

Vaccination and Renal Patients: A Critical Examination of Assumed Safety and Effectiveness - By Suzanne Humphries, M.D. – 18/10/2011

"...health is not sacrosanct or free from vested interests. The traditional grandeur of the learned profession of medicine cannot be taken for granted. It has to be earned by every new generation of physicians."[1]

Nephrologists are in the position of overseeing the health of patients with inflammatory kidney diseases of unknown origin, autoimmune disorders, and acute and chronic kidney diseases of many etiologies. A nephrologist is a specialist consultant and the patients we see are often referred by family doctors and internal medicine physicians. Several doctors who routinely refer patients to me have unquestioningly accepted the idea that "vaccines are safe for everyone" and the "benefit outweighs the small risk." They inquired about my reasoning to withhold vaccinations in sick kidney patients.

Until I did my own research, I was also uninformed and accepted vaccines as safe and effective. Doctors do not receive any education on vaccine composition and the potential adverse effects. In medical training, we were told that patients should receive the vaccine schedule, and were assured that vaccines are safe and effective, except perhaps in a very small minority of people – maybe one in a million.

Information given to doctors about the 200-year history of vaccination is limited to carefully selected sound-bites that pre-empt any concerns. We were led to believe that vaccines are solely responsible for the eradication of infectious diseases such as smallpox. Most accepted, without question or personal study, that vaccines greatly reduced illnesses and are a benefit to overall human health. Few know that the mortality for "vaccine preventable diseases" had massively declined before the vaccine campaigns began.[2] In Figure 1 (at end), it is painfully obvious that the mortality of diseases for infectious disease regressed to nearly undetectable levels in the population – long before vaccines were introduced.

Patients with acute and chronic illnesses are focus groups to be heavily vaccinated even though vaccines have barely been tested for safety or long-term consequences in these populations. Most doctors and patients assume that vaccines are simply a solution of sterile saline and "dead" microorganisms. They are not aware of the manufacturing process to make a vaccine, the contents in the vial, or the potential risks of each component. Doctors wrongly assume that vaccines "protect" their patients from disease, without any adverse consequences on their health, and that vaccinated people won't get that disease.

Other than vaccines, is there any other drug or biological, that is given across-the-board to all comers, without regard for health status, age, or risk of aggravating an existing illness? Given the conflict of interest among members of the major vaccine-promoting committees, vaccines fall into a category that deserves independent study by health care providers.

Every patient should be informed about the potential risks of vaccination and the lack of evidence that vaccines will not harm them over the long-term. Patients have a personal right to choose – and refuse. Their informed choices should be respected. But in order for them to be informed, the person informing them would have to be informed – and doctors are not informed.

Autoimmune and inflammatory considerations

Some of the causes of kidney disease are autoimmune, vasculitic (inflammation of blood vessels), and granulomatous (described below). There are many conditions labeled as "idiopathic"(cause unknown) in nephrology and many are inflammatory in nature. When will doctors make the connection between vaccination and these adverse events ?

A mechanism called “molecular mimicry”[3] occurs when an antibody generated by a vaccine inadvertently recognizes and binds to healthy tissue in the body. The immune system then senses the antibody-healthy tissue complex as foreign and attacks it. As a result, the previously healthy tissue, such as kidney glomeruli (the tiny filters in the kidney) or small blood vessels in the kidney, can develop significant inflammation and disease. This is an autoimmune reaction (against self).

“There is, last but not least, a paucity of clinical and epidemiological data on the potential of vaccines to induce autoimmune hazards. These adverse events, whether they appear days, weeks or months following vaccination, might be frequently overlooked. The awareness of physicians and caregivers to these associations and reports such as the one described in this issue by Vainer-Mossel et al. might enable better assessment of post-vaccination complications as well as susceptibility and safety issues.”[4]

Vaccines are designed to create a state of inflammation, and raise LDL and CRP levels. [5] Why then would we give a vaccine to a patient who already has an inflammatory kidney or heart event? Why wouldn't it be obvious that vaccination can make these conditions worse? With an understanding of the above and the absence of placebo-controlled, long-term follow up studies, we cannot reassure people that vaccines will not create or exacerbate an autoimmune disease. Vaccine-induced acute autoimmune reactions including Guillain-Barre syndrome, thrombotic thrombocytopenic purpura, vasculitis and nephritis [6] are well-described in the medical literature and often listed on vaccine package inserts. If patients were followed longer and if doctors took a more accurate vaccine administration history (of the vaccines given before the new medical problems occur), more vaccine-associated damage would become obvious.

“The rarity and subacute presentation of post-vaccination autoimmune phenomena means that ascertaining causality between these events can be difficult. Moreover, the latency period between vaccination and autoimmunity ranges from days to years.” [7]

A granuloma is a circumscribed nodular inflammation. Granulomas have a typical pattern when examined under a microscope and contain macrophage cells, lymphocytes, neutrophils, and eosinophils (allergy-related immune cells). Granulomas can be caused by a variety of biologic, chemical and physical irritants of tissue.

Some idiopathic (no known cause) renal diseases are granulomatous in nature, and may be caused by an allergic reaction. [8] Patients with granulomatous diseases often present with renal failure and can have allergic manifestations. [9] No cause is ever found for half [10] of all granulomatous interstitial nephritis – a specific granulomatous condition.

Aluminum in vaccines is a documented cause of granuloma formation [11], and there is no certainty that aluminum in vaccines is not the cause of many occult or idiopathic kidney problems. Aluminum is in the following vaccines: DTP, DTaP, some Hib, Pneumococcal conjugate vaccine, Hepatitis B, all combination DTaP/Hib, Tdap or Hepatitis B vaccines, Hepatitis A, HPV, Anthrax and Rabies vaccines. Can patients be assured that their renal interstitial granulomatous or autoimmune illness is not due to an allergic reaction to a previous vaccination? Or that they will not develop an atypical allergy to a vaccine component? The answer, of course, is no.

Here is a partial list of diseases that are “granulomatous,” involve the kidney and more frequently than not, the underlying cause is never known:

- Wegener's granulomatosis

- Churg-Strauss disease
- Sarcoidosis
- Granulomatous interstitial nephritis

These diagnoses often carry very poor prognoses, and their treatments are very unpleasant and dangerous. Given the likelihood that vaccines can cause disease in vulnerable patients it is impossible to predict safety across the board, and it is even more difficult to know which patients will suffer the consequences of a vaccine. The risk-benefit ratio is not necessarily one of favor for vaccination, and our inflamed kidney patients should not be reassured that the vaccine is necessary and safe. Most people would rather choose getting the flu with the miniscule risk of its complications, than develop a vaccine-induced kidney ailment. But for an unidentifiable part of the population this choice cannot be made. Vaccination is like a game of roulette. Some people seem to tolerate it (at least for the first few weeks, and thereafter nobody knows) while others could become case reports in medical literature.

Medical Center Experience

I witnessed multiple patients who were stable for years with chronic kidney disease (CKD) deteriorate or relapse rapidly after the flu and/or pneumonia vaccines. Other doctors just assume that deterioration is what you expect in a person with chronic disease, so when they see it, they don't connect it with a vaccine. Yet given how often it happens, if doctors asked questions about vaccines when renal patients suddenly and rapidly decline, and saw that it happens repeatedly, you would think that they would make the link. But they don't. It is a mysteriously huge blind spot.

In the Winter of 2009, I treated multiple adult patients who required dialysis after receiving both seasonal and H1N1 vaccines and/or pneumonia vaccines. No other cause for their renal failure could be identified. Some patients stated that they became ill after their flu shot. Two of these patients died and one remained on dialysis.

On the other hand no patients were dialyzed, in my eleven years of service at this hospital, simply after a case of influenza. We can see patients develop renal failure during flu-like illnesses – but almost exclusively only if they are prescribed and take large doses of NSAID pain medicine (e.g., ibuprophen), Angiotensin-Converting Enzyme Inhibitors (blood pressure drugs), Angiotensin Receptor Blockers, and/or they were severely volume depleted (dehydrated).

When recently-vaccinated people present to the doctor with acute kidney failure, have not taken any other nephrotoxin, and have no other cause for the kidney failure, the vaccine must be seriously considered as having precipitated the problem. Yet physicians will go out of their way to deny the vaccine as culprit even after they fail to find any other underlying cause. They have no problem admitting that other drugs cause kidney disease, but seem to have a reflex to deny a vaccine as problematic. Could this be from the sound-bites they have heard over and over – about vaccines being safe?

The CDC recommendations: [12]

“In general, vaccinations should be deferred when a precaution is present. However, a vaccination might be indicated in the presence of a precaution because the benefit of protection from the vaccine outweighs the risk for an adverse reaction. This is left to the healthcare provider to make a decision. The following are precautions for TIV:

- Presence of a moderate or severe acute illness with or without a fever. Persons who were hospitalized with an acute illness but who are now well enough to be discharged from a hospital can be vaccinated.”

This recommendation leaves loopholes to vaccinate just about anyone, but is there any science to defend it? How could the benefit of vaccinating a severely-ill patient, or a patient who has organ impairment (and may not mount a significant antibody response anyway) outweigh the risk? Why is there such a rush to

vaccinate all hospital patients even though any potential protection will not be present for weeks? Could it have more to do with medical policy and reimbursement than with what is in the best interest of a sick patient?

As doctors, this CDC recommendation isn't adhered to, because before we evaluate a patient, vaccines have already been given by nurses and others who have no medical mandate. This often occurs on the first hospital-day, not when they are "well enough to be discharged." My efforts to change the hospital vaccine policy to wait until discharge was categorically refused by the administration and hospital policy makers – at a meeting that I was not invited to attend.

Patients are routinely given influenza and pneumonia vaccines on their first day of hospitalization; after a major surgical procedure; during an acute illness (like kidney failure, lymphoma, pneumonia, infections, auto-immune diseases, heart attacks) and often before a full diagnosis has been made.

In many cases, I would try to cancel or defer vaccinations using a written order, but was thwarted because a nurse had already injected the patient with a vaccine ordered by the pharmacist- via a standing hospital policy. I found this unacceptable, and my effort to adjust the inpatient vaccination policy of the hospital was futile.

These vaccines can harm patients who are already ill, especially renal patients. While the nephrologists are left trying to figure out the cause of the patient's renal failure, any vaccine can make the inflammatory reactions already occurring in the kidney worse.

Some of the cases of acute hospital-acquired renal failure that developed within 24 hours of a newly marketed "high-dose Fluzone" vaccine were in ill patients who had slightly-impaired kidneys at the time of vaccine administration. In these cases the kidney function plummeted abruptly after the vaccines. There is NO data to support such a vaccination practice. In addition, the package insert of the flu vaccine and the CDC documents admit "Data from clinical trials comparing Fluzone to Fluzone High-Dose among persons aged 65 years or older indicate that a stronger immune response (i.e., higher antibody levels) occurs after vaccination with Fluzone High-Dose. Whether or not the improved immune response leads to greater protection against influenza disease after vaccination is not yet known." Thus, effectiveness for this particular vaccine is completely unknown and efficacy is measured by an antibody. And, as always, there is no data on carcinogenicity or renal safety.

The peer-reviewed literature and vaccine package inserts report that antibody production is often blunted in high-risk groups. [13] So even if vaccine-induced antibody production did correlate with effectiveness, there is no reason to believe that it would be a manner of protection for chronically ill people.

It is well-accepted that renal vulnerability to inflammatory and drug insults can stem from diabetes, concomitant kidney-toxic drugs, myeloma, recovering acute kidney injury, or an existing, but as yet undiagnosed renal disease. Giving vaccines as soon as a patient is admitted to the ward makes no logical scientific sense, and complicates the environment where doctors are expected to diagnose the admitting problem. Needless vaccination is a liability issue for the doctor and the hospital that must be carefully reviewed.

Peer-Reviewed Literature

The literature is peppered with case reports of acute kidney injury, renal failure and vasculitis after vaccines. [14] In 2009, the BMC Nephrology published a case report that concluded, "Our case as well as previous anecdotal reports suggests that vaccination and the resulting stimulations of the immune system might cause Nephrotic Syndrome(MCNS) and other severe immune reactions. Increased awareness in that regard might help to expand the database of those cases." [15]

Increased awareness will only happen if doctors and hospitals are open to the likelihood of vaccine reactions in their patients, and are taking an accurate vaccine history. They must consider the possibility of

a vaccine reaction occurring weeks to months after a vaccine, since this time period is rational – and since vaccine events have not been studied for auto-immunity over such a time frame. The burden of proof still rests upon the vaccine manufacturers and advisory groups who have neglected to do long-term studies, yet still tout vaccines as an acceptable preventative in the chronically ill, based on limited scientific information.

I have spent the past few years reading much of the available literature on the safety of vaccines – both conventional and alternative. None of these studies can convincingly conclude that vaccines are safe or protective. None discuss the safety of injecting two vaccines on the same day into a patient with acute or chronic kidney disease. If a patient with new-onset kidney failure gets a vaccine and does not recover kidney function, how can anyone be certain that recovery would not have taken place without a vaccine? The assumption is always that the vaccine had nothing to do with the poor outcomes.

Placebo-controlled double blind studies using a saline placebo, with statistical power, and follow-up longer than a few weeks, demonstrating the efficacy and renal safety of any vaccine in the renal failure population, are lacking. Yet renal patients are constantly told that the benefit outweighs the risk; where does this come from? Extrapolation and “consensus opinion-based” recommendations of the MMWR.[16] Immune-complex glomerulonephritis and renal vasculitis are very serious types of inflammatory disorders. They are difficult to treat, and the patients find the suppressive treatments very stressful, both physically and emotionally. For this reason, doctors should consider the possible adverse outcomes or jeopardized renal recovery after injecting antigens, adjuvants, detergents, stealth viruses and preservatives into patients with these illnesses.

A review of the research often concludes that vaccines can be given “safely” to all renal patients, no matter what their chronic illness may be. These same studies only follow a very small numbers of patients for 4-6 weeks. These articles show that many of the test subjects were taking NSAIDS, corticosteroids, methotrexate or rituximab, a powerful monoclonal anti-B-cell antibody. They suggest that adequate antibody response can be achieved in chronically-ill persons, but rarely if ever discuss the relapse or exacerbation rate of the original disease after the vaccine is given. The immune-suppressing drugs in these studies may very well mask acute inflammatory vaccine reactions leading the analysis of the vaccine effect to be negligible. But who can extrapolate the effect on long-term remission after a vaccine has been given and the drugs are tapered? Vaccination studies do not follow subjects looking at decline in kidney function from normal kidneys or already- injured kidneys, subsequent inflammatory disorders, or reactivation of renal inflammatory disorders after being in remission for years. Nor do they assess the rate of myocardial infarctions, strokes, and cancer. None of these articles can convincingly conclude that vaccines are safe or protective in the chronically ill, and few even have the goal to do so.

In 2004, the journal, Vaccine published an article titled, “Impaired response rates but adequate protection rates to influenza vaccination in dialysis patients.”[17] This misleading article is typical of the research that suggests vaccines are safe and protective for people on dialysis. After reading the article, one is left wondering how such a conclusion was made from the data in the study. The patients on dialysis did not respond to the vaccine, even after multiple injections. Protection was considered adequate if the person had a “hemagglutinin titer greater than 40” but there was no longitudinal follow-up to see if any of the vaccinated people contracted influenza throughout the rest of the winter.

It is well-documented that an antibody titer is not an adequate reflection of immunity. For example, recent outbreaks of mumps[18] and pertussis[19] were in populations where more than 80 percent had been adequately vaccinated and assumed to have had protective titers. From the MMWR report on mumps[17] “Of the 24 patients for whom vaccination status was reported, 20 (83%) had received age-appropriate vaccination with 2 doses, one (4%) had received partial age-appropriate vaccination with 1 dose” From the BMJ[15] 85.9% of children with pertussis who presented to the doctor with over 14 days of coughing, were

fully vaccinated.

Protective immunity is a complex mechanism and involves much more than an antibody. Keeping in mind that IgA is the natural antibody on mucus membranes and that cell-mediated immunity is the other arm of immunity- antibody production being the one most focused on with vaccination; Dr. Jerry Weir of the FDA has said “No specific IgA antibody titer has been correlated with reduction in influenza-like illness...Cell-mediated immunity (CMI) is a likely contributor to protection and may provide some degree of cross-protection[to other types of influenza].No specific measure of cell-mediated immunity has been correlated with reduction in influenza-like illness.”[20]

Thus, there are other important aspects of immunity that remain complete unknowns when it comes to vaccinations and the peer-reviewed literature. It is a leap of faith to assume that immunity can be reliably replicated solely by the crude process of inducing a temporary antibody through vaccination.

Efficacy of Influenza Shots in Adults

A study that shows a treatment approach to be “efficacious” means that the study produced good outcomes in a controlled experimental trial, often in highly-constrained conditions. Translating efficacious practices to routine practice settings to produce effective results (i.e., results that show protection in the face of the disease, or “effectiveness”) is one of the more challenging issues of evidence-based practice. Efficacy in the vaccine literature is usually measured as antibody production at a desired titer. The assumption that an antibody titer of 1:40 is protective and translates into effectiveness is nothing more than an educated guess and far from a scientifically-established truth. These are some of the statements from leading authorities on the titer being protective:

“In some human challenge studies, antibody titers of $\geq 1:40$ have been associated with protection from influenza illness in up to 50% of subjects.”[21]

“..., hemagglutination-inhibition and microneutralization antibody titers of 1:40 or more were seen in 92 to 100% and 100% of recipients of MF59-adjuvanted vaccine, respectively, and in 74 to 79% and 78 to 83% of recipients of nonadjuvanted vaccine, respectively...Monovalent 2009 influenza A (H1N1) MF59-adjuvanted vaccine generates antibody responses likely to be associated with protection after a single dose is administered.”[22]

“The criterion of an HI titre of at least 40 IU is based upon the assumption of a correlation with a reduction in influenza-like illness when most of the vaccinated population has some degree of pre-existing immunity against inter-pandemic strains.”[23]

“A serum antibody hemagglutination inhibition (HI) titer of 40 is accepted [but not proven] as the level of serum HI antibody associated with >50% reduction of the risk of contracting an influenza infection or influenza disease. However, it should be kept in mind that other immune parameters also contribute to protection so that HI titer alone may not guarantee immunity or predict susceptibility.”[24]

While there are thousands of published studies on different aspects of the influenza vaccines, the results are widely variable as are the study designs. But underlying most of them is an assumption that a titer of 1:40 protects; not a fact, proof or truth. This must be taken into consideration when making sweeping statements about the efficacy and effectiveness of influenza vaccines.

Effectiveness would be a preferred end point in a study since it is more reflective of reality than the constraints in an efficacy study. While the media hype and policy-making medical boards report on the safety and effectiveness of flu vaccines, this simply has never been proven. Cohort studies examining the rates of influenza disease and morbidity in the vaccinated vs. the unvaccinated are scarce, but not non-existent. Manzoli et al. reported in a 2009 cohort study involving 32,457 vaccinated vs. unvaccinated individuals showed “vaccination did not significantly reduce the risk of in-hospital death, influenza or pneumonia admission.”[25]

Hazardous Components in Pneumonia and Influenza Vaccines

The effects of the various toxic components in vaccines, such as formaldehyde and thimerosal in influenza vaccines, and phenol in the adult pneumonia vaccines, have been poorly studied in the medical literature, but the toxic levels are well documented by the Environmental Protection Agency (EPA).

The National Institute for Occupational Safety and Health (NIOSH) states that formaldehyde is immediately dangerous to life and health at 20 ppm (parts per million).[26] All injectable influenza vaccines have measureable amounts of formaldehyde. Listed on the package inserts as “micrograms per dose,” a conversion reveals that influenza vaccines can contain 50 to 200ppm of formaldehyde. The detractors from this argument will cite evidence that the body makes formaldehyde, but this is an invalid comparison. An injection in micrograms/ml concentration is not comparable to the natural and widely dispersed production in nanogram quantities of formaldehyde-like hydrocarbons within the body. The human body makes highly-acidic stomach secretions, stool and bile. It is a natural occurrence in a natural location. Injecting these secretions into a muscle would not have the same benign effect. There are no published studies that examine the outcome of injecting 50-200ppm of formaldehyde year after year.

Formaldehyde in small amounts is known to have synergy with other toxic substances,[27] and is a known carcinogen with multiple cellular toxicities, including DNA damage, allergies and spontaneous abortion.[28] The International Agency for Research on Cancer (IARC) classifies formaldehyde as a human carcinogen.[29]

Several commonly-used influenza vaccines still contain mercury in the form of thimerosal. Mercury is a known neurotoxin and nephrotoxin, which contributes to hypertension, immunosuppression, renal tubular necrosis, renal failure, anemia, proteinuria and a host of other illnesses. The multidose vial of Fluzone, manufactured by Sanofi-Pasteur, contains 25 mcg of thimerosal in each adult dose. The cumulative effect of annual mercury-containing vaccines, from childhood through adult life, cannot promote health and its neurotoxicity and nephrotoxicity are very real risks.

The EPA has determined that the level of phenol in lakes and streams should be limited to less than 21 ppm to avoid toxic exposure. Yet doctors don't appear to be disturbed when they read in the manufacturer's documents, that the concentration of phenol in the adult pneumonia vaccines is 2,500 ppm (0.25%). OSHA documents that, “The effects of phenol exposure in humans are similar to those produced in animals: systemic absorption causes central nervous system impairment and liver and kidney damage.”[30]

Other ingredients found in flu shots may surprise the uninformed: avian (stealth) viruses[31], antibiotics (aminoglycosides), detergents (triton X-100 and sodium deoxycholate), hydrocortisone, monosodium glutamate(MSG), polysorbate 80, sucrose, thimerosal (mercury) and gelatin. All of these substances can be dangerous and toxic – especially when injected.

Monkey kidney cells, aborted human fetus, immortalized (like cancer) cells are among the cell line substrates used for manufacturing viral vaccines. The contamination of any vaccine with animal cells and animal or recombinant DNA is a very real possibility, and in fact these elements are listed on several of the package inserts.[32],[33] The FDA has published concerns over it[34]. Animal matter has contaminated vaccines since the inception of vaccination, and continues to occur today. Vaccines are tested for occult viruses, and if they are not found are considered “specific-pathogen free.” But vaccines can only be tested for viruses that are known, and for which a test has been developed.

The original polio vaccines were made from infected neural tissue. It was deemed too risky to use such tissue for human vaccines, due to the possibility of inducing encephalitis and severe anaphylactic reactions. Instead, monkey kidney tissue was chosen and is still used for polio vaccine and vaccinia vaccine (smallpox) manufacture. Early on, in the 1950's concern was raised over the possibility that antigens from monkey kidney tissue would pose a risk for nephritis in children injected with residual monkey kidney cells from

vaccines. Today's polio and smallpox vaccine ingredients still list "monkey kidney tissue." To date, no adequate long-term studies have put this concern to rest. As seen above, nephritis can occur months to years after vaccination. Since nephritis is a low-incidence condition, a large sample of vaccinated and unvaccinated children would need to be followed, for a period of months to years, to adequately rule out the higher incidence of nephritis in polio-vaccinated children.

Polyoma viruses

It is now an accepted fact that vaccines have been a vehicle for polyoma (poly meaning multiple and oma meaning tumor, as these viruses are known to cause multiple tumors) virus transmission from animals to humans. The simian virus40 originated in monkey kidneys and has been associated with two common forms of human renal pathology called FSGS[35](focal and segmental glomerulosclerosis), and tubular necrosis[36].

Other polyoma viruses can be reactivated during immunosuppressive treatment of kidney diseases and transplantation, and result in transplant failure and cancers.

SV40 was given its name as it was the fortieth monkey virus discovered. Since then, over 100 such viruses have been detected. SV40 has tropism (attraction) for human kidneys. Stealth pathogens that can't be tested for could lead to devastating problems later after the vaccinee's immune system is compromised. Modern detection assays for SV40 have been shown to be insufficient by a leading investigator of SV40.[37]The stealth virus problem is not just a thing of the distant past that has been addressed and contained. "Seed virus" used to grow polio virus in cultures was taken from stored contaminated polio vaccines as late as the 1990's.[38]Inactivated vaccines against adenoviruses and hepatitis A virus also exposed humans to SV40.[39]

Acceptance of the monkey virus called SV40 as a carcinogenic vaccine contaminant took the medical and pharmaceutical community over 30 years. During that time, hundreds of millions of people were infected with it. This potent cancer virus has been described by one of the foremost scientists in the field of virology, Dr Michele Carbone, as "the perfect war machine" because it affects at least 4 major cellular mechanisms that either promote cancer or interfere with cancer fighting defenses.[40] Recently, three new polyoma viruses (KIV, WUV, and Merkel Cell Py (MCV)) were added to the list of viruses that infect humans, yet SV40 is the only one to even have cursory study in conjunction to vaccine contamination. And that was only because a scientist working for the Division of Biologics (now FDA) named Dr. Bernice Eddy in the 1950's publicized her findings despite concerted efforts to silence her. Polyoma viruses are now considered ubiquitous and the consensus is that they are acquired in childhood. The question is, are they acquired as a normal part of life or are they acquired from animal-derived vaccines given during childhood? This is an area of virology that has not been touched.

Polyoma viruses that infect humans become activated during episodes of immunosuppression.[41]Another type of polyomavirus, called BK polyoma virus, is associated with failed renal transplants and malignancies in renal transplant patients[42]. Viral reactivation has been well documented in patients who have undergone organ transplantation.[43]As any transplant nephrologist will attest, polyoma virus reactivation often culminates in transplant rejection, and transplant patients have a much higher incidence of malignancies than the general population.

BK polyoma is also a recognized complication of kidney failure in patients undergoing immunosuppression for cancers and for non-renal organ transplants.[44]While BK polyoma is considered a rare complication, renal failure is not rare in patients undergoing chemotherapy. Without a more comprehensive investigation in the area of renal failure during chemotherapy, it will remain unknown how often these problems are silently occurring. Most cases of renal failure during chemotherapy are simply called tubular necrosis and are not deeply investigated.

Many renal patients are given immunosuppressive medications to treat their native glomerular kidney disease (various forms of inflammatory nephritis), which could certainly reactivate latent polyoma viruses. A little-known fact is that both BK polyoma and SV40 are capable of causing renal tubular necrosis[[45]; another cause of kidney failure for which doctors frequently never find an underlying cause.

Focal and segmental glomerulosclerosis (FSGS) is another serious kidney disease and it is difficult to reverse. The nephrology literature documents that the SV40 polyoma virus has been discovered in FSGS lesions on kidney biopsy.[[46]The accepted medical treatment involves high doses of corticosteroids and immunosuppressive medications, often for months or years. The consequence of potential latent viral activation could be additional kidney injury or cancer stimulation during the immunosuppressive treatments in patient's FSGS. We know that the immunosuppressive treatments can be carcinogenic but there has not been serious investigation into dormant cancer viruses contributing to the increased rates of cancer in persons undergoing immunosuppressive treatments. Until these concerns can be put to rest, we cannot simply say that the benefit of vaccination outweighs the risk.

When a patient does not recover after a treated episode of glomerulonephritis it is always assumed that the treatment simply didn't work, but is it possible that the kidneys fail due to a reactivated latent kidney virus? Much more research is needed in order to understand the potential consequences of polyoma virus infection in patients treated for auto-immune diseases with steroids and cytotoxic agents aimed at purposefully impairing the immune cells of the body.

A potential stealth virus problem will exist as long as vaccines use animal products. Most vaccines contain more than one animal byproduct. In 2009, a porcine (pig) virus was discovered in both brands of the infant rotavirus vaccine manufactured from monkey-gut viruses. PCV-2 (porcine circovirus 2), came from a commonly-used protease extracted from pigs, called trypsin.[47]This virus is known a known cause of wasting-disease and immunosuppression in pigs.

The FDA issued a statement reinstating the rotavirus vaccines from both companies for ingestion in infants, citing the benign nature of the virus in humans. This proclamation was made without any research into the effect a pig virus can have on infants, now or in the future. Any correlation between vaccine contaminants and cancers or wasting disease, especially in the immunosuppressed, will remain unknown and unstudied.

Immunity to responsibility

In 1986, a law was passed that exempted Pharmaceutical companies and doctors from any liability after a vaccine adverse event. "No vaccine manufacturer shall be liable in a civil action for damages arising from a vaccine-related injury or death." (Public Law 99-660) At that time a fund was established which is filled by tax-payer money. This fund is designed to compensate the most severe cases. Patients whose chronic inflammatory issues are worsened by vaccines do not qualify.

In 2010 the US Supreme Court ruling in the case of *Bruesewitz et al. v. Wyeth LLC*, set a new precedent that further pads the vaccine manufacturers. The decision stated that vaccines are "unavoidably unsafe."

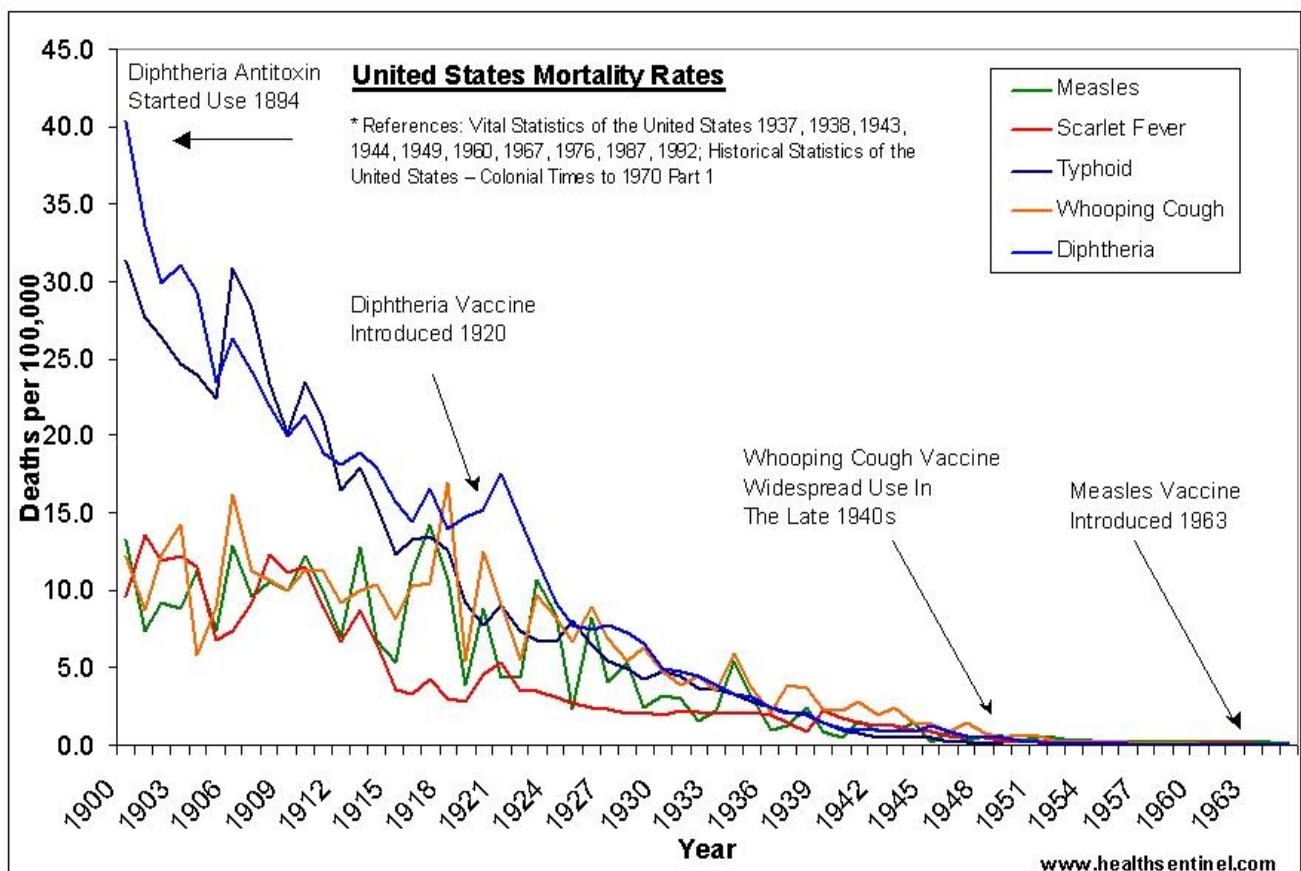
Summary

All healthcare providers involved with the care of renal patients should evaluate the true risk of the vaccine vs. the benefit of overall health. This needs to be done by taking into consideration the broad array of information available. Those who do this will undoubtedly be surprised at what they find when addressing the topic thoroughly, with an open mind, realizing that there is not one single drug or procedure that they routinely give to all their patients, six months of age and older, every year of life.

Many patients are fearful of repercussions from providers for refusing vaccines. Health care providers should be caregivers and informed consultants, not dictators. Patients deserve to have their long-term health carefully considered with information that encompasses more than "protocols" and CDC guidelines that have no consideration for each individual's health or need. Health care providers are not mandated to

push the issue of vaccination, and they are hopefully bound to their oath to do no harm. In today's environment, health care providers have unfortunately become glorified slave- technicians rather than free-thinking, intellectual advocates of health. As we can see here, at the very least for kidney patients, vaccination recommendations and assumptions have outpaced their science base. It therefore rests on the shoulders of health care providers who wish to give the best possible care, to individualize treatment for those patients for whom data is absent, incomplete or questionable. Physicians are free to individualize medical care and that includes vaccination, but in order to do so they must independently research the very real risks involved in assembly-line vaccination.

Figure 1



Sources

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