An update on COVID-19 prevention

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Since the availability to the COVID-19 vaccines, I have been asked two or three times a day by patients: “Should I get the vaccine?”

My answer has been consistently the following:

Do your own thinking, but first inform yourself.

Infectious diseases specialists and especially public health agencies are not as worried about COVID-19 as they are about SARS (severe acute respiratory syndrome) or MERS (Middle East respiratory syndrome), because of the considerably greater mortality rate associated with SARS and MERS than with COVID-19.

The mortality rate from COVID-19 is reported to be 2.5% on average, which is based on the number of diagnosed cases. However, the *true* mortality rate is about 10 times less, as they are about *ten times more people* that actually have antibodies to the SARS-CoV-2 (the name of the virus associated with the current COVID-19 pandemic) than there were cases diagnosed with COVID-19 before vaccination was introduced.[i]

Therefore, the *true* mortality rate from COVID-19 is closer to 0.25%, which is slightly higher than the mortality rate from influenza, which is about 0.14%.

Importantly, SARS was associated with an average mortality rate of 14.5% and was above 50% in people over 64,[ii] and MERS was associated with a mortality rate of 35%.[iii]

But even with a true mortality rate of 0.25%, COVID-19 remains a formidable disease to tackle, first, because its virus is new to the human species, which means it could remain endemic for a long time, and second, because it has a

relatively high transmission rate or reproductive number (R_0), which is around 2.25 compared to 1.28 for influenza,[iv] 1.8 for SARS and less than 1 for MERS.[v]

With a world population of 7.8 billion, and assuming that every human being will eventually come in contact with SARS-CoV-2, a 0.25% mortality rate could lead to up to 20 million deaths around the globe. However, these estimates are inherently unreliable, as the course of an epidemic can change for the better or the worse depending on many factors, including mutation of the virus as it is the case in the current pandemic.

After the outbreaks of SARS in 2002-2003 and MERS in 2012, great efforts were made to develop vaccines to protect against coronaviruses, but now eighteen years later there are still no vaccines for SARS or MERS,[vi] which raises a very poignant question, why?

One of the main reasons is that no vaccine was found to be safe in animal experiments.

Four different types of vaccines for humans, including an rDNA type, were tested in many different animal models, including mice, ferrets and other small animals, and as well in rhesus macaques and other non-human primates. As a whole, the animals took the vaccines relatively well with the development of the anticipated antibodies.

However, when the animals of the any of the animal models where challenged by other viruses, including an influenza virus or one of the benign cororaviruses, *all the vaccinated animal models with all the vaccines* developed a prominent eosinophilic lung infiltration, which was *absent in all the control groups*.[vii] One of the research teams summarized their conclusions, “Caution in proceeding to application of a SARS-CoV vaccine in humans is indicated.”[viii]

This lung affection suggested a state of hypersensitivity that is reminiscent of an immune reaction that was also met in young children who had been given an inactivated respiratory syncytial virus (RSV) vaccine and became subsequently infected with naturally-occurring RSV.[ix] “Most of these children experienced severe disease with infection that led to a high frequency of hospitalizations; two children died from the infection. The conclusion from that experience was

clear; RSV lung disease was enhanced by the prior vaccination. ... In addition to the RSV experience, concern for an inappropriate response among persons vaccinated with a SARS-CoV vaccine emanated from experiences with coronavirus infections and disease in animals that included enhanced disease among infected animals vaccinated earlier with a coronavirus vaccine."[x]

Caution is furthermore necessary, as there are no long-term studies for safety for any of the currently offered COVID-19 vaccines.

Moreover, it is important to understand that many vaccines will change immunity by making people potentially more susceptible to other infectious agents, as was seen in the RSV experience.

As a rule, it is very difficult to assess the overall risk and benefit balance associated with any single vaccine, as they are almost no prospective studies of the overall health of vaccinated versus unvaccinated populations, including offspring.

Scientists and organizations that have been critical about the safety of vaccines have asked agencies, such as the CDC and the World Health Organization, to do controlled studies with vaccines in order to be able to see the overall health outcome of vaccinated versus unvaccinated groups. The industry, is of course, not interested in conducting such research, and health agencies refuse to mandate such research, supposedly for ethical reason.

But this paternalistic and unscientific attitude of health agencies seems as if they had *pre-decided* the outcome and with a form of circular logic (if A, then B and if B, then A): even though it would be unethical to give a vaccine that causes more harm than good, we still give the vaccine even though we don't really know its overall effects on a population, because it has never been tested, as we think it is unethical to test it.

This is a very unfortunate stance in order to be able to resolve a scientific question regarding potential harm to our species. However, there are actually a few experiments, which give a glimpse of the great value of comparing the overall outcome of vaccinated versus unvaccinated groups.

In a “natural experiment,” a group of researchers looked retrospectively at a migrant population of Guinea-Bissau in which a portion of the children had been vaccinated and another portion had not been vaccinated due to the difficulty in meeting all the members of the tribe at their proper age. The researchers found that children who had randomly received DTP (diphtheria-pertussis-tetanus) vaccinations early in life when compared with children who had not received these vaccinations had *in actuality a 10-time higher mortality rate than the non-vaccinated children*.

Researchers of this unplanned randomized trial concluded, “All currently available evidence suggests that *DTP vaccine may kill more children from other causes than it saves from diphtheria, tetanus or pertussis*. Though a vaccine protects children against the target disease it may simultaneously increase susceptibility to unrelated infections.”[xi]

In a rare, planned double-blind study with vaccines that was conducted in Japan for an influenza vaccine, children who received the trivalent inactivated influenza vaccine (TIV) were compared with children who had received a placebo. Over the following 9 months, TIV recipients had a *4.4 increase risk* of virologically-confirmed non-influenza infections. The authors concluded, “Being protected against influenza, TIV recipients may lack temporary non-specific immunity that protected against other respiratory viruses.”[xii]

This phenomenon is called virus interference, which is when a vaccine increases protection against a target virus but increases susceptibility to other viral agents.

Another instance of this phenomenon was reported in a study that had been submitted for publication before the advent of the current COVID-19 pandemic, but was published in its midst in April 2020. It was reported that the 2017 and 2018 influenza recipients among the US Department of Defense personnel had a significantly higher ($p<0.01$) susceptibility to coronaviruses and human metapneumovirus when compared to unvaccinated individuals.[xiii]

Here is another example of this phenomenon: children in Guinea-Bissau who received the H1N1-influenza vaccine became more susceptible to other unrelated infections.[xiv]

As one of the golden rules of medicine is primum non nocere (physician, above all, do not harm), physicians have a moral obligation to make sure that their diagnostic, prophylactic and therapeutic interventions don't cause further harm. Incidentally, this golden rule has been shrugged off for centuries by physicians of the conventional school of medicine, which obliges physicians to use even great scrutiny in assessing all conventional medical practices, which includes vaccines.

Homeopathic physicians have a remarkable advantage over all other physicians to make more intelligent decisions regarding vaccination for their patients. First, because it is relatively easy to treat patients affected with infectious diseases even the most virulent ones in the most handicapped patients (including COVID-19 in elderly persons with co-morbidities), when the pull power of natural interventions are adequately used;[xv] and second, that we can use our remedies *preventatively* to protect populations during epidemics with very high degree of efficacy, and this without doing any harm.

Since the beginning of the current pandemic, we have systematically been using Bryonia as a prophylactic remedy against COVID-19.

We estimate this to be about 1000 patients and members of their families and friends who have been taking Bryonia weekly, biweekly or monthly (depending on the potency used and the exposure and sensitivity of each individual person). As far as we know, there is a very small minority of people who have taken Bryonia regularly, and have become sick, testing positive for COVID-19. In each instance, the person had a relatively mild, and easily treated (with homeopathy) case.

We have had maybe about a dozen patients who had symptoms similar to COVID-19 (i.e., cold or flu-like symptoms with lost of taste or smell) who were either not tested for COVID-19 or tested negative.

Cases of failure in homeoprophylaxis is not unusual, as it offers in the best of circumstances an average of 98% protection rate across the board, which is comparable or even better than with most conventional immunization, but is of course devoid of short- and long-term side effects and is low in cost.

Another advantage of homeoprophylaxis is that the small percentage of people who do fall sick to the target disease despite taking the preventative homeopathic remedy tend, as a rule, to develop a mild case of the disease, which is also the case with conventional immunization.

It is interesting to note that many in the approximate dozens of people who fell sick with what looked like COVID-19 despite having properly taken Bryonia recovered quickly by simply taking Bryonia more often or in a higher potency.

Moreover, we have about 15 families in which only some members took Bryonia while others who live in the same house didn't care to take the prophylactic remedy. So far, very few of the members of these families who took Bryonia tested positive to COVID-19 when there were one or more members of the household testing positive. For instance, in one family, we had a woman of about 60 years old who regularly took Bryonia since the spring. Her husband fell sick and tested positive for COVID-19. Some days later her brother who also live in the same house fell sick and tested positive for COVID-19. Neither her husband nor brother had taken Bryonia for protection. However, they both began to recover quickly when Bryonia was given to them soon after the brother tested positive. The husband who is not my patient insisted to talk to me on the phone afterward. He said, "I was quite sick and bedridden with COVID, and I believe Bryonia saved my life."

I hope that an upcoming book on the risks and benefits of vaccination that I am currently writing will provide everyone with tools to make intelligent decisions about vaccination. This book will examine the benefits of vaccines and some of the short and long-term side effects of the oldest vaccine and of a newly developed vaccine; how vested interests have muddled the discussion and have been able to influence decisions regarding vaccination. It is in fact hard to trust anybody when billions of dollars are at stake and it is then better to stick with the science.

The book will also examine in detail the current controversy about measles vaccination; present a historical perspective of the different paradigms in medicine and the prophylactic and therapeutic potential and raison-d'être of alternative medicine; present the position taken by some of the leading homeopathic practitioners regarding vaccination from Hahnemann onward.

I am currently completing a chapter on homeoprophylaxis, which will focus on the protection of scarlet fever with Belladonna that was first reported by Hahnemann in 1801 and was put to the test in numerous countries and for many decades afterward by prominent and public health physicians of the conventional school of medicine, but without acknowledging and more likely not knowing that that they were actually applying a homeopathic principle in their attempt to save lives in their respective populations.

Scarlet fever was also chosen as an example to look at homeoprophylaxis because no vaccine exists in conventional medicine to protect against it, and it has recently begun to re-emerge in different parts of the world.[xvi] Even with antibiotics, scarlet fever can carry a very high mortality rate approaching 50% when it turns malignant,[xvii] and whose victims would meet modern-day clinical definitions of invasive group A streptococcus (GAS) infection with streptococcal toxic shock syndrome.[xviii]

It is unfortunate that physicians of the conventional school of medicine have stopped using homeoprophylaxis as GAS is still among the top ten infectious causes of human mortality, with more than 500,000 deaths annually. In addition to this persistently high disease burden especially in low-resource countries, an unprecedented global resurgence of scarlet fever and severe invasive group A streptococcal infections has been seen in the past few decades around the world.[xix]

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