousness of symptoms in COVID-19 individuals infected with the SARS-CoV-2 Alpha, Delta, and Omicron variants, as well as the effectiveness of mRNA immunizations versus each variant among individuals admitted to hospitals in the United States from March 2021 to January 2022. COVID-19 vaccines were discovered to be quite efficient (90%) in avoiding intensive care unit (ICU) admissions caused by Alpha, Delta, and Omicron variants. However, three vaccine injections were needed to give protection against the Omicron variant, whereas two injections sufficiently safeguarded against the Alpha and Delta variants [2]. When people were admitted to hospitals, the Omicron variant was linked to fewer clinical adverse outcomes than the Delta variant. Despite that, the Omicron variant still produced considerable clinical symptoms and mortality [2,3,4,5,6].

It is worth noting that there are conflicting pieces of information about the level of protection offered by these vaccines. Although the Center for Disease Control (CDC) in the United States has stated that throughout the pandemic, mortality rates have been higher in the unvaccinated than in the vaccinated [7], the data in the United Kingdom contradict the CDC's findings. Specifically, the Office for National Statistics (ONS) in the United Kingdom has reported that from April to mid-November 2021, deaths in unvaccinated people were higher in comparison with vaccinated people who had received a second vaccine dose. However, from the end of November 2021 to December 2022, this situation reverted: deaths were higher in vaccinated people who received a third vaccine dose compared with the unvaccinated [8]. Moreover, a recent work investigated a probable relationship between COVID-19 vaccination uptake in Europe in 2021 and monthly excess all-cause mortality in 2022; that is, mortality was higher than before the pandemic. All-cause mortality during the first 9 months of 2022 increased more in countries with higher 2021 vaccination uptake, according to analyses of 31 countries estimated by population size; a one percentage point increase in 2021 vaccination uptake was associated with a monthly mortality increase in 2022 of 0.105% (95% CI, 0.075–0.134). The relationship remained strong after adjusting for alternative factors [9].

Although they can induce significant neutralizing anti-spike IgG and IgA responses, all three anti-COVID-19 vaccines: Pfizer, Moderna, and Astra Zeneca ChAdOx1, (Cambridge, UK) appeared to be only transiently protective against SARS-CoV-2 infection and transmission [10,11,12,13]. The high rate of breakthrough infections brought on by the Omicron variant suggests that the sterilizing protection offered by the existing immunization schedules is minimal [14]. There are several evasion strategies that SARS-CoV-2 uses to elude immunological monitoring and attack, including the impairment of interferon synthesis [15,16,17,18,19,20], disruption in antigen presentation [21,22], evasion of humoral attack by constructing nanotubes [23,24], and induced lymphopenia through syncytia formation [25,26,27].

Lethal COVID-19 cases have been linked to higher levels of IgG4 antibodies [28,29], and it has also been documented that mRNA vaccines trigger their synthesis [30,31]. It is, therefore, important to analyze this issue in depth. In this paper, we provide the scientific rationale suggesting that repeated vaccination with mRNA vaccines could generate an immune tolerance mechanism, thereby favoring unopposed SARS-CoV-2 replication. The long-term consequence of this tolerance could be the establishment of a permissive state of the host leading to chronic infection and other unintended consequences induced by mRNA vaccination in susceptible individuals.

2. Characteristics of the Unusual IgG4 Antibody

Several immunoglobulin classes and subclasses that constitute the antibody immune arsenal, including IgA, IgE, IgM, and IgG, are essentially identified by the structure of their heavy chain constant region. Human immunoglobulins G (IgG) are divided into four subcategories based on the immunogenicity of their heavy chains (IgGl, IgG2, IgG3, and IgG4) [32,33,34]. Immunoglobulin subclasses differ in their basic physiologic regulation, localization throughout the organism, and engagement with receptors on immune system effector cells [35]. IgG4, the less prevalent subclass, is found in serum at mean values of 0.35–0.51 mg/mL [36], while the levels of IgG1, the most prevalent subclass, fluctuate between 5 and 12 mg/mL [37]. Due to its unusual biological characteristics and deficiency of effector functions, such as the ability to destroy infected cells through the activation of the complement system or using antibodies, IgG4 has been referred to as an unusual antibody by not adhering to the accepted theory of antibody structure and function [38,39].

The mechanism behind the reaction involving the replacement of one half of an antibody with another, also known as Fab arm exchange and specific to IgG4 antibodies, has been elucidated over the past twenty years [40]. The heavy chains can dissociate and then recombine arbitrarily due to the enhanced propensity of the natural IgG4 joint disulfide bonds to reduction, resulting in a heterogeneous group of IgG4 molecules with random heavy-chain and light-chain couples (**Figure 1**) [40].

13-1

Diverging maternal and infant cord antibody functions from SARS-CoV-2 infection and vaccination in pregnancy

Emily H. Adhikari, Pei Lu, Ye jin Kang, Ann R. McDonald, Jessica E. Pruszynski, Timothy A. Bates, Savannah K. McBride, Mila Trank-Greene, View ORCID ProfileFikadu G. Tafesse, Lenette L. Lu

May 2, 2023 – Preprint - BioRxiv

Abstract

Immunization in pregnancy is a critical tool that can be leveraged to protect the infant with an immature immune system but how vaccine-induced antibodies transfer to the placenta and protect the maternal-fetal dyad remains unclear. Here, we compare matched maternal-infant cord blood from individuals who in pregnancy received mRNA COVID-19 vaccine, were infected by SARS-CoV-2, or had the combination of these two immune exposures. We find that some but not all antibody neutralizing activities and Fc effector functions are enriched with vaccination compared to infection. Preferential transport to the fetus of Fc functions and not neutralization is observed. Immunization compared to infection enriches IgG1-mediated antibody functions with changes in antibody post-translational sialylation and fucosylation that impact fetal more than maternal antibody functional potency. Thus, vaccine enhanced antibody functional magnitude, potency and breadth in the fetus are driven more by antibody glycosylation and Fc effector functions compared to maternal responses, highlighting prenatal opportunities to safeguard newborns as SARS-CoV-2 becomes endemic.

One Sentence Summary SARS-CoV-2 vaccination in pregnancy induces diverging maternal and infant cord antibody functions.

Full 38 page document at
https://www.biorxiv.org/content/10.1101/2023.05.01.538955v1.full

14-1

COVID Vaccine roll-out caused 338x increase in AIDS-associated Diseases & Cancers in 2021 says CDC

THE EXPOSÉ MAY 11, 2023

Official data made available by the U.S. Government and Centers for Disease Control strongly suggests that fully vaccinated Americans may be developing Acquired Immunodeficiency Syndrome or a similar disease that is decimating the innate immune system.

But they are not alone, because further data made available by the UK Government and the Government of Canada suggests the vaccinated population in both of these respective countries are also developing the debilitating condition.

It's a common misconception that Acquired Immunodeficiency Syndrome (AIDS) is only caused by the HIV virus. This simply isn't true.

Acquired (or secondary) immunodeficiency is one of the major causes of infections in adults. These immunodeficiency disorders affect your immune system partially or as a whole, making your body an easy target for several diseases and infections. (*Source*)

When immunodeficiency disorders affect your immune system, your body can no longer fight bacteria and diseases. (*Source*)

Several factors in the environment can cause secondary immunodeficiency disorders. (*Source*)

Some common ones are:

- Radiation or chemotherapy, which can lead to a secondary immunodeficiency disorder known as neutropenia
- Infections due to human immunodeficiency virus (HIV) can result in acquired immune deficiency syndrome (AIDS)
- Leukaemia, a cancer that begins in the cells of the bone marrow that can lead to hypogammaglobulinemia—a type of secondary immunodeficiency
- Malnutrition, which affects up to 50% of populations in underdeveloped countries and leaves people vulnerable to respiratory infections and diarrhoea

But some of the less common causes include **Drugs or medications.** (*Source*)

So it's perfectly possible for a medication or drug to cause acquired immunodeficiency syndrome, and data published by the U.S Government and Centers for Disease Control (CDC) strongly suggests the Covid-19 injections should be added to the list.

For months on end, official data coming out of both the UK and Canada has strongly insinuated that the vaccinated population are developing a new form of AIDS. This is because the Covid-19 injections are proving to have a real-world negative effectiveness, implying that they are causing damage to the natural immune system.

Full 16 page document at: https://expose-news.com/2023/05/11/cancer-aids-covid-vaccine-usa/

15-1

Dr. David Martin Reveals the Truth About Covid Jabs: 28 Years of Science Said 'They Didn't Work' (Video)

May 7, 2023

Dr. David Martin Reveals the Truth About Covid Jabs: 28 Years of Science Said 'They Didn't Work'

16-1

SARS-CoV-2 Spike Protein Accumulation in the Skull-Meninges-Brain Axis: Potential Implications for Long-Term Neurological Complications in post-COVID-19

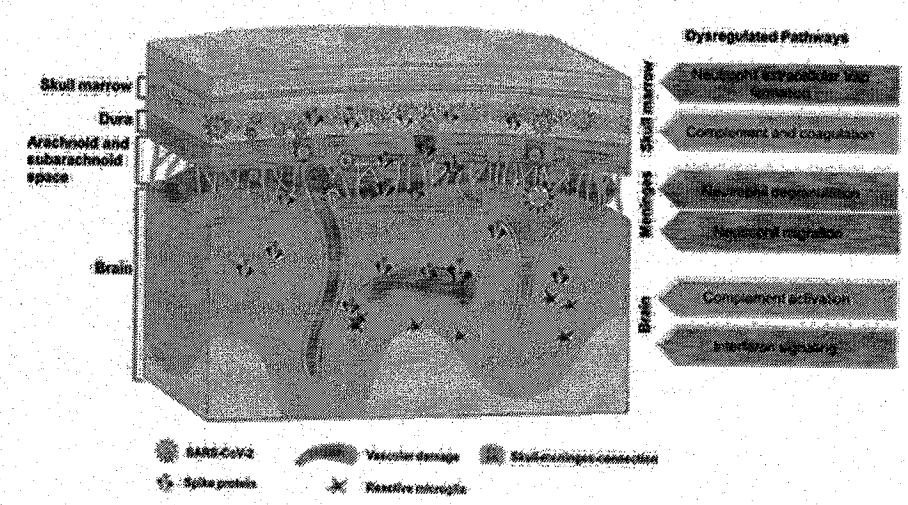
Zhouyi Rong, Hongcheng Mai, Saketh Kapoor, VictorG. Puelles, Jan Czogalla, Julia Schädler, Jessica Vering, Claire Delbridge, Hanno Steinke, Hannah Frenzel, Katja Schmidt, Özüm Sehnaz Caliskan, Jochen Martin Wettengel, Fatma Cherif, et al.

April 4, 2023

This article is a preprint and has not been certified by peer review

ABSTRACT

Coronavirus disease 2019 (COVID-19), caused by the severe acute respiratory syndrome coronavirus type 2 (SARS-CoV-2), has been associated mainly with a range of neurological symptoms, including brain fog and brain tissue loss, raising concerns about the virus's acute and potential chronic impact on the central nervous system. In this study, we utilized mouse models and human post-mortem tissues to investigate the presence and distribution of the SARS-CoV-2 spike protein in the skull-meninges-brain axis. Our results revealed the accumulation of the spike protein in the skull marrow, brain meninges, and brain parenchyma. The injection of the spike protein alone caused cell death in the brain, highlighting a direct effect on brain tissue. Furthermore, we observed the presence of spike protein in the skull of deceased long after their COVID-19 infection, suggesting that the spike's persistence may contribute to long-term neurological symptoms. The spike protein was associated with neutrophil-related pathways and dysregulation of the proteins involved in the PI3K-AKT as well as complement and coagulation pathway. Overall, our findings suggest that SARS-CoV-2 spike protein trafficking from CNS borders into the brain parenchyma and identified differentially regulated pathways may present insights into mechanisms underlying immediate and long-term consequences of SARS-CoV-2 and present diagnostic and therapeutic opportunities.



Short Summary The accumulation of SARS-CoV-2 spike protein in the skull-meninges-brain axis presents potential molecular mechanisms and therapeutic targets for neurological complications in long-COVID-19 patients.

16-2

INTRODUCTION

SARS-CoV-2 infection is associated with numerous neurological and neuropsychiatric complications[1-3], including anosmia, dysgeusia, fatigue, myalgia, depression, headache, encephalopathy and meningitis and also substantially increase the risk for ischemic strokes[4-5]. Even patients with mild cases of COVID-19 often suffer from long-term SARS-CoV-2 effects in the brain, including fogging, reduced grey matter thickness, and brain size[6-8]. Several studies have investigated the involvement of the central nervous system (CNS) in COVID-19-related symptoms, and although SARS-CoV-2 was detected in brain tissue in some samples and studies[9-12], other studies failed to detect the virus[12-16]. Various technical issues such as contamination from the blood in PCR-based methods, misidentification of capillaries as parenchyma in immunohistochemistry, staining errors using inappropriate antibodies[17] or differences in patient populations might explain this discrepancy. However, even without detectable virus RNA in the brain parenchyma, signs of widespread immune activation could be detected[18]. The lack of evidence for the viral presence and especially viral replication in the brain led to the hypothesis that virus-shed proteins circulating in the bloodstream may promote an inflammatory response independent of direct viral infection of the affected organs, including the brain[19-20]. Notably, the highly immunogenic spike protein, also used in COVID-19 vaccines[21-23], might be a candidate for triggering infection-independent effects.

The spike protein has been shown to affect endothelial function in vitro[24-26] and in vivo[27-28] and induce TLR2-mediated inflammatory responses in vitro after intraperitoneal injection in mice[29], but whether such responses can also be observed in patients has not been thoroughly investigated. However, the long persistence of the spike protein has been shown in the patient's immune cells (at least 15 months)[30] and in the patient's blood plasma (at least 12 months in a preprint)[31]. Radio-labeled free spike protein has been shown to cross mice's blood-brain barrier and enter the brain parenchyma[32]. However, due to the limited resolution of the methods employed, the exact routes of spike protein entry to the brain, their targets, and molecular changes associated with spike protein accumulation in brain tissue remain largely unclear[33-34].

Here, we used optical tissue clearing to identify all tissues that accumulated SARS-CoV-2 spike protein in mice and investigated the distribution of spike protein in post-mortem samples from COVID-19 patients. We also characterize the protein expression consequences of SARS-CoV-2 infections in different skull tissues from post-mortem human samples with mass spectrometry-based proteomics. We found an accumulation of spike protein in the skull marrow niches, recently discovered skull-meninges connection (SMC)[35-40], meninges, and the brain parenchyma in both mouse and human samples. The human proteomics data showed dysregulation of complement and coagulation cascades, neutrophil-related pathways, and an upregulation of pro-inflammatory proteins. Injecting spike protein to skull marrow niches directly in healthy mice triggered proteome changes and cell death in the brain parenchyma. Surprisingly, we identified lingering spike protein in the skull samples of a subset of individuals who recovered from COVID-19 and died due to non-COVID-related causes. Thus, accumulation of SARS-CoV-2 and spike protein at the CNS borders can contribute to changes in the brain, suggesting a possible mechanism for the neurological effects of SARS-CoV-2 infection.

Full 21 page document at:
https://www.biorxiv.org/content/10.1101/2023.04.04.535604v1.full

17-1

STUDY: Spike Protein from COVID Vax Accumulates in Brain

Ezekiel Loseke May 8, 2023

'The highly immunogenic spike protein, also used in COVID-19 vaccines, might be a candidate for triggering infection-independent effects...'

A new study suggested that spike proteins that were encouraged to grow by the COVID-19 vaccine accumulate in the skull, causing great harm to the mental capacity of those who were jabbed.

In April 2022, a doctor who specializes in pathology argued that spike proteins directed to grow by mRNA vaccines (of which the COVID jabs are one) caused heart inflammation and cancers.

The COVID-19 vaccine encouraged the growth of spike proteins in order to counter other spike proteins produced by the COVID 19 virus, according to the National Library of Health Medicine.

"However, recent reports have raised some skepticism as to the biologic actions of the spike protein and the types of antibodies produced," the library reported.

"One paper reported that certain antibodies in the blood of infected patients appear to change the shape of the spike protein so as to make it more likely to bind to cells, while other papers showed that the spike protein by itself (without being part of the corona virus) can damage endothelial cells and disrupt the blood-brain barrier," it added.

Thus, the National Library of Health recognized that the COVID jab by itself could cause damage to the brain.

The new study, posted by bioRxiv reported that spike proteins associated with COVID-19 and the COVID-19 jabs were accumulating in the skull and causing intellectual problems for those who have taken the jab.

"SARS-CoV-2 infection is associated with numerous neurological and neuropsychiatric complications, including anosmia, dysgeusia, fatigue, myalgia, depression, headache, encephalopathy and meningitis and also substantially increase the risk for ischemic strokes," the report said.

"Even patients with mild cases of COVID-19 often suffer from long-term SARS-CoV-2 effects in the brain, including fogging, reduced grey matter thickness,

17-2

and brain size," the study said, showing both sets of spike proteins endanger brain health.

However, the study indicated that this hypothesis failed to account for all the facts in the case.

"Several studies have investigated the involvement of the central nervous system (CNS) in COVID-19-related symptoms, and although SARS-CoV-2 was detected in brain tissue in some samples and studies, other studies failed to detect the virus," meaning that the virus may not be responsible for all the damages to the brain the study detected.

"However, even without detectable virus RNA in the brain parenchyma, signs of widespread immune activation could be detected," the report explained, indicating that the brain was responding to something.

The study suggested two potential explanations regarding the causes of the damages.

The first possibility was that "virus-shed proteins circulating in the bloodstream may promote an inflammatory response independent of direct viral infection of the affected organs, including the brain."

The second possibility was that "the highly immunogenic spike protein, also used in COVID-19 vaccines, might be a candidate for triggering infection-independent effects."

18-1

Risk assessment of retinal vascular occlusion after COVID-19 vaccination

Jing-Xing Li, Yu-Hsun Wang, Henry Bair, Shu-Bai Hsu, Connie Chen, James Cheng-Chung Wei & Chun-Ju Lin
Published: 02 May 2023 in *Vaccines* volume 8

Abstract

Coronavirus disease 2019 (COVID-19) vaccines are associated with several ocular manifestations. Emerging evidence has been reported; however, the causality between the two is debatable. We aimed to investigate the risk of retinal vascular occlusion after COVID-19 vaccination. This retrospective cohort study used the TriNetX global network and included individuals vaccinated with COVID-19 vaccines between January 2020 and December 2022. We excluded individuals with a history of retinal vascular occlusion or those who used any systemic medication that could potentially affect blood coagulation prior to vaccination. To compare the risk of retinal vascular occlusion, we employed multivariable-adjusted Cox proportional hazards models after performing a 1:1 propensity score matching between the vaccinated and unvaccinated cohorts. Individuals with COVID-19 vaccination had a higher risk of all forms of retinal vascular occlusion in 2 years after vaccination, with an overall hazard ratio of 2.19 (95% confidence interval 2.00–2.39). The cumulative incidence of retinal vascular occlusion was significantly higher in the vaccinated cohort compared to the unvaccinated cohort, 2 years and 12 weeks after vaccination. The risk of retinal vascular occlusion significantly increased during the first 2 weeks after vaccination and persisted for 12 weeks. Additionally, individuals with first and second dose of BNT162b2 and mRNA-1273 had significantly increased risk of retinal vascular occlusion 2 years following vaccination, while no disparity was detected between brand and dose of vaccines. This large multicenter study strengthens the findings of previous cases. Retinal vascular occlusion may not be a coincidental finding after COVID-19 vaccination.

Full 30 page document at: https://www.nature.com/articles/s41541-023-00661-7

19-1

Dr. Paul Alexander : The Silenced Jab Injured Are Committing Suicide

June 8, 2023 Kristi Leigh

Dr. Paul Alexander supported the Canadian Trucker protest and continues to advocate for freedom and warn against the dangers of the jab -especially now for pregnant women and babies. He is sounding the alarm that not only side effects are injuring and killing people, but the cover-up is leaving the injured so defeated many are now taking their own lives. *** Paul Elias Alexander, Ph.D. is a global expert on COVID-19. Alexander holds master's level study at York University Canada, a master's in epidemiology at the University of Toronto, a master's in evidence-based medicine at Oxford and a doctorate in evidence-based medicine and research methods from McMaster University in Canada. He also served as former senior advisor to COVID pandemic policy in Health and Human Services in the Trump administration. *** https://substack.com/@drpaulalexander

VIDEO: https://rumble.com/v2sspas-dr.-paul-alexander-the-silenced-jab-injured-are-committing-suicide.html

20 -1

Pro-Vaccine Italy Changes Its Tune, Exposes Massive Vaccine Damage (Video)

March 3, 2023

The following video is from the Italian television program CortoTG about the disastrous effects of the Covid vaccine. The show spotlights the uptick in cases of shingles (herpes zoster) and fulminant (sudden onset) leukemia due to the vaccine.

The common thread connecting the two types of disease is the disruption of the body's immune system. The vaccines seem to "reprogram" people's immune functions, increasing the risk of infection, cancers, tumors, and various autoimmune disorders.

Video: https://rumble.com/v2bedfu-japanese-scientists-discover-link-between-pfizer-vaxx-and-turbo-cancer.html

21-1

German Pathologist Warns Women Not to Have Kids With Men Who've Been Covid Jabbed

June 2023

Video:
https://rumble.com/v2rtl90-german-pathologist-warns-women-not-to-have-kids-with-men-whove-been-covid-j.html

22-1

The Culling of Mankind: Government Reports & Pfizer Documents reveal a Sinister Agenda exists to Depopulate the Planet through COVID Vaccination

THE EXPOSÉ APRIL 7, 2023

If an experimental vaccine were to damage the heart and immune system in a significant number of individuals who received it, it is possible that it could lead to a decline in the overall population size.

This could occur for a number of reasons.

- First, damage to the heart could lead to an increase in cardiovascular diseases, which are a leading cause of mortality worldwide. This could result in a higher number of deaths among individuals who received the vaccine.
- Second, damage to the immune system could leave individuals more susceptible to other infections and diseases, which could also contribute to an increase in mortality.
- Last, but by no means least, the negative impacts of the vaccine on fertility and reproductive health could lead to a decline in the number of births, further contributing to a decline in the overall population size.

If such a vaccine were to be developed and distributed, it could potentially lead to depopulation due to increased mortality and decreased fertility.

Unfortunately, the world has found itself in a situation where powerful institutions and Governments have coerced millions of people into getting an experimental Covid-19 vaccine that causes all of the ill-fated things mentioned above.

Official Government reports and confidential Pfizer documents prove it.

Therefore, you are witnessing mass depopulation unfold before your very eyes.

The push for mass Covid-19 vaccination was never about combating a virus. It was about reducing the global population.

This goal aligns with the interests of certain powerful corporations and individuals who stand to benefit from a smaller, more manageable population now that AI is advanced enough to replace hundreds of millions of workers.

Regardless of the specific cause, the implications of what is currently occurring in the real world are significant.

Millions have 'Died Suddenly'

Did you know that data on excess deaths in 15% of the world's countries can be found on the website of the Organisation for Economic Co-operation and Development (OECD)?

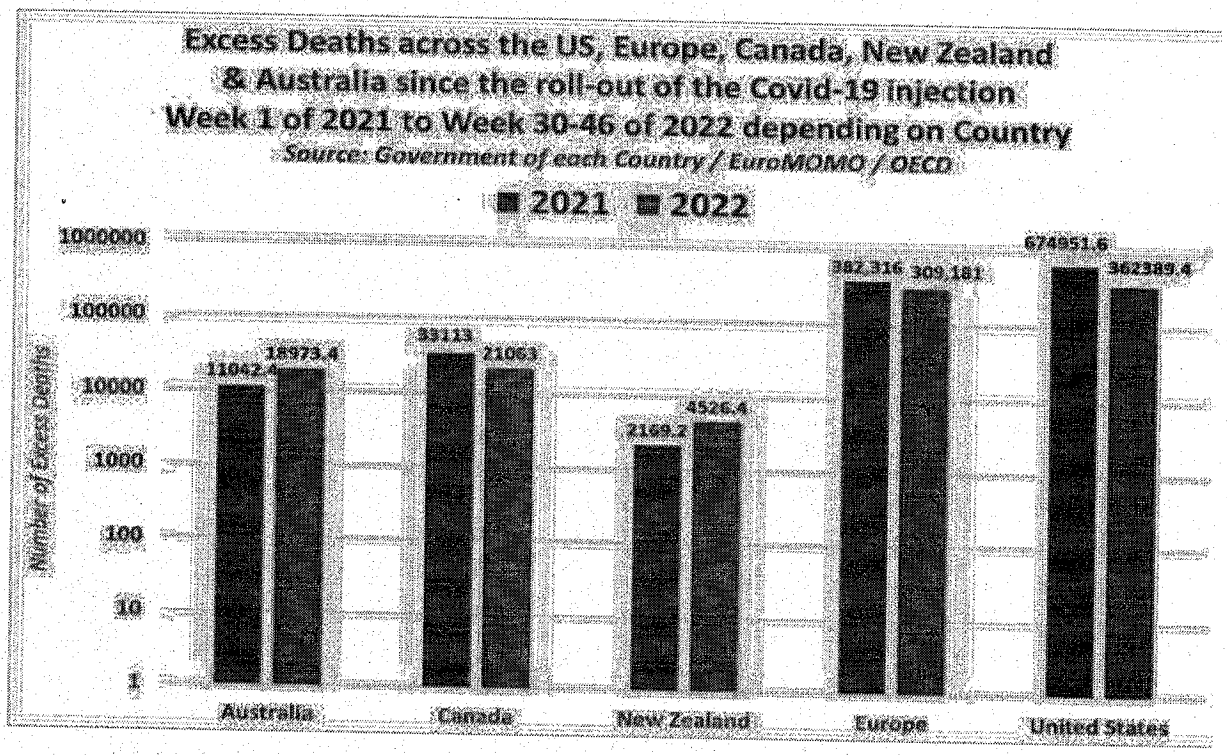
This includes major countries like the USA, Canada, and the UK.

Additionally, we were able to extract even more up-to-date data on 28 European countries from EuroMOMO.

All of this information has been provided to the OECD and EuroMOMO by each country's Government organizations, such as the Centers for Disease Control in the USA and the Office for National Statistics in the UK.

The following chart illustrates the disturbing trend of excess deaths in the "Five Eyes" countries (Australia, Canada, New Zealand, the UK, and the US) as well as 27 other European countries –

22-2



Are you aware of the staggering number of excess deaths that have occurred in the US and Europe in recent years?

In 2021, the US saw almost 700,000 excess deaths, with another 360,000 excess deaths by November 11th, 2022.

Europe had a similarly alarming 382,000 excess deaths in 2021, with 309,000 excess deaths by November 2022.

And these figures don't even include Ukraine!

Shockingly, even countries like New Zealand, Australia, and Canada have seen excess deaths that have not decreased since the rollout of the Covid-19 vaccine.

The following chart illustrates the disturbing trend of overall excess deaths in Australia in 2020, 2021, and up to week 30 of 2022 –

Full 27 page document at: HTTPS://EXPOSE-NEWS.COM/2023/04/07/THE-CULLING-OF-MANKIND-VIA-COVID-VACCINATION/

23-1

Effectiveness of the Coronavirus Disease 2019 (COVID-19) Bivalent Vaccine

Nabin K. Shrestha, Patrick C. Burke, Amy S. Nowacki, James F. Simon, Amanda Hagen, Steven M. Gordon
Now published in *Open Forum Infectious Diseases* October 2022

ABSTRACT

Background The purpose of this study was to evaluate whether a bivalent COVID-19 vaccine protects against COVID-19.
Methods Employees of Cleveland Clinic in employment on the day the bivalent COVID-19 vaccine first became available to employees, were included. The cumulative incidence of COVID-19 was examined over the following weeks. Protection provided by vaccination (analyzed as a time-dependent covariate) was evaluated using Cox proportional hazards regression. The analysis was adjusted for the pandemic phase when the last prior COVID-19 episode occurred, and the number of prior vaccine doses received.
Results Among 51011 employees, 20689 (41%) had had a previous documented episode of COVID-19, and 42064 (83%) had received at least two doses of a COVID-19 vaccine. COVID-19 occurred in 2452 (5%) during the study. Risk of COVID-19 increased with time since the most recent prior COVID-19 episode and with the number of vaccine doses previously received. In multivariable analysis, the bivalent vaccinated state was independently associated with lower risk of COVID-19 (HR, .70; 95% C.I., .61-.80), leading to an estimated vaccine effectiveness (VE) of 30% (95% CI, 20-39%). Compared to last exposure to SARS-CoV-2 within 90 days, last exposure 6-9 months previously was associated with twice the risk of COVID-19, and last exposure 9-12 months previously with 3.5 times the risk.
Conclusions The bivalent COVID-19 vaccine given to working-aged adults afforded modest protection overall against COVID-19, while the virus strains dominant in the community were those represented in the vaccine.
Summary Among 51011 working-aged Cleveland Clinic employees, the bivalent COVID-19 vaccine booster was 30% effective in preventing infection, during the time when the virus strains dominant in the community were represented in the vaccine.

INTRODUCTION

When the original Coronavirus Disease 2019 (COVID-19) vaccines first became available in 2020, there was ample evidence of efficacy from randomized clinical trials [1,2].Vaccine effectiveness was subsequently confirmed by clinical effectiveness data in the real world outside of clinical trials [3,4], including an effectiveness estimate of 97% among employees within our own healthcare system [5]. This was when the human population had just encountered the novel Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) virus, and the pathogen had exacted a high burden of morbidity and mortality across the world. The vaccines were amazingly effective in preventing COVID-19, saved a large number of lives, and changed the impact of the pandemic.
Although the vaccines were very effective, the majority of the population in resource-poor countries could not get vaccinated in time, and waves of infection occurred around the world. Continued acquisition of mutations in the virus, from natural evolution in response to interaction with the immune response among the human population, led to the emergence and spread of SARS-CoV-2 variants. Despite this, those previously infected or vaccinated continued to have substantial protection against reinfection by virtual of natural or vaccine-induced immunity [6]. The arrival of the Omicron variant in December 2021, brought a significant change to the immune protection landscape. Previously infected or

23-2

vaccinated individuals were no longer protected from COVID-19 [6]. Vaccine boosting provided some protection against the Omicron variant [7,8], but the degree of protection was not near that of the original vaccine against the pre-Omicron variants of SARS-CoV-2 [8]. After the emergence of the Omicron variant, prior infection with an earlier lineage of the Omicron variant protected against subsequent infection with a subsequent lineage [9], but such protection appeared to wear off within a few months [10]. During the Omicron phase of the pandemic, protection from vaccine-induced immunity decreased within a few months after vaccine boosting [8].

Recognition that the original COVID-19 vaccines provided much less protection after the emergence of the Omicron variant, spurred efforts to produce newer vaccines that were more effective. These efforts culminated in the approval by the US Food and Drug Administration, on 31 August 2022, of bivalent COVID-19 mRNA vaccines, which contained antigens represented in the original vaccine as well as antigens representing the BA.4/BA.5 lineages of the Omicron variant. Given the demonstrated safety of the earlier mRNA vaccines and the perceived urgency of need of a more effective preventive tool, these vaccines were approved without demonstration of effectiveness in clinical studies.

The purpose of this study was to evaluate whether the bivalent COVID-19 vaccine protects against COVID-19.

METHODS

Study design

This was a retrospective cohort study conducted at the Cleveland Clinic Health System (CCHS) in the United States. The study was approved by the Cleveland Clinic Institutional Review Board as exempt research (IRB no. 22-917). A waiver of informed consent and waiver of HIPAA authorization were approved to allow the research team to access to the required data.

Setting

Since the arrival of the COVID-19 pandemic at Cleveland Clinic in March 2020, employee access to testing has been a priority. Systems were designed to enable Occupational Health to interview and remotely monitor symptoms for all employees while the latter were isolated at home. Voluntary vaccination for COVID-19 began on 16 December 2020, and the monovalent vaccine as a booster became available to employees on 5 October 2021. The bivalent COVID-19 vaccine began to be offered to employees on 12 September 2022. This date was considered the study start date.

The circulating variants of SARS-CoV-2 varied over the course of the study. The majority of infections in Ohio were caused by the BA.4 or BA.5 lineages of the Omicron variant during the first 10 weeks of the study, based on SARS-CoV-2 variant monitoring data available from the Ohio Department of Health. By December, the BQ.1, BQ.1.1, and BF.7 lineages accounted for a substantial proportion of the infections.

23-3

Participants

CCHS employees in employment at any Cleveland Clinic location in Ohio on 12 September 2022, the day the bivalent vaccine first became available to employees, were included in the study. Those for whom age and gender were not available were excluded.

Variables

Covariates collected were age, gender, job location, and job type categorization into clinical or non-clinical, as described in our earlier studies [5–7]. Institutional data governance rules related to employee data limited our ability to supplement our dataset with additional clinical variables. Subjects were considered pre-pandemic hires if hired before March 16, 2020, the day COVID-19 testing became available in our institution, and pandemic hires if hired on or after that date.
Prior COVID-19 was defined as a positive NAAT for SARS-CoV-2 any time before the study start date. The date of infection for a prior episode of COVID-19 was the date of the first positive test for that episode of illness. Subsequent positive tests within 90 days were considered part of the same episode of illness. A positive test more than 90 days following the date of a previous infection, was considered a new episode of infection. Since the health system never had a requirement for systematic asymptomatic employee test screening, most of the positive tests during the study period would have been tests done to evaluate suspicious symptoms. Some would have been to evaluate known exposures. A small proportion could have been tests done as part of pre-operative or pre-procedural screening.

The pandemic phase during which a subject had his or her last prior episode of COVID-19 was also collected as a variable. To determine this, the pandemic was divided into pre-Delta, Delta, Omicron BA.1/BA.2, and Omicron BA.4/BA.5 phases, based on which variant/lineages accounted for more than 50% of infections in Ohio at the time. The data for this determination was obtained from variant proportion data provided by the Centers for Disease Control and Prevention (CDC) [11].

Outcome

The study outcome was time to COVID-19, the latter defined as a positive NAAT for SARS-CoV-2 any time after the study start date. Outcomes were followed until December 12, 2022.

Statistical analysis

A Simon-Makuch hazard plot [12] was created to compare the cumulative incidence of COVID-19 in the bivalent vaccinated and non-vaccinated states, by treating bivalent vaccination as a time-dependent covariate. Individuals were considered bivalent vaccinated 7 days after receipt of a single dose of the bivalent COVID-19 vaccine. Subjects who had not developed COVID-19 were censored at the end of the study follow-up period. Those whose employment was terminated during the study period before they had COVID-19 were censored on the date of termination of employment. Curves for the non-vaccinated state were based on data while the bivalent vaccination status of subjects remained "non-vaccinated". Curves for the bivalent vaccinated state were based on data from the date the bivalent vaccination status changed to "vaccinated".
Multivariable Cox proportional hazards regression models were fitted to examine the association of various variables with time to COVID-19. Bivalent vaccination was included as

23-4

a time-dependent covariate [13]. The primary model included all study subjects. The secondary model included only those with prior exposure to SARS-CoV-2 by infection or vaccination. Vaccine effectiveness was calculated from the hazard ratios for bivalent vaccination in the models.
The analysis was performed by N. K. S. and A. S. N. using the *survival* package and R version 4.2.2 (R Foundation for Statistical Computing) [13–15].

RESULTS

Of 51977 eligible subjects, 966 (1.9%) were excluded because of missing age or gender. Of the remaining 51011 employees included in the study, 34507 (68%) had been in employment since before the onset of the COVID-19 pandemic (pre-pandemic hires). 1794 subjects (3.5%) were censored during the study period because of termination of employment before the end of the study. By the end of the study, 10804 (21%) were bivalent vaccine boosted. The bivalent vaccine was the Pfizer vaccine in 9595 (89%) and the Moderna vaccine in the remaining 1178. Altogether, 2452 employees (5%) acquired COVID-19 during the 13 weeks of the study.

Baseline characteristics

Table 1 shows the characteristics of subjects included in the study. Notably, this was a relatively young population, with a mean age of 42 years. Among these, 20689 (41%) had previously had a documented episode of COVID-19 and 12029 (24%) had previously had an Omicron variant infection. 44592 subjects (87%) had previously received at least one dose of vaccine, 42064 (83%) had received two doses, 27254 (53%) had received at least three doses, and 3858 (8%) had received four or more doses. 46340 (91%) had been previously exposed to SARS-CoV-2 by infection or vaccination.

Table 1.Baseline characteristics of 51011 employees of Cleveland Clinic in Ohio

Risk of COVID-19 based on prior infection and vaccination history

The risk of COVID-19 varied by the phase of the epidemic in which the subject's last prior COVID-19 episode occurred. In decreasing order of risk of COVID-19 were those never previously infected, those last infected during the pre-Delta or Delta phase, those last infected during the Omicron BA.1/BA.2 phase, and those last infected during the Omicron BA.4/BA.5 phase (Figure 1).

23-5

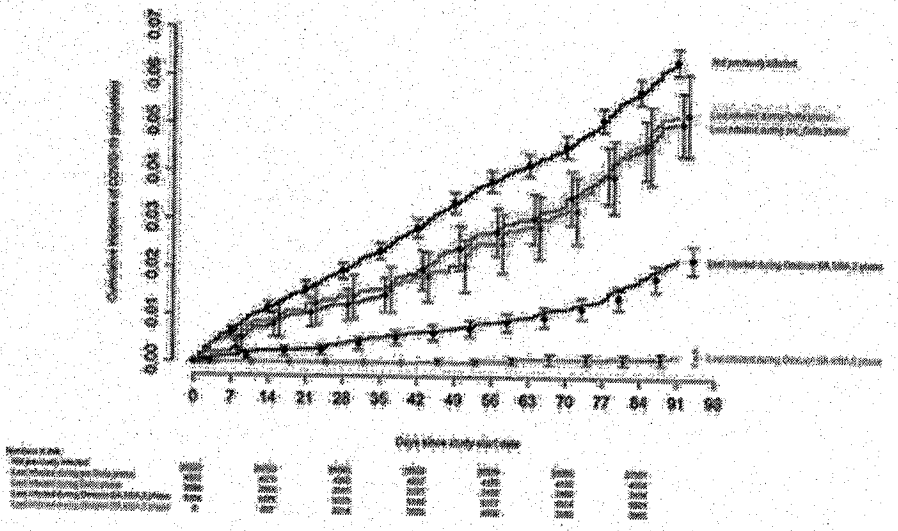


Figure 1.

Simon-Makuch plot comparing the cumulative incidence of COVID-19 for subjects stratified by the pandemic phase during which the subject's last prior COVID-19 episode occurred. Day zero was 12 September 2022, the day the bivalent vaccine began to be offered to employees. Point estimates and 95% confidence intervals are jittered along the x-axis to improve visibility.

The risk of COVID-19 also varied by the number of COVID-19 vaccine doses previously received. The higher the number of vaccines previously received, the higher the risk of contracting COVID-19 (Figure 2).

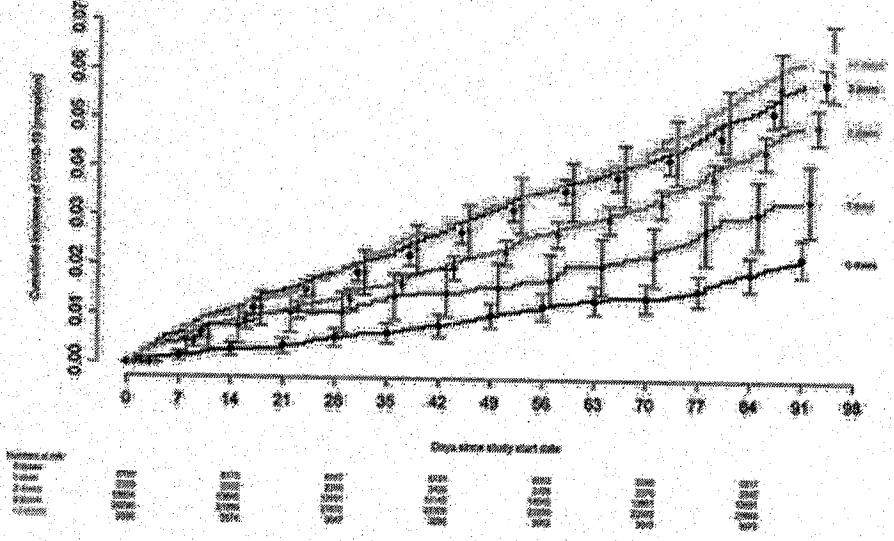


Figure 2.

Simon-Makuch plot comparing the cumulative incidence of COVID-19 for subjects stratified by the number of COVID-19 vaccine doses previously received. Day zero was 12 September 2022, the day the bivalent vaccine began to be offered to employees. Point estimates and 95% confidence intervals are jittered along the x-axis to improve visibility.

Bivalent vaccine effectiveness

In a multivariable Cox proportional hazards regression model adjusted for age, gender, hire cohort, job category, number of COVID-19 vaccine doses prior to study start, and

epidemic phase when the last prior COVID-19 episode occurred, a bivalent vaccine provided some protection against COVID-19 (HR, .70; 95% C.I., .61-.80; P-value, <.001). Point estimates and 95% confidence intervals for hazard ratios for the variables included in the unadjusted and adjusted Cox proportional hazards regression models are shown in Table 2. The calculated overall vaccine effectiveness from the model was 30% (95% C.I., 20% - 39%).

Table 2.Unadjusted and Adjusted Associations with Time to COVID-19

The multivariable analyses also found that, the more recent the last prior COVID-19 episode was the lower the risk of COVID-19, and that the greater the number of vaccine doses previously received the higher the risk of COVID-19.

Bivalent vaccine effectiveness among those with prior SARS-CoV-2 infection or vaccination

Given that both natural immunity and vaccine-induced immunity protect against COVID-19, and both forms of immunity wane over time, one way to assess the effectiveness of a vaccine is to adjust for time since the proximate SARS-CoV-2 exposure by infection or vaccination. Among persons with prior exposure to SARS-CoV-2 by infection or vaccination, hazard ratios for bivalent vaccination for individuals, after adjusting for time since proximate SARS-CoV-2 exposure, are shown in table 3. This analysis shows that, in addition to a 21% protective effect of bivalent vaccination, those with last exposure to SARS-CoV-2 6-9 months previously have twice the risk, and those exposed 9-12 months previously have 3.5 times the risk, of COVID-19, compared to those with last exposure within the preceding 90 days.

Table 3.Adjusted associations with time to COVID-19, among those with prior SARS-CoV-2 exposure, adjusted for time since proximate SARS-CoV-2 exposure by prior infection or prior

---

DISCUSSION

This study found that the current bivalent vaccines were about 30% effective overall in protecting against infection with SARS-CoV-2, when the Omicron BA.4/BA.5 lineages were the predominant circulating strains. The magnitude of protection afforded by bivalent vaccination was similar to that estimated in a recent study using data from the Increasing Community Access to Testing (ICATT) national SARS-CoV-2 testing program [16].
The strengths of our study include its large sample size, and its conduct in a healthcare system where a very early recognition of the critical importance of maintaining an effective workforce during the pandemic led to devotion of resources to have an accurate accounting of who had COVID-19, when COVID-19 was diagnosed, who received a COVID-19 vaccine, and when. The study methodology, treating bivalent vaccination as a time-dependent covariate, allowed for determining vaccine effectiveness in real time.

The study has several limitations. Individuals with unrecognized prior infection would have been misclassified as previously uninfected. Since prior infection protects against subsequent infection, such misclassification would have resulted in underestimating the protective effect of the vaccine. However, there is little reason to suppose that prior infections would have been missing in the bivalent vaccinated and non-vaccinated states at disproportionate rates. Those who chose to receive the bivalent vaccine might have been more worried about infection and might have been more likely to get tested when they had

symptoms, thereby disproportionately detecting more incident infections among those who received the bivalent vaccine. This risk is mitigated by the time-dependent treatment of bivalent vaccination, because with such treatment, risk of disproportionate detection is actually in the opposite direction. If individuals received the bivalent vaccine thinking it would reduce their risk of infection, they would have been less inclined to get tested for the same symptoms after getting the vaccine (bivalent vaccinated state) than before getting the vaccine (non-bivalent vaccinated state), providing greater opportunity to detect infection in the non-boosted than the boosted state, thereby having the effect of overestimating vaccine effectiveness. Those who chose to get the bivalent vaccine were also more likely to have lower risk-taking behavior with respect to COVID-19, having the effect of a higher risk of COVID-19 in the non-boosted state (as those who chose not to get the bivalent vaccine, expectedly with higher risk-taking behavior, remained in the non-boosted state throughout the duration of the study), thereby again potentially overestimating vaccine effectiveness. The widespread availability of home testing kits might have reduced detection of incident infections. This potential effect should be somewhat mitigated in our healthcare cohort because one needs a NAAT to get paid time off, providing a strong incentive to get a NAAT if one tested positive at home. Even if one assumes that some individuals chose not to follow up on a positive home test result with a NAAT, it is very unlikely that individuals would have chosen to pursue NAAT after receiving the bivalent vaccine more so than before receiving the vaccine, at rates disproportionate enough to affect the study's findings. We were unable to distinguish between symptomatic and asymptomatic infections, and had to limit our analyses to all detected infections. Variables that were not considered might have influenced the findings substantially. There were too few severe illnesses for the study to be able to determine if the vaccine decreased severity of illness. Our study of healthcare personnel included no children and few elderly subjects, and the majority would not have been immunocompromised. Lastly, during most of the study the circulating variants were those represented in the vaccine. It is not known if the vaccine will be equally effective when the strains circulating in the community are not those represented in the vaccine.

A possible explanation for a weaker than expected vaccine effectiveness is that a substantial proportion of the population may have had prior asymptomatic Omicron variant infection. About a third of SARS-CoV-2 infections have been estimated to be asymptomatic in studies that have been done in different places at different times [17–19]. If so, protection from the bivalent vaccine may have been masked because those with prior Omicron variant infection may have already been somewhat protected against COVID-19 by virtue of natural immunity. A seroprevalence study conducted by the CDC found that by February 2022, 64% of the 18-64 age-group population and 75% of children and adolescents had serologic evidence of prior SARS-CoV-2 infection [20], with almost half of the positive serology attributed to infections that occurred between December 2021 and February 2022, which would have predominantly been Omicron BA.1/BA.2 lineage infections. With such a large proportion of the population expected to have already been previously exposed to the Omicron variant of SARS-CoV-2, there could be some concern that a substantial proportion of individuals may be unlikely to derive substantial benefit from a bivalent vaccine.

The evolution of the SARS-CoV-2 virus necessitates a more nuanced approach to assessing the potential impact of vaccination than when the original vaccines were developed.

Additional factors beyond vaccine effectiveness need to be considered. The association of increased risk of COVID-19 with higher numbers of prior vaccine doses in our study, was unexpected. A simplistic explanation might be that those who received more doses were more likely to be individuals at higher risk of COVID-19. A small proportion of individuals may have fit this description. However, the majority of subjects in this study were generally

young individuals and all were eligible to have received at least 3 doses of vaccine by the study start date, and which they had every opportunity to do. Therefore, those who received fewer than 3 doses (>45% of individuals in the study) were not those ineligible to receive the vaccine, but those who chose not to follow the CDC's recommendations on remaining updated with COVID-19 vaccination, and one could reasonably expect these individuals to have been more likely to have exhibited higher risk-taking behavior. Despite this, their risk of acquiring COVID-19 was lower than those who received a larger number of prior vaccine doses. This is not the only study to find a possible association with more prior vaccine doses and higher risk of COVID-19. A large study found that those who had an Omicron variant infection after previously receiving three doses of vaccine had a higher risk of reinfection than those who had an Omicron variant infection after previously receiving two doses of vaccine [21]. Another study found that receipt of two or three doses of a mRNA vaccine following prior COVID-19 was associated with a higher risk of reinfection than receipt of a single dose [7]. We still have a lot to learn about protection from COVID-19 vaccination, and in addition to a vaccine's effectiveness it is important to examine whether multiple vaccine doses given over time may not be having the beneficial effect that is generally assumed.

In conclusion, this study found an overall modest protective effect of the bivalent vaccine booster against COVID-19, among working-aged adults. The effect of multiple COVID-19 vaccine doses on future risk of COVID-19 needs further study.

24-1

Heart Inflammation Not Recovered in 80 Percent at 6 Months After Vaccination

Dr. Peter A. McCullough, MD, John Leake May 10 2023

Worrisome serial MRI results in adolescents after primary mRNA series

Every cardiology office in America should be recognizing COVID-19 vaccine-induced myocarditis presenting in young persons, 90 percent are male, with chest pain, effort intolerance, arrhythmias, and cardiac arrest after injections of mRNA vaccines. As I see these patients, the common question is, "When is this over?"

While ECG and blood tests tend to normalize quickly, my concern is that ongoing inflammation is occurring due to continued production of Wuhan Spike protein coded by the long-lasting Pfizer or Moderna mRNA vaccines. While blood tests can give inferences on inflammation, cardiologists also use cardiac MRA to visualize the inflammation, establish the diagnosis, and craft a prognosis. We would hope young teenagers would resolve their MRI results and go on with life. A recent report to the contrary caught my attention.

Barmada et al. studied a clinical cohort consisting of 23 patients hospitalized for vaccine-associated myocarditis and/or pericarditis. The cohort was predominately male (87 percent) with an average age of 16.9 plus/minus 2.2 years (ranging from 13 to 21 years). Patients had largely noncontributory past medical histories and were generally healthy before vaccination. Most patients had symptom onset 1 to 4 days after the second dose of the BNT162b2 mRNA vaccine.

Six patients either first experienced symptoms after a delay of more than seven days after vaccination or were incidentally positive for SARS-CoV-2 by polymerase chain reaction (PCR) testing upon hospital admission—these six patients were thus excluded from further analyses, although they potentially reflect the breadth of clinical presentations of vaccine-associated myopericarditis.

The remaining cohort of 17 patients showed no evidence of recent prior SARS-CoV-2 infection, with antibodies to spike (S) protein but not to nucleocapsid (N) protein and negative nasopharyngeal swab reverse transcription quantitative PCR at hospital admission.

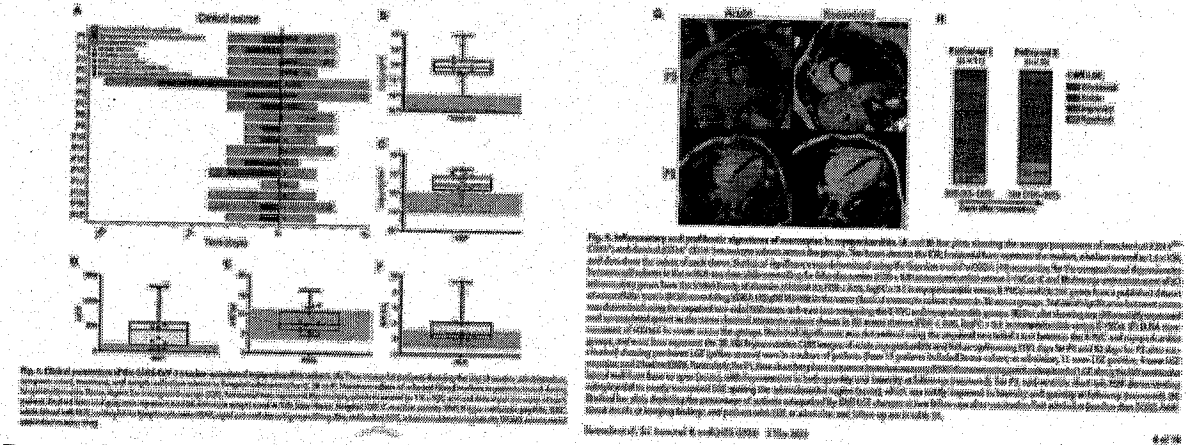
24-2

SCIENCE IMMUNOLOGY | RESEARCH ARTICLE

CORONAVIRUS

Cytokinopathy with aberrant cytotoxic lymphocytes and profibrotic myeloid response in SARS-CoV-2 mRNA vaccine–associated myocarditis

Anis Barmada[1†], Jon Klein[1†], Anjali Ramaswamy[1†], Nina N. Brodsky[1,2†], Jillian R. Jaycox[3], Hassan Sheikha[1,2], Kate M. Jones[3], Victoria Habet[3], Melissa Campbell[3], Tomokazu S. Sumida[3], Amy Kontorovich[4], Dusan Bogunovic[4,5], Carlos R. Oliveira[2], Jeremy Steele[2], E. Kevin Hall[2], Mario Pena-Hernandez[1], Valter Monteiro[1], Carolina Lucas[1,6], Aaron M. Ring[1], Saad B. Omer[7,8,9], Akiko Iwasaki[1,10,11*], Inci Yildirim[2,8,9,9*], Carrie L. Lucas[1,9*]



Barmada A, Klein J, Ramaswamy A, Brodsky NN, Jaycox JR, Sheikha H, Jones KM, Habet V, Campbell M, Sumida TS, Kontorovich A, Bogunovic D, Oliveira CR, Steele J, Hall EK, Pena-Hernandez M, Monteiro V, Lucas C, Ring AM, Omer SB, Iwasaki A, Yildirim I, Lucas CL. Cytokinopathy with aberrant cytotoxic lymphocytes and profibrotic myeloid response in SARS-CoV-2 mRNA vaccine-associated myocarditis. Sci Immunol. 2023 May 12;8(83):eadh3455. doi: 10.1126/sciimmunol.adh3455. Epub 2023 May 5. PMID: 37146127.

While the authors clearly show high levels of inflammatory markers, my attention was drawn to the follow-up MRI scans. As shown in the figure, only 20 percent had resolved their abnormalities (late gadolinium enhancement) at over six months (199 days).

This paper raises questions:

1. Is there ongoing heart damage and inflammation at six months?
2. Does the LGE in 80 percent represent a permanent "scar" putting these children at risk for future cardiac arrest? These data strongly call for large-scale research into this emerging problem given the large number of potential young persons at risk.

25-1

Covid Vaccines Increase Menstrual Bleeding Risk by Up to 41%, BMJ Study Finds – But the Authors Downplay it

Thorsteinn Siglaugsson | Daily Sceptic May 9, 2023

I have previously written about a tendency by medical study authors to downplay their results if they don't conform with the official narrative regarding the COVID-19 vaccines.

A study done in Iceland and published last summer **found** that double-vaccinated individuals were 42% more likely to become reinfected than others. But in their conclusions the authors called this just a "slightly higher" probability.

Now, a new **study** is out, published in the *BMJ*, that deals with female menstruation problems following vaccination. Nothing to worry about, according to mainstream media **reporting**. Indeed, in their conclusions the authors say:

Weak and inconsistent associations were observed between SARS-CoV-2 vaccination and healthcare contacts for bleeding in women who are postmenopausal, and even less evidence was recorded of an association for menstrual disturbance or bleeding in women who were premenopausal. These findings do not provide substantial support for a causal association between SARS-CoV-2 vaccination and healthcare contacts related to menstrual or bleeding disorders.

No reason to worry – really? Let's take a look at the results section now:

2,580,007 (87.6%) of 2,946,448 women received at least one SARS-CoV-2 vaccination and 1,652,472 (64.0%) 2,580,007 of vaccinated women received three doses before the end of follow-up. The highest risks for bleeding in women who were postmenopausal were observed after the third dose, in the 1-7 days risk window (hazard ratio 1.28 (95% confidence interval 1.01 to 1.62)) and in the 8-90 days risk window (1.25 (1.04 to 1.50)). The impact of adjustment for covariates was modest. Risk of postmenopausal bleeding suggested a 23-33% increased risk after 8-90 days with BNT162b2 [Pfizer] and mRNA-1273 [Moderna] after the third dose, but the association with ChAdOx1 nCoV-19 [AstraZeneca] was less clear. For menstrual disturbance or bleeding in women who were premenopausal, adjustment for covariates almost completely removed the weak associations noted in the crude analyses.

So, actually significant risk for postmenopausal even after adjustments, but for premenopausal the "weak associations" were removed after adjustment for covariates. Why those huge adjustments? Before adjustment they found statistically significant increases of up to 44% – but that top figure was 'adjusted' away to just 4% (see **Table 3**). Yet even after these heroic adjustments there was still a 25% increase in menstrual disturbance following the first dose.

Anyhow, let's look at the actual numbers by product for postmenopausal.

First Pfizer: adjusted risk (right-hand column) is 1.41 or 41% higher than the unvaccinated after 1-7 days from the third dose and 1.23 or 23% higher after 8-90 days. Both are statistically significant. "Weak and inconsistent?" Really?

25-2

BNT162b2 (Pfizer-BioNTech)					
Unvaccinated	646 760	3144	486.1	ref	ref
Dose 1:					
1-7 days	20 466	120	586.3	1.16 (0.96 to 1.40)	1.09 (0.90 to 1.32)
8-90 days	103 775	532	512.6	1.11 (0.99 to 1.24)	1.01 (0.90 to 1.14)
Dose 2:					
1-7 days	21 006	101	480.8	1.13 (0.92 to 1.40)	1.02 (0.83 to 1.26)
8-90 days	247 223	1240	501.6	1.24 (1.13 to 1.37)	1.14 (1.04 to 1.26)
Dose 3:					
1-7 days	15 668	95	606.3	1.59 (1.23 to 2.06)	1.41 (1.09 to 1.83)
8-90 days	138 714	724	521.9	1.36 (1.13 to 1.63)	1.23 (1.02 to 1.48)

Now for Moderna: adjusted risk is 1.33 or 33% higher than unvaccinated after 1-7 days from first dose and also 8-90 days after the third (the latter is statistically significant). Again, "weak and inconsistent"?

mRNA-1273 (Moderna)					
Unvaccinated	646 760	3144	486.1	ref	ref
Dose 1:					
1-7 days	2612	18	689.2	1.44 (0.90 to 2.03)	1.33 (0.84 to 2.13)
8-90 days	13 911	73	524.8	1.24 (0.97 to 1.58)	1.13 (0.88 to 1.44)
Dose 2:					
1-7 days	2691	5	185.8	0.45 (0.19 to 1.08)	0.41 (0.17 to 0.99)
8-90 days	31 409	150	477.6	1.23 (1.02 to 1.48)	1.12 (0.92 to 1.35)
Dose 3:					
1-7 days	7238	33	455.9	1.17 (0.80 to 1.72)	1.04 (0.71 to 1.53)
8-90 days	47 539	272	572.2	1.53 (1.22 to 1.91)	1.33 (1.06 to 1.67)

Finally AstraZeneca: adjusted risk is 1.24 or 24% higher than the unvaccinated 1-7 days after the first dose and 1.21 or 21% higher than unvaccinated after the second (though neither result is statistically significant).

25-3

ChAdOx1 nCoV-19 (AstraZeneca)					
Unvaccinated	646 760	3144	486.1	ref	ref
Dose 1:					
1-7 days	4429	28	632.2	1.14 (0.78 to 1.66)	1.24 (0.85 to 1.81)
8-90 days	41 414	239	577.1	1.16 (1.01 to 1.34)	1.17 (1.01 to 1.35)
Dose 2:					
1-7 days	3518	16	454.8	1.27 (0.76 to 2.11)	1.21 (0.73 to 2.02)
8-90 days	41 671	171	410.4	1.17 (0.95 to 1.43)	1.14 (0.92 to 1.40)

Last October, the European Medicines Agency finally **recommended** adding menstrual problems to the already long list of COVID-19 vaccine side-effects. It was about time, after the flood of reports from women. The results of the new study reinforce those concerns, as shown above.

The question that remains is why the glaring discrepancy between the actual results and the authors' conclusions?

The authors know full well that most journalists neither read nor understand scientific studies; they know how their highest ideal of verification is **appeal to authority** ('the authors say, therefore it is true'). Every scientist knows this. Therefore, it is the authors' responsibility to correctly portray and highlight their actual findings. But instead they try to hide them.

Why?

Is the answer to be found in the 'competing interests' section, perhaps?

Competing interests: All authors have completed the ICMJE uniform disclosure form at www.icmje.org/disclosure-of-interest/ and declare: MG reports personal fees from AstraZeneca, Gilead, GSK/ViiV, MSD, Biogen, Novocure, Amgen, Novo Nordisk, outside the submitted work. SL reports consulting for Scandinavian Biopharma and is an employee of AstraZeneca since 16 January 2023. The work in this article was performed before this employment commenced. FN reports prior employment at AstraZeneca until 2019, and ownership of some AstraZeneca shares. MB and YX declare no competing interests. AS reported participating in research funded by governmental agencies, universities, Astellas Pharma, Janssen Biotech, AstraZeneca, Pfizer, Roche, (then) Abbott Laboratories, (then) Schering-Plough, UCB Nordic, and Sobi, with all funds paid to Karolinska Institutet, outside of the submitted work. RL reported receiving grants from Sanofi Aventis paid to his institution outside the submitted work; and receiving personal fees from Pfizer outside of the submitted work.

26-1

RFK Jr: Pharma Makes $60 Billion/Yr From Vaccines, $500 Billion Selling Remedies for VAXXX Injuries

May 2023

Video - https://rumble.com/v2l1d7u-rfk-jr-pharma-makes-60-billionyr-from-vaccines-500-billion-selling-remedies.html