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How the Endless Boosters Will Destroy Immune Function

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The COVID shots reprogram your immune system to respond in a dysfunctional manner. Aside from increasing vulnerability to infections, this can also result in autoimmune diseases and cancer

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Antigens in vaccines have been shown to induce defects in the immune system that can raise the risk of autoimmune diseases

Leaky or nonsterilizing vaccines can also trigger the evolution of more hazardous viruses, and the COVID jabs are among the leakiest "vaccines" ever created

According to health authorities, the vaccine-evading Omicron variant necessitates a third COVID injection, but this recommendation will only perpetuate mutation

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A number of medical experts, scientists and published studies now warn that the COVID shots reprogram your immune system to respond in a dysfunctional manner. Aside from increasing vulnerability to infections, this can also result in autoimmune diseases and cancer.

Pfizer Shot Reprograms Both Arms of Your Immune System

A paper[1] posted May 6, 2021, on the preprint server medRxiv reported that the Pfizer/BioNTech COVID jab "reprograms both adaptive and innate immune responses," causing immune depletion.

While they confirmed the jab "induced effective humoral and cellular immunity against

several SARS-CoV-2 variants," the shot "also modulated the production of inflammatory cytokines by innate immune cells upon stimulation with both specific (SARS-CoV-2) and nonspecific (viral, fungal and bacterial) stimuli."

In other words, we're looking at a horrible tradeoff. You may get some protection against SARS-CoV-2 and its variants, but you're weakening your overall immune function, which opens the door wide to all sorts of other health problems, from bacterial, fungal and viral infections to cancer and autoimmunity.

After the injection, innate immune cells had a markedly decreased response to toll-like receptors 4, 7 and 8 (TLR4, TLR7, TLR8) ligands, while cytokine responses induced by fungi were stronger. According to the authors, defects in TLR7 have previously been linked to an increased susceptibility to COVID-19 in young males.

People who were "fully vaccinated," having received two doses of the Pfizer shot, also produced significantly less interferon upon stimulation, and this can hamper the initial innate immune response against the virus.

Repeated Vaccinations and the Risk of Autoimmunity

Pathogenic infections and cancer are but two potential outcomes of this kind of reprogramming. Previous research, for example, has linked defects in the immune system to a higher risk of autoimmune diseases. What's more, it's been shown that antigens in vaccines, specifically, can induce this kind of immune system dysfunction.[2] As reported in the paper in question:[3]

> "Repeated immunization with antigen causes systemic autoimmunity in mice otherwise not prone to spontaneous autoimmune diseases. Overstimulation of CD4+ T cells led to the development of autoantibody-inducing CD4+ T (aiCD4+ T) cell which had undergone T cell receptor (TCR) revision and was capable of inducing autoantibodies.
>
> The aiCD4+ T cell was induced by de novo TCR revision but not by cross-reaction, and subsequently overstimulated CD8+ T cells, driving them to become antigen-specific cytotoxic T lymphocytes (CTL).
>
> These CTLs could be further matured by antigen cross-presentation, after which they caused autoimmune tissue injury akin to systemic lupus erythematosus (SLE). Systemic autoimmunity appears to be the inevitable consequence of over-stimulating the host's immune 'system' by repeated immunization with antigen, to the levels that surpass system's self-organized criticality."

Fast-forward to mid-May 2021, when a study[4] in the Journal of Clinical Investigations reported that "SARS-CoV-2 mRNA vaccines induce broad CD4+ T cell responses that recognize SARS-CoV-2 variants and HCoV-NL63." HCoV-NL63 is a human coronavirus associated with the common cold.

> "Interestingly, we observed a 3-fold increase in the CD4+ T cell responses to HCoV-NL63 spike peptides after vaccination," the authors stated, adding, "Our results suggest that T cell responses elicited or enhanced by SARS-CoV-2 mRNA vaccines may be able to control SARS-CoV-2 variants and lead to cross-protection against some endemic

> coronaviruses."

What they did not address was that excessive CD4a+ T cell responses could also result in the development of autoantibodies and autoimmune disease.

COVID Shots May Also Cause More Hazardous Variants

We've long known that leaky or nonsterilizing vaccines can trigger the evolution of more hazardous viruses.[5,6,7,8] So far, SARS-CoV-2 variants have mutated into less dangerous versions, which is fortunate, but the risk of the COVID shots creating a "monster" still remains.

In a February 9, 2021, article,[9] NPR highlighted this risk, stating that "vaccines could drive the evolution of more COVID-19 mutants." According to NPR science correspondent Richard Harris, "the virus is always mutating. And if one happens to produce a mutation that makes it less vulnerable to the vaccine, that virus could simply multiply in a vaccinated individual."

The Omicron variant appears to have significant resistance against antibodies produced by the original COVID shots, which is why Omicron infection is being primarily reported in those who have received the injections.

In 2018, Quanta Magazine detailed how vaccines drive the evolution of pathogens.[10] I've referenced that article on previous occasions, as have many others. In response, the editor of Quanta Magazine added a "disclaimer" dated December 6, 2021, to the article, stating:

> "This article from 2018 discusses how leaky vaccines — vaccines that do not reduce viral replication or transmission to others — can drive the pathogens they target to evolve and become more virulent. These concerns do not apply to COVID-19 vaccines, because COVID-19 vaccines significantly reduce coronavirus replication and transmission, reducing the chance that mutations occur and variants arise …"

That statement is clearly false, as studies have repeatedly shown the COVID shots are in fact leaky. They do not "significantly reduce" viral replication or transmission, as the editor claims. Quite the opposite.

People who have received one or more COVID shots have been found to harbor higher viral loads than the unvaccinated, and Israel (which appears to have the best tracking and monitoring) reports that the worst COVID cases are in those who are fully vaxxed.

December 6, 2021, Newsweek[11] reported a COVID outbreak among "fully vaccinated" hospital staff in Spain. After a Christmas dinner with more than 170 fully vaxxed health care workers in attendance, nearly 70 of them tested positive for COVID. Some reported mild symptoms. Daniel Horowitz pointed out the editor's false note in a December 9, 2021, Blaze post:[12]

> "Leaky vaccines are worse than no vaccine at all. That is the unmistakable conclusion one would derive from a May 2018 article in Quanta magazine, a top scientific publication, about the unsuccessful attempts to create vaccines for HIV, malaria, and anthrax that aren't leaky and don't run the risk of making the pathogens more

> dangerous.
>
> Yet now that we are seeing such a microbiological Frankenstein play out in real life and people like Dr. Robert Malone have been citing this article to raise red flags about the leaky COVID shots, Quanta magazine took the unprecedented step of slapping an editor's note on an article three and a half years later to get people to stop applying it to the leakiest vaccine of all time."

COVID Shots Stop Working Within a Few Months

A study in the New England Journal of Medicine, published December 9, 2021, also confirms that whatever protection you get from the Pfizer COVID shot is short in duration. As explained by the authors:[13]

> "In December 2020, Israel began a mass vaccination campaign against coronavirus disease 2019 (Covid-19) by administering the BNT162b2 vaccine, which led to a sharp curtailing of the outbreak.
>
> After a period with almost no cases of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) infection, a resurgent Covid-19 outbreak began in mid-June 2021. Possible reasons for the resurgence were reduced vaccine effectiveness against the delta (B.1.617.2) variant and waning immunity.
>
> We used data on confirmed infection and severe disease collected from an Israeli national database for the period of July 11 to 31, 2021, for all Israeli residents who had been fully vaccinated before June 2021.
>
> We used a Poisson regression model to compare rates of confirmed SARS-CoV-2 infection and severe Covid-19 among persons vaccinated during different time periods, with stratification according to age group and with adjustment for possible confounding factors.
>
> Among persons 60 years of age or older, the rate of infection in the July 11-31 period was higher among persons who became fully vaccinated in January 2021 (when they were first eligible) than among those fully vaccinated 2 months later, in March (rate ratio, 1.6 …)
>
> Among persons 40 to 59 years of age, the rate ratio for infection among those fully vaccinated in February (when they were first eligible), as compared with 2 months later, in April, was 1.7 … Among persons 16 to 39 years of age, the rate ratio for infection among those fully vaccinated in March (when they were first eligible), as compared with 2 months later, in May, was 1.6 …
>
> The rate ratio for severe disease among persons fully vaccinated in the month when they were first eligible, as compared with those fully vaccinated in March, was 1.8 … among persons 60 years of age or older and 2.2 … among those 40 to 59 years of age …
>
> These findings indicate that immunity against the delta variant of SARS-CoV-2 waned in all age groups a few months after receipt of the second dose of vaccine."

Two Doses Aren't Enough

Earlier this year, vaccine makers and health authorities said the shots were about 95% effective and if enough people got the shots, normalcy would be restored. We now know that was a false promise. The goal post was moved back with the emergence of Delta and then Omicron, for which we're now told we need a third booster.

December 13, 2021, Reuters[14] reported that British scientists have concluded "two-dose COVID-19 vaccine regimens do not induce enough neutralizing antibodies against the Omicron coronavirus variant," and that "increased infections in those previously infected or vaccinated may be likely."

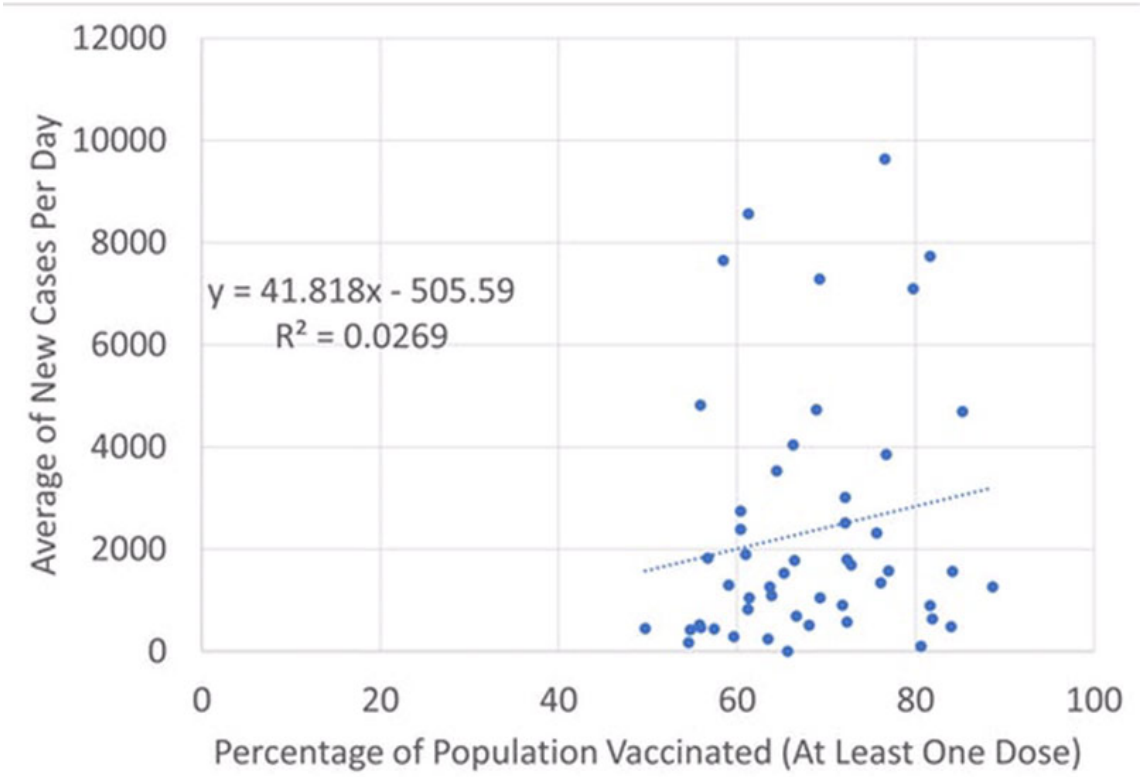
'Just Deal With' Booster Shots, Fauci Says

When in mid-December 2021, Dr. Anthony Fauci was asked if Americans should expect annual COVID boosters, he replied in the affirmative, saying that Americans will "just have to deal with" the prospect of getting boosters at regular intervals.[15] So, in essence, Fauci wants us to accept that booster deficiency is the reason why the COVID-19 "pandemic" continues.

Clearly, that is not the case. The real reason COVID is still an issue is because Fauci and the medical establishment have suppressed viable early treatments. If early treatment was the norm, COVID would rapidly become a distant memory.

As predicted over a year ago, we're now on an injection treadmill with no end in sight, and every single dose carries the risk of serious side effects, up to and including permanent disability and death. The only scientifically sound way out of this failed experiment is to stop. No more boosters.

Instead, the captured U.S. Food and Drug Administration granted emergency use authorization to novel gene transfer technologies that don't work like conventional vaccines in that they don't prevent infection and spread, thus creating an evil cycle of new vaccine-resistant variants. As demonstrated by James Lyons-Weiler (in a now broken weblink), the more we vaccinate, the higher the COVID caseload.



Weiler's graph looks very much like that in a September 30, 2021, study[16] in the European Journal of Epidemiology, which found that the higher the vaccination rate in a given area, the higher the COVID case rate.

Dr. Chris Martenson discusses this finding in the video below. As noted by Martenson, "the line goes the wrong way," meaning the more heavily "vaccinated" a population is, the worse things get.

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Fortunately, it seems most Americans are starting to catch on, and so far, the fearmongering around Omicron has not resulted in a rush for boosters.[17] According to an Axios/Ipsos poll conducted December 10 through December 13, 2021, 67% of unvaccinated respondents said Omicron makes no difference in their decision of whether to get vaccinated; 19% said it makes them more likely while 11% said it makes them less likely to get the shot.

Among respondents who already had received one or two doses, 59% said Omicron makes no difference in their decision to get a third dose; 36% said it makes them more likely and 5% said it makes them less likely to get it.

Considering the shots have been shown to deregulate your immune function, it would be wise to "just say no" to further boosters. Should you develop symptoms of SARS-CoV-2 infection, remember there are safe and effective early treatment protocols, including the I-MASK+[18] and I-MATH+,[19] protocols, which are available for download on the COVID Critical

Care website in multiple languages. Other protocols that have great success are:

- The AAPS protocol
- Tess Laurie's World Council for Health protocol
- America's Frontline Doctors
- Dr. Peter McCullough's Ambulatory Treatment of COVID-19

This is a load of information to review, especially if you are fatigued and sick with COVID or have a family member struggling. After reviewing all of these protocols, I believe the Front Line COVID-19 Critical Care Alliance's protocol is among the easiest to follow. Below is a summary of that protocol, with minor amendments.

I-MASK+

PREVENTION & EARLY OUTPATIENT TREATMENT PROTOCOL FOR COVID-19

EARLY TREATMENT PROTOCOL (for Delta variant)

1. First line agents (use any or all medicines; listed in order of priority/importance)

ANTI-VIRALS

Ivermectin
0.4–0.6 mg/kg per dose (take with or after a meal) — one dose daily, take for 5 days or until recovered.
Use upper dose if: **1)** in regions with aggressive variants (e.g. Delta); **2)** treatment started on or after day 5 of symptoms or in pulmonary phase; or **3)** multiple comorbidities/risk factors.

and/or **Nitazoxanide**
500 mg 2 x daily for 5 days after meals. Combine with ivermectin (preferred) or substitute if ivermectin is not available. (Nitazoxanide is often unavailable or high-priced in the USA.)

ANTI-SEPTIC ANTI-VIRALS

Nebulized Hydrogen Peroxide 5 ml of 0.1% peroxide dissolved in 0.9% normal saline every hour or two. It's best to use nebulizer that plugs into the wall, as these are more effective than battery operated ones.
Antiviral Mouthwash: Gargle 3x daily (do not swallow; must contain chlorhexidine, povidone-iodine, or cetylpyridinium chloride).
Iodine Nasal Spray / Drops: Use 1% povidone-iodine commercial product as per instructions 2–3 x daily. If 1 %-product not available, must first dilute the more widely available 10%-solution and apply 4–5 drops to each nostril every 4 hours. (No more than 5 days in pregnancy.)

ANTI-COAGULANTS / IMMUNE FORTIFYING

Aspirin	325 mg daily (unless contraindicated)
Vitamin D	Vitamin D3 5,000 IU daily. Preferred form if available: Calcitriol 0.5 mcg on day 1, then 0.25 mcg daily for 7 days
Melatonin	10 mg before bedtime (causes drowsiness)

NUTRITIONAL THERAPEUTICS (for 14 days)

Curcumin	(turmeric)	500 mg 2 x daily
Nigella Sativa	(black cumin seed)	80 mg/kg daily
Honey		1 gram/kg daily

SYNERGISTIC THERAPIES

Quercetin	500 mg 2 x daily
Zinc	50 mg/day (elemental zinc)
Liposomal Vitamin C	1-2,000 mg 4-6 x daily
NAC	500 mg 2 x daily
Fibrinolytic Enzymes	lumbrokinase, serrapeptidase or nattokinase, two to four tablets, two to three times a day, on an empty stomach (one hour before or two hours after a meal). This will help break down any microclots.

2. Second line agents (listed in order of priority/importance)

Add to first line therapies above if: 1) ≥5 days of symptoms;
2) Poor response to therapies above; 3) Significant comorbidities.

DUAL ANTI-ANDROGEN THERAPY

1. **Spironolactone** 100mg 2 x daily for ten days.
2. **Dutasteride** 2 mg on day 1, followed by 1 mg daily for 10 days. If dutasteride not available, use **Finasteride** 10 mg daily for 10 days.

FLUVOXAMINE

50 mg 2 x daily for 10 days
Consider **Fluoxetine** 30 mg daily for 10 days as an alternative (it is often better tolerated). Avoid if patient is already on an SSRI.

MONOCLONAL ANTIBODY THERAPY

Casirivimab/Imdevimab
600 mg each in a single subcutaneous injection. Antibody therapy is for patients within 7 days of first symptoms and one or more risk factors as: Age>65y; BMI>25; pregnancy; chronic lung, heart, or kidney disease; diabetes; immunosuppressed; developmental dis- ability; chronic tracheostomy; or feeding tube.

3. Third line agent

If below criteria are met, consider

CORTICOSTEROIDS

Prednisone or **Methylprednisolone** 1 mg/kg daily for 5 days followed by slow taper or escalation according to patient response.

Criteria:

After day 7–10 from first symptoms and patient has either: abnormal chest x-ray, shortness of breath, or oxygen saturations of 88–94 %.

If oxygen saturation is lower than 88 %, emergency room evaluation should be sought.

Additional information

Pulse Oximeter (usage instructions)

In symptomatic patients, monitoring with home pulse oximetry is recommended (due to asymptomatic hypoxia). The limitations of home pulse oximeters should be recognized, and validated devices are preferred. Multiple readings should be taken over the course of the day, and a downward trend should be regarded as ominous. Baseline or ambulatory desaturation < 94% should prompt hospital admission. The following guidance is suggested:

- Use the index or middle finger; avoid the toes or ear lobe.
- Only accept values associated with a strong pulse signal.
- Observe readings for 30–60 seconds to identify the most common value.
- Remove nail polish from the finger on which measurements are made.
- Warm cold extremities prior to measurement.

Calculation for ivermectin dose (0.2 mg per kg)

Body weight **Conversion: 1 kg ≈ 2.2 lbs** (doses calculated per upper end of weight range)		Dose **0.2 mg/kg ≈ 0.09 mg/lb** (Each tablet = 3 mg; doses rounded to nearest half tablet above)	
70–90 lb	32–40 kg	8 mg	(3 tablets = 9 mg)
91–110 lb	41–50 kg	10 mg	(3.5 tablets)
111–130 lb	51–59 kg	12 mg	(4 tablets)
131–150 lb	60–68 kg	13.5 mg	(4.5 tablets)
151–170 lb	69–77 kg	15 mg	(5 tablets)
171–190 lb	78–86 kg	16 mg	(5.5 tablets)
191–210 lb	87–95 kg	18 mg	(6 tablets)
211–230 lb	96–104 kg	20 mg	(7 tablets = 21 mg)
231–250 lb	105–113 kg	22 mg	(7.5 tablets=22.5 mg)
251–270 lb	114–122 kg	24 mg	(8 tablets)
271–290 lb	123–131 kg	26 mg	(9 tablets = 27 mg)
291–310 lb	132–140 kg	28 mg	(9.5 tablets=28.5 mg)

For higher doses used in our I-MASK+ Protocol please multiply the value found in the table for 0.2 mg/kg, e.g.:

- **0.4 mg/kg:** double the 0.2 mg/kg dose
- **0.6 mg/kg:** triple the 0.2 mg/kg dose

Tablets can be halved for more accurate dosing. Then round to nearest half tablet above.

Note that Ivermectin is available in different tablet strengths (e.g. with 3, 5 or 6 mg) and administration forms (tablets, drops) depending on the country (please refer to the package information).

In our table we calculate doses using 3 mg tablets (the most common dose per tablet in the U.S.).

If your tablets contain a different amount of ivermectin than 3 mg, you must calculate the number of tablets to equal the dose of ivermectin required.

- For instructions on nebulized peroxide you can go to Bitchute.com and type in "mercola nebulized peroxide" and you will find many videos that go into specific details. Dr. Thomas Levy's also has a free e-book, "Rapid Virus Recovery" that reviews the protocol https://rvr.medfoxpub.com/.
- If you need a physician to prescribe some of the drugs you can find one at America's Front Line Doctors list https://americasfrontlinedoctors.org/covid/early-treatment/

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Notes

[1] medRxiv May 6, 2021

[2, 3] PLOS ONE 2009; 4(12): e8382

[4] Journal of Clinical Investigations May 17, 2021; 131(10):e149335

[5] Live Science July 29, 2015

[6] Newsweek July 27, 2015

[7] National Geographic July 27, 2015

[8, 10] Quanta Magazine May 10, 2018

[9] NPR February 9, 2021

[11] Newsweek December 6, 2021

[12] The Blaze December 9, 2021

[13] NEJM 2021; 385: e85

[14] Reuters December 13, 2021

[15] Fox News December 13, 2021

[16] European Journal of Epidemiology September 30, 2021: 1-4

[17] Forbes December 14, 2021

[18] FLCCC Alliance I-MASK+ Protocol

[19] FLCCC MATH+ Hospital Protocol

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