

It's Great to be Back! We give WAVES a facelift after a conspicuous absence.

WAVES

The newsletter of the Immunisation Awareness Society of New Zealand

Worth the Risk to Your Baby?

Concerns about Prevnar,
the new pneumococcal
vaccine for infants

Colloidal Silver

A current HOT Topic in
the world of medicine

Recovery From Autism

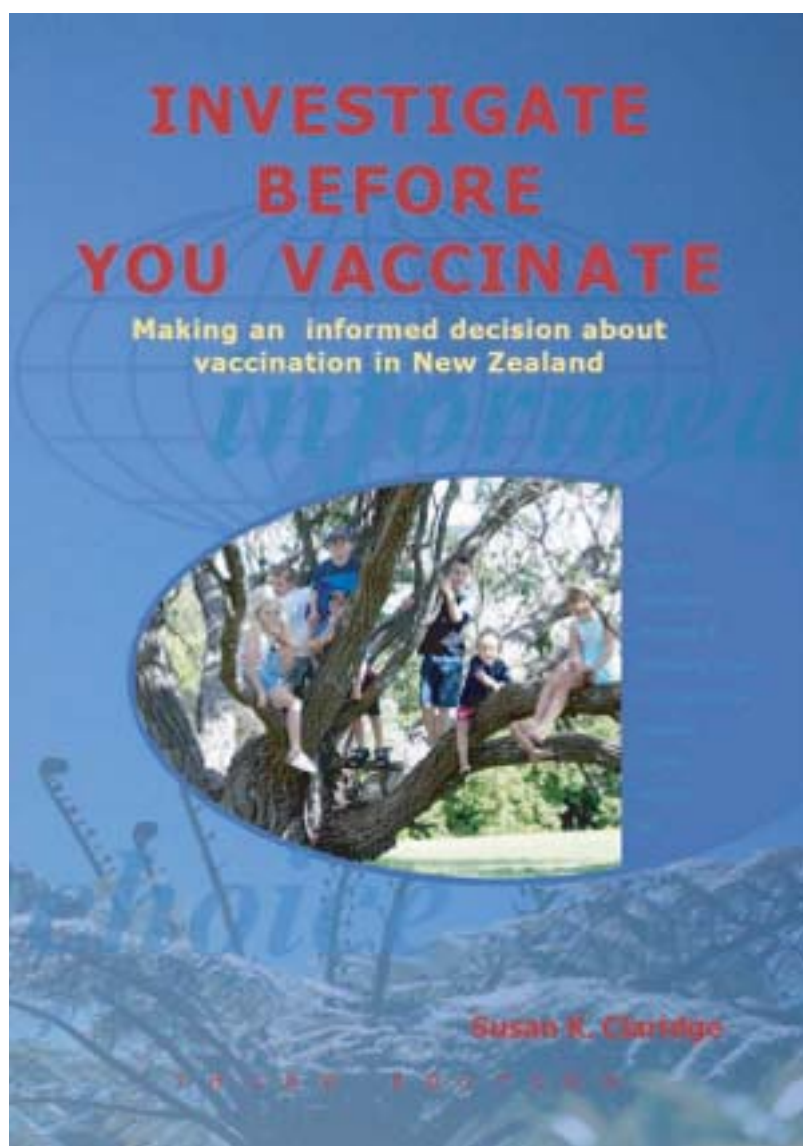
The remarkable story of
Kyle Deane

September / October 2006

Investigate Before You Vaccinate

Making an informed decision about vaccination in New Zealand.

By Susan K. Claridge (Third Edition)



For the first time there is a book on the safety and efficacy of vaccination, written specially for parents in New Zealand parents so that they can make an informed decision about vaccinating their children.

Published by The Immunisation Awareness Society, this book does not set out to present the easily accessible information on the supposed “benefits” of vaccination as promoted by the Medical Establishment and the pharmaceutical companies. The information presented is the information that doctors, nurses and other health professionals are unlikely to provide you with, even if you knew the right questions to ask.

Drawing on international and New Zealand studies this thoroughly researched book cites more than 580 medical texts, vaccine data sheets and medical journal papers.

The third edition contains up to date information, including the new vaccines available - or soon to be available - in New Zealand. The entire book is much thicker, almost double the text from the last edition, with over 580 references.

The Book that **EVERY** New Zealand Parent Should Read!

“All the vaccines on the New Zealand childhood schedule are injected directly into the body, bypassing the body’s normal immune defences. Vaccination ignores thousands of years of evolutionary wisdom and does what nature would never allow – provides viruses and bacteria (and the toxic brew in which they are carried) with direct access to the bloodstream.”

“The chances of obtaining full disclosure of the facts from your health professional about the risks and “benefits” of vaccination, balanced against the actual risks should a healthy child contract a childhood disease, are very remote.”

ORDER NOW from our website at www.ias.org.nz, or by using the form at the back of this publication

WAVES

Volume 1, Issue 1, September / October 2006

FEATURES

PREVNAR - Is it Worth the Risk?

10

Recent reports about Prevnar, a pneumococcal vaccine for infants, seem to confirm earlier concerns and raise questions about its effectiveness, its safety and its ultimate impact.

On February 17, 2000, Prevnar, a pediatric 7-valent pneumococcal conjugate vaccine was licensed in the United States for administration at 2, 4, 6 and 12-15 months to "prevent invasive pneumococcal disease"

"PREVNAR, A Critical Review of a New Childhood Vaccine", by Michael Horwin, JD, MA published September 19, 2000, is a comprehensive review of that controversial vaccine and the many undeclared conflicts of interest that surrounded its development and trials.

This report discusses information that should be carefully reviewed by the public and vaccine authorities in countries considering the introduction of a Prevnar vaccination program.

COLLOIDAL SILVER

18

Colloidal silver, a liquid suspension of the metal silver, is currently a hot topic in the world of medicine. While alternative medicine praises its use as an antibiotic, mainstream medicine considers it somewhat of a poison. But colloidal silver is neither a poison nor a panacea: It is a safe and proven topical antibiotic that may cautiously be used internally.

RECOVERY FROM AUTISM

24

Kyle Neil was born on April 19, 1998, a healthy beautiful baby boy. We kept Kyle's vaccinations up to date. With each shot he would get extremely sick, running a fever and develop a croup cough. His behavior was on a steady decline, with bizarre behaviors and decreasing speech. Kyle was sinking into Autism, a developmental disability we knew little about. Read Kyle's story as told by his Mum MARIE GEARY.

WAVES (ISSN 1174-6076) is the Newsletter of The Immunisation Awareness Society Incorporated.

IAS subscriptions are \$40 per year for New Zealand residents and \$50 per year internationally.

Articles herein express the opinion of the author and any such opinions do not necessarily reflect those of the IAS. No liability is therefore accepted for any of these opinions or statements. Readers are advised to consult a health professional.

Contributions are welcomed, preferably typed, and must be accompanied by full name and contact details. If you wish to have your work returned to you, please enclose a self-addressed envelope. If in any doubt as to the suitability of your work, please contact the Editor at the below address.

Please address all correspondence to the Editor. Any letter not intended for publication should be clearly marked as such.

Email: info@ias.org.nz

Internet: <http://www.ias.org.nz>

Phone: (09) 303 0187

Postal Address (cleared daily):

P.O. Box 56-048

Dominion Road

AUCKLAND

New Zealand

2007 Copy Deadlines:

15 February

17 April

17 June

18 August

18 October

Editorial	5
Chairperson's Report	6
Letters to the Editor	7
PREVNAR - Is it Worth the Risk?	10
Colloidal Silver	18
Recovery from Autism - Kyle's Story	24
Local Support Contacts	27
Library List	28



From the Editors Desk

After quite a delay, I'm sure you will all be delighted to have your WAVES arrive in your mailbox again.

Well, now our children are no longer dying of meningococcal B thanks to the success of the MenZB vaccine (which is of course debatable, as it is more likely due to the natural decline of the illness) we are being bombarded with another form of meningitis. This time it is pneumococcal that is the culprit - yes it's going to kill your child if you don't vaccinate with the newly approved PREVNAR vaccine. This is yet another one that's going to be introduced to the schedule next year, with the usual fanfare that we have become so familiar with. To prepare you for this, we have an article on the PREVNAR vaccine, so you can empower yourself with the information.

Also this month we look at the wonders of colloidal silver, with an in-depth article. I have had personal experience with colloidal silver, having used it myself and administered it to my children with great success.

Our other main article is about the tragedy of a child who developed autism from vaccinations, and the struggle and determination of his parents to turn his life around and bring him back. This of course coincides with the article on TV One's *Expose* program on Monday 14th August about Louise Bewsher's battle to help her two sons who also developed autism from vaccination. To me, there is very little doubt that vaccines are contributing hugely to the massive rise in autism and autistic-spectrum disorders. Not only do the medical fraternity continue to deny this, they also rubbish any natural therapy that helps these children. Despite this, they have nothing substantive to offer the parents; instead leaving them floundering once their child has been diagnosed. But there is hope for these children as our article shows, so if you know of any parents who are wondering how they're going to help their autistic child, you might like to pass the article on.

We are continually busy replying to emails from parents with various questions on vaccinations. There is a selection of these emails in *Letters to the Editor*. We would love to receive correspondence from you, be it questions, or personal experiences such as how you coped with a natural childhood illness, broke the news to your in-laws that you had chosen not to vaccinate your child, how your doctor coped with your decision not to vaccinate, your experience with a child that has reacted to a vaccination, birth stories, breastfeeding stories, or pretty much anything to do with child health. Just send them to our email address.

We hope you enjoy our latest WAVES.

Michelle
WAVES Editor

Chairpersons Report

Welcome to the September issue of WAVES.

We realise it has been a while since some of you have had any direct contact from the IAS committee so let me get you up to date.

Our last newsletter was published late last year and, at that time, we were a group of five doing our best to get real and current vaccination information out to New Zealanders. After many requests for a new editor we decided it was best to put that project to one side and concentrate on our book, "Investigate before you Vaccinate, making an informed decision about vaccination in NZ" written by Susan Claridge. It has been a resounding success and next month we will be launching the 3rd edition with several important updates. There is more about the book in this issue.

We also had a particularly busy time during the MeNZB roll out and the months following. Our answerphone and email contact were swamped with requests for information, support and reassurance from members and non-members that the decision that YOU had made about protecting your child's health was the right one. And it is.

The decision was made in April 2006 to re-visit the practicality and costs of getting a newsletter out to our subscribers. Many of us felt that this was an integral part of our philosophy/service. A new editor has been sourced and we are delighted to tell you that, going forward, members will receive five issues each year. You can expect them in March, May, July, Sept and November.

At this point it is important to acknowledge that some of you will be 'owed' issues to meet what we promised as part of your subscription. Our membership secretary has provided us with an up-to date list of how many newsletters you are entitled to and by way of an apology for the long pause we will be providing these members with one free newsletter to encourage you to re-subscribe and support the IAS for another year.

If your babies have grown into toddlers or your toddlers have started school and you think you are past this decision then remember that the MOH plans to regularly entice parents to agree to vaccines all the way through their school years....to infinity and beyond. If you have no further need for the newsletter please pass it on to someone who does and if you can subscribe or send a gift donation for a pregnant woman or couple then I'm sure they would appreciate the gesture.

Should you prefer to receive this newsletter in a PDF file please e-mail the membership secretary at emmalea@orcon.net.nz. Members who choose this option will not only save us time and paper but they will also receive an extension on their subscription by one extra issue.

Lastly I would like to thank you for your patience and your encouragement over the last few years. Only time will tell if we are on the right side of the debate; I know which part of common sense I am backing.

Erin Hudson
IAS Chairperson

Letters to the Editor

MMR Separated?

Do you know if it is possible to get a separate rubella vaccination rather than the combined MMR. I am very wary about giving any vaccinations to my children but are considering the rubella injection for my daughter due to the possibility of her catching rubella when pregnant (in the very distant future, I hope). I have had her blood tested but unfortunately she currently has no natural immunity. The practise nurse has told me that the rubella only injection is no longer available?

Heather

Editors Response

As far as we know rubella is not available as a single vaccine & you have to have the MMR. Even if your daughter has the vaccination & she does gain any immunity to rubella there is no guarantee she will still have that immunity when she reaches childbearing age as the immunity from vaccination tends to wear off, hence the reason they keep introducing more & more boosters to the schedule.

If you have a look at our website www.ias.org.nz there is a lot of information on there regarding rubella. The window is actually very small as far as the danger to a foetus if you come into contact with rubella when pregnant, it is only a danger in the first trimester of pregnancy and even if you do catch rubella in that first trimester, there is still only about a 7% chance of the baby being affected. So if your daughter still hasn't had rubella by the time she is thinking of having a baby, her best form of defence is to ensure she doesn't come into contact with anyone who could be contagious, or anyone that has recently been vaccinated with the MMR vaccine, whilst in that first trimester of pregnancy. If she does come into contact with someone she can boost her Vitamins C & A to reduce the risk to her baby should she too become infected with the illness in that first trimester.

Vaccinating 2 Year Old

I have chosen not to immunise my child until she

was two. She is coming up to her 2nd birthday and im at a cross roads as what to do.. I am unsure of immunising, but think it might be better to, rather than have to constantly get flack for not immunising.

My daughter is basically a healthy child, but has mild allergies to certain foods. I fear that if she is vaccinated that she may react to the vaccine. I am also wanting to put her into some sort of day-care, and i must admit i am quite intimidated by some the daycares, playgrouds, childcares perceive non immunised children. She is my only child so i fear i am too over protective?

Mihi

Editors Response

If you are still unsure of whether or not to vaccinate your child it is vital you do more research & not choose until you are absolutely sure. You could start with our website www.ias.org.nz we also have an excellent book available "Investigate Before You Vaccinate" this is a very good resource to have on hand in these situations.

If your daughter already has allergies & you choose to vaccinate, you will probably find her allergies will get worse, it is also very difficult to know if she has allergies to any contents in the vaccines, firstly because it is impossible to know exactly what's in the vaccines & because they inject so many all at once, so if she does have a reaction (as most children do) you won't know what she had the reaction to.

It is important to remember that vaccination is a choice in NZ & you are perfectly & legally entitled to choose NOT to vaccinate your daughter, she is a healthy child in which case she is no danger to other children. She is also entitled to a pre-school education & centres should not be discriminating against your child because of health choices you have made for her. If you get negatve feedback from a centre just remind them of these points. Most centres don't discriminate as there are quite a few parents choosing not to vaccinate these days, you just may have to look around a bit to find one. However if it is a state owned kindy they have to allow your daughter to attend by law, I think that also goes for Barnar-

dos caregivers.

Giving Parents The Confidence

Thank you so much for your articles on the Meningococcal B Vaccine. I found the information well-researched, expansive and insightful. The articles have really helped me make an educated decision, and have given me permission to say 'no'.

As a parent, the amount of intimidation to have my children vaccinated (MeNZB) has been unprecedented (friends, media, NEWS, Baby Charlotte, posters, postal drops, School/Kindergarten, letters from my doctor's surgery, telephone calls from the nurse, culminating in an actual unsolicited visit to my home from a MeNZB Outreach Coordinator - with needle in hand!!)

Now I have confidence to question other vaccinations.

Kim

Editors Response

Thankyou so much for your correspondence, it's great to hear from people like you to let us know that we're not just continuously banging our heads against a brick wall, which is what it feels like alot of the time. I'm so glad you found our info helpful & that it saved your children from yet another useless & dangerous vaccine. It really is a shame we don't have the same bottomless pit of resources & finance to bombard the public like the MoH have & you're right, you do have to be strong to go against the onslaught.

The Pressure To Consent

I would just likesome information about my right-regarding vaccination consent forms that children bring home from school. My 12 year old son brought home a form for tetanus and diptheria a few weeks ago that are to be given by the public health nurse at his school. Since he had a bad reaction to the MMR jab and now, since the age of 2 he has asthma, allergies and repeated ear infections, I have not let him have any immunisations since. I threw the form in the bin and have just found out from my son that his teacher kept him, and the other children in his class who have not returned their consent forms, in at lunchtime

and were made to do work. The teacher has told the class that she is going to keep them in every lunchtime to do extra work until they bring their forms back. I have rung the principal about this and he told me I have to send the form back either way to let them know whether or not he is getting the vaccinations. I told him that it clearly states on the form that "information provided here is voluntary but we cannot immunise your child without it" and therefore I do not have to send anything back to the school at all and the teacher has no right to keep the children in at lunch time. He keeps insisting that I have to complete the form. Could you please give me some advice on my rights and my child's rights and what I should do about the situation.

Donna

Editors Response

It is apalling that your son has been treated like this, it is blatant discrimination and you could get the MoE involved & the human rights commission. You are under absolutely NO legal obligation to sign & return a consent form of any kind. You might like to get the principal to contact IMAC to confirm this to him, then get him and the teacher to personally appologise to you, your son and all the other children that were kept in at lunch time. We had a lot of this when the consent forms were sent out for the MenzB vaccine, teachers need to get off their high horse and do what we the tax payer are paying them to do (teach our children), leaving us the parents to make decisions in regards to our childrens health. If your child had been treated like this because you had refused to fill in a form telling them what religion you choose, or what ethnic background you are there would be hell to pay, as far as I'm concerned this is exactly the same.

Outcome

Thanks for your advice about my rights regarding the consent form issue. After sending you the email my son and other children were kept in again at lunchtime, and I was furious especially as the principal told me he would get the teacher to contact me. I sent a letter to the teacher stating my rights and also included a copy of the part on the forms where it states that providing the

information is voluntary. I also informed her that the school has no right to be keeping any children in for not completing forms of a voluntary nature. She sent a note home to me apologising about it and said she was doing what she had been told to do (I assume by the principal) and that she thought they were compulsory. I have left it at that. I phoned IMAC and was quite surprised at the conversation I had with the lady I spoke to, I think she was an immunisation nurse and thought you may be interested in hearing about it. When I told her what was going on she wanted to know why I objected to completing the form, I told her I didn't want the school knowing any of my personal information, she asked then what information I objected to providing, I said I didn't want them to know whether I was consenting or not consenting, she then said aren't I giving the message that I'm not consenting by not completing the form. I then said no, because other parents aren't returning their forms because their children had already had the immunisations at their doctors. She said it was more that the public health nurse needs to know how many injections to bring and that's why the school needs the forms returned. I told her that I had been advised by the IAS that I am under no legal obligation sign consent forms of any kind and that it clearly states on the forms that the information is voluntary. She then when and got a copy of the form and said I can see how you may have thought that (it is on page 3 in blue writing), but she believed it referred to providing details about your child rather than completing the form and returning it. I then repeated again that I am under no legal obligation..... She finally agreed with me and suggested I contact the school again. It sounds like the IMAC are not really sure themselves about parental rights.

Tetanus Only

My 12 year old is due for a tetanus booster. While I am yet undecided as to whether he will have this, I have been making enquiries as to the availability of a tetanus-only vaccination rather than a combination.

So far I have not been able to ascertain whether this is available, the doctors and nurses I have spoken to know only of the tetanus-diphtheria combination.

Can you help me as to whether this is available or where I should go to look for it?

Julie

Editors Response

The single tetanus vaccine is no longer available, only the ADT (adult diphtheria, tetanus) which of course, being an adult vaccine, contains the mercury derivative Thimerosal.

Tetanus is often one illness that parents, who choose not to give their children other vaccines, tend to get a bit worried about, this mostly comes from information they get from the medical association. Tetanus is actually every where, not just on the end of rusty nails, or in the soil, it is in house dust & generally all around us, so it is interesting we're not all dying of tetanus & I can assure you it has very little, if anything to do with vaccination. The only times tetanus is a threat is with deep puncture wounds that don't bleed & heal quickly. In these situations you can administer the homeopathic *Ledum 30c*.

It has been found that most of us already have natural immunity to tetanus through breathing in the spores, this is actually the only way you do become immune to tetanus, not through deep puncture wounds, such as needle jabs, in fact people that live in rural areas are more likely to be naturally immune than city dwellers.

PREVNAR - Is it Worth the Risk?

Recent reports about Prevnar, a pneumococcal vaccine for infants, seem to confirm earlier concerns and raise questions about its effectiveness, its safety and its ultimate impact

By F. Edward Yazbak, MD, FAAP

On February 17, 2000, Prevnar, a pediatric 7-valent pneumococcal conjugate vaccine was licensed in the United States for administration at 2, 4, 6 and 12-15 months to “prevent invasive pneumococcal disease”

“PREVNAR, A Critical Review of a New Childhood Vaccine”, by Michael Horwin, JD, MA published September 19, 2000, is a comprehensive review of that controversial vaccine and the many undeclared conflicts of interest that surrounded its development and trials. (1)

This report discusses information that should be carefully reviewed by the public and vaccine authorities in countries considering the introduction of a Prevnar vaccination program.

The pneumococcus (*Streptococcus pneumoniae* or *Diplococcus pneumoniae*) was isolated by Louis Pasteur in 1881. The organism is surrounded by a polysaccharide capsule. Differences in the composition of the capsule have helped identify over 90 capsular serological types. Both vaccine-induced and disease-induced immunity are type-specific.

Pneumovax 23 by Merck is an adult pneumococcal vaccine (PPV 23) that was licensed in the U.S. in 1983. It contains polysaccharides from types 1, 2, 3, 4, 5, 6B, 7F, 8, 9N, 9V, 10A, 11A, 12F, 14, 15B, 17F, 18C, 19A, 19F, 20, 22F, 23F, and 33F pneumococci (Danish classification). At the time the vaccine was licensed, those 23 bacterial types were responsible for 87% of reported bacteremic pneumococcal disease. The vaccine was not indicated for children under 2 because it failed to result in any measurable immunity. Pneumune® 23 by Wyeth is also licensed in the U.S. but less used. One dose of vaccine is required except in certain conditions in which a second dose within 5 to 10 years is indicated.

After two decades of significant use, PPV 23
10, WAVES Newsletter September/October 2006

vaccination has not resulted in a change in the distribution of vaccine-type and non-vaccine-type organisms. On the other hand it has not been followed by clinically significant decreases in carrier rates among vaccine recipients. (2)

Until the late eighties, meningitis due to *Haemophilus influenzae* B (HIB) was the most prevalent bacterial meningitis in children under five. It also caused other very serious invasive diseases. The introduction of the polysaccharide and later the conjugate HIB vaccines was promptly followed by a significant reduction and practical elimination of HIB invasive disease. Although there were concerns about the serotype specificity of conjugate vaccines and the possibility that their use may increase carriage of non-vaccine serotypes, this did not happen with the HIB conjugate vaccines after 15 years of intense use.

With the success of conjugate HIB vaccines, *S. pneumoniae* became the leading cause of bacterial meningitis in the United States. During the nineties, the incidence of pneumococcal meningitis among infants was around 10/100,000, higher than any other group. (3, 4) This, together with the increased antibiotic resistance of the pneumococcus because of the inordinate use of antibiotics, prompted the development of Prevnar.

Available details about Prevnar from the Centers for Disease Control and Prevention and the rationale for the Advisory Committee on Immunization Practices (ACIP) for its recommendation of the vaccine were published in the *Morbidity and Mortality Weekly Report (MMWR)* of October 6, 2000. (4)

*“The new 7-valent pneumococcal conjugate vaccine (PCV7; ** Prevnar,™ licensed in February 2000 and marketed by Wyeth Lederle Vaccines) should be a key addition to existing pneumococcal disease prevention measures... In 1998, estimated incidence in the United States of invasive pneumococcal infections among children aged*

<12 months and 12--23 months were 165 and 203 cases/100,000 population, respectively, with peak incidence occurring among children aged 6-11 months (235/100,000). In contrast, incidence among persons of all ages and among persons aged >65 years were 24 and 61/100,000, respectively...In the United States, the most common manifestation of invasive pneumococcal disease among young children is bacteremia without a known site of infection, which accounts for approximately 70% of invasive pneumococcal cases among children aged <2 years...With the success of conjugate vaccines in preventing invasive *Haemophilus influenzae* type b (Hib) disease, *S. pneumoniae* has become the leading cause of bacterial meningitis in the United States. Children aged <1 year have the highest incidence of pneumococcal meningitis, which is approximately 10/100,000 population...A substantial reduction in episodes of AOM (acute otitis media) was found. Vaccine impact was greatest for frequent otitis and tympanostomy tube placement...Among a subset of study children with spontaneously ruptured tympanic membranes, *S. pneumoniae* was cultured from the draining ears of 6 children vaccinated with PCV7 and 17 children who received the control vaccine (vaccine efficacy was 65% for AOM caused by vaccine-serotype pneumococci [$P = 0.035$]).”

Prevnar includes seven purified capsular polysaccharides of *S. pneumoniae* [4, 6B, 9V, 14, 18C, 19F, 23F] each coupled with a nontoxic variant of diphtheria toxin, CRM197 (CRM, cross-reactive material). The vaccine contains 0.125 mg of aluminum/0.5-ml dose as an aluminum phosphate adjuvant but no thimerosal. Five of the seven serotypes included in PCV7 (6A, 9A, 9L, 18B, and 18F) accounted for 86% of bacteremia cases, 83% of meningitis cases, and 65% of cases of acute otitis media (AOM) among U.S. children under 6 between during the years 1978 to 1994.

A review by Lipsitch in the CDC's Emerging Infectious Diseases Perspectives (5) detailed pneumococcal serotype replacement in several studies:

“...pneumococcal conjugate vaccine studies show considerable evidence of serotype replacement, as measured by nasopharyngeal carriage of nonvaccine type organisms. Increases in the carriage of nonvaccine serotypes have occurred in three major ongoing clinical trials of pneumococcal conjugate vaccines. In Gambia, carriage of nonvaccine serotypes was 79% in children re-

ceiving three doses of a pneumococcal conjugate vaccine (compared with 42.5% in controls). In trials of a 9-valent vaccine in South Africa, carriage of nonvaccine serotypes increased from 21% in controls to 39% in vaccine recipients. Serotype replacement was observed in the second of two large studies in Israel; the reason for the difference in outcome between the two studies remains unclear...”

Lipsitch concluded “The occurrence of serotype replacement in three trials of pneumococcal conjugate vaccines confirms the validity of concerns expressed in anticipation of these trials...”

In the review, Lipsitch mentioned that “In the first phase-III trial for which data were presented, (6) no increase was observed in invasive disease from nonvaccine types (REF). While this result is encouraging, it may not be indicative of what will occur as conjugate vaccines enter widespread use in a variety of communities.”

It should be noted that Lipsitch was not referring “carriage” but to actual invasive disease during the U.S. phase III trial and that he cautiously suggested that things may be different after widespread use of the vaccine.

It is not known why the disturbing results of the foreign studies were not seriously considered by the CDC, the ACIP and the Food and Drug Administration (FDA).

Although most U.S. pediatricians were not aware of the problems encountered in the overseas trials, many wondered anyway what would or could happen with the planned wide use of Prevnar. Would it result in an increase in cases of pneumococcal invasive disease due to non-vaccine serotypes? Could it lead to an increase in invasive disease caused by other bacteria like the HIB vaccine did?

Pediatricians were also puzzled how Prevnar was going to “prevent” ear infections. It was well known that at least 60 percent of acute otitis media (AOM) were viral and the pneumococcus was only one of several bacteria responsible. In addition there were 90 + strains of pneumococcus and only seven in the vaccine. More importantly, why did we need another vaccine to be added to the already substantial U.S. vaccination schedule when according to the American Academy of Pediatrics “Approximately 80 percent of children

with AOM get better without antibiotics and children whose ear infections are not treated immediately with antibiotics are not likely to develop a serious illness" (7)

More importantly, would Prevnar reduce the incidence of recurrent otitis media with effusion (OME) and the need for insertion of ventilating tubes?

There were many rave reviews about Prevnar after its introduction, several by the same researchers who had done the original investigations. Sales of the vaccine were phenomenal and Wyeth-Ayerst's stockholders pinched themselves after each quarterly report. The always generous CDC is still paying top dollar for the 6 year old vaccine: (US) \$57.59 per dose and the present contract expires 3/31/07. Doctors and clinics pay (US) \$ 69.25/dose. (9) In other words, in the last few years, the four doses of Prevnar amounted to about 40% of the total cost of recommended pediatric vaccines.

The "financial performance" of the vaccine has been simply remarkable: "PREVNAR(R), Wyeth's vaccine to prevent invasive pneumococcal disease in both infants and young children, achieved net revenue of \$401 million for the 2005 fourth quarter, an increase of 18% over the 2004 fourth quarter. In 2005, Prevnar celebrated its fifth year on the U.S. market and more than 26 million doses were sold globally. Prevnar achieved worldwide net revenue of \$1.5 billion for the 2005 full year, an increase of 43% over the prior year. During 2005, Prevnar was launched in 13 international markets -- setting the stage for continued growth."(8)

That perfect bliss lasted until late in 2005 when researchers from the CDC, of all places, decided to reveal the results of a careful study they had just finished.

Postvaccine genetic structure of Streptococcus pneumoniae serotype 19A from children in the United States by Pai R, Moore MR, Pilishvili T, Gertz RE, Whitney CG, Beall B; Active Bacterial Core Surveillance Team, CDC

"BACKGROUND: The introduction of the 7-valent conjugate pneumococcal vaccine (PCV7) in children may result in serotype replacement. We estimated the rate of increase of invasive pneumococcal disease (IPD) caused by serotype 19A in children <5 years old and determined the genetic composition of these isolates.

RESULTS: ...The rate of serotype 19A IPD in children <5 years old increased significantly from 2.6 cases/100,000 population in 1999-2000 to 6.5 cases/100,000 population in 2003-2004; this was accompanied by significant increases in penicillin nonsusceptibility (P=.008) and multidrug resistance (P=.002) among serotype 19A isolates. As was observed during the pre-PCV7 era, clonal complex (CC) 199 predominated within serotype 19A, representing approximately 70% of invasive serotype 19A isolates from children <5 years old during 2003-2004. New serotype 19A genotypes were observed during 2003-2004, including 6 CCs that were not found among pneumococcal serotype 19A isolates during surveillance in 1999.

CONCLUSION: Serotype 19A is, at present, the most important cause of IPD by replacement serotypes, and it is increasingly drug resistant. CC199 is the predominant CC among type 19A serotypes in children <5 years old. Our data suggest that some of the increase in rates of infection with serotype 19A may be due to serotype switching within certain vaccine type strains." [Journal of Infectious Diseases, December 2005]

In the spring of 2006, things really took a bad turn for Prevnar, its maker and its supporters with the publication of several studies back to back.

Effect of combined pneumococcal conjugate and polysaccharide vaccination on recurrent otitis media with effusion by van Heerbeek N, Straetemans M, Wiertsema SP, Ingels KJ, Rijkers GT, Schilder AG, Sanders EA, Zielhuis GA., Radboud University Nijmegen Medical Centre, The Netherlands

"BACKGROUND: Otitis media with effusion (OME) is very common during childhood. Because Streptococcus pneumoniae is one of the most common bacterial pathogens involved in OME, pneumococcal vaccines may have a role in the prevention of recurrent OME...

RESULTS: The overall recurrence rate of bilateral OME was 50%. Pneumococcal vaccinations induced significant 4.6- to 24.4-fold increases in the geometric means of all conjugate vaccine serotype antibody titers but did not affect recurrence of OME. CONCLUSIONS: Combined pneumococcal conjugate and polysaccharide vaccination does not prevent recurrence of OME among children 2 to 8 years of age previously known to have persistent OME. Therefore, pneumococcal vaccines are not indicated for the treatment of children suffering from recurrent OME." [PEDIATRICS, March 2006]

The findings of this Dutch study were a good par-

allel to a small but carefully designed and undertaken study in Kentucky that had examined changes in the bacteriological isolates in cases of acute otitis media.

Community-wide vaccination with the heptavalent pneumococcal conjugate significantly alters the microbiology of acute otitis media. Block SL, Hedrick J, Harrison CJ, Tyler R, Smith A, Findlay R, Keegan E. Kentucky Pediatric Research, Inc., Bardstown, KY

BACKGROUND: Community-wide use of conjugated heptavalent pneumococcal vaccine (PCV7) in children <2 years of age could affect the microbiology of acute otitis media (AOM) in vaccinees, particularly for penicillin-nonsusceptible Streptococcus pneumoniae (PNSP).

RESULTS: Comparing each cohort (1992-1998 versus 2000-2003), the proportion of S. pneumoniae decreased from 48% to 31% ...and nontypable Haemophilus influenzae increased from 41% to 56%... The proportions of intermediate PNSP and resistant PNSP, respectively, were 16% and 9% versus 13% and 6% pre- and post-PCV7, respectively...

DISCUSSION: The overall proportion of S. pneumoniae isolates and vaccine serotypes in AOM were significantly reduced by community-wide use of PCV7 vaccine in our practice. The proportion of Gram-negative bacteria became 2-fold more frequent than S. pneumoniae in AOM in PCV7-vaccinated young children where PCV7 uptake was community-wide and supply was adequate. [Pediatric Infectious Disease Journal September 2004]

Three more studies were published in April 2006, each inflicting damage in its own way.

I. Emergence of vaccine-related pneumococcal serotypes as a cause of bacteremia. Steenhoff AP, Shah SS, Ratner AJ, Patil SM, McGowan KL. The Children's Hospital of Philadelphia

"BACKGROUND: The heptavalent pneumococcal conjugate vaccine (PCV7) has decreased the incidence of invasive pneumococcal disease among children in the United States. In the postlicensure period, the impact of non-PCV7 serotypes against pediatric pneumococcal bacteremia is unknown.

CONCLUSIONS: During the postlicensure period, there were significant decreases in the incidence of pneumococcal bacteremia caused by vaccine serotypes; however, rates of penicillin resistance and bacteremia due to vaccine-related serotypes

increased." [Clinical Infectious Diseases, April 2006]

II. Changing epidemiology of outpatient bacteremia in 3- to 36-month-old children after the introduction of the heptavalent-conjugated pneumococcal vaccine by Herz AM, Greenhow TL, Alcantara J, Hansen J, Baxter RP, Black SB, Shinefield HR. Kaiser Permanente, Hayward, CA

"BACKGROUND: The introduction of routine vaccination with heptavalent conjugated pneumococcal vaccine has changed the overall incidence of bacteremia in children 3 months-3 years old.

RESULTS: Implementation of routine vaccination with the conjugated pneumococcal vaccine resulted in an 84% reduction of Streptococcus pneumoniae bacteremia ...By 2003, one-third of all pathogenic organisms isolated from blood cultures were Escherichia coli, one-third were non-vaccine serotype S. pneumoniae, the majority of the remaining one-third were Staphylococcus aureus, Salmonella spp., Neisseria meningitidis and Streptococcus pyogenes...

CONCLUSION: In the United States ...As the incidence of pneumococcal bacteremia has decreased, E. coli, Salmonella spp. and Staphylococcus aureus have increased in relative importance..." Note: These results represent outcome of a longitudinal follow-up by the same team of the same population in whom the vaccine was originally tested. [Pediatric Infectious Disease Journal, April 2006]

III. Effect of introduction of the pneumococcal conjugate vaccine on drug-resistant Streptococcus pneumoniae. Kyaw MH, Lynfield R, Schaffner W, Craig AS, Hadler J, Reingold A, Thomas AR, Harrison LH, Bennett NM, Farley MM, Facklam RR, Jorgensen JH, Besser J, Zell ER, Schuchat A, Whitney CG; Active Bacterial Core Surveillance of the Emerging Infections Program Network., CDC

"BACKGROUND: Five of seven serotypes in the pneumococcal conjugate vaccine, introduced for infants in the United States in 2000, are responsible for most penicillin-resistant infections. We examined the effect of this vaccine on invasive disease caused by resistant strains. METHODS: We used laboratory-based data from Active Bacterial Core surveillance to measure disease caused by antibiotic-nonsusceptible pneumococci from 1996 through 2004. Cases of invasive disease, defined as disease caused by pneumococci isolated from a normally sterile site, were identified in eight surveillance areas. Isolates underwent serotyping

and susceptibility testing.

RESULTS: ... An increase was seen in disease caused by serotype 19A, a serotype not included in the vaccine."

CONCLUSIONS: The rate of antibiotic-resistant invasive pneumococcal infections decreased in young children and older persons after the introduction of the conjugate vaccine. There was an increase in infections caused by serotypes not included in the vaccine." [New England Journal of Medicine, April 2006]

The study findings were featured in a Reuters Health Report on April 5, 2006: "The Active Bacterial Core Surveillance of the Emerging Infections Program Network, headed in this phase of study by Dr. Cynthia G. Whitney, tracked rates of antibiotic-resistant pneumococcal disease in the United States between 1996 and 2004.

Rates of penicillin-resistant strains peaked in 1999 at 6.3 cases per 100,000 and fell to 2.7 cases per 100,000 cases in 2004, for a decline of 57 percent. Rates of multiple drug-resistant pneumococcal infections peaked at 4.1 cases per 100,000 in 1999 to 1.7 cases per 100,000 in 2004, for a drop of 59 percent.

Between 1999-2004, penicillin-resistant *S. pneumoniae* strains fell 81 percent among children less than two years of age, and fell 49 percent among individuals aged 65 and older. Rates of all resistant diseases caused by vaccine serotypes fell 87 percent.

However, there was an increase in resistance to serotype 19A-related disease, from 2.0 to 8.3 cases per 100,000 in children less than two years of age. This strain was not included in the conjugate vaccine.

"Physicians should be seeing fewer treatment failures due to resistant pneumococci in their patients," Whitney told Reuters Health. "However, pneumococci have shown a remarkable ability to adapt and we need to continue to use antibiotics carefully if we want to preserve the benefits that the pneumococcal conjugate vaccine is having on resistance." (9)

The above under the title "Pneumonia vax has lowered drug-resistant pneumonia" is not likely to ring alarm bells. Yet the findings clearly indicate that:

- While rates of all resistant diseases caused by the vaccine serotypes fell 87 percent, rates of serotype 19A-related disease, a deadly type in the very young, rose by 315 percent between 1999 and 2004
- And while rates of multiple drug-resistant pneumococcal infections peaked at 4.1 cases per 100,000 in 1999, rates of serotype 19A-related disease in children less than two years of age –the most vulnerable age group- peaked at a remarkable 8.3 cases per 100,000 in 2004.
- Lastly, that in addition to serotype 19A, there are some 80 (EIGHTY) serotypes of pneumococcus that were not included in the vaccine, each with its own cadre of troubles.

A just-published study in PEDIATRICS, the journal of the American Academy of Pediatrics, appears to bring even worse news.

Effect of pneumococcal conjugate vaccine on nasopharyngeal bacterial colonization during acute otitis media. Revai K, McCormick DP, Patel J, Grady JJ, Saeed K, Chonmaitree T. Department of Pediatrics, University of Texas Medical Branch, Galveston, TX 77555-0371, USA.

The heptavalent pneumococcal conjugate vaccine (PCV7) has been shown to reduce the incidence of acute otitis media (AOM) caused by Streptococcus pneumoniae by 34% and reduces the overall incidence of AOM by 6% to 8%. More recent studies have shown increases in the proportion of Haemophilus influenzae and Moraxella catarrhalis in the middle-ear fluid of PCV7-immunized children. There has been no report on the effect of PCV7 on all 3 bacterial pathogens combined, either in the middle-ear fluid or nasopharynx of individual children with AOM. We investigated the impact of PCV7 on nasopharyngeal colonization with bacterial pathogens during AOM in the pre-PCV7 and post-PCV7 vaccination eras. Four hundred seventeen children (6 months to 4 years of age) were enrolled onto AOM studies between September 1995 and December 2004. Of these, 200 were enrolled before the vaccine use (historical controls), and 217 were enrolled after the initiation of PCV7 vaccination (101 were underimmunized, and 116 were immunized). Although the nasopharyngeal colonization rate for S pneumoniae was not different between the 3 groups, a significantly higher proportion of PCV7-

immunized children with AOM were colonized with M catarrhalis. Overall, the mean number of pathogenic bacteria types isolated from immunized children (1.7) was significantly higher than in controls (1.4). The increase in bacterial colonization of the nasopharynx during AOM could be associated with an increase in AOM pathogens and theoretically can predispose PCV7-immunized children with AOM to a higher rate of antibiotic treatment failure or recurrent AOM. [PEDIATRICS, May 2006]

The results of this latest study deserve review:

- 1 Previously only 25% of all cases of AOM was due to pneumococcus and only 34% of those improved after administration of Prevnar ie one third of one quarter of all cases of acute otitis media, possibly 6-8 % of the total, potentially got better.
- 2 Vaccinated and unvaccinated children had similar colonization.
- 3 A “significantly” higher proportion of vaccinated children with AOM were colonized with Moraxella catarrhalis.
- 4 The mean number of pathogenic bacteria types isolated from children who received Prevnar was significantly higher than in children who had not received the vaccine so that vaccinated children were likely not to respond to antibiotic treatment and have repeated of ear infections.

VAERS (The Vaccine Adverse Event Reporting System) - PREVNAR.

A report to VAERS does not mean that the adverse event was caused by the vaccine or vaccines that was/were administered shortly before the event.

There were 11,138 reports to VAERS concerning Prevnar before December 31, 2005. The first report (150275) was filed on March 28, 2000. The last report (249970) was filed On December 30, 2005. There were 4,668 Emergency Room visits and 1,306 hospital admissions. In most cases, the child had received other vaccines.

Death Reports: 348 death reports following Prevnar vaccination. The first report (154522) was filed on 6/17/2000. The baby received DTaP (#3), HIB (#3) and first Prevnar on May 10 and

died on May 13, 2000. “Three days post vax the pt died of unknown cause most likely related to severe BPD, prematurity and failure to thrive.”

Pneumococcal Meningitis: 11 reports. The first (#161415) was filed on November 7, 2000. That 4 month old male infant received a dose of each DTaP, Comvax, IPV in addition to Prevnar on Aug. 22, 2000 and expired on Sep. 28, 2000. CSF culture: Pneumococcus.

Pneumococcal Bacteremia: 21 reports. The first report (#168059) was filed on April 6, 2001. That baby survived but his condition is unknown.

SIDS: 150 reports. Six of the first 10 reports were about infants who expired suddenly one day following multiple vaccinations. Of the last ten reports filed, two (# 232015 and # 235456) described infants who died less than five hours following vaccination.

From January 1, 2005 to November 30 inclusive, VAERS registered 28 reports of death following the administration of Prevnar, Pediarix and HIB vaccines. Pediarix is a new vaccine containing DTaP, Hepatitis B and the Inactivated Polio Virus (IPV) vaccine [see table on following page].

**VAERS Reported Deaths Following Prevnar, Pediarix and HIB Vaccines
(1 JAN-30 NOV 2005)**

VAERS Report	Received	State	Age (Years)	Sex	Vaccine Date	Symptoms Date	Days SPT	Death Date	Days Death
231965	1/4/2005	VA	0.2	M	8/26/2004	8/26/2004	0	8/27/2004	1
232015	1/6/2005	CA	0.1	M	12/27/2004	12/27/2004	0	12/27/2004	0
232507	1/19/2005	CA	0.4	M	1/5/2005	1/9/2005	4	1/9/2005	4
233066	1/28/2005	IA	0.4	M	1/10/2005	1/14/2005	4	1/14/2005	4
233419	2/4/2005	IA	0.4	M	1/28/2005	2/1/2005	4	2/2/2005	5
233427	2/7/2005	CA	0.5	M	8/10/2004	8/11/2004	1	8/11/2004	1
235154	3/18/2005	NY	0.2	M	3/14/2005	3/15/2005	1	3/15/2005	1
235456	3/28/2005	SC		F	1/20/2005	1/20/2005	0	1/20/2005	0
235675	4/1/2005	GA	0.3	M	1/26/2005	1/27/2005	1	1/27/2005	1
235687	4/1/2005	CA	0.2	F	3/30/2005	3/31/2005	1	3/31/2005	1
236715	4/28/2005	OH	0.2	F	3/8/2005	3/10/2005	2	3/11/2005	3
239722	6/13/2005	TN	0.4	M	5/12/2005	5/16/2005	4	5/16/2005	4
239724	6/13/2005	KY	0.2	M	12/28/2004	1/3/2005	6	1/3/2005	6
240408	6/24/2005	TN	0.2	M	6/17/2005	6/18/2005	1	6/18/2005	1
240945	7/5/2005	WV	0.2	M	6/21/2005	6/27/2005	6	6/27/2005	6
241542	7/20/2005	NJ	0.3	F	6/13/2005	6/14/2005	1	6/14/2005	1
241557	7/20/2005	MN	0.2	M	7/11/2005			7/13/2005	2
242400	8/8/2005	AR	0.4	F	7/20/2005	7/22/2005	2	7/22/2005	2
243253	8/22/2005	AL	0.2	M	8/18/2005	8/19/2005	1	8/19/2005	1
243594	8/30/2005	MO	0.2	M	8/19/2005	8/21/2005	2	8/21/2005	2
244138	9/14/2005	GA	0.3	F	9/12/2005	9/13/2005	1	9/13/2005	1
244255	9/19/2005	IA	0.4	F	9/6/2005			9/7/2005	
244917	10/5/2005	CA	0.3	M	9/19/2005	9/19/2005	0	9/19/2005	0
244965	10/5/2005	IL	0.2	M	9/29/2005	10/1/2005	2	10/1/2005	2
245770	10/20/2005	MO	0.4	M	10/11/2005	10/17/2005	6	10/17/2005	6
246641	11/2/2005	MO	0.4	M	6/15/2005	6/21/2005	6	6/21/2005	6
247838	11/14/2005	CT	0.3	F	9/22/2005	9/25/2005	3	9/25/2005	3
247838	11/18/2005	MS	0.3	F	10/18/2005	10/19/2005	1	11/19/2005	1

Summary

- The excessive and often unnecessary use of antibiotics had led to the appearance of antibiotic-resistant bacteria.
- With the success of the HIB conjugate vaccines in preventing invasive Haemophilus influenzae type b disease in the United States, the pneumococcus or Streptococcus pneumoniae became the leading cause of bacterial meningitis in children under five and particularly infants under the age of 12 months.
- Increases in the carriage of non-vaccine serotypes in major pre-licensure clinical trials of 7 and 9-valent pneumococcal vaccines in Gambia, Israel and South Africa were not publicized before Prevnar a 7-valent vaccine, was licensed in 2000.
- A highly Prevnar-vaccinated population of children with acute ear infections had a marked increase in Gram-negative bacteria isolates that are almost always more difficult to treat than pneumococcus.
- Although pneumococcal vaccination produces significant antibody titers, it does not seem to affect the course of pediatric recurrent otitis media with effusion, the second target of the Prevnar vaccination program.

- New serotype 19A genotypes have appeared in the last three years making serotype 19A, an increasingly drug resistant strain, the leading cause of invasive pneumococcal disease.
- As the incidence of pneumococcal bacteremia decreases with the use of Prevnar, blood stream infections with the more serious E. coli, Salmonella and Staphylococcus aureus are increasing.
- Similarly, significant decreases in the incidence of pneumococcal bacteremia caused by vaccine serotypes are accompanied by increased incidence of bacteremia due to penicillin resistant vaccine-related serotypes.
- An increase in infections caused by pneumococcal serotypes not included in the vaccine is also becoming obvious.
- Prevnar may be less effective in preventing acute ear infections than previously believed or not effective at all. Its use may lead to significant colonization by other pathogens that are potentially more resistant to antibiotics and likely to cause prolongation or recurrence if the ear infections.
- An inordinate number of reports of adverse events have been filed with VAERS, the Vaccine Adverse Event Reporting System, after Prevnar vaccination administered alone or with other vaccines. Though such reports do not signify causality, they nevertheless deserve attention.
- Prevnar is unacceptably expensive.

Conclusion

- Prevnar a 7-valent conjugate vaccine used in the U.S. has had clear problems before it was licensed.
- Serious difficulties related to the use of Prevnar are becoming apparent and are expected to increase with time.
- In the United States, an honest re-appraisal of Prevnar including its unacceptably high cost is long overdue.
- Countries considering the introduction of Prevnar or a 9-valent pneumococcal vaccine should seriously review all related factors.
- Parents should always weigh risks and benefits.

References

- 1 PREVNAR, A Critical Review of a New Childhood Vaccine, by Michael Horwin, JD, MA. September 19, 2000. Available at <http://www.whale.to/v/prevnar2.html>
- 2 Pneumococcal Disease, National Immunization Program, CDC, Pink Book p. 255-268. Also available at <http://www.cdc.gov/nip/publications/pink/pneumo.pdf>
- 3 Schuchat A, Robinson K, Wenger JD, et al. Bacterial meningitis in the United States in 1995. *N Engl J Med* 1997;337:970-6.
- 4 Preventing Pneumococcal Disease Among Infants and Young Children, Recommendations of the Advisory Committee on Immunization Practices, CDC, *MMWR* October 06, 2000 / 49(RR09);1-38. Available at <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr4909a1.htm>
- 5 Lipsitch M, Bacterial Vaccines and Serotype Replacement: Lessons from Haemophilus influenzae and Prospects for Streptococcus pneumoniae, Perspectives, Volume 5, Number 3, CDC Emerging Infectious Diseases. Also available at <http://www.cdc.gov/ncidod/eid/vol5no3/lipsitch.htm>
- 6 Black S, Shinefield H, Ray P, Lewis E, Fireman B, The Kaiser Permanente Vaccine Study Group. Efficacy of heptavalent conjugate pneumococcal vaccine (Wyeth Lederle) in 37,000 infants and children: results of the Northern California Kaiser Permanente Efficacy Trial. Proceedings from the 38th Interscience Conference on Antimicrobial Agents and Chemotherapy; September 24-27, 1998; San Diego, California. LB-9.
- 7 American Academy of Pediatrics and American Academy of Family Physicians, Question and Answers on Acute Otitis Media, Posted: March 9, 2004. Available at <http://www.aap.org/advocacy/releases/aomqa.htm>
- 8 Wyeth Investor News, Wyeth Reports Earnings Results for the 2005 Fourth Quarter and Full Year. Also available at <http://tinyurl.com/kmgrt>
- 9 Kerr M. Pneumonia vax has lowered drug-resistant pneumonia. Reuters Health, Wednesday April 5, 2006. Available at http://www.nlm.nih.gov/medlineplus/news/fullstory_31933.html

Colloidal Silver

Gaining ground as a proven, effective antibiotic remedy

Colloidal silver, a liquid suspension of the metal silver, is currently a hot topic in the world of medicine. While alternative medicine praises its use as an antibiotic, mainstream medicine considers it somewhat of a poison. But colloidal silver is neither a poison nor a panacea: It is a safe and proven topical antibiotic that may cautiously be used internally.

“In the 1940s, the FDA began its decades-long oppression of medicinal silver under the guise that it was unsafe”...

In the nineteenth century, colloidal silver -- also known as *Argentum colloidal*, *Argentum crede* and *collargolum* -- was a prominent treatment for everything from colds to skin infections. In the 1940s, the FDA began its decades-long oppression of medicinal silver under the guise that it was unsafe; however, in reality, the FDA banned silver because of the threat it poses to the antibiotics industry, rather than any threat it poses for your body. If you'd like to learn more about the FDA's campaign against silver, be sure to download the Health Ranger's Commentary on Curad bandages made with silver. In his commentary, he not only praises Curad's new bandages, but also details how astounding their FDA approval is, given the FDA's historical campaign against the medicinal use of silver.

“When all else fails, it can beat infections presumed unbeatable”...

As you can see from Curad's new bandages, colloidal silver is a safe and effective topical method to fight infections. As Phyllis A. Balch and Dr. James F. Balch write in *Prescription for Nutritional Healing*, colloidal silver can safely and inexpensively protect you from infection in a wide variety of ways: “Topically, it can be used to fight fungal infections of the skin or nails and to promote the

healing of burns, wounds, cuts, rashes, and sunburn. It can be used on toothaches and mouth sores, as eye drops and as a gargle to fight tooth decay and bad breath. It can also be used as sterilizer and can even be sprayed on air-conditioning filters and air ducts and vents to prevent germs from growing.” In addition to those found in air conditioning vents, germs make many other aspects of our environment both unhealthy and bad-smelling. Colloidal silver, as a powerful antibiotic and antifungal agent, can make your environment just as healthy as it can make your body.

According to Joseph B. Marion's *Anti-Aging Manual*, Pierce Instruments manufactures a nylon-Silver fabric called Silvelon. They use Silvelon to make everything from odor-proof socks and shoe liners to antiseptic kitchen sponges. Of course, you can also make your own odor-proof socks by soaking regular socks in colloidal silver solution, but the choice is yours.

According to many sources, it is not dangerous to use colloidal silver internally, as long as you take it in the recommended, reasonable dosages. This means using the colloidal silver product as directed and not taking it for more than two weeks at a time, according to Janet Zand in *Smart Medicine for Healthier Living*. Of course, you shouldn't use just any colloidal product out there, either. In his *A-List of Top Products*, the Health Ranger recommends Silver 100 as the top colloidal silver product. It's safe – very safe – at only 100 silver parts per million.

“Taken internally, colloidal silver can be used to fight infection. It has been shown to be effective against more than 650 disease-causing organisms, including *Escherichia coli* (*E. coli*) bacteria and the fungus *Candida albicans*,” writes Dr. James F. and Phyllis A. Balch. As you may remember from the hamburger scares of the 1990s, *E. coli* infections can be deadly, especially among young children, the elderly and people with weakened immune systems. In this sense, colloidal silver is a lifesaver: When all else fails, it can beat infections presumed unbeatable. It is under these extreme conditions that patients may justifiably consider using colloidal silver internally -- but only under the direction of a qualified health practitioner such as a naturopath.

AIDS-related pneumonia due to staphylococcal,

pneumocystis, streptococcal, klebsiella and fungal infections may also warrant internal use of colloidal silver. These types of pneumonia are very difficult to fight with traditional antibiotic treatment; moreover, people with weakened immune systems, such as acquired immune deficiency syndrome, are especially prone to them. For a weak immune system, these types of pneumonia are sometimes unbeatable, making alternative measures a necessity. "Dr. Marchial-Vega had considerable clinical experience with a colloidal silver preparation that contains between 20 and 25 parts of silver per million parts of water. This preparation has proven effective in patients with HIV... In the hospital, the therapy is administered by a special nebulizer as well as orally," reports Dr. James Howenstine in *A Physician's Guide to Natural Healing Products that Work*.

"You don't have to be afraid of genuine colloidal silver. There are a multitude of safe and effective colloidal silver products on the market"...

You don't have to be afraid of genuine colloidal silver. There are a multitude of safe and effective colloidal silver products on the market, so be sure to research what you use before you use it and, by all means, use it as recommended on the label. As a side note, some colloidal silver companies claim that colloidal silver is an anti-cancer agent. According to Dan Labriola's *Complementary Cancer Therapies*, "There is no reliable human evidence that this (colloidal silver) is an effective cancer treatment." But as a broad-spectrum antibiotic, colloidal silver is well proven.

The experts speak on Colloidal Silver

Just as it sounds, colloidal silver is a liquid suspension of the metal silver. It is marketed by a number of companies for a variety of uses, including as an antibiotic and anticancer agent. There is no reliable human evidence that this is an effective cancer treatment.

Complementary Cancer Therapies by Dan Labriola ND, page 190

Colloidal silver is an inexpensive healing agent and disinfectant that has a myriad of applications. It is a clear golden liquid composed of 99.9-percent pure silver particles approximately 0.001 to 0.01 microns in diameter that are suspended in pure water. Colloidal silver can be mixed with either tap or distilled water and applied topically, taken by mouth, or administered intravenously.

Prescription For Nutritional Healing by Phyllis A Balch CNC and James F Balch MD, page 66

Silver is highly toxic to most microbial cells and can be used as an antimicrobial agent. Silver-containing compounds, such as silver sulfadiazine, which has broad antimicrobial as well as antifungal activity, and silver nitrate, are used in medicine as topical agents. Colloidal silver is a suspension of extremely small silver particles and was used in medicine until the 1940s as both a topical and an internal antiseptic. Colloidal silver was also known as argentum colloidal, argentum crede and collargolum.

PDR For Nutritional Supplements by Sheldon Saul Hendle and David Rorvik, page 110

Colloidal silver has a long history in medicine as a natural antibiotic. It is very effective in killing bacteria, viruses,

The Natural Way to Heal by Walter Last, page 161

Colloidal silver is a safe and effective topical method to fight infections. Topically, it can be used to fight fungal infections of the skin or nails and to promote the healing of burns, wounds, cuts, rashes, and sunburn. It can be used on toothaches and mouth sores, as eye drops, and as a gargle to fight tooth decay and bad breath. It can also be used as sterilizer and can even be sprayed on air-conditioning filters and air ducts and vents to prevent germs from growing.

Prescription For Nutritional Healing by Phyllis A Balch CNC and James F Balch MD, page 66

Pierce Instruments in Stowe, Vermont, markets Silvelon, a nylon-Silver fabric used to make odor-

proof socks and shoe-liners, antiseptic kitchen sponges, wound and burn healing aids, and topical applications to speed healing of cuts, canker sores, warts, and acne releasing colloidal silver on site. Argentum Research has Silverlon.

Anti-Aging Manual by Joseph B Marion, page 12

To treat ringworm, use a sterile pad and apply colloidal silver to the affected area. Hands and feet can also be soaked in this solution, a natural antibiotic that destroys some 650 different microorganisms.

Prescription For Nutritional Healing by Phyllis A Balch CNC and James F Balch MD, page 388

Colloidal silver is considered to have antibacterial properties. Take it as directed on the product label. Do not take this supplement for more than two weeks at a time.

Smart Medicine For Healthier Living by Janet Zand LAc OMD Allan N Spreen MD CNC James B LaValle RPh ND, page 566

Because colloidal silver loses its potency over time, the best bet is also a kit that permits mixing the solution and using it immediately. You should then discard any excess you can not use. Whenever you use it, keep in mind the fact that the silver will be accumulating in your body. Once you get too much silver in your system, you're stuck with it for life. Avoid getting yourself into this predicament by using colloidal silver only when other methods of killing bacteria are not available.

Attaining Medical Self Efficiency An Informed Citizens Guide by Duncan Long, page 200

Colloidal silver. Dose: Internally—60 to 120 drops three to four times daily. Externally, applied to a wound or burn—two to three times daily.

Herbal Medicine Healing Cancer by Donald R Yance Jr, page 314

Colloidal silver is commercially available with a common solution strength of five silver atoms per

million molecules of water, or 5 ppm, but it may be up to 50 ppm in very concentrated remedies. However, the size of the colloids may be more important than the strength in parts per million.

The Natural Way to Heal by Walter Last, page 162

It is difficult to assess which of the many commercial remedies available work best or even which ones work and which do not. Therefore I recommend building your own colloidal silver generator.

The Natural Way to Heal by Walter Last, page 162

Micronic Silver from Lifestar Millennium is a good source of colloidal silver. Cold Combat! from Tri-Medica, Inc. is a combination of sublingual forms of colloidal silver, colloidal copper, zinc, and the homeopathic remedies Cinnabaris and Rhus toxicodendron. It is good for fighting colds and flu.

Prescription For Nutritional Healing by Phyllis A Balch CNC and James F Balch MD, page 66

Taken internally, colloidal silver can be used to fight infection. It has been shown to be effective against more than 650 disease-causing organisms, including Escherichia coli (E. coli) bacteria and the fungus Candida albicans.

Prescription For Nutritional Healing by Phyllis A Balch CNC and James F Balch MD, page 66

Dr. Marchial-Vega has had considerable clinical experience with a colloidal silver preparation that contains between 20 and 25 parts of silver per million parts of water. This preparation has proven effective in patients with HIV in quickly resolving pneumonias due to pneumocystis, streptococcal, staphylococcal, klebsiella and fungal infections. In the hospital, the therapy is administered by a special nebulizer as well as orally.

A Physicians Guide To Natural Health Products That Work By James Howenstine MD, page 262

In contrast to medical antibiotics that can be used only against specific microbes, colloidal sil-

ver has a wide range of effectiveness, eliminating bacteria as well as viruses and fungi. Unlike medical antibiotics, colloidal silver is not known to cause undesirable side effects. Colloidal zinc can be especially effective against viruses. The colloids of copper and gold, on the other hand, are strong anti-inflammatory agents; in addition, copper and zinc can be used chelated (bound) with salicylic acid for similar benefits.

The Natural Way to Heal by Walter Last, page 161

Use with informed caution. I'm not suggesting that colloidal silver should be avoided altogether. I think it is ideal for some purposes and might be of use in an emergency or for last-ditch treatment of a bacteria that has grown resistant to antibiotics. However the use of this medication must be approached very cautiously.

Attaining Medical Self Efficiency An Informed Citizens Guide by Duncan Long, page 200

These maximum doses are large compared to the doses ingested with health food colloidal silver supplements. However it should be remembered that these are most likely the totals for an entire lifetime, given the slow rate that silver is removed from the body For this reason I tend to see colloidal silver as an "emergency only" medication, rather than the "once a day" use some alternative medicine people are now suggesting.

Attaining Medical Self Efficiency

An Informed Citizens Guide by Duncan Long, page 180

This liquefied form of silver is a powerful natural antibiotic that can help knock out an acute sinus infection, says John M. Sullivan, M.D., a physician in Mechanicsburg, Pennsylvania. Buy a bottle of colloidal silver, put some full-strength into a spray bottle, and use one or two squirts into your nose twice a day until the infection has been noticeably gone for 3 days.

Alternative Cures by Bill Gottlieb, page 553

Robert C. Beck's battery-powered electromagnetic electrode transfer of 50-100 microamperes by arm or foot electrodes may inhibit HIV outer

protein's ability to bind to Lymphocyte receptor sites 50-95%, and neutralize 95-100% of pathogens in blood, lymph, and tissues in 37 days. Start with half-hour on day 1, to 2 hours on days 7 through 30, tapering off to 15 minutes on day 37; taking Ozone water, colloidal silver, activated Charcoal, and hot/cold Water showers to breakdown and eliminate toxins.

Anti-Aging Manual by Joseph B Marion, page 548

Combination Remedy for Colds and Sore Throats: One teaspoon of bee propolis in a homeopathic solution is combined with extracts of red clover and licorice root. Ten drops of colloidal silver are added. Gargling with this formula and then swallowing it, every four hours, can help knock out local bacterial and viral infections in the throat and trachea.

Complete Encyclopedia Of Natural Healing by Gary Null PhD, page 127

Other vitamins that have been proven to help increase fertility in women are: iron (35 mg); folic acid (one mg three times daily), to help normalize blood chemistry; vitamin B12, to help normalize reproductive function; colloidal silver, to help cleanse the system when chlamydia is causing infertility; and bioflavonoids (found in broccoli, green peppers, parsley, and citrus fruits), to help develop a healthy uterine lining.

Complete Encyclopedia Of Natural Healing by Gary Null PhD, page 241

Vitamin and mineral intake can make a difference. Specific recommendations for men are zinc, selenium, and vitamins E, D, and C. Particular suggestions for women include vitamins C, B6, and B12, in addition to iron, folic acid, colloidal silver, and bioflavonoids.

Complete Encyclopedia Of Natural Healing by Gary Null PhD, page 243

I also take [supplements]. I eat organic vegetarian foods. I took ozone a few times. I had the silver removed from my teeth. I took colloidal silver, which helped my pneumonia tremendously.

WAVES Newsletter September/October 2006, 21

Treat the infection: Your physician can prescribe an appropriate antibiotic to treat the underlying infection. If you are working with a physician who specializes in natural therapies, he or she may suggest the use of colloidal silver, golden seal and/or grapefruit seed extract.

*Digestive Wellness By Elizabeth Lipski MS CCN, page
274*

Small bowel infections, esophageal Candida and other infections are likely to reoccur. No specific research has been done to show that use of supplementation with flora and other natural therapies can help with reoccurrence, but they do help to boost the immune system. You may be able to keep the infection at bay with use of colloidal silver, grapefruit seed extract or garlic capsules. Each of these substances has wide antimicrobial properties, low toxicity and a low incidence of negative side effects.

*Digestive Wellness By Elizabeth Lipski MS CCN, page
313*

Eliminate parasites, Candida, and other microbes by using an herbal parasite cure based on wormwood and investigate using colloidal silver, oxygen therapy, and an electronic zapper.

*Disease Prevention And Treatment by Life Extension
Foundation, page 1104*

When chlamydia is causing infertility, colloidal silver helps to clean up the system.

Get Healthy Now by Gary Null, page 715

Rashes, including blistering types, are frequently due to what we put on our skin. One cause is soap because it may contain an artificial chemical that produces an adverse reaction. If you have a rash problem, it is advisable to use the type of soap that is 100 percent natural, or at least one that is unscented. A rash can be cleaned with a mixture composed primarily of aloe vera, along with col-

loidal silver, bee propolis, pau d'arco, and purified water. Then, wrap the area with gauze that is kept somewhat moist, so the mixture remains on the rash. After four or five hours, the rash should begin to heal.

Power Aging by Gary Null, page 307

Persistent bowel problems have been correlated with recurrent UTIs. Our bodies eliminate wastes in several ways, including the excretion of feces by the bowels, the expulsion of carbon dioxide by the lungs, perspiration by the skin, and the discharge of urine by the kidneys and bladder. If any of these processes is malfunctioning, an excessive burden is placed upon the other systems. I do not believe that antibiotics are the proper treatment for UTIs because they do not get to the underlying cause. The proper approach is to re-balance the system by switching from an acidic diet to an alkaline one. Unsweetened cranberry juice with cherries and raspberries, four to five times a day, can ameliorate the severe pain. Pomegranate juice, two times a day, and grapefruit juice with the seeds and the skins are valuable too. Lemon, lime, and bee propolis with 10 drops of colloidal silver are also helpful. Because of the vitamin C content, these juices will create acidic urine (but not acid in the body), which creates an unfavorable environment for bacteria in the urine and bladder. Chlorophyll from spirulina (see related ebook on spirulina) is exceptionally good for the body as well.

Power Aging by Gary Null, page 365

Now a great remedy is available for itchy eyes tat works like pure magic every time. It's colloidal silver drops. Just two drops in each eye can stop itching for a week or more.

*Proven Health Tips Encyclopedia By American Medical
Publishing, page 197*

Colloidal silver, which can be found in any health food store, is a powerful antibiotic. It can cure conjunctivitis, or pink eye, as well as simple eye irritation.

*Proven Health Tips Encyclopedia By American Medical
Publishing, page 197*

If you store drinking water for a longer time, you can add some colloidal silver or hydrogen peroxide to keep it free of molds and other microbes or possibly put a piece of clean copper or a silver coin at the bottom of the container.

The Natural Way to Heal by Walter Last, page 40

At the beginning of your health improvement efforts and several times each year, you can take a remedial course of colloidal silver for several weeks to keep down any undesirable microbes that have arisen in your body. Have a sip or tablespoonful three times daily. Preferably, store colloidal silver in a dark glass bottle in a dark and cool place.

The Natural Way to Heal by Walter Last, page 162

Source: <http://www.newstarget.com/010038.html>

Autism After Vaccination

*Kyle's Story, as told by his Mum,
Marie Geary*

Kyle Neil was born on April 19, 1998, a healthy beautiful baby boy. He progressed normally, at 12 months he was walking, at 15 months he had about 10 words, and at 18 months he was developing normally. We were counting our blessings.

"We kept Kyle's vaccinations up to date. With each shot he would get extremely sick, running a fever and develop a croup cough"...

We kept Kyle's vaccinations up to date. With each shot he would get extremely sick, running a fever and develop a croup cough. Since our doctor had told us this might happen, we thought that the reaction was just part of the process. Kyle started a slow descent into his own little world. His behaviour was on a steady decline, with bizarre behaviours and decreasing speech. Kyle was sinking into Autism, a developmental disability we knew little about. He now had our full attention.

We noticed Kyle started becoming extremely finicky when it came to food. He would only eat chicken nuggets, pizza, and drink lots of milk. Kyle was drinking about 8 cups of milk a day, along with watching 6 hours of movies a day. We thought, "milk, does a body good". That's the slogan we grew up with - how could milk be bad for him?

Kyle frequently had bright red cheeks and his stool was always runny (diarrhoea). He had problems sleeping every other night. He would no longer make eye contact. You could yell his name and he would not look at you. He started to walk on his tiptoes. He would walk back and forth behind our plaid couch focusing on the pattern with his eyes. He would drop puzzles pieces in front of his eyes and run his fingers and toys

slowly in front of his eyes. This is called self-stimming. He would line his toys up. The little boy we could take anywhere and liked to go out all the time started to scream with any transition. We couldn't go anywhere without an outburst. The only way to control his outburst was a sippy cup, full of milk. We had to have the milk close at hand. When I would go to the park with my girlfriend and her kids there where many times I would ask for some milk and joke, "we need to give Kyle his drug". If only I had known what I was saying.

Kyle was diagnosed in January 2001. He was 2 years 8 months old. We were in disbelief. There was no family history of any developmental delays on either side. We had his blood drawn right then and there to check for the fragile X chromosome. The doctor told us that Kyle's test returned negative, but that that didn't mean he was not Autistic. That was enough for us to start our fight.

Throughout February and March we started private speech [therapy], Occupational Therapy services through the school system, and our research. I started reading and came across Karyn Seroussi's book *Unraveling The Mystery Of Autism And PDD*, and was intrigued and couldn't put it down. Miles (Karyn's son) and Kyle had many similarities. As I was reading I told my husband, "If this helps Kyle 2%, we are going to do it".

We discovered Kyle actually had severe food allergies. This was evident by immediately removing milk from his diet, after which we noticed he started making eye contact with us. After two weeks of being on the diet, Kyle accidentally drank his sister's milk. Before I could say a word he spit it out like a cat remembering bad food. Within three weeks of O.T. therapy I told the therapist "My son is back." She looked at me with sympathy.

We slowly started taking foods containing gluten (a wheat by-product) away. We also eliminated soy and corn. When the corn was reintroduced Kyle immediately developed diarrhoea; he had the same reaction to soy. We introduced supplements such as DMG, SuperNuThera, and Probiotic Primadophilus, and slowly noticed improvements in Kyle's speech and language. We started the diet in full force in April 2001.

Taking away the foods that Kyle had a craving / addiction for was no easy task, . There was a fairly dramatic withdrawal reaction - Kyle woke up in the middle of the night and acted as if heavily drugged. He was definitely in a world of his own. He started to drag his forehead on the carpet. I was in complete tears every night. It was hard to watch my baby go through this.

The initial die-off only lasted one week. After a month, Kyle was catching up. He was now more consistent with his eye contact. He started to point at things he wanted, if not ask for them by name. His speech was good, but rote, with some echolalia. He still had some autistic behaviour from time to time. There were many times we wanted to give up, however we did get to a point where the behaviours became very minimal. We knew we had to give GF/CF diet 100%.

“We took Kyle back to the doctor that diagnosed him. When she walked into the exam room Kyle said, “Hello doctor.” She acted as if he wasn’t the same child she diagnosed a year ago”...

After a few months on this strict diet we still felt that something was missing. We came across a type of supplement called Glyconutrients. There are case studies of Glyconutrients helping Autistic/AD(H)D children. When we implemented this supplement we couldn’t believe the positive effect it had on Kyle. We noticed immediate improvement in Kyle’s cognitive ability, his eye contact, his gross and fine motor skills, his imaginative play, and his social interaction. For example, we noticed Kyle alternating his feet on the stairs spontaneously (which means he was using both sides of his brain). But the autistic behaviours were still present. The reason was that his body was cleansing. The life of a new blood cell is every four months. After four months on this supplement his behaviours completely subsided. His speech is no longer rote or echolalia. This was clearly another die-off reaction.

Kyle loves to play Board Games, Animals in the Jungle, Dinosaurs, Trains, Dress-up, and “Little People”. He rides a two-wheeler with training wheels. He draws beautiful pictures and much, much more. He swallows pills, knows what he

can and can’t eat, and lets us put supplement powders in his food and water. We feel that Kyle is fully aware of what has happened to him. We think he might have some memories of his food intolerance and knows how much better he feels with his supplements. When you give Kyle his pills, he pops them in his mouth and in the same breath says, “thank you”. Kyle is definitely one special kid.

On December 10, 2001 we took Kyle back to the doctor that diagnosed him. When she walked into the exam room Kyle said, “Hello doctor.” She acted as if he wasn’t the same child she diagnosed a year ago. Through the next two hours of tests, she looked at him in disbelief. Kyle had recovered: he had shed all of the traits that labelled him Autistic. He is at his age level in social, self-help, and motor skills. He was two months behind in language skills with an extraordinary vocabulary (that of a 5-7 year old).

We attribute Kyle’s success to KYLE, Glyconutrients, Karyn Seroussi’s book, and definitely hard work. Kyle is in a regular preschool, and plays with his school and neighbourhood friends. He has scored average or above average on all evaluation tests and has no Autistic traits.

Kyle’s current update: Kyle graduated Preschool with flying colours. He has been dismissed from all Special Education services and will be entering Kindergarten in Fall 2003.

For more information on this new science contact Marie Geary, Ph (09) 813 9644.

“ *It is not...that some people do not know what to do with truth when it is offered to them, but the tragic fate is to reach, after patient search, a condition of mind-blindness, in which the truth is not recognized, though it stares you in the face.*

”

Sir William Osler, physician, 1849-1919

Kyle Before:

- Couldn't interact with peers
- Couldn't alternate feet on the stairs
- Couldn't say Mummy
- Lost the skill of feeding himself
- Couldn't climb a ladder & go down a slide
- Couldn't ride a tricycle
- Couldn't make a circle
- Had no imaginative play
- Had dry and brittle hair
- Had bright red cheeks
- Was always sick, with a runny nose and/or cough
- Had chronic ear infections
- Was not potty trained or near ready
- Had no social interaction

Kyle After:

- Has many friends and a crush on a girl
- Runs up and down the stairs
- Talks in complete sentences
- Is our neatest eater
- Races up a ladder and flies down a slide
- Rides a two-wheeler with training wheels
- Draws tigers, giraffes, dogs, etc
- Has great imaginative play
- Has softer, lighter in coloured hair
- Has a beautiful complexion
- Is NEVER SICK
- Hasn't had one ear infection
- Was potty-trained in a week (including night)
- Is a social butterfly

Local Support Contacts



NATIONAL SUPPORT GROUP CO-ORDINATOR Alice Kleinsman	Phone & Fax: (06) 363 7575 E-mail: badi@clear.net.nz
NORTHLAND (Rangiputa) Vanessa Goodwin	Phone: (09) 406 7735 E-mail: svgoodwin@xtra.co.nz
WELLSFORD - WHANGAREI	(support person required)
AUCKLAND - CENTRAL	(support person required)
AUCKLAND - SOUTH Mathilde Schuurkamp	Phone: (09) 292 8109 E-mail: mathilde@hollandlandscaping.co.nz
AUCKLAND - NORTH WEST Michelle Rudgley	Phone: (09) 817 9797 E-mail: info@ias.org.nz
AUCKLAND - WEST Tania Hogan	Phone: (09) 832 4493 E-mail: taniah@paradise.net.nz
AUCKLAND – WAIHEKE ISLAND Di Stodart	Phone: (09) 372 6311 E-mail: dstodart@ihug.co.nz
AUCKLAND – NORTH SHORE Emma Greenslade	Phone: (09) 445 7742 E-mail: emmalea@orcon.net.nz
AUCKLAND – HIBISCUS COAST Anne Mandeno	Phone: (09) 424 3924 E-mail: anne.mandeno@xtra.co.nz
AUCKLAND - EAST Erin Hudson	Phone: (09) 537 2436 E-mail: hudzfam@xtra.co.nz
WAIKATO (HAMILTON) Sarsha Coker	Phone: (07) 843 7663 E-mail: nzlchickie@hotmail.com
BAY OF PLENTY (ROTORUA) Jackie Pittman	Phone: (07) 347 8394 E-mail: pittman@wave.co.nz
HAWKES BAY (GISBORNE) Louise Paipa	Phone: (06) 863 2220
TARANAKI	(support person required)
MANUWATU (FOXTON) Alice Kleinsman	Phone & Fax: (06) 363 7575 E-mail: badi@clear.net.nz
WELLINGTON	(support person required)
MALBOROUGH (NELSON) Joanne Feely	Phone: (03) 542 4445 E-mail: jofeely@paradise.net.nz
WEST COAST Nadine Kachev	Phone: (03) 755 7676
CHRISTCHURCH Jackie Burling	Phone: (03) 342 8750 E-mail: jackie@index-software.com
NORTH CANTERBURY Sheree Reynolds	Phone: (03) 312 3640 E-mail: shereer@xtra.co.nz
DUNEDIN (D.V.A.G) Vivienne Stevenson	Phone: (03) 488 1998 E-mail: wildwomum@xtra.co.nz
SOUTHLAND (GORE) Debora Anderson	Phone: (03) 208 0772 E-mail: deboraandian@inspire.co.nz

Library List



The Immunisation Awareness Society has a library of books, videos and audio tapes available for members to borrow. If you wish to borrow an item, please send a bond of \$10 per book or audio tape and \$20 per video plus postage in stamps (\$3.00 North Island and \$5.00 South Island) to "The Librarian", P.O. Box 56-048, Dominion Rd, Auckland. Allow up to 28 days for delivery.

BOOKS

<i>Australian</i>	Vaccination Roulette: Experiences, Risks Vaccination Network And Alternatives.
<i>Baratossy, Peter</i>	There Is Always An Alternative
<i>Buchwald, Gerhard</i>	Der Rückgang Der Schwindsucht Trotz "Schutz"-impfung [Text In German]
<i>Cahill, Kevin</i>	The AIDS Epidemic
<i>Colgan, M</i>	Your Personal Vitamin Profile
<i>Coulter, H & B. Fisher</i>	DPT – A Shot In The Dark
<i>Cribb, Julian</i>	The White Death
<i>Curtis, Suzanne</i>	A Handbook Of Homoeopathic Alternatives To Immunization
<i>Dole, L</i>	The Blood Poisoners
<i>Davis, Adele</i>	Let's Eat Right To Get Fit
<i>Davis, Adele</i>	Lets Get Well
<i>Davis, Adele</i>	Let's Have Healthy Children
<i>Day, Phillip</i>	Cancer - Why We're Still Dying To Know The Truth
<i>De Baïracli Levy, J</i>	Herbal Handbook For Farm And Stable
<i>Dettman, Glen et.al</i>	Vitamin C: Nature's Miraculous Healing Missile
<i>Dew, Kevin</i>	The Measles Vaccination Campaigns In Nz, 1985 & 1991: The Issues Behind The Panic
<i>Eisen, Jonathan</i>	Supressed Inventions And Ther Discoveries
<i>Glöcklers, Michaela</i>	A Guide To Child's Health
<i>Golden, Isaac</i>	Vaccination? – A Review Of Risks And Alternatives
<i>Hilton, James</i>	Last Call
<i>Horowitz, Leonard</i>	Death In The Air
<i>Hume, E</i>	Béchamp Or Pasteur
<i>Inglis, Brian</i>	Natural Medicine
<i>Kenton, Leslie</i>	Nature's Child
<i>Lanctôt, Guylaine</i>	Medical Mafia
<i>McBean, Eleanor</i>	The Poisoned Needle
<i>McTaggart, Lynn</i>	What Doctors Don't Tell You
<i>Mendelsohn, Robert</i>	How To Raise A Healthy Child... In Spite Of Your Doctor
<i>Miller, Neil Z.</i>	Immunization – The People Speak
<i>Miller, Neil Z.</i>	Immunization – Theory Versus Reality
<i>Miller, Neil Z.</i>	Vaccines, Are They Safe And Effective?
<i>Neustaedter, Randall</i>	The Vaccine Guide (1st And 2nd Editions)
<i>Nikiforuk, Andrew</i>	The Fourth Horseman: A Short History Of Epidemics, Plagues, Famines & Other Scourges
<i>Overell, Bette</i>	Animal Research Takes Lives – Humans & Animals Both Suffer
<i>Priest, Janice</i>	Can You Remember What To Take?
<i>Rose, Greg</i>	Compulsory Immunisation
<i>Royal, Penny</i>	Herbally Yours

<i>Sampson, Brenda</i>	Anti-stress Nutrition Program To Improve Mood, Health, Behaviour And Learning
<i>Sampson, Brenda</i>	New Zealand's Greatest Doctor – Ulric Williams Of Wanganui; A Surgeon Who Became A Naturopath
<i>Scheibner, Viera</i>	Vaccination: 100 Years Of Orthodox Research Shows That Vaccines Represent A Medical Assault On The Immune System
<i>Scheibner, Viera</i>	Behavioural Problems In Childhood: The Link To Vaccination
<i>Sinclair, Ian</i>	Health, The Only Immunity
<i>Sinclair, Ian</i>	Vaccination, The Hidden Facts
<i>Sinclair, Ian</i>	You Can Overcome Asthma
<i>Smith, Kathryn</i>	The Cancer Prevention Handbook
<i>Stephens, I</i>	Shot To Hell
<i>West, J</i>	The AIDSTime Bomb
<i>West, J</i>	Pasteur, Béchamp And Aids
<i>W.H.O</i>	Cholera Immunology
<i>Ziff, S</i>	The Toxic Time Bomb (Mercury Fillings)

AUDIO TAPES

<i>IAS</i>	For An Informed Choice
<i>Eisen/Smith</i>	IAS Talks Evening 21 November 2000
<i>Mendelsohn, Robert</i>	How To Raise A Healthy Child... In Spite Of Your Doctor

VIDEO TAPES

<i>AVN</i>	Vaccination – The Hidden Truth.
<i>Eva Snead M.D.</i>	AIDS, Cancer, Vaccines And Genocide
<i>Health Freedom International</i>	Modern Medicine And Our Freedom
<i>Esther talkshow 30/1/96</i>	Vaccination (BBC).
<i>Dispatches</i>	Monkey Business (SV40 And Polio Vaccine).
<i>Health Care Reform The hand that rocks the cradle (SIDS). Group</i>	The Hand That Rocks The Cradle (SIDS).
<i>IAS</i>	The Vaccination Dilemma II: Lectures From The 2nd International Symposium.
<i>Leonard Horowitz</i>	AIDS, Ebola And Vaccines.

If you have any IAS library books that you have finished with - please return them! Other members are waiting patiently for their chance to read many books that are out on loan.

Please remember to enclose stamps to cover the cost of postage when you wish to borrow any items from our library.

Investigate Before You Vaccinate

Making an informed decision about vaccination in New Zealand.

By Susan K. Claridge (Third Edition)

ORDER FORM

Order the Book that **EVERY** New Zealand Parent Should Read!

You can ORDER NOW ONLINE from our website at www.ias.org.nz