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Why Children that Have Been Recently Vaccinated with Live Virus Vaccines Should be the Ones that Are Isolated (Rather than the Healthy Unvaccinated Ones)

Why Children that Have Been Recently Vaccinated with Live Virus Vaccines (Such as MMR) Should be the Ones that Are Isolated (Rather than the Healthy Unvaccinated Ones) But should they be arrested if they are found at the mall?

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"Vaccines are often administered before a diagnosis of combined immune deficiency is made. ...live vaccines may produce chronic infections in patients with combined immune deficiency." – Infectious Diseases Society of America (2013)

"It is now known that vaccine viruses can be serially transmitted through human hosts, and may revert genetically toward wild-type transmissibility and virulence." — U.S. and European health officials (2008)

Vaccine Strain Live Viruses Can Infect Others

Just like people with viral infections can shed and transmit wild-type virus, 86 people given live virus vaccines can shed and transmit vaccine strain live attenuated virus. 87 Like wild-type virus, vaccine strain live virus can be shed in body fluids, such as saliva, 88 89 nasal and throat secretions, 90 breastmilk, 91 92 urine and blood, 93 94 stool, 95 and skin lesions. 96 Shedding after vaccination with live virus vaccines may continue for days, weeks or months, depending upon the vaccine and the health or other individual host factors of the vaccinated person.

Vaccinia Virus Shedding for Two to Three Weeks

After primary smallpox vaccination, vaccinia virus is shed for two to three weeks and can be transmitted to others through body secretions and especially through skin contact with the open vaccinia virus lesions at the site of the vaccination until the lesion scabs over and separates from the skin. The CDC states:

> "After a person is vaccinated with vaccinia, the vaccination site contains infectious virus from the time of papule formation until the scab separates from the skin (a period of approximately 2–3 weeks). During this period, a risk exists for inadvertent inoculation to another body site or another person. The most frequently reported sites of vaccinia infections caused by unintentional transfer are the face, nose, mouth, lips, genitalia, anus, and eye."

In 1961, the Sabin live attenuated oral polio vaccine (OPV) was licensed and soon U.S. public

health officials recommended that all infants and children be given OPV instead of the inactivated, injectable Salk vaccine, which had been licensed in 1955 and widely used. OPV contains three vaccine strain polioviruses given orally by liquid drops in the mouth and public health officials adopted the Sabin live attenuated oral polio vaccine (OPV) as the preferred polio vaccine because OPV not only vaccinated the recipient but also "passively" vaccinated those coming in close contact with a recently vaccinated child shedding vaccine strain live polioviruses in the stool, saliva and nasal secretions."

Millions Infected with Polio Vaccine Strain Viruses

In 2008, U.S. and European health officials analyzed eight outbreaks of paralytic polio between 2000 and 2005 in Hispaniola, Indonesia, Egypt, Philippines, Madagascar (2), China and Cambodia that were caused by circulating vaccine-derived poliovirus (cVDPV). The officials admitted *"it is now known that vaccine viruses can be serially transmitted through human hosts, and may revert genetically toward wild-type transmissibility and virulence."* — U.S. and European health officials

Acute Flaccid Paralysis Cases Increase Dramatically in India

Following two decades of repeated child vaccination campaigns using OPV (oral polio vaccine) in India, the World Health Organization in early 2014 pronounced India "free" of wild-type polio.

The controversial declaration comes at a time when India has been experiencing a huge increase in reported cases of non-polio acute flaccid paralysis (NPAFP).

In 2004, 12,000 cases of non-polio paralysis were reported but that number had increased by 2012 to *53,563* cases for a national rate of 12 per 100,000 children.

Two pediatricians in India compiled data from the national polio surveillance project and discovered a link between the increase in OPV use among children during stepped-up polio eradication campaigns and the increasing cases of NPAFP among children.

In a 2012 article published in a medical ethics journal, the doctors stated, "Clinically indistinguishable from polio paralysis but twice as deadly, the incidence of NPAFP was directly proportional to doses of oral polio received." Because polio is among the more than 200 related viruses in the Picornaviridae family of enteroviruses, the doctors suggested that public health officials investigate " the influence of strain shifts of enteropathogens induced by the [polio] vaccine given practically every month."

Majority of Babies Shed Vaccine Strain Live Virus

In one study, MedImmune reported that after FluMist vaccination 89 percent of babies between six and 23 months of age shed vaccine strain live influenza virus and 20 percent of adults between 18 and 49 years old shed vaccine virus.

Vaccine-strain virus shedding reached a peak between two and three days after FluMist was inhaled and shedding was generally finished by day eleven.

MedImmune also measured transmission of live vaccine-strain live influenza virus between several hundred young children in a daycare setting: "A prospective, randomized, double-blind, placebo-controlled trial was performed in a daycare setting in children younger than 3

years of age to assess the transmission of vaccine viruses from a vaccinated individual to a non-vaccinated individual…

At least one vaccine strain was isolated from 80% of FluMist recipients; strains were recovered from 1-21 days post vaccination…One placebo subject had mild symptomatic Type B virus infection confirmed as a transmitted vaccine virus by a FluMist recipient in the same playgroup."

A 2011 published study of children aged six to 59 months in a daycare setting found that most of the children given trivalent live attenuated influenza vaccine (LAIV) shed more than one vaccine virus within 11 days of vaccination.

Warning for the Immuno-compromised

However, CDC warns that

> "Persons who care for severely immunosuppressed persons who require a protective environment should not receive LAIV, or should avoid contact with such persons for 7 days after receipt, given the theoretical risk for transmission of the live attenuated vaccine virus."

Majority of Vaccinated Infants Shed Vaccine Strain Rotavirus for A Week or Longer

In the 2013 RotaTeq product information insert, Merck reported that vaccine-strain rotavirus shedding was documented in the stool of 32 of 360 (8.9 percent) patients following one dose of RotaTeq and appeared as early as one day and as late as 15 days after vaccination.

The drug company acknowledged that "Transmission of vaccine virus strains from vaccinees to non-vaccinated contacts has been observed post-marketing." 238 The CDC reported that

> "Fecal shedding of rotavirus antigen was evaluated in all or a subset of infants from seven studies in various countries. After dose 1, rotavirus antigen shedding was detected by ELISA in 50% to 80% (depending on the study) of infants at approximately day 7 and 0 to 24% at approximately day 30. After dose 2, rotavirus antigen shedding was detected in 4% to 18% of infants at approximately day 7, and 0 to 1.2% at approximately day 30. The potential for transmission of vaccine virus to others was not assessed."

Measles, Mumps, Rubella Viruses and Live Attenuated Measles, Mumps, Rubella Viruses

Measles virus is a paramyxovirus, genus Morbillivirus with a core of single-stranded RNA. It is rapidly inactivated by heat and light and has a short survival time (less than two hours) in the air or on objects. Measles is highly contagious and causes a systemic infection that begins in the nasopharynx.

The virus is shed through respiratory secretions (nasal discharge, coughing sneezing) for four days before symptoms appear until three to four days after rash onset, when it is most easily transmitted.

The incubation period from exposure to symptoms is 10-12 days and symptoms start with fever, cough, runny nose, conjunctivitis, white sports in the mouth and progresses to a rash

that starts on the face and spreads to the rest of the body and lasts for about a week.

Complications include very high fever, diarrhea, otitis media, seizures, pneumonia, encephalitis (0.1% reported) and very rarely subacute sclerosing panencephalitis (SSPE) and death.

Merck's MMR Vaccine

The live attenuated combination measles-mumps-rubella (MMR) vaccine used in the U.S. is manufactured by Merck and contains the following warnings about vaccine strain measles virus infection and shedding:

- ***"Measles inclusion body encephalitis (MIBE), pneumonitis and death as a direct consequence of disseminated measles vaccine virus infection have been reported in immunocompromised individuals inadvertently vaccinated with measles-containing vaccine;"*** although Merck also states that "Children and young adults who are known to be infected with human immunodeficiency viruses and are not immunosuppressed may be vaccinated" and that "The ACIP has stated that "patients with leukemia in remission who have not received chemotherapy for at least 3 months may receive live virus vaccines.
- Short-term, low- to moderate-dose systemic corticosteroid therapy, topical steroid therapy (e.g. nasal, skin), long-term alternate-day 6 treatment with low to moderate doses of short-acting systemic steroid, and intra-articular, bursal, or tendon injection of corticosteroids are not immunosuppressive in their usual doses and do not contraindicate the administration of [measles, mumps, or rubella vaccine]."
- Excretion of small amounts of the live attenuated rubella virus from the nose or throat has occurred in the majority of susceptible individuals 7 to 28 days after vaccination. There is no confirmed evidence to indicate that such virus is transmitted to susceptible persons who are in contact with the vaccinated individuals. Consequently, transmission through close personal contact, while accepted as a theoretical possibility, is not regarded as a significant risk. However, transmission of the rubella vaccine virus to infants via breast milk has been documented."
- "There are no reports of transmission of live attenuated measles or mumps viruses from vaccinees to susceptible contacts."
- "It is not known whether measles or mumps vaccine virus is secreted in human milk. Recent studies have shown that lactating postpartum women immunized with live attenuated rubella vaccine may secrete the virus in breast milk and transmit it to breast-fed infants. In the infants with serological evidence of rubella infection, none exhibited severe disease; however, one exhibited mild clinical illness typical of acquired rubella."
- ***"There have been reports of subacute sclerosing panencephalitis (SSPE) in children who did not have a history of infection with wild-type measles but did receive measles vaccine***. Some of these cases may have resulted from unrecognized measles in the first year of life or possibly from the measles vaccination."

Vaccine Strain Measles Reported

There have been published reports of vaccine strain measles with clinical symptoms that are indistinguishable from wild-type measles.

There are also a few reports of measles vaccine strain virus shedding and lab confirmed infection in children following MMR vaccination.

In 2002, there was a published report by researchers in France of “a child presenting with fever 8 days after vaccination with a measles-mumps-rubella vaccine. Measles virus was isolated in a throat swab taken 4 days after fever onset. This virus was then further genetically characterized as a vaccine-type virus.”

In 2010, Eurosurveillance published a report about excretion of vaccine strain measles virus in urine and pharyngeal secretions of a Croatian child with vaccine-associated rash illness.

A healthy 14-month old child was given MMR vaccine and eight days later developed macular rash and fever. Lab testing of throat and urine samples between two and four weeks after vaccination tested positive for vaccine strain measles virus. Authors of the report pointed out that when children experience a fever and rash after MMR vaccination, only molecular lab testing can determine whether the symptoms are due to vaccine strain measles virus infection. They stated: “According to WHO guidelines for measles and rubella elimination, routine discrimination between aetiologies of febrile rash disease is done by virus detection.

However, in a patient recently MMR-vaccinated, only molecular techniques can differentiate between wild type measles or rubella infection or vaccine-associated disease.

This case report demonstrates that excretion of Schwartz measles virus occurs in vaccinees.” In 2012, a report was published describing a healthy 15-month old child in Canada, who developed irritability, fever, cough, conjunctivitis and rash within seven days of an MMR shot.

Source: author

Blood, urine and throat swab tests were positive for vaccine strain measles virus infection 12 days after vaccination. Addressing the potential for measles vaccine strain

virus transmission to others, the authors stated,

> "While the attenuated virus can be detected in clinical specimens following immunization, it is understood that administration of the MMR vaccine to immunocompetent individuals does not carry the risk of secondary transmission to susceptible hosts."

Not Known How Long Vaccine Strain Measles Virus Infection and Shedding Lasts

In 2013, Eurosurveillance published a report of vaccine strain measles occurring weeks after MMR vaccination in Canada. Authors stated,

> "We describe a case of measles-mumps-rubella (MMR) vaccine-associated measles illness that was positive by both PCR and IgM, five weeks after administration of the MMR vaccine."

The case involved a two-year-old child, who developed runny nose, fever, cough, macular rash and conjunctivitis after vaccination and tested positive for vaccine strain measles virus infection in throat swab and blood tests.

Canadian health officials authoring the report raised the question of whether there are unidentified cases of vaccine strain measles infections and the need to know more about how long measles vaccine strain shedding lasts.

They concluded that the case they reported "likely represents the existence of additional, but unidentified, exceptions to the typical timeframe for measles vaccine virus shedding and illness."

They added that "further investigation is needed on the upper limit of measles vaccine virus shedding based on increased sensitivity of the RT-PCR-based detection technologies and immunological factors associated with vaccine-associated measles illness and virus shedding."

V*accine manufacturers and the medical community caution susceptible individuals, including pregnant women, newborns, and those with a compromised immune system to avoid close contact with anyone who has been recently vaccinated with either live varicella zoster (chickenpox) or herpes zoster (shingles) vaccines.*

Conclusion

Live vaccine virus shedding is a possible source of transmission of vaccine-strain viral infection but how frequently that occurs is unknown

There is no active surveillance of live virus vaccine shedding and most vaccine strain virus infections likely remain unidentified, untested and unreported.

The risks associated with exposure to someone vaccinated with one of the live attenuated vaccines can be greater or lesser, depending on the vaccine and the general health of an unvaccinated (or vaccinated) person.

Some passively acquired immunity to vaccine-strain viruses may occur with widespread use

of live virus vaccines in populations but it is unknown how long that immunity lasts.

It is also not known how many vaccine strain infections, which occur in vaccinated persons or close contacts, lead to chronic health problems or even death.

The development of experimental genetically engineered live virus vaccines and virus vectored vaccines, especially those that are being "fast tracked," have the potential to cause unknown negative effects on human health and the environment. There is a vacuum of knowledge about the potential of live attenuated and genetically engineered vaccine viruses to mutate and recombine with other viruses and create new viruses that will cause disease or affect the integrity of the human genome, human microbiome and healthy functioning of the immune and neurological systems.

The impact of vaccine-strain virus shedding infection and transmission on individual and public health is a question that deserves to be asked and more thoroughly examined by the scientific community.

The fact that children and adults given live virus vaccines have the potential to pose a health risk to both unvaccinated and vaccinated close contacts should be part of the public conversation about vaccination.

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Since his retirement from his holistic mental health practice, Dr Kohls has been writing the weekly Duty to Warn column for the Duluth Reader, Minnesota's premier alternative newsweekly magazine. His columns, which have been re-published all around the world for the last decade, deal with a variety of justice issues, including the dangers of copper/nickel sulfide mining in water-rich northeast Minnesota and the realities of pro-corporate "Friendly" Fascism in America, militarism, racism, malnutrition, Big Pharma's over-drugging, Big Vaccine's over-vaccinating, Big Medicine's over-screening and over-treating agendas, as well as other movements that threaten human health, the environment, democracy, civility and the sustainability of the planet and the populace. Many of his columns have been archived at a number of websites, including the following four:

http://duluthreader.com/search?search_term=Duty+to+Warn&p=2;

http://www.globalresearch.ca/author/gary-g-kohls;

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