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Dear Colleagues!

Welcome to the PAAM Medical Letter! Thank you for your ongoing support of PAAM and this publication.

Please note: This Letter is for your thoughtful consideration and personal research and is not to be taken as something dogmatic to believe in, nor promote as something official from PAAM or the international anthroposophic medical movement.

Meditation

Meditative Verses

Two mantric verses from Steiner, found in CW 268, Soul Exercises Vol 2: Mantric Verses 1903-1925 p.122, seem apropos at the end of the year 2022, and for physicians and therapists:

You are seeking
The light of the spirit
Explore in your own Self
And you will find it for certain.

You are seeking
Your own Self
Explore it in the working of the world
And you will find it for certain

The shadow of your being
It darkens the world.
To lack knowledge of the world
Will freeze your own Self.

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I carry within me the events of the past,
I feel within me all that arises,
I carry both into the future—in willing.

Faith looks back on past events,
It is grounded in truth.
Trust looks to all that arises,
It is grounded in the future.
Love embraces every moment,
What eternally happened,
What eternally is.

~ Rudolf Steiner

Given all the deaths and suffering people have experienced from COVID illness, from serious vaccine injuries, from many wars, as well as from poverty and exploitation, Steiner's following prayerful mantra can be helpful. From 1914-1918 he frequently spoke the following mantra (in slightly different versions) at the start of a lecture for both the angels of the living and of the dead:

Spirits, guardian of earthly souls,
who live and weave within these earthly souls,
safeguarding and protecting them with love
flowing from universal wisdom:
O hear our plea,
perceive our love
that wishes to unite with your
radiant, helping powers;
that desires to send
our spirit-surrendered love.

Spirits, guardians of sphere-borne souls,
who work and weave upon these sphere-borne souls,
safeguarding and protecting them with love
flowing from universal wisdom:
O hear our plea,
perceive our love
that wishes to unite with your
radiant, helping powers;
that desires to shine forth
our spirit-intuiting love.

At least once, immediately after speaking these verses, Steiner added:

For many years now, through the knowledge of the spirit to which we aspire, we have thought to approach closer to the being who resolved to pass through the Mystery of Golgotha for the earth's healing and for the freedom and progress of humanity.
May this being be with you now in your difficult undertakings.

~ Rudolf Steiner

Calendar of the Soul

Verse #37 Winter Solstice

To bear spirit-light in world winter night
Aspires blissfully my hearts striving desire;
That luminous seeds of soul
In grounds of worlds take root,
And the word of God in senses' darkness
Resounds, transfiguring all existence.

Verse #16 (Complementary verse)

To shelter the spirit-gift within
Commands me sternly my presentiment
That ripening gifts of God,
In soul-grounds fructifying
Bring to selfhood fruit.

Virtues of the Month
Sagittarius (11/21-1/1): Control of speech becomes a feeling for truth
Capricorn (12/21-2/1): Courage becomes the power of redemption, the power to transform

Medical and Relevant Literature

Attachment 1: Here is a small, preliminary study (https://doi.org/10.7812/TPP/22.071) that correlates the high prevalence of various sensory dysfunctions in children with attending a pediatric GI clinic, independent of the diagnosed GI disorder. These patients were compared with a general pediatric patient population where GI disorders were excluded. There is a small but growing body of literature supporting a link between sensory processing dysfunction and psychologic and behavioral problems, as well as a link between psychological and behavioral problems and GI dysfunction. Sensory factors have been linked to specific pediatric GI conditions such as defecation disorders, irritable bowel syndrome, feeding difficulties, Crohn's disease, and functional abdominal pain. The authors could only analyze 141 of the 201 parental surveys (~30% inadequate surveys), so getting statistical significance can be a problem. The types of sensory dysfunctions they looked at in the study were over- or under-responsivity and passive or active self-regulation in response to stimuli. Other ways of looking at sensory integration problems would be to look at sensory modulation dysfunction due to sensory over-responsivity or sensory under-responsivity, sensory-based motor disorder (e.g., dyspraxia, postural or movement disorder) and a sensory discrimination disorder. These sensory integration disorders are usually focused on the lower senses of the Nerve-Sense system (NSS) which would include touch, balance, movement, and proprioception. The higher senses of hearing, sight, warmth, sense of speech (word), and sense of thought, for example, can also be a problem in terms of difficulty with sensory integration.

The main point of the study was to show that aspects of the dysfunctional NSS correlates with metabolic-limb system (MLS) disorders, specifically the GI conditions. The authors found increased prevalence of sensory over-responsivity in pediatric GI patients, regardless of their diagnosis, and this was especially true for girls, ages 3-8 years. The behaviors that parents reported more often were temper tantrums and easily provoked frustration. An AM approach that attends to the care of the lower senses with fun exercises, that decreases NSS stimulation, increases soul warmth in the care giver, instills more rhythm in the child's life, engages in outside physical activities, as well as uses various AM remedies can be very helpful. In terms of remedies, one can calm the overly activated NSS with Aurum Stibium Hyoscyamus. Cuprum ointment or Melissa cupro cultum can be helpful for functional, spastic abdominal complaints. If anxiety is a factor in poor sensory integration, then adding Bryophyllum Avena is a good choice. For restless body movements, consider Bryophyllum 50% powder or perhaps Cuprum aceticum zincum valerianicum 5X.These are just some ideas to consider. A comprehensive and clinically useful discussion about AM treatment of poor sensory integration is beyond the scope of this letter.

Attachment 2 and Attachment 3: These two attachments complement each other and give a more complete view of the topic of the childhood vaccination schedule leading to more health problems in

children. The first attachment is a peer-reviewed article by Lyons-Weiler J and Blaylock R from an open access journal, International Journal of Vaccine Theory, Practice, and Research 2(2), Sept 26, 2022. They do a thorough analysis of a previously retracted paper by Lyons-Weiler and Thomas in Nov 2020. Since placebo-controlled RCTs on vaccines, either singularly or in combination, comparing vaccinated and unvaccinated groups are not being done by biomedical authorities, then observational studies, both good retrospective ones and prospective ones, can only be done by interested and independent researchers without industry and government sponsorship. Prospective observational studies are also quite difficult in the current environment when the ideology is that vaccines are "safe and effective." This is a well-done retrospective study that proves that the Nov 2020 previously published paper's results were not spurious, due to unaccounted for confounders, or selection bias. Using various analytic methods beyond what was done in the original paper, the authors show that there was no variance in health care seeking behavior between the vaccinated and unvaccinated that could explain the marked difference between the two groups. For many conditions, the vaccinated have a higher disease and symptom burden than the unvaccinated, even when they are matched for age, days of care and health care utilization behavioral differences. The paper also confirmed the previous paper's use of relative incidence of office visits as a good measure of the difference in health conditions. The most common conditions shown to be higher (with respect to odd ratios) in vaccinated children are gastroenteritis, eczema, anemia, otitis media, and food allergy. The Nov 2020 paper documented additional significantly higher office visits for ADHD, asthma, allergic rhinitis, and respiratory and behavioral problems. This article should be kept as a reference. The list of references at the end of the article may also be helpful. In there you'll find a link to the retracted article that can be downloaded for your perusal.

The second attachment by Jeremy Hammond, a free-lance journalist, is also freely available on his website. It gives helpful background information about the first Nov 2020 study, its results, and the background controversy and unjustified criticism of the first paper. He provides good argumentation against the unjustified criticism of Lyons-Weiler and Thomas' Nov 2020 paper that led to the retraction without any valid scientific reasons given. He gives you a picture of both articles and the critic's reasoning. Jeremy Hammond has obvious definite experience and expertise in reading the scientific literature and evaluating the bogus reasoning and ad hominem arguments by many of the medical "authorities". The only disagreement I have is that a critic of the original article does not have to have scientific evidence for the critique about a potential cofounder in the study, i.e., that the unvaccinated group may have had less office visits and the study made it appear that the vaccinated group was sicker with various conditions. Observational studies (both prospective and retrospective) can be subject to unknown confounders. What is inappropriate is for the journal to retract the paper for this reason. Much of the observational medical literature would have to be retracted if this was the standard (of unaccounted for confounding). In addition, the recent study by Lyons-Weiler and Blaylock did do a thorough analysis of their data and proved that the critic's claim was scientifically unfounded. This means that the original (Nov 2020) and subsequent (Sept 2022) published articles both have valid conclusions: the vaccinated children have worse health outcomes than the unvaccinated ones.

Attachment 4 and Attachment 5: The following two attachments are part 1 and part 2 of a narrative review by the UK cardiologist and public health advocate, Aseem Malhotra, about the "scientific" misinformation on COVID-19 mRNA vaccines. This easy-to-read, two-part article has been published in a journal that is independent from industry, otherwise I don't think it would have been published, given the contamination of medical science by the biomedical industrial complex. Part 1 re-analyzes the RCT data and looks at pharmacovigilance systems to show that the mRNA genetic vaccines have anywhere between 1/800-1/1000 serious adverse events. This is probably an underestimate because the trail data and pharmacovigilance data have been largely recognized to have incomplete capture of

adverse events and/or blatant mis-categorization of them during the trials. Even if we take these estimates as accurate, this means for most people (of low to moderate risk) the risk of a vaccine injury is greater than the risk of being hospitalized with serious COVID illness. You can read how this author was disillusioned by his personal experience with his father and the mRNA injection, by his discovery of what the current literature says about the incidence of vaccine-associated adverse events, by his then assessment of the pharmacovigilance data, and by his own re-analysis and reasoning. In addition, there is a well-done, detailed, prospective study from Thailand on 301 adolescents (doi.org/10.3390/tropicalmed7080196) that shows a 2.33% incidence of myocarditis (both subclinical and clinical). Another supportive study from Basel, Switzerland by cardiologist, Christian Mueller, presented at the 2022 European Society of Cardiology (presentation slides are behind a paywall) that documented a 2.8% incidence of myocarditis in health care workers after their third dose of a genetic vaccine. These studies of vaccine-induced myocarditis specifically are much higher than the published rates in the literature, where only significant symptomatic disease is usually detected.

The Part 2 article reviews current and historical driving factors that underlie the pandemic of misinformation. Primary among them is increasing regulatory capture by the pharmaceutical industry (via funding and control of the biomedical narrative of what is studied). In addition, the public health messaging was narrowly focused on novel gene therapy “vaccines” to end the pandemic, wrongly applied universal vaccination to the whole population despite low risk factors for serious disease in much of the population, oversold the genetic vaccines as to be able to stop transmission, and ignored well-established and low-cost lifestyle factors to mitigate risk of serious infection in a relatively short period of time. He criticizes physicians who go along with the opinion and statements of biomedical authorities without critically looking at the evidence and distorted presentation of the trial results. The medical profession, from academics to practicing clinicians, accept and use industry-sponsored studies for treatment decisions (like the pivotal RCTs), while independent researchers have repeatedly stated that industry sponsored trials should be seen more as marketing, until proven otherwise. There is a major lack of transparency in these trials that are optimally designed to favor the pharmaceutical product and are designed to downplay adverse events or hide the full extent of them. Currently, the pharmaceutical corporations can shape the narratives on the determinants of health by running their own trials without independent supervision/oversite, and through ownership of the mass media via their advertising revenue. The reversal of metabolic conditions of the US population is important to lower the risk of many diseases, including infectious ones. Both Part 1 and Part 2 site the scientific, ethical, and moral case to halt the vaccination campaign until all the raw data has been subjected to fully independent scrutiny and appraisal. It is said that a former editor at the New England Journal of Medicine, Marcia Angell, MD, once said that “the real battle in medicine is between truth and money.”

Attachment 6: This is an open access article in the BMJ’s Journal of Medical Ethics (doi:10.1136/medethics-2022-108449). In this tight, rigorous, and well-reasoned article, the academic authors tackle the specific issue of mandated COVID-19 genetic vaccine boosters for young adults at US universities. They give cogent scientific and ethical arguments against mandating these injections in this specific population. They use published, but flawed, figures from the CDC and others that, as acknowledged in the paper, both underestimate the risk of harms in young adults and overestimate the benefits from the mRNA vaccine for them. They outline the reasons for both effects. Despite these limitations in accuracy, these scientifically generated statistics indicate that the harms are likely to be worse than the marginal benefit from the genetic vaccines. The authors focus on especially serious adverse events and the elevated risk of myopericarditis in young people. They then enumerate 5 ethical principles that make the University booster mandates unethical: 1) They are not based on an updated stratified risk-benefit assessment for this age group (16-29) during the Omicron era; 2) The genetic vaccine boosters may result in a net harm to healthy young adults; 3) There is a lack of proportionality,

meaning that the expected harms are not outweighed by public health benefits due to the modest and transient effectiveness against transmission of these genetic vaccines; 4) The mandates violate the reciprocity principle because serious vaccine-related harms are not reliably compensated due to gaps in the vaccine injury compensation schemes available in the US and the inability to sue the vaccine manufacturers under an FDA-approved emergency use authorization; 5) The genetic vaccine mandates may result in wider social harms, such as resistance and anger about the coercion done, personal autonomy violation, as well as generating mistrust in societal institutions and mistrust of vaccines in general. Lastly, the authors criticize and rebut the arguments by proponents for the university COVID-19 booster mandates.

Attachment 7: This is a freely available article on the doctors4covidethics.org website published 8/18/22. It summarizes the experimental and autopsy evidence of patients dying after COVID-19 genetic vaccination (most were with the mRNA vaccine, a few were with the adenoviral vectored vaccines). No autopsy evidence of nucleocapsid antibodies were found, indicating that infection with SARS-CoV-2 was not present. The findings demonstrate that: 1) The mRNA vaccines do not stay in the deltoid muscle at the injection sites (as originally claimed), but instead travel throughout the body via the blood [and probably via the lymphatic vessels—editor's note] and accumulate in various organs (at least in plasma, liver, spleen, ovaries and adrenal glands); 2) The mRNA-based COVID vaccines induce long-lasting expression of the SARS-CoV-2 spike protein in many organs; 3) Vaccine-induced expression of the spike protein induces autoimmune-like inflammation [chronic autoimmune inflammation that leads to fibrosis, sclerosis and hardening]; 4) Vaccine-induced inflammation can cause grave organ damage, especially in blood vessels, with possible deadly outcome; 5) The damage mechanism discovered from autopsy studies is a general mechanism that would likely apply similarly to any mRNA vaccine against other infectious agents.

There are many helpful graphics and photographs that illustrate the findings. Most of the evidence in this report comes from the 15-17 autopsies done by pathologist Arne Burkhardt, MD, from Germany. The website has other informative and helpful articles free to download.

Attachment 8: This is another open access article on the "Autopsy-based histopathological characterization of myocarditis after anti-SARS-CoV-2-vaccination" in Clinical Research in Cardiology (doi.org/10.1007/s00392-022-02129-5), published online 11/27/22. The authors describe the autopsy findings and common characteristics of (epi-)myocarditis in 5 of 25 unexpected deaths within 3-9 days in vaccinated but uninfected persons at the University of Heidelberg, Germany. They did not report on other organ systems in this study like the autopsies above. There was a total of 35 cases after SARS-CoV2 vaccination that were examined. The supplement in the article shows that many died of cardiovascular complications, but they couldn't say for sure that cause was from the genetic vaccines, since there was an alternative explanation. So, the 5 cases represent a conservative assessment of possible vaccine-associated deaths. One of the 2 genetic mRNA vaccines encoding the SARS-CoV-2 spike glycoprotein was administered to the 5 people. The pathologists also looked at past autopsy files to retrieve myocardial samples and report they have never observed comparable myocardial inflammatory infiltration. Most of the cells in the focally inflamed tissue were T lymphocytes (CD4+ and CD3+) with some macrophages as well. This phenotype suggests an immune-mediated mechanism of damage. The authors note that most of the cases of myocarditis reported in the literature were "mild" and symptoms resolved without treatment. However, possible long-term or subclinical effects were not studied. Because this is a small, selected study, no conclusions can be drawn about the epidemiology (incidence and prevalence) of myocarditis. However, this and the above autopsy findings do help establish the occurrence and mechanism of deaths in some patients with vaccine-associated deaths.

Attachment 9: This is an open access article of an interim analysis of a (rare) prospective, longitudinal multi-center, cohort study on persistent symptoms at 3 months after largely non-serious acute COVID illness (only 10.8% were hospitalized in PCR+ group and 1.5% in the PCR- group) compared to COVID-negative controls who also presented with acute symptoms and were tested with PCR for SARS-CoV-2. This study had recruitment until September 2021, before the Omicron era. Most studies on long COVID lack a control group or they involve big data analytics from the US Veterans Administration system, which matches positive PCR tests done at the VA (a selected population of veterans that used the VA system) and ICD-10 codes, without measuring how patients feel and function, nor having any granular clinical information. Despite some limitations and the short follow-up, the main result of this study is that patients in both groups by 3 months are trending at feeling better and having improved function. More remarkable was that, at 3 months, the COVID patients were even doing better than the non-COVID patients with similar presenting symptoms. Because of the limitations of the study, a more conservative interpretation would be that at least the COVID patients were not dramatically worse. Most physicians know, and certainly AM physicians are aware, that convalescence after a serious inflammatory illness ("infections") in adults can be prolonged and that the prominent neurasthenic and cardiovascular symptoms causing cognitive impairments, fatigue, and poor physical and social function must be specifically treated. Also, any serious infectious illness requiring hospitalization or ICU admission will have long-term sequelae. This study doesn't disprove the phenomenon of long COVID (with its unique set of symptoms) that patients suffer from, but it does make us think what it is like to endure and live with persistent, somewhat ill-defined, and conventionally non-diagnosable symptoms.

Attachment 10: For those who have not seen this, here is an article that is freely available on the Anthromedics website (https://www.anthromedics.org/PRA-0993-EN#list-sections-5), published 9/27/21 on the topic of long COVID, especially its understanding and possible treatment options from an AM perspective.

Enjoy the holiday season!

On behalf of the PAAM Board, and to you, our valued colleagues,

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