

Comments on JAPANESE SIDS REBUTTAL by Dr. Vera Scheibner.

Firstly, the author of this "Rebuttal" (Australian Skeptics) hasn't done his homework: he can't even spell my name and my book VACCINATION was published in 1993 and not 1992. In my opinion, his homework about vaccines and infant deaths is of the same quality as his homework about my book and my work.

1. Between 1970 and 1974, 37 infant death occurred after DPT vaccination in Japan; because of this the doctors in one prefecture boycotted vaccination (Iwasa et al. 1985 and Noble et al. 1987). Consequently, the Japanese Government first stopped DPT vaccination for 2 months in 1975, and, when vaccination was resumed, the vaccination age was lifted to 2 years. Interestingly, not only the entity of sudden death disappeared from vaccine injury compensation claims (only 2 deaths were subject of vaccine injury compensation claims in the 2-year olds compared with 37 in younger children), but the the overall infant mortality has improved: Japan zoomed from 17th to first place in infant mortality in the world. This means that Japan moved from a very high bracket to the lowest infant mortality rate in the world (Jenny Scott 1991). Interestingly, Noble et al. (1987) who spent some 2 weeks in Japan studying the acellular whooping vaccine there, wrote that "It is difficult to exclude pertussis vaccines as a causal factor even when other etiologies are suggested, particularly when the adverse events occur in close temporal association with vaccination".

The same thing happened in England after 1 July 1975 when thanks to the first media reports of brain damage linked to vaccination, parents stopped vaccinating: the compliance fell down to 30% or even 10% in some areas. As unwittingly documented by McFarlane (1982), the overall infant mortality rate plummeted. She wrote:

"The postneonatal mortality fell markedly in 1976, the year in which a sharp decline in perinatal mortality rate began. Between 1976 and 1979, however, neither the late nor the postneonatal mortality rates fell any further. Indeed, the postneonatal mortality rate increased ,slightly among babies born in 1977". This very closely correlates with the documented oscillations in vaccination compliance: low compliance was linked to low death rate and vice versa. The vaccination compliance was lowest in 1975-76. Then it started climbing up in 1977-78, simply because people have short memories and the new parents did not know about the publicity surrounding vaccination as the cause of serious side effects (young couples become interested in these issues only after they have their first children). Fine and Clarkson (1982) wrote "...it is surprising that the interepidemic period did not decrease after the 1974 fall in vaccine uptake." They expected the incidence to increase in the unvaccinated children. Indeed, this interepidemic period was unusually long with the lowest incidence of whooping cough on record.

When in 1988 Japanese parents were given the choice to start vaccinating anything between 3 months of 4 years, obviously many ignorant parents started at 3 months because the low SIDS rate increased fourfold in the last 13 years (Byron Shire Echo; June 1994). The article quoted Professor Hiroshi Nishida of Tokyo Women's Medical College,

who said that the SIDS rate among babies aged under 1 year had sharply increased to 0.33 % in 1992 when compared with 0.07 % in 1980.

2. SIDS is a rather rubbery diagnosis and the figures can be and are manipulated. However, the total infant deaths are a bit more difficult to manipulate. The definition of SIDS is a death of a child unexpected by history and with insufficient determination of cause of death. So, it depends on the degree of damage whether the infant death will be diagnosed as Sudden Infant Death Syndrome or pneumonitis, bronchiolitis, brain edema etc. With the increasing number of vaccines administered as part of the "routine" now, we shall see increasing numbers of babies with very serious reactions to vaccines and they will not be diagnosed as SIDS. We already see it in the epidemic of Shaken Baby Syndrome, when babies develop serious brain and other haemorrhages and die or remain seriously damaged and the parents are being accused of causing it by allegedly shaking their babies to death (Scheibner 1998).

Cherry et al. (1988) discussed the pertussis vaccine deaths in a rather odd way. Under the subheading Non-SIDS deaths they quoted Madsen's (1933) description of two babies who died soon after pertussis vaccination. In a way which can be described as contemptuous they tried to explain these immediate deaths (one-half hour after the second vaccination given four days after the first) and two hours after the second vaccination respectively) and Werne and Garrow (1946) who reported on the deaths of identical twins following the second injection of diphtheria and pertussis antigens. These children died within 24 hours of their vaccinations and had symptoms of anaphylactic shock (Cherry et al. 1988 wrote "suggestive" of shock) and then concluded that the injuries were also consistent with diffuse viral infection such as that which might be due to an enterovirus. No evidence whatsoever was offered for this unfounded assumption.

Under a subheading "SIDS", Cherry et al. (1988) tried to diffuse the impact of the published data on vaccine deaths by writing about a small section of the Tennessee deaths within 24 hours of their DPT vaccination. "An extensive evaluation of this possible association was made, and there was a weak statistical association with one lot of vaccine. It was the impression of the investigators and a panel of outside consultants that there was no causal relationship between the specific lot of vaccine and SIDS." and "A statistically significant number of excess deaths was noted in the first week following immunization (observed 17, expected 6.75 P less than .0005). This study was criticized by Mortimer and colleagues (1992) because ...did not take cognizance of the well-known age distribution of SIDS". This is a blatant circular argument: the well-known distribution of SIDS follows closely the vaccination schedule and none of the studies of SIDS distribution or incidence was the vaccination status of the SIDS victims even mentioned. This is "science" squarely standing on its head.

They also wrote that of the six children having serious side effects to Wellcome pertussis vaccines (described by Griffith (1978), "one was found to have pneumonia, one Reye Syndrome, and a four-day febrile illness, one acute tracheobronchitis, one tuberculous

meningitis, and one an encephalomyelitis which had its onset seven days after immunization". Vaccines are known to cause pneumonia; the Reye Syndrome is a recognised side effect of vaccination, vaccines cause febrile illnesses and seven days is one of the characteristic critical days for the onset of vaccine reactions. I would also like to see details of the "tuberculous meningitis" before concluding that this was not a reaction to the administered vaccines.

Wilkins (1988) dealt with the question of delayed reactions to vaccines. She wrote that "if one assumes that the adverse reaction to the DTP vaccine may result from an immunologic intravascular complexing of particular antigen (whole-cell or disrupted organisms) with specific antibody to produce a Jarisch-Herxheimer reaction, then adverse reaction may not occur within 24 hours of inoculation...If the post inoculation interval is extended to 2 weeks, an additional 93 case infants (now representing a total of 98 case infants) might have been at risk for an adverse reaction to DTP vaccine."

Perhaps the most revealing is the comment of Cherry et al. (1988) about articles by Torch (1982 and 1986a, b). Even though the two articles published in 1986 were available at the time. Cherry et al. (1988) did not quote them. One wonders why? Perhaps, the answer is contained in the articles (see below).

Torch (1982 and 1986 a,b) analysed the symptoms and postmortem findings in babies and small children after vaccination and described them in sufficient detail not to leave anything to imagination. Torch (1986b) concluded that "Although many feel that the DPT-SIDS relationship is temporal, this author and others maintain a causal relationship exists in a yet-to-be determined SIDS fraction."

3. Even though vaccinators as a rule are very reluctant to use the word CAUSED when they talk about vaccine damage, they, interestingly, talk about REACTIONS to vaccination. The word reaction in itself implies the causal link, though it does not actually say so. You can't have a coincidental reaction to vaccination, you can only have coincidental occurrence of some damage or symptoms, demonstrably caused by something else. They often use the word "TEMPORAL" meaning occurring in time, always overlooking the fact that these "TEMPORAL REACTIONS" always occur AFTER and not NOT BEFORE vaccination, and that the reality of the occurrence after vaccination is the first condition to fulfill when establishing causality; if something happens before vaccination we would not even consider it being caused by the subsequent administration of vaccines.

4. In the past, vaccinators were denying that vaccines cause any adverse effects. Thanks to strong anti-vaccination awareness, vaccinators now have to admit that yes, no vaccines are 100% safe or 100% effective and reactions do occur and the vaccinated children are getting the "vaccine-preventable diseases". Yes, there are mild or strong local reactions; and yes, there are systemic reactions, like fever, convulsions, hypotonic-hyporesponsive episodes, screaming (a cerebral cry), drowsiness, but only within a maximum of 7 days after vaccination. They also have great difficulty recognising and accepting the damage in individual cases. They always claim that the damage was coincidental, or worse still,

caused by the parents of the affected or killed child by accusing them of Shaken Baby Syndrome.

The vast majority of published studies of vaccine reactions included a follow-up of up to only 48 hours. This conveniently excludes about 90% of reactions to vaccination (see also Wilkins 1988).

Characteristically, most vaccine reactions are delayed, many starting only 2-3 weeks after vaccination.

5. With this introduction, we may find it rather curious why Cherry et al. (1988) would even contemplate to publish some 40 pages of a Report of the Task Force on Pertussis and Pertussis Immunization in which they analyse in quite a detail all those "temporal" reactions to the pertussis vaccine. But they did.

Among many other examples of this remarkable, and as it might seem, wholly misplaced diligence. Cherry et al. (1988) looked into sudden infants deaths after pertussis vaccination. That babies as a rule are given the pertussis vaccine together with the diphtheria and tetanus toxoids as DPT did not seem important to these authors. If you administer 3 in 1 vaccines how do you know which vaccine caused what? Unless, of course, you know precisely what damage the pertussis component of this toxic trio causes. In fact, the pertussis vaccine is as a rule used to induce encephalomyelitis in laboratory animals (Steinman et al. 1982) and when these unfortunate animals develop encephalomyelitis, as expected, and intended, it is never considered just coincidentally temporally related to the administration of the pertussis vaccines, or a result of some Shaken Rat Syndrome inflicted by laboratory staff: it is only when the same vaccine causes the same reactions in babies, it is as a rule considered coincidental and only temporally related or a result of Shaken Baby Syndrome inflicted on them by their parents or other carers. Kirschner and Stein (1985) called this hostile attitude of medical staff a form of medical abuse.

On page 971, Cherry et al. (1988) under the heading "development of alternative B pertussis vaccines" write that "During the past several decades, many laboratories attempted to identify and separate significant protective antigens from those bacterial components that account for adverse reaction. Until recently, this effort amounted to a trial and error process that proved to be exceedingly difficult in face of the array of biologically active products that could be derived from B pertussis organisms...-Two of the extracted vaccines will be described. The experimental vaccine of Pillemer et al. (319) was partially purified by adsorption to human RBC stroma. In extensive comparative field trials in the United Kingdom, it was highly protective in children but caused significantly more systemic reactions than available conventional whole-cell vaccines. It was not pursued further." We should not even have to go any further. Cherry et al. (1988) here clearly and without a shadow of a doubt (at least in my mind) used the word "caused" when describing the adverse systemic reactions which were observed and documented as a result of this pertussis vaccine administration in extensive comparative trials.

But let's read further:

"An extracted pertussis vaccine (TRiSolgen manufactured by Eli Lilly Co) was marketed in the United States from 1962 to 1977 (for fifteen years!). "There are few published data evaluating this product. The antigen was chemically extracted from whole bacteria, cell debris was removed by centrifugation and no additional purification steps were taken. The vaccine was never well characterized, two published small field trials provided information regarding reaction data and agglutinin titers. 320, 321 Only one of these trials, was carried out in a randomized, double-blind fashion, and in this study the difference between the reaction rates following the extracted vaccine varied only slightly from the comparative whole-cell vaccines. The local reactions were less frequent with extracted vaccine, although the systemic reactions were not significantly different.

In addition, there are no specific data concerning efficacy or frequency of uncommon temporally related severe neurologic events with this extracted vaccine."

So, vaccines which were discontinued (after 15 years of use!) or never reached the distribution do cause serious side effects and have never been properly researched.

Also, ordinary systemic reactions are caused by the vaccine, but when it comes to the 'severe neurologic events' they are suddenly only temporally related. In other words, the vaccine causes only mild reactions and the severe reactions are caused by nothing.

But Cherry et al.(1988) continued in their strange rhetoric. On page 972 (Development of Acellular Vaccines in Japan) they write under a subheading (Transient Local and Systemic Reactions): "In general, transient local and systemic reactions caused by acellular vaccines were less frequent and milder when compared with Japanese conventional whole-cell vaccines. A small number of children in the United States received a Japanese T-type component vaccine and similar mild reactions were observed." Well, no problem using the word 'caused' when it comes to what they called transient local and systemic reactions.

However, when it comes to severe events, they suddenly change their choice of words into "Temporally Related Severe Events" (p. 972). Cherry et al. (1988) write here: "In the 5 year period from 1970 through 1974, a period when standard whole-cell DTP immunization was started routinely at 3 to 5 months, there had been a total of 57 severe temporally related events and 37 deaths (9.5 severe reactions and 6.1 deaths per year) including presumed vaccine-associated encephalopathy and other CNS diseases, as determined by claims paid by the Japanese national compensation system. When whole-cell vaccines were initiated at 24 months of age, in the six years between 1975 and 1980, there were eight severe temporally related events (average 1.6 [per] year) and three deaths. The whole-cell DTP vaccines used in the latter period were equivalent to those in prior use. Thus, the age of starting routine immunization appears to be a far more important determinant of temporally associated reactions than the switch from conventional whole-cell vaccine to acellular vaccines".

And then Cherry et al. (1988) continued:

"The conclusion can be drawn that either (1) DTP prepared with whole-cell B pertussis is less likely to cause neurologic disease when begun at 24 months or (2) the purported reactions in infants were in large part unrelated developmental events expected commonly in that age group but attributed to vaccine because they were time related... The rate of severe reactions does not differ significantly between the acellular and whole-cell vaccine when used at 24 months of age. (Table 8). The decrease in severe reactions is slight, if any. The category "sudden death" is also instructive in that the entity disappeared following both whole-cell and acellular vaccines, when immunization was delayed until a child was 24 months of age." And further: "It is clear that delaying the initial vaccination until a child is 24 months, regardless of the type of vaccine, reduces most of the temporally associated severe adverse events. Furthermore, analysis of cases with paid claims in the Japanese national compensation system indicates many of the putative cases to be related to other medical conditions".

This paragraph is the source of controversy. As I see it. Cherry et al. (1988) here clearly indicate that the shift of the start of vaccination to 2 years reduced the incidence of (what they would describe as temporal) severe adverse events. Without saying in which age group, one can reasonably assume that he also meant the unvaccinated babies younger than 2 years of age. All this must inevitably change the temporal into causal; the continued use of the word temporal is inappropriate. This interpretation is supported by the lack of decline in the incidence of these reactions after DTP vaccination of 2 year-olds and the causal link is very obvious.

As far as the infant death rate or SIDS rate and vaccination schedule is concerned, it is quite clear that the shift of the lower vaccination limit to 2 years resulted in Japan zooming from 17th to first place in infant mortality rate: meaning from very high to the lowest rate in the world. This could hardly be interpreted to mean that only the number of vaccine deaths which were subject to compensation claims declined as the proponents of vaccination claim.

As far as low vaccination compliance in the seventies and the incidence of whooping cough is concerned. Noble et al. (1987) published a very interesting graph on their Figure 21 (page 1352) which is showing that whilst the vaccination compliance started climbing up after 1976, so did the incidence of whooping cough. Far from showing the effectiveness of vaccination, this figure 2 shows that vaccination was at best irrelevant to the issue of the incidence of whooping cough. Inappropriate correlations abound in this article, like for example comparing the incidence of whooping cough in 1884 (the epidemic year) with the incidence in 1970 (a non-epidemic year). Equally unreliable are the data on adverse reactions to the acellular vaccine. Indeed, when acellular vaccines were tested in the nineties in Sweden, they expected 20 deaths and experienced 45 (plus one accidental death) (Olin et al. 1997 and elsewhere). Also, the rate of side effects was much higher than anticipated. This includes a large epidemic of whooping cough within about 7 months into the trial, and in the children who were given three trial doses, which prompted the discontinuation of the trial before the planned date (Olin 1995). This shows

that like the whole cell pertussis vaccine, the acellular one causes whooping cough. When the US mandated DPT vaccination in 1978, it resulted in the sustained three-fold increase in the incidence of whooping cough particularly in the well-vaccinated age group between 2 and 6 months (Hutchins et al. 1988). This explains the substantial increases in the incidence of whooping cough in Japan after 1976, when the vaccination compliance started climbing up. In fact, one must read the figures 1 and 2 of Noble et al. (1987) correctly, as showing a fall in the incidence with the falling vaccination compliance and the increasing incidence with the upward climb in compliance. Any other interpretation offends common sense.

Perhaps the most important statements in Noble et al. (1987) are on page 1355: "It is difficult to exclude pertussis vaccine as a causal factor even when other etiologies are suspected, particularly when the adverse events occur in close temporal association with vaccination" and on page 1356: "If acellular vaccines have produced a reduction in the occurrence of serious reactions with sequelae in children over 2 years of age, the decrease is slight".

My evaluation of the "Japanese SIDS Rebuttal" is that it is as bad as they come, and it is poor on real facts and real analysis and rich in abusive language and reasoning unworthy of a scientific analysis, not withstanding compassion for the pain and documented suffering vaccination causes to infants and all their recipients. The Skeptic Magazine never published either the longer or the shorter version of my response to Basser's original article. I am back to my original response which is ignoring this type of literature and groups of people who are not interested in the truth or real facts, but in silencing people who express opinions and publish facts which are uncomfortable for them.

And last but not the least: Japan discontinued MMR vaccination in 1993, and shortly afterwards, compulsory vaccination of any kind.

REFERENCES

Iwasa, Ishida, S., and Akama, K. 1985. Swelling of the brain in mice caused by pertussis vaccine - its quantitative determination and the responsible factors in the vaccine. *Japan J Med Sci Biol*; 38: 53-65.

Noble, G.R., Bernier, R.H., Esber, E.C., Hardegree, M.C., et al. 1987. Acellular and whole-cell pertussis vaccines in Japan: report of a visit by US scientists. *JAMA*; 257(10): 1351-1356.

Jenny Scott, 1990. *Press & Sun Bulletin* (taken from *Los Angeles Times*); March 1, 1990. Report: U.S. slips in fight to cut infant mortality.

Mason, J.O., 1991. Reducing infant mortality in the United States through "healthy start". *Publ Health Reports* (Sep-Oct).

McFarlane, A., 1982. Infant deaths after four weeks. *Lancet* (Oct 23).

Fine, P.E., and Clarkson, J., A., 1982. The recurrence of whooping cough: possible implications for assessment of vaccine efficacy. *Lancet* (March 20): 666-669.

The Byron Shire Echo (June 22, 1994). SIDS cases quadruple in 13 years.

Scheibner, V., 1998. Shaken Baby Syndrome - the vaccination link. *Nexus* (August-September): 35-38 & 88.

Cherry, J.S., Brunell, P.A., Golden, G.S., and Karzon, D.T., 1988. Report of the task force on pertussis and pertussis immunization. *Pediatrics* (suppl): 939-984.

Madsen, T., 1933. Vaccination against whooping cough. *JAMA*; 101: 187-188.

Werne, J., & Garrow, I., 1946. Fatal anaphylactic shock: Occurrence in identical twins following second injection of diphtheria toxoid and pertussis antigen. *JAMA*; 131: 730-735.

Griffith, A., H., 1978. Reactions after pertussis vaccine: A manufacturer's experience and difficulties since 1964. *Br Med J*; 1: 809-815.

Bernier, R., H., Frank, J.A.S., Dondero, T.J., Jr. 1982. Diphtheria-Tetanus-Pertussis vaccination and sudden infant deaths in Tennessee. *J Pediatr*; 1982; 101: 419-421.

Baraff, L.J., Ablom, W.J., Weiss, R.C., et al. 1983. Possible temporal association between diphtheria-tetanus-toxoid-pertussis vaccination and sudden infant death syndrome. *Pediatr Infect Dis*; 2: 7-11.

Mortimer, E.A., Jr., Jones, P.K., and Adelson, L. 1983. DTP and SIDS. *Pediatr Infect Dis*; 2: 492.

Wilkins, J., 1988. What is 'significant' and DTP reactions. *Pediatrics*; 81(6): 912-913.

Torch, W.S., 1982. Diphtheria-pertussis-tetanus (DPT) immunization: a potential cause of the Sudden Infant Death Syndrome (SIDS). *Neurology*; 32(4): A169 abstract).

Torch, W.C., 1986 a. Characteristics of diphtheria-pertussis-tetanus (DPT) postvaccinal deaths and DPT-caused Sudden Infant Deaths Syndrome (SIDS): a review. *Neurology* (suppl 1); 36: 148 (abstract).

Torch, W.C., 1986 b. Diphtheria-pertussis-tetanus (DPT) immunization may be an unrecognized cause of Sudden Infant Death (SIDS) and Near-Miss Syndrome (NMS): 12 case reports. *Neurology* (suppl 1); 36: 149 (abstract).

Steinman, L., Weiss, A., Adelman, N. et al. 1985. Pertussis toxin is required for pertussis vaccine encephalopathy. *Proc Natl Acad Sci USA*; 82: 8733-8736.

Kirschner, R.H., and Stein, R.J., 1985. The mistaken diagnosis of child abuse. A form of medical abuse? *Am J Dis Child*; 139: 873-875.

Pillemer, L., Blum, L., and Lepow, I.H. 1954. Protective antigen of *Haemophilus pertussis*. *Lancet*; 1: 1257-1260.

Olin, P., Rasmussen, F., Gustafsson, L., Hallander, H.O., et al. 1997. Randomised controlled trial of two-component, three-component, and five-component acellular pertussis vaccines compared with whole-cell pertussis vaccine. *Lancet*; 350: 1569-1577.

Olin, P., 1995. Acellular vaccines - a question of efficacy. *J Hosp Infect*; 30 (suppl): 503-507.

Hutchins, S.S., Cochi, S.L., Brink, E.W., et al. 1988. Current epidemiology of pertussis in the United States. *Tokai J exp din Med*; 13 (suppl): 103-109.

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