The PAAM Medical Letter

Vol 12, Issue 1

March 4, 2025

Dear Colleagues!

Welcome to another edition of the PAAM Medical Letter! Thank you to all who have renewed their 2025 membership in PAAM or your subscription to the PAAM Medical Letter. We need your support!

Open access back issues (older than 12 months), may be accessed here. For those who are new to the PAAM Medical Letter: Most of the repository of ~ 500 articles, collections/journals and audio files on AM are open access, and do not require an account. Questions and feedback regarding AnthroMed Library (anthromed.org): library@anthroposophicmedicine.org.

Please note the following:

First, this Letter is for your thoughtful consideration and personal research and is not to be taken as something dogmatic to believe in, nor to promote as something official from PAAM or from the international anthroposophic medical movement. The content of the letter is the sole responsibility of the editor.

Second, the PAAM Medical Letter will continue not having the attachments of the articles separate from the text and content of the letter. Instead, the direct links to the articles are provided at the end of the summary and contents of each one. A few of them will not be open access. These few articles you can find by clicking the link to the appropriate journal website or on PubMed which often has the articles as an abstract or the full article to retrieve. The change will make it simpler and quicker to format the Letter and send it out in a timelier fashion. Thank you.

Third, this will be my last year as the editor and writer of the PAAM Medical Letter. Thank you for your support and encouragement over the years. Please let the PAAM Board know if any of you are interested in writing something informative for the members and subscribers on a regular basis. The format is open and certainly does not have to be something like the past PAAM Medical Letters. Please seriously consider contributing something. Thank you!

Meditation

The sphere of the Spirit is the soul's true home
And a person will surely reach it
By walking on the path of honest thought;
By choosing as one's guide, the fount of love
Implanted in one's heart;
By opening the eyes of the soul
To nature's script
Spread out before the soul through all the universe,
Telling the story of the Spirit
In all that lives and thrives,
And in the silent spaciousness of lifeless things,
And in the becoming stream of time.

Rudolf Steiner, p.139 in *Verses and Meditations,* Rudolf Steiner Press,2004 [Modified slightly by the editor]

The stars once spoke to Man
It is world destiny
That they are silent now.
To be aware of the silence
Can become pain for earthly Man.

But in the deepening silence
There grows and ripens
What Man speaks to the stars.
To be aware of the speaking
Can become strength for Spirit-Man.

Rudolf Steiner, p.97 In *Verses and Meditations*, Rudolf Steiner Press, 2004

Note: In this verse, the word "Man" means both each individual human being—male or female-(like the original Adam Kadmon meaning)- as well as at the same time all of humankind. Substituting "Man" with the words "the human being, human beings or humanity" would not due justice of what Steiner was saying, nor would it be very poetic. The German word Steiner uses is "Menschen" which is gender neutral. "Spirit-Man" is a technical term in anthroposophy that is also gender neutral and refers to a far-off time when human beings and humankind will have reached its lofty distant goal . A distant time when we will have finally transformed and purified our lower members by our willed "I" and, of course, with ever present help of lofty spiritual beings who are very interested in our succeeding. The developing germ of Spirit-Man already exists in each person. It is up to each of us to find ways to spiritually develop and contribute to the forming our won ideal as Spirit-Man.

Strength by overcoming obstacles and the role of illnesses--excerpt:

Man has to acquire his strength by overcoming obstacles in the world, one after another. Strictly speaking all our strength was acquired by the overcoming of obstacles in previous incarnations. Our present capacities are the result of our illnesses in earlier lives.

Rudolf Steiner (GA 107) The Being of Man and His Future Evolution – **VI. Illness and Karma,** Berlin, 26th January 1909, https://rsarchive.org/Lectures/GA107/English/RSP1981/19090126p01.html

Translated by Pauline Wehrle

The Calendar of the Soul

Verse #45

There grows firm the power of thought
In union with the Spirit's birth;
It brightens the senses dull enticements
To lucid clarity.
When the soul—in fullness—
Seeks to unite itself with the world's becoming
Must sense-revelation
Receive the light of thinking.

Verse #8 (complementary verse)

There waxes warm the senses' power
In union with the Gods' creating;
It presses down thinking's strength [its vigor]
To a dreamy dullness.
When godly being
Seeks to unite itself with my soul
Must human thinking
In dream existence humbly rest content.

Virtues of the Month

Aquarius: (1/21 – 3/1) Discretion, reticence becomes meditative strength, meditative capacity
Pisces: (2/21 – 4/1) Magnanimity becomes love

Medical and Other Relevant Literature

Featured articles:

1. Anthroposophic Medicine's activity-based mindfulness via an online program.

   This is an open access article published on 10/15/24 by AM researchers at University of Bern and an eurythmy teacher in Nidau, Switzerland. They performed uncontrolled observational single-arm design testing on whether an AM-based mindfulness-based intervention would address and help (perceived) stress reduction and improve mindfulness, based on validated surveys. They did a large-scale study using their well - developed AM- and activity-based online program given over 8 weeks with up to four measurements. The training had four components, such as extensive self-experience with the practices, attending a sequence of training lectures, completing a practicum in which trainees had to teach the specific methods used in the program (Activity-Based Stress Release, "ABSR") in a group setting, and a final assessment by means of a written report or presentation.

   There were 830 subjects who took part in the study, but only 53.5% completed at least two survey questionnaires and only 22.4% completed all four planned surveys. This large drop-out rate is typical for most online survey studies. Table 1 gives a brief description of the 8 ABSR modules. The modules included 8 different aspects of stress or mental restlessness (Steiner's "nervousness"), 8 activity-based exercises which were conscious mental exercises or practices to be done and 8 corresponding eurythmy exercises.

   The authors demonstrated a statistically significant difference at 4 and 8 weeks. A 12-weeks follow-up survey showed non-significant change from 8 weeks, which means the effects were durable up to 12 weeks.

This study showed very similar results to other mindfulness-based studies for stress reduction, but adds an important dimension that a different, less passive -inward approach of AM-based exercises can also work.

They discussed the usual limitations of this preliminary study and acknowledged the need for RCTs with longer follow-up to be conducted to confirm and expand on the research.

Citation: Timm E, Ko YM, Hundhammer T, Berlowitz I and Wolf U (2024) Activity-based mindfulness: large-scale assessment of an online program on perceived stress and mindfulness.
Front. Psychol. 15:1469316.Doi: 10.3389/fpsyg.2024.1469316.
https://www.frontiersin.org/journals/psychology/articles/10.3389/fpsyg.2024.1469316/full. (Open access)

2. A real-world comparative study on using *Viscum album* L. and immune checkpoint inhibitors for advanced or metastasized non-small-cell lung cancer in terms of overall survival.

This is open access medium-sized , nonrandomized , observational study from the accredited German registry, Network Oncology, published in 4/21/24. It had a total of 415 patient cases with two nonrandomly allocated but comparable groups with respect to clinical status, tumor stage, histology and some tumor molecular biomarkers, conventional oncologic treatments, comorbidities, and patient characteristics. However, obesity was significantly higher in the control groups (PD-1/PD-L1 inhibitors- treated patients), and tumor molecular markers such as BRAF V600E and EGFR were not known in the majority. This is important because EGFR (Epidermal Growth Factor Receptor) mutations are known to activate the EGFR signaling pathway leading to a likely uninflamed tumor microenvironment from increased immunosuppressive factors like TGF-✔ that lead to less inflammatory interleukins like IL-6, IL-8 and TNF-✔. This

specific non-inflammatory tumor type may respond differently to *Viscum album* treatment.

The overall results between the two groups show a significant difference in overall survival (a hard and favored endpoint) in the combination group with add-on *Viscum album* treatment with a 7-month-longer median survival (13.8 months vs. 6.8 months, by $\chi^2 = 17.5$, $p < 0.001$). See graph of Fig. 2 for an easy visual difference and how the two graphs tend to converge somewhat at the end with very few patients in either group surviving. These graphs demonstrate that few patients survive in either group by 50 months.

There was no difference in adverse reactions. Unfortunately, this paper did not give any details of the route and dose of *V. album* used in the combination group. In addition, there was no published measure of patients' quality of life. The authors did point out that a small "real-world evidence study" presented at the German Cancer Congress, Berlin in 2018, did indicate that adding *V. album* to standard nivolumab (Immune checkpoint inhibitor) reduced nivolumab-induced toxicity by 50%.

This medium-sized nonrandomized observational study adds to the evidence of other smaller studies that the addition of *Viscum album* to immune checkpoint inhibitors treatment in cancer is safe and seems to have a synergic effect for modestly improving overall survival by about 7 months. A hypothesis-generating subgroup analysis (N=171) of advanced or metastatic NSCLC patients with PD-L1 tumor proportion score $\geq$1% and first-line immune checkpoint blockade suggests a more significant median overall survival of 21 months longer (26.4 months vs. 5.4 months). See Figure 3.

Two major limitations of the study are 1. Nonrandomization which can lead to unrecognized confounders that could be responsible for the difference and can't establish a causation of *V. album*. To reduce the confounding bias the authors applied multivariable logistic regression methods addressing known confounders. This is helpful

and reassuring but unknown cofounders potentially affecting the positive results can't be identified and accounted for. 2. Most patients' molecular tumor marker status was unknown, and since the start of the study, there have been additional biomarkers identified that could have an impact on prognosis.
The authors rightly call for prospective RTCs to validate the study's findings and to help further understand the specific impact of *V.album* added to PD-1/PD-L1 inhibitors.

For those who are contemplating using mistletoe in conjunction with immune checkpoints inhibitors, they should definitely read the introduction and discussion sections to get a better grasp of the context and important details of this and other studies.

Citation: Schad, F.; Thronicke, A.; Hofheinz, R.-D.; Matthes, H.; Grah, C. Patients with Advanced or Metastasised Non-Small-Cell Lung Cancer with Viscum album L. Therapy in Addition to PD-1/PD-L1 Blockade: A Real-World Data Study. *Cancers* 2024, 16, 1609. https://doi.org/10.3390/cancers16081609. https://www.mdpi.com/2072-6694/16/8/1609. (Open access)

3. Criticism of neoDarwinian evolution through natural selection.

There has always been cogent criticism of Darwin's theory of natural selection as the main or only driver of evolution. Recently there have been more criticism from biologists themselves. The standard Modern Synthesis of neoDarwinism is "gene-centric" in nature, emphasizing genes, mutations, genetic drift in population, and adaption through the materialist and mechanistic process of natural selection—a gradual process. Over the past two decades there has been a coalescing of sorts around a new Extended Evolutionary Synthesis that is more "organism-centric." It doesn't deny that natural selection exists nor that the mechanisms of the Modern Synthesis aren't valid in some sense, but this new working framework extends and reformulates these ideas into a new synthesis by emphasizing instead a different set of factors. These include development biases that limit what genetic changes will succeed, developmental plasticity, a focus on

evolvability, inherency of form, the dimensionality of fitness landscapes, as well as multilevel selection in major, nongradual evolutionary changes, epigenetic inheritance, niche construction in an environment by organisms that facilitates their adaptation, and other aspects. An internet search about the Extended Evolutionary Synthesis can give the reader further details and information.

The theoretical biologist, S.N. Salthe has published an analysis on his website. It is a critique of the concept of natural selection and the neoDarwinian theory of evolution, ie., the Modern Synthesis, that can be very illuminating. His working article is freely available on his website. Only a few salient points can be addressed here.

1. In the Origin of Species (1859), Darwin explicitly mentions that he took the political economist Mathus' view of the population law of geometric increase in the population with a scarcity of resources that leads to a need for competition for survival, ie., the theory of Capitalism ,and applied it, projected it, onto organic evolution as a simple and efficacious explanation of it .This, of course, makes the theory suspect because it came from British (and American) views of Capitalism as the best form of economy and government. Darwin's natural selection theory privileges short-gain expedience, gradualism and opportunism, which are essential aspects of Capitalism. Peter C. Reynolds in his Life Without Darwin (2019) goes into much detail about this.
2. A corollary to the above is that the theory of natural selection(and attendant competition of the fittest for survival) fits very neatly the conceptual and world view of our culture. It's "truth" is suspect since that is the lens that Darwinian (and many of us) use to "see" the world.
3. The theory is materially empty. This is because it has incorporated multiple fields into its view. Since, if all is required is pre-existing variability, trait heritability, a need to fit into an environment to better survive, and any variant trait can be equality propagated, then there is little restriction on the kinds of systems/organisms that could be susceptible to a selectionist interpretation. Consequently, anything found in nature can be explained, in some way, as a result of natural selection.

4. Philosophers and cognitive scientists have pointed out that the theory of natural selection is so broad that it lacks any true explanatory power,; it only gives tautologies (truths said in different but equal ways), lacks predictive power and lacks true verification and potential falsifiability. These are philosophical and logical arguments that are devastating to any theory. Jerry Fodor and Massimo Piattelli-Palmarini write about this in their book, *What Darwin Got Wrong* (2010).Their analysis is brilliant, but their style of writing can be difficult to understand at times.
5. Models developed for evolutionary change are unsatisfactory. They can't model generally more than a single (or two) phenotypic trait(s) during a given period of time. Population models only go out three generations and often shown negative reduction in variability of traits and not new traits developing. Darwinian models can't explain convergent evolution and ecological vicariance (environmental fragmentation so that a large population of a species is divided environmentally distinct subgroups that evolve separately).

Finally, what does anthroposophy have to say? Certainly, there has been both organic and spiritual evolution. The discovery of evolution in a modern sense is an advance over having only static created forms in biology. Natural selection is a relatively obvious way some of evolution can occur, but it is trivial compared to other, more far more, important factors, such as evolution from spiritual beings and forces who develop material forms over time for the major kingdoms of mineral, plants, animals and humans. Evolution is not only gradual, but at times takes leaps in development (a form of saltation debated in biology). Spiritual evolving forces and beings as the primary movers in evolution are compatible with observable organic evolution. Evolution is not a primarily a materialist mechanism—this is only a reflection of the ingrained materialistic thinking that is in science and society since the early 19th century. This only a brief summary of some key points.

Citation: SN Salthe, Analysis and critique of the concept of Natural Selection (and of the neoDarwinian theory of evolution) in respect (Part 1) to its suitability as part of

Modernism's origination myth, as well as (Part 2) of its ability to explain organic evolution. https://www.nbi.dk/~natphil/salthe/Critique_of_Natural_Select_.pdf. Last update 3.2006. (Open access)

4. The health effects of polyunsaturated fatty acids (PUFAs), especially linoleic acid (LA).

Many conservative commentaries argue that vegetable oils ("seed oils") are unhealthy and their increase intake of LA in the standard American diet is associated with all the increasing common chronic diseases. They argue principally based on basic scientific studies, biochemistry/molecular biology, animal studies and the complicated production methods used in the industry. Their arguments have only a very thin base of evidence in clinical human studies.

Joseph Mercola and Christopher R. D' Adams argue this criticism in their extensive 2023 review (Mercola, J.; D'Adams, C.R .Linoleic Acid: A Narrative Review of the Effects of Increased Intake in the Standard American Diet and Associations with Chronic Disease. *Nutrients* 2023, 15, 3129.(https://doi.org/10.3390/nu15143129,) Other authors also argue this same basic point.

However, two subsequent comprehensive reviews with clinical human studies, both prospective observational trials and RCTs argue the opposite, ie., LA, linoleic acid, at clinically recommended doses is overall healthy with no demonstrated detrimental effects. The current recommendation in the USA is to have between 5-10% of calories, or 12 g/d for women and 15-17 g/d for men, depending on age. (In the EU it is $\geq$4 g/d.) These two reviews provide additional helpful information about PUFAs and LA, as well as the flaws on the critics' reasoning about their ill effects.

Many Americans eating the standard American diet are currently getting 20-25% of the calories for poor quality and poorly handled vegetable oils (including tropical oils) in

association with processed and ultra-processed foods, and these are undoubtedly bad for people's health. This diet is not what health experts (nutritionists, epidemiologists and cardiologists, etc.) recommend. On this point, the critics of seed oils and health experts agree. However, the critics go far beyond that and claim that LA , while an essential PUFA, is intrinsically bad in the diet in excess of 2-3% of total calories and is also potentially bad because of the unstable and easily oxidized 2 or more carbon double bonds in LA and other PUFAs. Again, this is almost exclusively argued on the basis of non-human studies and non-trial data. The critics want to return to historical use of beef tallow, butter and ghee (as well as now adding coconut oil) when CVD disease was quite low.

In summary, these two clinical and basic science reviews state: 1. There is strong and consistent evidence demonstrating that higher intake of PUFA, up to 10% of calories, by replacing saturated and trans-fat sources, is associated with less CV disease incidence, CAD events and CV disease mortality. This PUFA intake also seems to be true for leading to less cancer incidence and mortality as well. 2. There is less strong, but suggestive, evidence for monosaturated fatty acids (MUFA) from plant sources replacing saturated fat is also associated with lower risk of CVD. 3. Clinical evidence also suggests that that diets higher in unsaturated fats (MUFA and PUFA) are associated with reducing the risk of T2DM and decreasing insulin resistance. 4. While basic science and animal studies suggest that diets high in PUFA run the risk of leading to more pro-inflammatory mediators and oxidized lipids that are highly reactive and detrimental, this is an oversimplification of what happens *in vivo* in human beings. Humans have complex oxidative-reduction pathways that mitigate any demonstrated significant increase in pro-inflammatory markers or oxidative stress and oxidized lipids *in vivo.* In addition, clinical human studies do not demonstrate these proposed ill effects of LA. Biochemistry and animals studies aren't always relevant for humans. A point Steiner has made over 100 years ago.

Now there are some caveats about the positive benefits of LA (at proper amounts). The meta-analyses and systematic reviews are often superficial with the omission of the assessment of quality of the clinical protocol and context of the intervention, The only quality assessment that concerned these reviews and meta-analyses of these trials have been a formal analysis of the design and execution of the RCT, However, the studied trials are often of short duration and their analyses by the reviews lack any addressing of various aspects of the clinical quality of the studies, such as the source of LA, the dose across the studies, etc. While the observational prospective trials have large datasets, there could still be confounders that are unknowingly affecting the positive results and not be due to the LA intervention.

While these can be important caveats that could potentially affect the conclusions made in the reviews, only longer, better designed human trials with attention to the clinical aspects of the protocol can adequately address these concerns. Arguing about the potential ill effects of seed oils based on in vitro and animal data is fraught with errors of judgment.

One of the reviews mention that the safe storage of the oils is to be at room temperature and kept in the dark away from light. Also use a vegetable/seed oil with a high smoke-point of about or near 450 F to be safe for high heat on the stove. Lastly safflower and sunflower oils that are safe for high heat are ones that have mid-high amount of oleic acid, a monosaturated fat.

Citations: Kristina H. Jackson, William S. Harris, Martha A. Belury4, Penny M. Kris-Etherton and Philip C. Calder. Beneficial effects of linoleic acid on cardiometabolic health: an update. *Lipids in Health and Disease* (2024) 23:296. https://lipidworld.biomedcentral.com/articles/10.1186/s12944-024-02246-2. (Open access)

Kristina S. Petersen, Kevin C. Maki, Philip C. Calder, Martha A. Belury, Mark Messina, Carol F. Kirkpatrick and William S. Harris. Perspective on the health effects of unsaturated fatty acids and commonly consumed plant oils high in unsaturated fat. *British Journal of Nutrition* (2024), 132, 1039–1050 https://doi.org/10.1017/S0007114524002459. (Open access)

5. Recent articles on the question of vaccines, specifically the MMR vaccine, not causing autism,

Previous observational-epidemiological studies trying to disprove the notion that "vaccines," more specifically the MMR, is not associated with autism are all plagued with methodological errors, specious statistical manipulations and downright fraudulent or incomplete data. A newer, epidemiological study on the MMR-autism connection has been claimed to be the best evidence to show "vaccines do not cause autism" in lay and professional media. Of course, anyone can see that the only vaccine being studied was the MMR vaccine. There is always this hyperbole by professional and lay leaders in the discussion about vaccines and autism because only the MMR, of all the vaccines, has had any dedicated study.

The study in question is Hviid, et al, Measles, Mumps, Rubella Vaccination and Autism in *Annals of Internal Medicine* 2019 (not open access). Many respected scientists have considered this study the best evidence so far in showing no association between the MMR and autism. It certainly is an improvement on previous published research. However, a careful scrutiny of the methods used in this study as well as the investigation of researchers and sponsors' conflict of intertest can sow sufficient doubt about the validity of the article's conclusion, let alone the hyperbole by biomedical and public health authorities.

A 2025 preprint review demonstrates all the weaknesses and problems with the study and has gathered together various criticisms already made by others. The article is Hviid et al.

2019 Vaccine-Autism Study: *Much Ado About Nothing?* (open access.) This long critical article was a monumental effort that is written in a style so that an intelligent reader with some basic knowledge about medical science can understand it. Given the ideology, censorship and bio-pharmaceutical industry capture demonstrated by medical journals, their editors, public health authorities and regulators, this article isn't likely to be accepted for publication in a mainstream journal

The authors systematically go through the study and all its methodological flaws, biased exclusions, discrepancies and statistical approach and conclude that authors "did not faithfully intend or interpret the data to this their hypothesis and therefore cannot possibly have falsified it." Furthermore, the authors' data is not available for an independent assessment by other scientists to check their results for reproducibility. The authors and sponsors also have significant conflicts of interest that would influence them to not want to have an association study between the MMR and autism to produce positive results. Reading this article will sharpen your critical skills to learn what to look for in these easily manipulated epidemiological studies and how there is incomplete and misleading disclosure statements for potential conflicts of interests.

Citations: Anders Hviid, DrMedSci; Jørgen Vinsløv Hansen, PhD; Morten Frisch, DrMedSci; and Mads Melbye, DrMedSci. Measles, Mumps, Rubella Vaccination and Autism: A Nationwide Cohort Study. *Ann Intern Med.* 2019 Apr 16;170(8):513-520.doi: 10.7326/M18-2101. Epub 2019 Mar 5. https://pubmed.ncbi.nlm.nih.gov/30831578/. (Non-open access)

Jeremy R. Hammond, Jeet Varia and Brian Hooker. Hviid et al. 2019 Vaccine-Autism Study: *Much Ado About Nothing?* Preprints.org. DOI:10.20944/preprints202501.0796.v1 . (Open access)

6. Risk factors for measles case fatality rate.

In the journal *Vaccines* is a paper that looked at population-level risk factors related to measles case fatality and the development of a conceptual framework. The authors consulted with several experts and did a literature review to come up with a list of important potential risk factors, largely based on developing countries where the risk factors are most relevant. Once they developed a long list (58) of potential risk factors, they shorten it to ones where there was reasonable evidence in the literature and at least one vote by the experts to include it (37 total). By their process, they also eliminated the lack of exclusive breastfeeding and the presence of poor sanitation quality as risk factors. While both seem likely to be important factors to consider, apparently, they didn't find any published evidence. In any case, no rationale was given for their exclusion as risk factors.

The published literature review only found evidence for 19 risk factors out of the 37, and these were placed into 5 clusters: health system access & care-seeking behavior, health system quality, measles control & epidemiology, nutritional status, and risk of a secondary infection. The literature came from developing country research as well as studies from France and Sweden. Interestingly, vitamin A *supplementation* has not been found helpful in reducing measles case mortality, only high dose Vitamin A *treatment* at 200K IUs/d X 2d (for children≥12 months of age who are likely to be malnourished) has been shown to reduce it. As expected, measles vaccination, especially 2 doses, does reduce mortality. A large average household size (with many children) does increase mortality and this is assumed, without evidence presented, to be due to secondary bacterial infections.

Potential evidence from AM or naturopathic treatment for decreasing measles case mortality has not been published. There is suggestive clinical evidence that both modalities can reduce measles mortality. AM has consistently maintained that measles and other benign childhood febrile (acute inflammatory) diseases serve a useful purpose

in terms of building biological-developmental strength, enhanced health with enduring broad-based immunity, and flexibility for the growing child's soul and spirit. These diseases come in epidemics because, periodically, new children need their assistance in reshaping and improving the body and soul for further steps in development.

Up until the early 1960s, measles was considered to be relatively benign, ie., "a self-limiting infection with moderate severity and low mortality" (Langmuir, Alexander.1962). The mortality of measles and other childhood febrile illnesses, steadily and markedly declined from the 1900s until 1960s. This decline correlates with concomitant improved public sanitation, decreased crowding and squalor, and likely improved nutrition from better socioeconomic conditions. The effective, attenuated live measles vaccine wasn't introduced until 1968, after the mortality of measles had declined about 90%. (The previously introduced killed virus vaccine in 1963 was not very effective.) Of course, the measles vaccine, and later the MMR vaccine, reduced the incidence of measles, but one could question if that is always a good thing. Is there a way to reduce measles mortality without universal measles vaccination or for a much more selective use of it in high-risk cases?

Between 1959 and1962 (before any measles vaccine introduction) there were about 400-500 measles deaths among about 4an estimated million cases a year. The estimated measles mortality would have been ~1/10,000 to ~1/8000. The CDC and biomedical authorities claim that the measles mortality in modern times is 1-3/1,000. However, these are the *reported* (and confirmed) measles cases, but at the same time most cases, some claim up to 75%, are not reported, thus skewing the mortality rate and making measles mortality appear more worrisome. All this information and graphs are brought together in Susanne Humphries, MD and Roman Bystrianyk's book, *Dissolving Illusions.* More recent data in 2013 from France's measles outbreak, *and accounting for an estimated 50% under reporting of measles cases,* suggests the measles mortality rate of 2-3/10,000.

The issue of measles is a complex topic and justice to it cannot be done here. Only a few facts and viewpoints can be brought up. In any event, AM feels that with proper home care and competent clinical care, complications of measles will be much less, and the benefits of measles will be there for the child. Despite claims to the contrary by biomedical authorities, there is treatment for measles with gamma immunoglobulin for acute, severe cases. There are also likely other promising conventional treatments that can explored. In addition, AM and naturopathy have effective natural treatments that are likely to be helpful. A preliminary 1999 study of less-than-optimal quality, yet still informative, with both prospective (N=866) and retrospective (N=115) elements, published in German, did suggest most children do well with measles and serious complications like pneumonia (2.2%), asthma (0.7%) were not that common. Easily-treated acute otitis media incidence was 9%. There were no neurological complications in the total sample of 1001 children. From British GPs' 1958-1959 experience of the measles epidemic published in the BMJ 2.7.59 demonstrated 1 measles death and no cases of encephalitis in 16,000+ reported cases over the epidemic.

Remember, so much more can be said. The citations below will be helpful.

Citations: A.N.; Jit, M.; Mosser,J.F.; Ferrari, M.; Cutts, F.; Papania, M.; Kretsinger, K.; McCarthy, K.A.;Thakkar, N.; Gaythorpe, K.A.M.; et al. Population-Level Risk Factors Related to Measles Case Fatality: A Conceptual Framework Based on Expert Consultation and Literature Review. Vaccines 2023, 11, 1389.https://doi.org/10.3390/ vaccines11081389. https://www.mdpi.com/2076-393X/11/8/1389. (Open access)

Susanne Humphries, MD and Roman Bystrianyk, *Dissolving Illusions. Disease, Vaccines, and the Forgotten History*. 2013, 2015. https://dissolvingillusions.com/.

McKinlay, John B., McKinlay, Sonia M. The Questionable Contribution of Medical Measures to the Decline of Mortality in the United States in the 20th Century. *The Milbank Memorial Fund Quarterly/Health and Society.* Summer 1977. https://www.milbank.org/wp-content/uploads/mq/volume-55/issue-03/55-3-The-Questionable-Contribution-of-Medical-Measures-to-the-Decline-of-Mortality-in-the-United-States-in-the-Twentieth-Century.pdf (Open access)

Armstrong, Gregory L, Conn, Laura A, Pinner, Robert W. Trends in Infectious Disease Mortality in the United States During the 20th Century. *JAMA.* 1999;281(1):61-66. doi:10.1001/jama.281.1.61. https://jamanetwork.com/journals/jama/fullarticle/768249. (Non-open access)

Kummer, Karl-Reinhard.1001 mal Masern - prospektive Untersuchung von 886 und retrospektive von 115 Verläufen in der Praxis
Der Merkurstab 1999;52(6):369-375. https://merkurstab.de/index.php5?page=108&lang=0&ausgabe=24. (Non-open access)

Physicians for Informed Consent. Measles-Disease Information Sheet. 12.2024. https://physiciansforinformedconsent.org/measles/ (Open access)

Physicians for Informed Consent. Waning Immunity and the MMR Vaccine 8.2024. https://physiciansforinformedconsent.org/mmr-waning-immunity/ (Open access)

Antona, D., Lévy-Bruhl, D., Baudon, C., Freymuth, F., Lamy, M., Maine, C....Parent du Chatelet, I. (2013). Measles Elimination Efforts and 2008–2011 Outbreak, France. *Emerging Infectious Diseases*, *19*(3), 357-364. https://doi.org/10.3201/eid1903.121360. (Open access)

7. A recent study evaluates the vaccine effectiveness of the booster mRNA COVID-19 vaccine for the 2023-2024 XBBV.1.5 variant.

This latest published study is a well-done target trial emulation study in high-risk groups (who were previously vaccinated on average 4 times) of the US VA system . It is an open access article (you may need to create an account with the publisher). The study claims to have long-term follow-up., but the enrollment period was only for 3 months, and the median follow-up time was only 176 d (~6 months). Other than this criticism, this study was carefully conceived and executed, is provides the strongest level of evidence against the effectiveness of an mRNA booster "vaccine". This study is NOT a problematic test-negative vaccine effectiveness study that the CDC, and many other authors, like to do. These common test-negative observational trials have the potential to be helpful, but in practice, the comparator groups are not truly comparable in important ways that will affect the validity of the claimed positive results of mRNA gene therapy effectiveness against COVID-19. In addition, most of the positive studies on the mRNA gene therapy have involved a case counting window bias that will bias the gene therapy results to look more positive than they really are. More on this in the next featured article.

I have copied the very readable and informative abstract below.

Abstract

Background:

Monovalent COVID-19 vaccines targeting the XBB.1.5 Omicron variant were introduced in September 2023. In the absence of randomized controlled trials demonstrating their efficacy, information on real-world vaccine effectiveness (VE) is needed.

Objective:

To determine XBB.1.5 COVID-19 VE and the extent to which it declines over time.

Design:

Target trial emulation.

Setting:

U.S. Veterans' Health Administration.

Participants:

Eligible XBB.1.5 vaccine recipients were matched 1:1 to unvaccinated persons in 7 sequential biweekly trials with enrollment from 2 October 2023 through 3 January 2024.

Intervention:

XBB.1.5 COVID-19 vaccination versus no XBB.1.5 vaccination.

Measurements:

Outcomes were ascertained through 10 May 2024 and included any positive result on a SARS-CoV-2 test from day 10 after the matched index date, subsequent hospitalization within 1 day before or 10 days after the positive result, or death within 30 days after the positive result. Vaccine effectiveness was estimated as 100 × (1 − risk ratio).

Results:

Participants (91.3% male; mean age, 69.9 years) included 587 137 pairs of vaccinated and matched unvaccinated persons. Over a mean follow-up of 176 days (range, 118 to 211 days), VE was −3.26% (95% CI, −6.78% to −0.22%) against documented SARS-CoV-2 infection, 16.64% (CI, 6.47% to 25.77%) against SARS-CoV-2–associated hospitalization, and 26.61% (CI, 5.53% to 42.32%) against SARS-CoV-2–associated death. When estimated at 60, 90, and 120 days, respectively, VE against documented infection (14.21%, 7.29%, and 3.15%), hospitalization (37.57%, 30.84%, and 25.25%), or death (54.24%, 44.33%, and 30.25%) showed substantial waning.

Limitation:

Potential for residual confounding and incomplete capture of COVID-19 vaccination and SARS-CoV-2–related outcomes.

Conclusion:

COVID-19 vaccines targeting the XBB.1.5 variant of Omicron were not effective in preventing infection and had relatively low VE against hospitalization and death, which declined rapidly over time.

Primary Funding Source:

U.S. Department of Veterans Affairs.

While the authors mention some limitations, given their way of addressing and correcting for them, they are relatively modest and don't appear to invalidate their published results. The strengths of the study are the inclusion of all-cause mortality as one of the primary outcomes, the careful matching of the treatment and control participants, and looking for the effects of the booster gene-therapy against preventing PCR+ SARS-CoV-2 infection, hospitalization and death. The way the PCR test is generated and used can certainly be problematic and can lead to both false positive and false negative results. When used correctly and intelligently, it is the best objective test we have. Viral cultures are cumbersome and also can be false negative.

These results give strong evidence of a less than 50% vaccine effectiveness for all 3 primary outcomes and time periods evaluated. (There was one exception of ~54% effectiveness against death, but only at 30 d.) This booster mRNA gene therapy does not meet the US FDA's stated claim that an emergency use authorization (EUA) will be granted if there is at least a 50% vaccine effectiveness. The FDA has not required any RCT or human trials of any kind for the EUA of the booster inoculations.

The study also demonstrated a rapid and significant waning in protection from 60-120 d. The booster mRNA gene therapy had even a *negative vaccine effectiveness* against PCR+ SARS-CoV-2 infection of -3.26% at about 6 months. This means you are at slight increased risk for getting more infections than those that did not receive the booster. Longer-term follow-up would have been instructive to see if the risk of infection would go up further.

There have been many other studies demonstrating a negative vaccine effectiveness for SARS-CoV-2 infections and a waning of vaccine-induced protection from SARS-CoV-2 infections, hospitalizations and deaths. Some of these studies are weak evidence because they are ecological, looking different populations with too many possible confounders, or are uncontrolled survey-based studies of patients. In some studies, the protection against death and hospitalization are substantial, even though the protection has been shown to

wane. Most studies do not check for inoculation protection beyond 6-8 months. Because of the waning immunity protection, most biomedical authorities recommend periodic boosters, but their protection has been shown to be short-lived to ~4 months or less.

The positive vaccine effectiveness studies were usually in the first stages of the pandemic, but many of those studies also had methodological problems that biased the published results. Significant protection from severe SARS-Co-V-2 disease and death during the earlier strains of the coronavirus seemed to be real and substantial, but certainly not necessary for healthy children, adolescents and young adults. The early hope for vaccine-induced herd immunity and stopping transmission turned out to be illusionary and not evidence based, but was only wishful thinking based on theoretical models and biased assumptions about a vaccine's effect.

Citation: George N. Ioannou, Kristin Berry, Nallakkandi Rajeevan, *et al.* Effectiveness of the 2023-to-2024 XBB.1.5 COVID-19 Vaccines Over
Long-Term Follow-up. A Target Trial Emulation. Ann Intern Med. Feb 2, 2025, doi:10.7326/ANNALS-24-01015. https://doi.org/10.7326/ANNALS-24-01015. (Non-open access)

8. Studies showing significant waning of protection or negative vaccine effectiveness against SARS-CoV-2 infections.

There are several studies demonstrating either significant waning of vaccine-induced protection against infection, hospitalizations and deaths, especially against the 2021-2022 Omicron variant and successive mutations since then. There are also several studies showing negative "vaccine" effectiveness (ie, they are *ineffective*) against SARS-CoV-2 infections. Some of the better studies showing negative mRNA gene-therapy effectiveness for infection or significant waning protection are the following:

1.Two Cleveland Clinic large, retrospective study results by Shrestha NK, et al were published on their (adult) Ohio healthcare system workers who had previously taken 0 to 4 doses (most commonly 1-4 doses) of the mRNA gene products previous to and during the waves of Omicron variants (BA.4/5, BQ strains and the XBB strains during 9/2022 and 1/2023 start dates) monitored with regular PCR testing. The introduced bivalent inoculation provided only 29% protection against the BA.4/5 lineages infections, 20% during the BQ lineages infections and no demonstrated effectiveness against infection during the XBB lineages. There were only rare severe infections that precluded any valid statistical numbers. The bivalent mRNA "vaccine" protection waned rapidly, likely because of the rapid spread and waves of continually mutating strains. The only significant protective factor was having had a recent previous infection against reinfection. This highly and regularly monitored population of ~50,000 healthcare workers included only adults, were relatively young (mean age ~42 $\pm$13 SD), and with the majority not having been immunocompromised.

2. The Qatar group has published a lot of information on the effects of the mRNA inoculations on their relatively young population (only 9% $\geq$ 50 years of age). In 2022 they published a relatively sound, test-negative case-control study of their whole population looking at the duration of mRNA gene therapies (both vaccine products) protection against Omicron BA.1 and BA.2 subvariants. After the second dose, completing the primary series, vaccine effectiveness protection 1-3 months afterwards was between 36- 71% for Moderna's product and 46-52% for Pfizer's product. This protection rapidly waned so that at $\geq$7 months there was negative effectiveness of the gene products ranging from -12 to-18% and -10 to -20%, for Pfizer and Moderna, respectively.

Receiving the third dose (booster) inoculations did temporarily re-establish "significant" protection against symptomatic, PCR+ COVID-19 infections but only to a range of 39-60% within under a month, but then then protection started to wane to 40-45% protection at $\geq$1 month after dose 3. Unfortunately, there was no longer follow-up after the third

dose, making any conclusion about a longer-term effective protection against infection impossible.

The authors did not state whether they had done any type of case-counting window to determine mRNA inoculation effectiveness. If they had, this would have biased their results in favor for mRNA inoculation effectiveness. The two groups appeared to be well matched ("exact-matched"). Any differences between the two group are likely subtle and unlikely to change the results. Since >85% of the population was vaccinated, this study is largely comparing effectiveness between 2 vs. 3 doses of the mRNA gene therapy.

3. Researchers in Iceland did a population-based cohort study of 11, 500 PCR+ persons during the Omicron wave (Dec. 1,2021 to Feb.13, 2022), ~2.5 months). The Icelandic population at the time had 71.1% vaccination/inoculation rate with 2 or more doses, compared to only 25.5% of the cohort with previous SARS-CoV-2 infections, and therefore, not fully inoculated. Out of an overall Omicron infection rate of 11.5%, the key finding of the study is that those with ≥2 doses had OR 1.42 for infection compared to those with only 0 or 1 dose, thereby documenting negative inoculation effectiveness. Of course, this is a crude, unadjusted study without the information and ability to adjust for many complex confounders. The graphs in the Figure in the paper for various age groups show essentially no effect on protection against Omicron infection for all age groups except the 16-29 -year-old group where ≥ 2 doses led to an increased risk of infection (negative vaccine effectiveness) starting day 50 from of their initial previous infection (during Alpha, Beta and Delta waves) and going up to 650 days.

These results are at least disturbing and should have sparked non-biased, rigorous vaccine effectiveness studies.

4. The UK's SIREN healthcare worker cohort study in 2024 of the 2nd booster dose (dose #4 in the series) of the mRNA inoculations only demonstrated a small and short-lived benefit, ie, 13.1% overall protection, 24% in the first two months post-inoculation, 10.3%

at 2-4 months and 1.7% (with large 95% CIs, -17 to 17.4). This study, as well as others, demonstrated rapid waning of immunity/protection, and likely negative "vaccine" effectiveness at ≥7 post-inoculation. This study appears to be well done with reasonably regular PCR and antigen testing. These 9,560 healthcare workers were relatively young working (non-elderly) adults, highly vaccinated, and with only 2% identified as immunocompromised.

These 4 articles are representative of the research; there are many more published articles showing waning of immunoprotection and even little, or negative, vaccine effectiveness.

From previous research, we know the original mRNA inoculations that were directed to the Wuhan strain led to eventual significant waning of immunoprotection for infection by 4-6 months, and for severe disease at ≥9 months. There were often wide confidence intervals and even wider prediction intervals in the vaccine effectiveness data, when the follow-up period was long enough. This was due to less immunoprotection to the evolving new strains during the pre-Omicron era. Hence, the suggestion for a booster mRNA injection to *partially* booster immunoprotection, at least temporarily, and then periodically thereafter because of waning protection from new variant strains appearing.

During this time, the natural immunity gained from a natural SARS-CoV-2 infection was high and durable (often superior to vaccine-induced immunoprotection) for up to a year or longer, not only against reinfection but also against severe disease. Many studies have shown this (see references below). However, the quality of the studies/data is sometimes suboptimal, with significant potential risk of biases. However, it must be pointed out that this is equally true for the data quality of the RCTs done, as well as various other study designs assessing the mRNA inoculations' effectiveness.

The immunoprotection for the booster inoculations waned even faster than the primary series. This was particularly true during the Omicron and post-Omicron eras.

For the vast majority of the population, a natural infection was with minimal risk (*especially if properly treated*) and with a significant gain in immunoprotection. This was not true for high-risk groups such as the elderly, those with comorbidities, significant disabilities, significant immunosuppression, or with social disadvantages. (There may be other high-risk groups as well.) Of course, a decision for an mRNA inoculation should be ethically done individually without coercion and with proper informed consent about the gaps in our knowledge, poor data and potential risks.

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9. Assessing the quality of the clinical trials, both randomized and observational, regarding their claim of high mRNA “vaccine“ efficacy or effectiveness against COVID illness.

During the publication of the pivotal RCTs in late 2020 and early 2021, and then the subsequent publications of many observational trials in 2021 and 2022, there was the reassuring refrain that the evidence presented shows the mRNA inoculations had high immunoprotection rates for infections and especially against severe disease (hospitalization, ICU admissions, and death). Real world data and critically looking at the extensive clinical documents sent to the US's FDA by the two mRNA product manufacturers, told a different story. Protection from infection was good, but certainly not "94-95%", and protection from severe disease was high and remained high, but only for the first 4-6 months when waning of protection during the pre-Omicron era became progressively worse and unacceptably low during the Omicron era. Because of this, inoculation boosters were hastily produced and recommended, continuing with new yearly formulations to this day. However, only a small minority of Americans (and citizens of other nations) obtain the new boosters.

Subsequent published papers tell a different story from the enthusiastic publications above and significantly question the quality of all these studies. A critical look at the submitted RCT documents to the FDA show disturbing discrepancies, manipulations of the data and analysis, and worse, more alarming counts of severe adverse reactions and death than reported in the published RCTs.

Fraiman J, et al 2022 and Doshi and Fung 2024 discuss many of the problems identified and the lack of full transparency that put into serious question the true efficacy and true adverse event rate as declared in the published RCTs.

Besides these two authors, others have found significant biases in the RCTs and observational trials due to various types of miscategorizations and biases that would alternatively, artificially inflate the "vaccine" efficacy (RCTs) and the effectiveness rate (observational studies) and also, lower the adverse events reporting rate for the mRNA products. This was especially true during 2021-2023 era of the pandemic.

One of the most important types of miscategorizations is the case-counting window bias that is usually and unfairly only applied to the vaccinated group. The rationale for this is to start counting the vaccine effects only after 7-14 days after the final dose given in the primary series, but the "partially vaccinated" are not counted at all for beneficial or negative effects, or worse yet, they are placed in with the "unvaccinated" group and counted that way. This asymmetry in counting nullifies or removes cases in the vaccinated group, but not in the unvaccinated group and biases the estimates of protection artificially upward and biases the differences in adverse events artificially downward, hiding the true adverse rate of the inoculations in the vaccinated group.

The preprint paper by Martin N, Fenton N ,and McLachlan S (2025), demonstrates statistically that the 38 reviewed studies, both RCTs and observational trials (often with a test-negative case-control design), contained the case-counting window bias and they could not be relied on for having reliable results. Using a simulated scenario, a" vaccine" with zero efficacy (a placebo) or even worse, a "vaccine" with slightly negative efficacy, with the case-counting window bias employed in these studies, can both show an efficacy of 100% for the first 5-6 weeks! These authors only found 38 studies, but another 2023 systematic and meta-analytic review by Wu N et al of 59 studies from 2021-2022, found there were 39 with test-negative case-control designs and 26 with cohort designs. This review included only 11 studies that overlapped with those found in Martin N, et al. In the Martin N, et al paper, the method and reason for their exclusion of 1,699 studies are not given. Nevertheless, it is likely that there were some additional trials that also had the case-counting window bias and thereby support the inflated "vaccine efficacy/effectiveness rates.

Besides this most important bias, the case-counting window bias, other biases in the literature exist that Fung et al point out such as the age bias where in observational trials, gene-therapy vaccination is not random, and older and higher-risk adults are likely receiving inoculations at a higher rate, making comparisons more difficult. Also, the background infection rate changes over time, so that the risk of an infection will vary

depending on the time period of the inoculation. The exposure time of between vaccinated and unvaccinated will be imbalanced. This time difference when the inoculation is done, the background infection rate bias, is inherent in all observational trials.

Lataster R (2024) delineates how the short case-counting window bias affects the genetic vaccines' safety calculations in the RCTs in deceptive way in favor of their safety; many adverse events are simply not looked for and not counted. Fraiman J, et al (2022) went through the first set of FDA-submitted documents by the vaccine manufacturers that were legally court-mandated for public release. They found alarming serious adverse events not reported in the published "pivotal RCTs" used for EUA in the US. They found that the serious adverse rate of special interest from Pfizer's mRNA "vaccine" is ~1/800, which is much higher, and an unacceptable rate, than what has been reported in the RTCs and subsequent observational trials.

In a multi-country cohort event monitoring survey study including 9 European countries, Raethke M et al (2024) found what they claimed was a "low" rate of serious adverse drug reactions (ADRs) of 0.24% (1/416) for first 2 doses and 0.26% (1/384) for the booster dose. This was the assessment that included all the various types of vaccines, not just the mRNA products. Serious ADRs include death, a life-threatening condition, initial or prolonged hospitalization, significant or persistent disability or incapacity, congenital anomaly or defect, or one that requires intervention to prevent one of these outcomes. These results are 2 times higher than found and reported by Fraiman J et al. For the general population and the campaign attempt at universal vaccination/inoculation, these rates are unacceptably high and mean that the inoculations of genetic vaccines have generated too much death and disability.

It is almost certain that the rates of serious ADRs is higher than reported above for several reasons. In the RCTs and observational trials, there was no independent safety monitoring board that tracked the serious and severe ADRs or events in the vaccinated

and unvaccinated groups. There was no attempt at recording all the outcomes that occurred each group in the trials, regardless of whether or not the outcome found was judged *a priori* to be not caused by the vaccine (as if the investigator could know this for sure). The was evidence of fraud, burying data, and misleading statements in the RCTs' documents. There were also case-counting window biases in the studies, including in the patient surveys, thereby ignoring and not counting ADRs outside the window time set up for counting an event. Lastly, patient surveys are often set up in a way to not allow certain outcomes to be counted, or if there is a free text option, those entries aren't included in the analyses.

Brief conclusion: The whole of vaccine medical science during this pandemic period, especially between 2021-2023 has been vitiated, polluted, by the above poorly done and biased research. One has to face this and acknowledge the huge implications. This doesn't mean that the gene-based vaccines had no positive effect. It does mean that the degree and duration of immunoprotection claimed in these biased studies and by public health authorities were an illusion. The pandemic response based on these misrepresentations had serious errors and bad consequences. It also means that the claim of "low adverse vaccine reactions" wasn't true and the medical profession, regulatory agencies, and medical journals gaslighted so many genetic vaccine-injured people, medical professionals, and vaccination-resistant people. This is a heavy indictment that our society, government, medical profession and culture have to bear and, one would hope, overcome and correct.

On a more positive note, the case-counting window bias appears to have been less frequent recently. The series of later epidemiological articles by the Qatar group (see Chemaitelly H, et al above as one example) and the recent Ioannou GN et al article in the *Annals of Internal Medicine* paper featured in #7 are both good recent examples of improved science with more reliable, trustworthy results.

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This is it for another edition of the PAAM Medical Letter. Thank you for reading the content--at least parts of it!

On Behalf of the PAAM Board and to You, Our Valued Colleagues,

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