Abundant Evidence Supports Immediate Market Withdrawal of COVID-19 Vaccines

SCIENCE, PUBLIC HEALTH POLICY AND THE LAW

POLICY CRITIQUE, REVIEW

Review: Calls for Market Removal of COVID-19 Vaccines Intensify as Risks Far Outweigh Theoretical Benefits

NICOLAS HULSCHER * MARY T. BOWDEN PETER A. MCCULLOUGH

PEER REVIEWED, POLICY, PUBLIC HEALTH 01/28/2025 v6.2019-2025

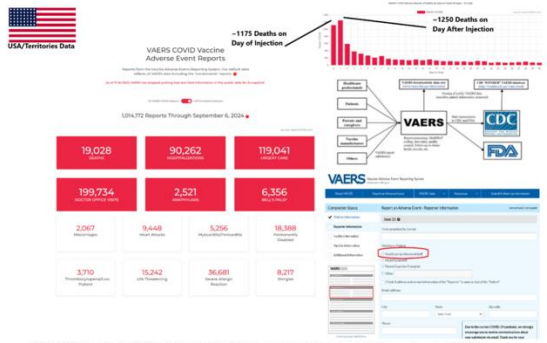

Figure 1. *United StatesCOVID-19 Vaccine VAERS Adverse Event Reports. Adapted from OpenVAERS [7].*

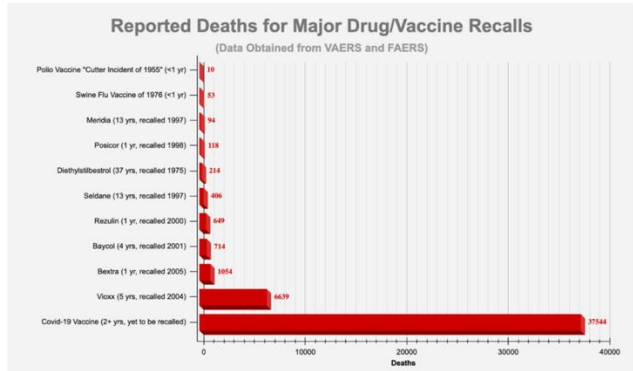

*Figure 2. Reported Deaths for Major Drug/Vaccine Recalls Versus Total COVID-19 Vaccine Deaths Reported to VAERS. *Figure reprinted from Rhodes and Parry [25], who obtained permission from VAERS Analysis to use their figure [26]. Permission to use this figure has been granted in accordance with the open access Creative Common CC BY-NC 4.0 license.*

Figure 3. Organizations that Called for COVID-19 Vaccine Market Withdrawal.

Study/Data Source	Key Finding
Vaccine Adverse Event Reporting System (VAERS) [7]	By September 6, 2024, the CDC has recorded 19,028 American COVID-19 vaccine deaths reported to them by healthcare professionals or pharmaceutical companies who believe the product is related to the death. The deaths reported in VAERS are estimated to be underreported by a conservative multiplier of 31 [5]. This means the American death toll from COVID-19 vaccination may be 589,868 (19,028 x 31).
Hulscher et al. [9]	Demonstrated a high likelihood of a causal link between COVID-19 vaccines and death and estimated that 73.9% of deaths after vaccination are directly caused or significantly contributed to by COVID-19 vaccination.
Rancourt et al. [10]	Estimated 17 million COVID-19 vaccine-related deaths worldwide by September 2023.
Mostert et al. [11]	Reported 3.1 million excess deaths potentially attributed to COVID-19 vaccination and lockdowns across 47 Western countries from 2020 to 2022.
Skidmore [12]	Estimated 278,000 Americans may have died from COVID-19 vaccines by December 2021.
Pantazatos and Seligmann [13]	Projected between 146,000 to 187,000 vaccine-associated deaths in the United States by August 2021.
Hulscher et al. [14]	Estimated 49,240 excess cardiac arrest deaths in the U.S. between 2021 and 2023, potentially linked to COVID-19 vaccination.
Aarstad and Kvitastein [15]	Found a significant association between higher vaccine uptake and increased all-cause mortality.
Alessandria et al. [16]	Revealed higher all-cause mortality risks for those vaccinated with one or two doses compared to unvaccinated individuals, with two doses leading to a 37% reduction in life expectancy during follow-up.
Lataster [17]	Demonstrated a consistent positive correlation between COVID-19 vaccination rates and excess mortality for every month analyzed.
Allen [18]	Uncovered a significant correlation between Australian excess deaths and COVID-19 booster injections, whereas no significant correlation was observed with the unvaccinated population.
Kuhbandner and Reitzner [19]	Observed a significant positive correlation between COVID-19 vaccination rates and the rise in excess mortality during the second and third pandemic years in Germany, with this correlation becoming particularly pronounced in the third year [19].
Rodrigues and Andrade [20]	Found that COVID-19 vaccination nearly doubles the risk of death from all causes after one-year post-COVID infection.

Table 1. COVID-19 Vaccine Excess Mortality.

Researcher	Affiliation, Country	Pharma Company	# of Vials	First reported	Methods	DNA/dose (limit 10 ng)	DNA/RNA ratio (limit 1/3030)	Concerns	Publication
McKernan, K. [33-35]	Medicinal Genomics, US	Pfizer, Moderna	a dozen	2023-04	Electrophoresis (Agilent)	2250 ng -- 3390 ng*	1/8 -- ½	Adverse events, Gene integration	Reported to FDA Presented at FDA Presented at WCH Reported by Epoch times Found gene integration in OvCar3 cancer cells transfected by Kämmerer Found SV40 in tumors
					Fluorometer (Qubit)	312 ng -- 843 ng*	1/47 -- 1/8		
					qPCR/RT-qPCR	12 ng	1/161 -- 1/43		
		Pfizer, Moderna, Daiichi-Sankyo (Japan)	5	2023-11	Fluorometer (Qubit)	17.5 -- 61.8 ng (after Triton-X/RnaseA)			
					qPCR	88.8 ng (Pfizer)			
Nitta, T. [36]	Tokyo Univ, Japan	Moderna	1 or 2	2023-06	qPCR/RT-qPCR	0.1 ng**	1/1,000,000	No Problem	No publication
Buckhaults, P. J. [37, 38]	USC, US	Pfizer, Moderna	some	2023-07	qPCR	0.6 ng -- 18.7 ng		Adverse events, Gene integration	Presented in South Caloraina Senate Presented gene integration to normal human epithelial stem cells
		Pfizer 2020, Pfizer 2023, Moderna 2020 Moderna 2023	4	2024-04	qPCR	7.7 ng (SV40, Pfizer) 4.5 -- 5.5 ng (Neo/Kan, Pfizer) 1.5 -- 9.0 ng (ORI, Pfizer) 2.5 -- 18.7 ng (Spike, Pfizer) 0.002 -- 0.004ng (ORI, Moderna 2023)			
König, B. Kirchner, J. O. [39]	MMD, Germany Indep., Germany	Pfizer, Moderna	4	2023-09	Fluorometer (Qubit)	3600 ng -- 5340 ng	1/12 -- 1/7	Adverse events, Gene integration	Reported to the German Ministry of Health Reported by local public broadcasting MDPI peer-reviewed paper
Speicher, D. J. McKernan, K. [40]	University of Guelph, Canada Medicinal Genomics, US	Pfizer, Moderna	27	2023-10	Fluorometer (Qubit)	1896 ng -- 5100 ng		Adverse events, Gene integration	Presented at WCH
					qPCR	0.22 ng -- 2.43 ng (Spike) 0.01 ng -- 4.27 ng (ORI)			
Speicher, D. J. [41]	University of Guelph, Canada	Pfizer, Moderna (Australia)	3	2024-06	Fluorometer (Qubit)	451 ng -- 1420 ng (after RNaseA/DNaseI)		Adverse events, Gene integration	Reported to Therapeutic Goods Administration (TGA) Under litigation
					qPCR	6.46 ng -- 163.68 ng (Spike) 0.54 ng -- 12.97 ng (ORI) 3.70 ng -- 14.69 ng (SV40, Pfizer)			
Raoult, D. [42]	Aix-Marseille Univ (Former Prof), France	Pfizer	some	2024-11	Fluorometer (Qubit)	216 ng (Avg) 5160 ng (Avg, after Triton-X-100)		Gene integration	Preprint
Kämmerer, U. [43]	Univ. Hospital of Würzburg, Germany	Pfizer	4	2024-12	Fluorometer (Qubit)	2712 – 3683 ng (after Triton-X-100) 32.71 -- 42.09 ng (after Triton-X-100/RNaseA)		Adverse events, Gene integration	Peer-reviewed paper of Science, public health policy and the law. Transfection to HEK293 cells
Wang [44]	Centreville High School, US	Pfizer	6	2024-12	Spectrometer (Nanodrop), Fluorometer (Qubit)	3450 – 6550 ng (Nanodrop), 41.4 – 109.5 ng (Qubit)		Adverse events, Gene integration	Peer-reviewed paper of the Journal of High School Science. Work performed in FDA lab.

*Table 2. Verifications of mRNA Vaccine DNA Contamination in the World. Red boxes indicate DNA contamination exceeding the regulatory limit of 10 ng per clinical dose. *Multiplied the value by 300 for ul. **From the description of DNA 44x10fg to mRNA 400 ng, the calculation for Moderna 1-dose as mRNA 100 ug. Credit for table creation and data extraction: Dr. Kenji Fujikawa, PhD, Institute of Medical Statistics, Information, and Communications, Japan.*

A total of **450 peer-reviewed studies** demonstrate that COVID-19 vaccines are fundamentally harmful due to the widespread biodistribution, persistence, and pathogenicity of modified mRNA, the resulting Spike protein (*n* = 320 studies, detected 709 days after injection), and their lipid nanoparticle (LNP) delivery system.

SARS-CoV2 spike protein pathogenicity research collection

Sass, Erik

Compiled by Dr. Martin Wucher, MSC Dent Sc (eq DDS), Erik Sass, et al.

Doi: **10.5281/zenodo.14559644**

Version 2, last updated December 26, 2024. Corresponding author: eriksass@gmail.com

Originally part of the outer coat of the SARS-CoV2 virus, where it functions as a “key” to “unlock” (infect) cells, spike proteins are also produced in large amounts by the mRNA “vaccines,” triggering a short-lived immune response in the form of antibodies. However, a growing body of evidence has shown that the spike protein is harmful by itself, independent of the rest of the virus.

The following (I. Alphabetical List) collects over 300 (**n=320**) peer-reviewed scientific studies confirming that the spike protein is highly pathogenic on its own; most *in vitro* studies cited here used recombinant spike proteins or spike proteins in pseudoviral vectors, and produced pathological effects not reliant on the SARS-CoV2 viral machinery.

The second section (II. Categories) organizes the research into broad categories including affected tissues and organ systems, mechanisms, and evidence from clinical pathology. Because these areas overlap, many articles appear more than once in the second section.

mRNA "vaccine" biodistribution, persistence, and adjuvant toxicity library

Sass, Erik (Contact person)

Compiled by Dr. Martin Wucher, MSC Dent Sc (eq DDS), Dr. Byram Bridle, PhD, Erik Sass, et al.

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Originally part of the outer coat of the SARS-CoV2 virus, where it functions as a “key” to “unlock” (infect) cells, spike proteins are also produced in large amounts by the mRNA “vaccines,” triggering a short-lived immune response in the form of antibodies. However, a growing body of evidence has shown that the spike protein is harmful by itself (see: “Spike protein pathogenicity research library,” https://zenodo.org/records/14559644). Furthermore, research has demonstrated that:

1) Both the “vaccine” mRNA encoding for the spike protein antigen and the spike protein itself can penetrate distant tissues, causing systemic harms.

2) “Vaccine” mRNA and the spike protein antigen persist in the tissues of human vaccine recipients and animal test subjects far longer than claimed by public health officials, while viral spike proteins have been shown to persist even longer.

3) The ionizable lipid nanoparticles (LNPs) used in the experimental mRNA injections are highly inflammatory on their own, including their polyethylene glycol (PEG) component, an established cause of anaphylaxis (an extreme allergic reaction).

The following research collection presents over 100 peer-reviewed studies (**n=130**) documenting I) the wide distribution and II) persistence of “vaccine” mRNA and the encoded spike protein, as well as III) the potential harms of the LNP delivery system (some studies with overlapping findings appear in more than one category). Taken together with evidence of the spike protein’s pathogenicity (https://zenodo.org/records/14559644), these findings suggest that the mRNA “vaccines” can distribute harmful, long-lasting spike protein uncontrollably throughout the body, causing injuries and death by various means.

Please note that a small number of studies in section I) investigate the ability of viral spike protein resulting from infection to cross important physiological barriers on its own, while some studies in section II) demonstrate the long persistence of viral-derived spike protein in the absence of viable virus, bolstering concerns about the identical “vaccine” spike.

Lipid nanoparticles (LNPs) carrying modified mRNA travel to **all organ systems**, instructing them to become toxic full-length, prefusion-stabilized Spike protein factories. Product mRNA and resulting Spike protein are found **directly in affected tissues** at autopsy.

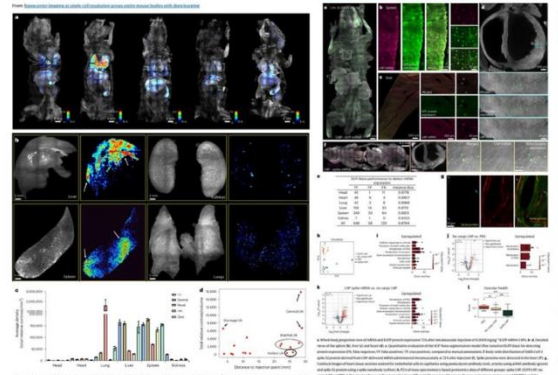
nature biotechnology

Article

Nanocarrier imaging at single-cell resolution across entire mouse bodies with deep learning

Fig. 3: SCP-Nano reveals differences in LNP biodistribution based on different application routes.

Fig. 4: SCP-Nano reveals protein expression from LNP-delivered mRNA and LNP off-targeting.



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REVIEW ARTICLE

The Journal of Gene Medicine

WILEY

Strategic deactivation of mRNA COVID-19 vaccines: New applications for siRNA therapy and RIBOTACs

Nicolas Hulscher[1] | Peter A. McCullough[1] | Diane E. Marotta[2]

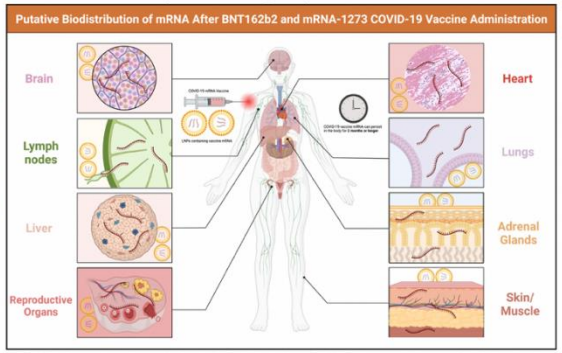

FIGURE 2 Putative biodistribution of mRNA after BNT162b2 and mRNA-1273 COVID-19 vaccine administration. COVID-19 vaccines inject lipid nanoparticles (LNPs) containing mRNA that encodes for the spike protein. Proxy construct studies demonstrate that LNPs and mRNA are widely distributed and persist throughout the body. *Created with Biorender.com. COVID-19, coronavirus disease 2019.

SARS-CoV-2 mRNA Vaccine (BNT162, PF-07302048)

マスキング箇所：調整中

2.6.5.5B. PHARMACOKINETICS: ORGAN DISTRIBUTION CONTINUED

Test Article: [3H]-Labelled LNP-mRNA formulation containing ALC-0315 and ALC-0159
Report Number: 185350

Species (Strain): Rat (Wistar Han)
Sex/Number of Animals: Male and female/3 animals/sex/timepoint (21 animals/sex total for the 50 µg dose)
Feeding Condition: Fed ad libitum
Method of Administration: Intramuscular injection
Dose: 50 µg [3H]-08-A81-C0 (lot # NC-0552-1)
Number of Doses: 1
Detection: Radioactivity quantitation using liquid scintillation counting
Sampling Time (hour): 0.25, 1, 2, 4, 8, 24, and 48 hours post-injection

Sample	Mean total lipid concentration (µg lipid equiv/eq/g (or mL) (males and females combined)							% of administered dose (males and females combined)						
	0.25 h	1h	2h	4h	8h	24 h	48 h	0.25 h	1h	2h	4h	8h	24 h	48 h
Adipose tissue	0.077	0.100	0.126	0.128	0.093	0.084	0.181	--	--	--	--	--	--	--
Adrenal glands	0.271	1.48	2.72	2.89	6.80	13.8	18.2	0.001	0.007	0.010	0.015	0.035	0.066	0.106
Bladder	0.041	0.130	0.146	0.167	0.148	0.247	0.365	0.000	0.001	0.001	0.001	0.001	0.002	0.002
Bone (femur)	0.091	0.195	0.266	0.276	0.340	0.342	0.687	--	--	--	--	--	--	--
Bone marrow (femur)	0.479	0.960	1.24	1.24	1.84	2.49	3.77	--	--	--	--	--	--	--
Brain	0.045	0.100	0.138	0.115	0.073	0.069	0.068	0.007	0.013	0.020	0.016	0.011	0.010	0.009
Eyes	0.010	0.035	0.052	0.067	0.059	0.091	0.112	0.000	0.001	0.001	0.002	0.002	0.002	0.003
Heart	0.282	1.03	1.40	0.987	0.790	0.451	0.546	0.018	0.056	0.084	0.060	0.042	0.027	0.030
Injection site	128	394	311	338	213	195	165	19.9	52.6	31.6	28.4	21.9	29.1	24.6
Kidneys	0.391	1.16	2.05	0.924	0.590	0.426	0.425	0.050	0.124	0.211	0.109	0.075	0.054	0.057
Large intestine	0.013	0.048	0.093	0.287	0.649	1.10	1.34	0.008	0.025	0.065	0.192	0.405	0.692	0.762
Liver	0.737	4.01	11.6	16.5	20.1	19.2	24.3	0.602	2.87	7.33	11.9	18.1	15.4	16.2
Lung	0.492	1.21	1.83	1.50	1.15	1.04	1.09	0.052	0.101	0.178	0.169	0.122	0.101	0.101
Lymph node (mandibular)	0.064	0.189	0.290	0.408	0.534	0.554	0.727	--	--	--	--	--	--	--
Lymph node (mesenteric)	0.050	0.146	0.530	0.489	0.689	0.985	1.37	--	--	--	--	--	--	--
Muscle	0.021	0.061	0.084	0.103	0.096	0.095	0.192	--	--	--	--	--	--	--
Ovaries (females)	0.164	1.34	1.64	2.34	3.09	3.24	12.3	0.001	0.009	0.008	0.016	0.025	0.037	0.095
Pancreas	0.081	0.207	0.414	0.380	0.294	0.358	0.599	0.003	0.007	0.014	0.015	0.015	0.011	0.019
Pituitary gland	0.339	0.645	0.868	0.854	0.405	0.478	0.694	0.000	0.001	0.001	0.001	0.000	0.000	0.001
Prostate (males)	0.061	0.091	0.128	0.157	0.150	0.183	0.170	0.001	0.001	0.002	0.003	0.003	0.004	0.003
Salivary glands	0.084	0.193	0.255	0.220	0.135	0.170	0.264	0.003	0.007	0.008	0.008	0.005	0.006	0.009
Skin	0.013	0.208	0.159	0.145	0.119	0.157	0.253	--	--	--	--	--	--	--
Small intestine	0.030	0.221	0.476	0.879	1.28	1.30	1.47	0.024	0.130	0.319	0.543	0.776	0.906	0.835
Spinal cord	0.043	0.097	0.169	0.250	0.106	0.085	0.112	0.001	0.002	0.002	0.003	0.001	0.001	0.001
Spleen	0.334	2.47	7.71	10.3	19.2	20.1	23.4	0.013	0.093	0.325	0.585	0.982	0.821	1.03
Stomach	0.017	0.065	0.115	0.144	0.268	0.152	0.215	0.006	0.019	0.034	0.030	0.040	0.037	0.039
Testes (males)	0.031	0.042	0.079	0.129	0.146	0.304	0.320	0.007	0.010	0.017	0.030	0.034	0.074	0.074
Thymus	0.088	0.243	0.340	0.335	0.196	0.207	0.331	0.004	0.007	0.010	0.012	0.008	0.007	0.008
Thyroid	0.155	0.536	0.842	0.851	0.544	0.578	1.00	0.009	0.003	0.001	0.001	0.001	0.001	0.001
Uterus (females)	0.043	0.203	0.305	0.140	0.287	0.289	0.456	0.002	0.011	0.015	0.008	0.016	0.018	0.022
Whole blood	1.97	4.37	5.40	3.05	1.31	0.909	0.420	--	--	--	--	--	--	--
Plasma	3.97	8.13	8.90	6.50	2.36	1.78	0.805	--	--	--	--	--	--	--
Blood:Plasma ratio*	0.815	0.515	0.550	0.510	0.555	0.530	0.540	--	--	--	--	--	--	--

PFIZER COVID MRNA VACCINE BIO-DISTRIBUTION STUDY

Sample Total Lipid Concentration (µg lipid equiv/g (or mL))

Injection site	0.25h 128.30	1h 393.80	2h 311.20	4h 338.00	8h 212.80	24h 194.90	48h 164.90
Adipose tissue	0.06	0.10	0.13	0.13	0.09	0.08	0.18
Adrenal glands	0.27	1.48	2.72	2.89	6.80	13.77	18.21
Bladder	0.04	0.13	0.15	0.17	0.15	0.25	0.37
Bone (femur)	0.09	0.20	0.27	0.28	0.34	0.34	0.69
Bone marrow (femur)	0.48	0.96	1.24	1.24	1.84	2.49	3.77
Brain	0.05	0.10	0.14	0.12	0.07	0.07	0.07
Eyes	0.01	0.04	0.05	0.07	0.06	0.09	0.11
Heart	0.28	1.03	1.40	0.99	0.79	0.45	0.55
Kidneys	0.39	1.16	2.05	0.92	0.59	0.43	0.42
Large intestine	0.01	0.05	0.09	0.29	0.65	1.10	1.34
Liver	0.74	4.62	10.97	16.55	26.54	19.24	24.29
Lung	0.49	1.21	1.83	1.50	1.15	1.04	1.09
Lymph node (mandibular)	0.06	0.19	0.29	0.41	0.53	0.55	0.73
Lymph node (mesenteric)	0.05	0.15	0.53	0.49	0.69	0.99	1.37
Muscle	0.02	0.06	0.08	0.10	0.10	0.10	0.19
Ovaries (females)	0.10	1.34	1.64	2.34	3.09	3.24	12.26
Pancreas	0.08	0.21	0.41	0.38	0.29	0.36	0.60
Pituitary gland	0.34	0.65	0.87	0.85	0.41	0.48	0.69
Prostate (males)	0.06	0.09	0.13	0.16	0.15	0.18	0.17
Salivary glands	0.08	0.19	0.26	0.22	0.14	0.17	0.26
Skin	0.01	0.21	0.16	0.15	0.12	0.16	0.25
Small intestine	0.03	0.22	0.48	0.88	1.28	1.30	1.47
Spinal cord	0.04	0.10	0.17	0.25	0.11	0.09	0.11
Spleen	0.33	2.47	7.71	10.30	22.09	20.08	23.35
Stomach	0.02	0.07	0.12	0.14	0.27	0.15	0.22
Testes (males)	0.03	0.04	0.08	0.13	0.15	0.30	0.32
Thymus	0.09	0.24	0.34	0.34	0.20	0.21	0.33
Thyroid	0.16	0.54	0.84	0.85	0.54	0.58	1.00
Uterus (females)	0.04	0.20	0.31	0.14	0.29	0.29	0.46
Whole blood	1.97	4.37	5.40	3.05	1.31	0.91	0.42
Plasma	3.96	8.13	8.90	6.50	2.36	1.78	0.81
Blood:plasma ratio	0.82	0.52	0.55	0.51	0.56	0.53	0.54

source: https://www.tga.gov.au/sites/default/files/foi-2389-06.pdf
Released March 2023 by the Australian health authorities in response to a freedom of information request.

International Journal of Molecular Sciences

MDPI

Article

Intramyocardial Inflammation after COVID-19 Vaccination: An Endomyocardial Biopsy-Proven Case Series

Christian Baumeier [1,*], Ganna Aleshcheva [1], Dominik Harms [1], Ulrich Gross [1], Christian Hamm [2,3], Birgit Assmus [3], Ralf Westenfeld [4], Malte Kelm [4], Spyros Rammos [4], Philip Wenzel [4], Thomas Münzel [4], Albrecht Elsässer [7], Mudather Gailani [8], Christian Perings [9], Alae Bourakkadi [10], Markus Flesch [11], Tibor Kempf [12], Johann Bauersachs [12], Felicitas Escher [1,13,14] and Heinz-Peter Schultheiss [1]

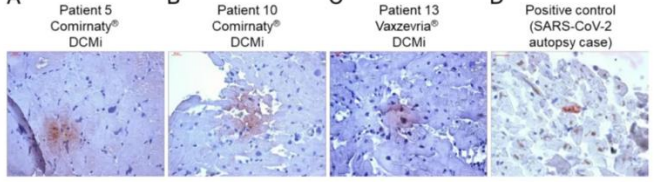

Figure 2. Evidence of SARS-CoV-2 spike protein in cardiac tissue after COVID-19 vaccination. **(A–C)** Representative immunohistochemical stainings of SARS-CoV-2 spike protein in EMBs from patients diagnosed with DCMi after receiving Comirnaty® (panel A and B, patients 5 and 10) or Vaxzevria® (panel C, patient 13). **(D)** SARS-CoV-2-positive cardiac tissue served as positive control. Magnification 400×. Scale bars 20 µm.

vaccines

MDPI

Case Report

A Case Report: Multifocal Necrotizing Encephalitis and Myocarditis after BNT162b2 mRNA Vaccination against COVID-19

Michael Mörz

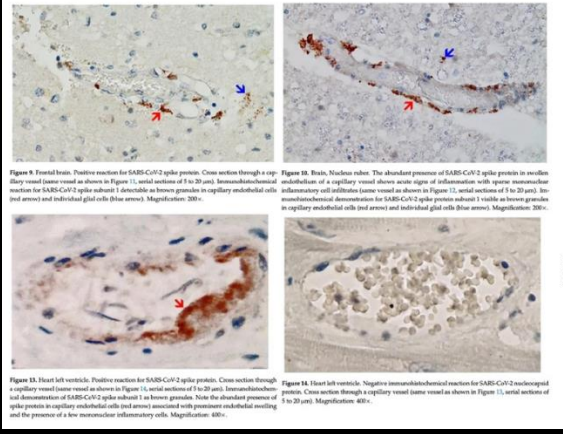

Figure 9. Frontal brain. Positive reaction for SARS-CoV-2 spike protein. Cross section through a capillary vessel (same vessel as shown in Figure 11, serial sections of 5 to 20 µm). Immunohistochemical reaction for SARS-CoV-2 spike subunit 1 detectable as brown granules in capillary endothelial cells (red arrow) and individual glial cells (blue arrow). Magnification: 200×.

Figure 10. Brain, Nucleus ruber. The abundant presence of SARS-CoV-2 spike protein in swollen endothelium of a capillary vessel shows acute signs of inflammation with sparse mononuclear inflammatory cell infiltrates (same vessel as shown in Figure 12, serial sections of 5 to 20 µm). Immunohistochemical demonstration for SARS-CoV-2 spike protein subunit 1 visible as brown granules in capillary endothelial cells (red arrows) and individual glial cells (blue arrow). Magnification: 200×.

Figure 13. Heart left ventricle. Positive reaction for SARS-CoV-2 spike protein. Cross section through a capillary vessel (same vessel as shown in Figure 15, serial sections of 5 to 20 µm). Immunohistochemical demonstration of SARS-CoV-2 spike subunit 1 as brown granules. Note the abundant presence of spike protein in capillary endothelial cells (red arrow) associated with prominent endothelial swelling and the presence of a few mononuclear inflammatory cells. Magnification: 400×.

Figure 14. Heart left ventricle. Negative immunohistochemical reaction for SARS-CoV-2 nucleocapsid protein. Cross section through a capillary vessel (same vessel as shown in Figure 15, serial sections of 5 to 20 µm). Magnification: 400×.

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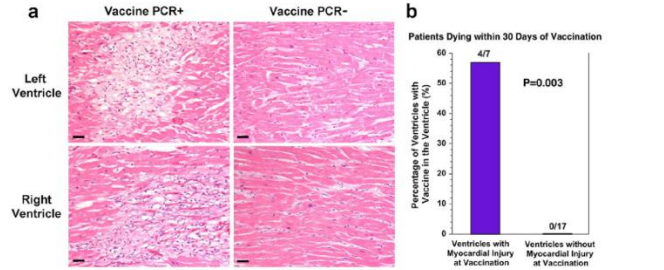
ARTICLE OPEN

Duration of SARS-CoV-2 mRNA vaccine persistence and factors associated with cardiac involvement in recently vaccinated patients

Aram J. Krauson[1], Faye Victoria C. Casimero[1,2], Zakir Siddiquee[1] and James R. Stone[1,2]✉



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CASE REPORT

Pathology WILEY

Multifocal meningoencephalitis after vaccination against COVID-19

Shuji Mikami[1] | Mitsuru Ishii[2] | Tetsuhiro Yano[2] | Ichiro Hirayama[2] | Yuichiro Hayashi[2] | Takayuki Shiomi[3] | Yoshiteru Tominaga[2] | Tsuyoshi Ishida[1]

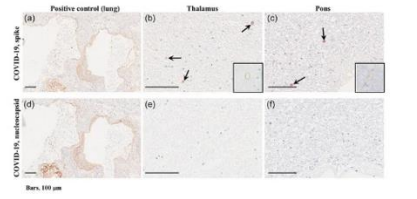


FIGURE 4 Immunostaining for SARS-CoV-2 spike protein in the positive control lung tissue (a), thalamus (b), and pons (c). SARS-CoV-2 nucleocapsid staining in the positive control tissue (d), thalamus (e), and pons (f). Arrows in (b, c) indicate SARS-CoV-2 spike protein staining-positive glia and insets in (b and c) indicate SARS-CoV-2 spike protein staining positive microvessels. Bars, 100 µm. SARS-CoV-2, severe acute respiratory syndrome coronavirus 2.

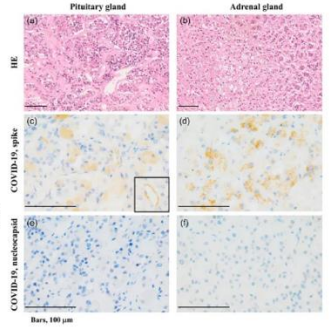


FIGURE 5 HE staining (a, b), SARS-CoV-2 spike protein immunostaining (c, d), and nucleocapsid staining (e, f) in the pituitary and adrenal glands. The inset in (c) indicates SARS-CoV-2 staining positive microvessels. Bars, 100 µm. SARS-CoV-2, severe acute respiratory syndrome coronavirus 2.

Post-mortem analyses of **325** peer-reviewed **autopsy reports** indicate a **high likelihood of a causal link between COVID-19 vaccination and death** involving multiple organ systems.

SCIENCE, PUBLIC HEALTH POLICY AND THE LAW

SYSTEMATIC REVIEW

A Systematic Review Of Autopsy Findings In Deaths After COVID-19 Vaccination

NICOLAS HULSCHER* PAUL E. ALEXANDER RICHARD AMERLING HEATHER GESSLING ROGER HODKINSON WILLIAM MAKIS HARVEY A. RISCH MARK TROZZI PETER A. MCCULLOUGH

PEER REVIEWED, PUBLIC HEALTH, SCIENCE 11/17/2024 v5.2019-2024

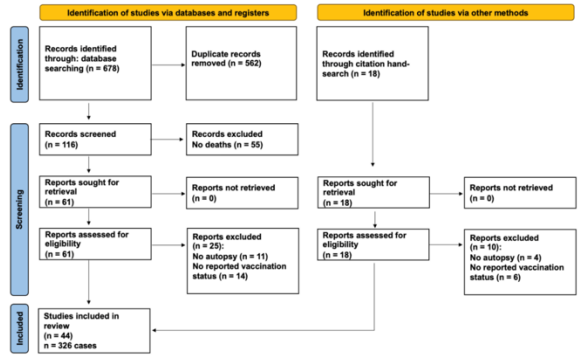


Figure 1.

Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) Flow Diagram Detailing the Study Selection Process

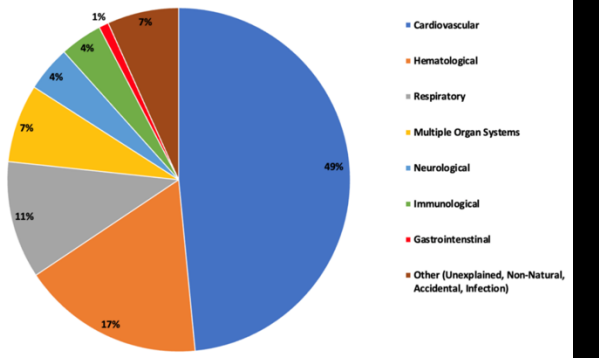


Figure 2. Proportion of Cases by Affected Organ System

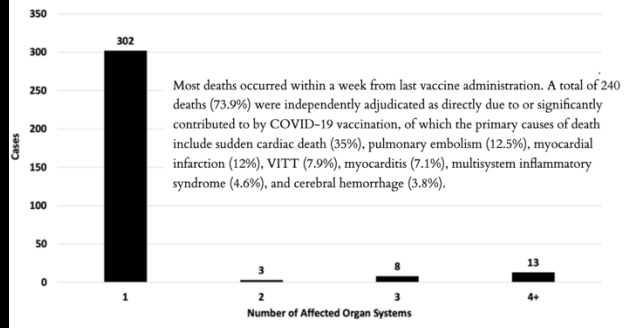


Figure 3. Number of Affected Organ Systems by Cases

Most deaths occurred within a week from last vaccine administration. A total of 240 deaths (73.9%) were independently adjudicated as directly due to or significantly contributed to by COVID-19 vaccination, of which the primary causes of death include sudden cardiac death (35%), pulmonary embolism (12.5%), myocardial infarction (12%), VITT (7.9%), myocarditis (7.1%), multisystem inflammatory syndrome (4.6%), and cerebral hemorrhage (3.8%).

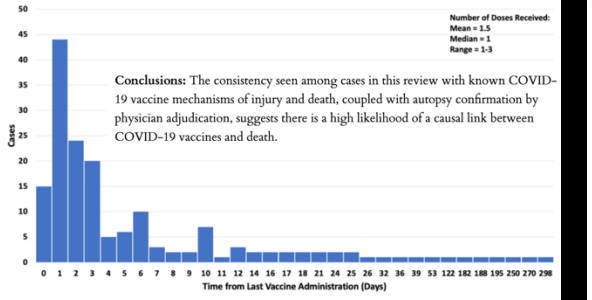


Figure 4.

Distribution of Time from Last Vaccine Administration to Death Among Cases

Conclusions: The consistency seen among cases in this review with known COVID-19 vaccine mechanisms of injury and death, coupled with autopsy confirmation by physician adjudication, suggests there is a high likelihood of a causal link between COVID-19 vaccines and death.

ESC Heart Failure Open Access

HFA Heart Failure Association

Autopsy findings in cases of fatal COVID-19 vaccine-induced myocarditis

Nicolas Hulscher, Roger Hodkinson, William Makis, Peter A. McCullough

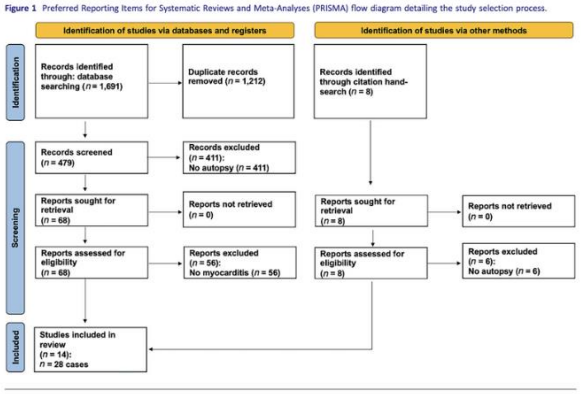


Figure 1 Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) flow diagram detailing the study selection process.

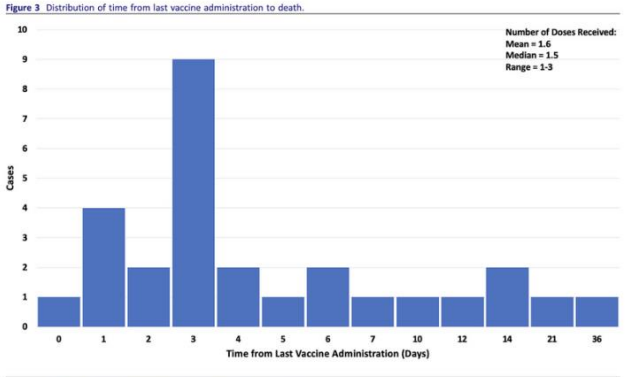


Figure 3 Distribution of time from last vaccine administration to death.

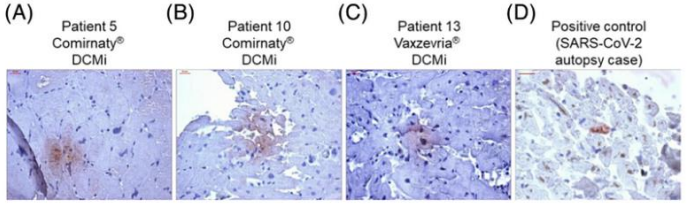
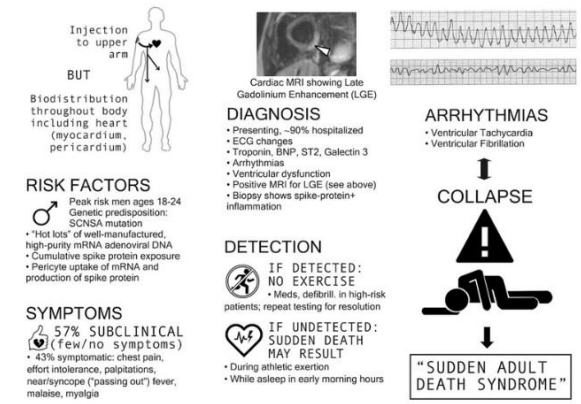


Figure 4 Evidence of SARS-CoV-2 Spike protein in cardiac tissue after COVID-19 vaccination. Representative immunohistochemical stainings of SARS-CoV-2 Spike protein in endomyocardial biopsies from patients diagnosed with inflammatory dilated cardiomyopathy (DCMi) after receiving Comirnaty® [(A, B) Patients 5 and 10] or Vaxzevria® [(C) Patient 13]. (D) SARS-CoV-2-positive cardiac tissue served as positive control. Magnification ×400. Scale bars: 20 m. Figure and legend reprinted from Baumeier *et al.*[17] Permission to use this figure has been granted in accordance with the open access Creative Commons CC BY 4.0 licence.



Excess Mortality

Along with VAERS, **12 studies** demonstrate that mass COVID-19 vaccination has led to increased mortality.

The total number of COVID-19 vaccine deaths worldwide may be greater than **17 million**.

Study/Data Source	Key Finding
Vaccine Adverse Event Reporting System (VAERS) [7]	By September 6, 2024, the CDC has recorded 19,028 American COVID-19 vaccine deaths reported to them by healthcare professionals or pharmaceutical companies who believe the product is related to the death. The deaths reported in VAERS are estimated to be underreported by a conservative multiplier of 31 [5]. This means the American death toll from COVID-19 vaccination may be 589,868 (19,028 x 31).
Hulscher et al. [9]	Demonstrated a high likelihood of a causal link between COVID-19 vaccines and death and estimated that 73.9% of deaths after vaccination are directly caused or significantly contributed to by COVID-19 vaccination.
Rancourt et al. [10]	Estimated 17 million COVID-19 vaccine-related deaths worldwide by September 2023.
Mostert et al. [11]	Reported 3.1 million excess deaths potentially attributed to COVID-19 vaccination and lockdowns across 47 Western countries from 2020 to 2022.
Skidmore [12]	Estimated 278,000 Americans may have died from COVID-19 vaccines by December 2021.
Pantazatos and Seligmann [13]	Projected between 146,000 to 187,000 vaccine-associated deaths in the United States by August 2021.
Hulscher et al. [14]	Estimated 49,240 excess cardiac arrest deaths in the U.S. between 2021 and 2023, potentially linked to COVID-19 vaccination.
Aarstad and Kvitastein [15]	Found a significant association between higher vaccine uptake and increased all-cause mortality.
Alessandria et al. [16]	Revealed higher all-cause mortality risks for those vaccinated with one or two doses compared to unvaccinated individuals, with two doses leading to a 37% reduction in life expectancy during follow-up.
Lataster [17]	Demonstrated a consistent positive correlation between COVID-19 vaccination rates and excess mortality for every month analyzed.
Allen [18]	Uncovered a significant correlation between Australian excess deaths and COVID-19 booster injections, whereas no significant correlation was observed with the unvaccinated population.
Kuhbandner and Reitzner [19]	Observed a significant positive correlation between COVID-19 vaccination rates and the rise in excess mortality during the second and third pandemic years in Germany, with this correlation becoming particularly pronounced in the third year [19].
Rodrigues and Andrade [20]	Found that COVID-19 vaccination nearly doubles the risk of death from all causes after one-year post-COVID infection.

Table 1. COVID-19 Vaccine Excess Mortality.

Historical Comparisons - FDA Class I Recall Indicated

The total number of COVID-19 vaccine deaths reported to VAERS (**37,544 among all participating countries**) have **far exceeded the recall limits of past vaccine withdrawals by up to 375,340%**.

In 1955, the Cutter polio vaccine was immediately recalled after **10 death reports**.

The swine flu vaccine of 1976 was recalled after **53 reported fatalities**.

In 1999, the Rotashield vaccine was suspended after **15 cases of bowel obstruction**.

The criteria for an FDA Class I recall, which applies to products with a reasonable probability of causing serious adverse health consequences or death, have been far exceeded.

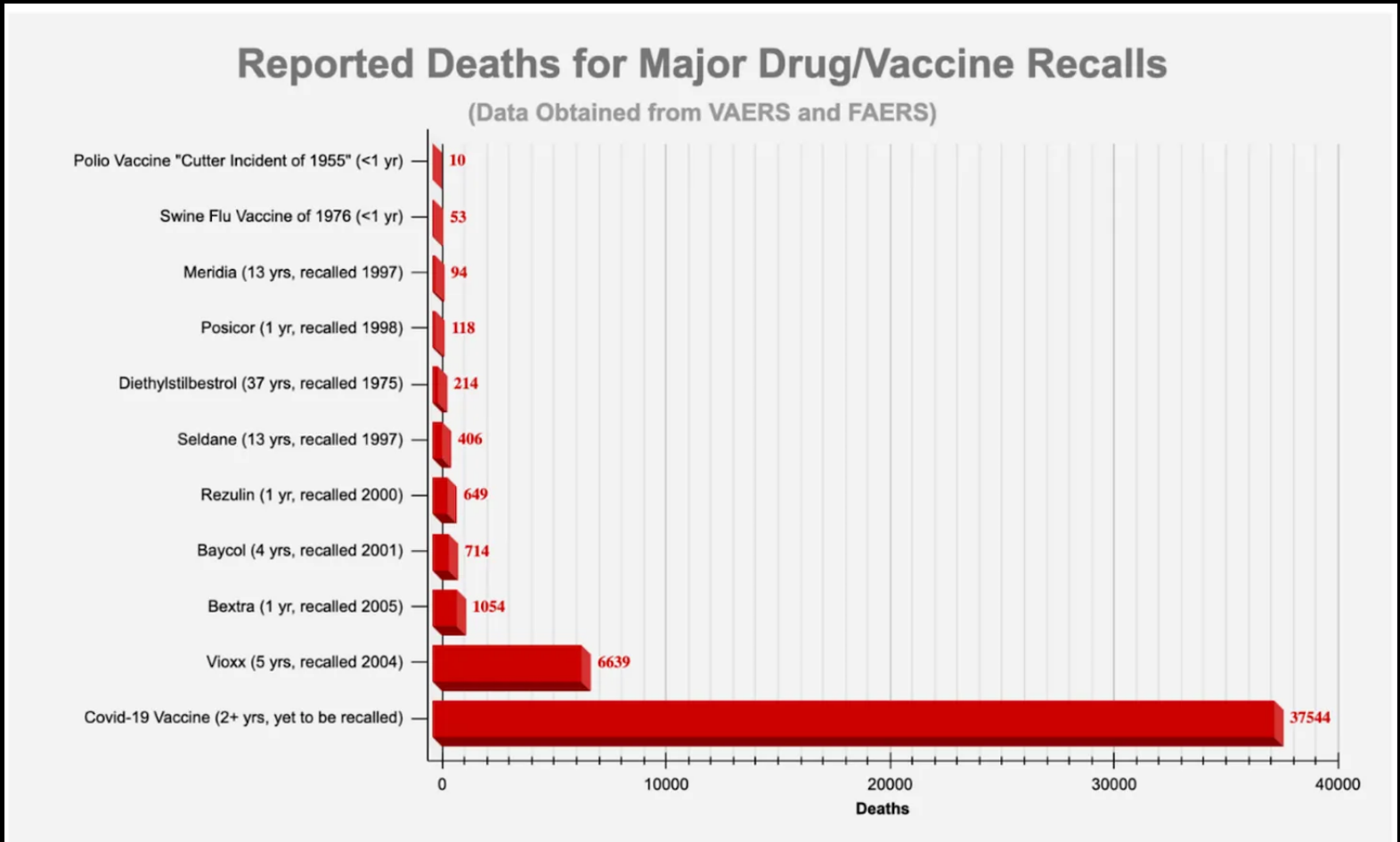


*Figure 2. Reported Deaths for Major Drug/Vaccine Recalls Versus Total COVID-19 Vaccine Deaths Reported to VAERS. *Figure reprinted from Rhodes and Parry [25], who obtained permission from VAERS Analysis to use their figure [26]. Permission to use this figure has been granted in accordance with the open access Creative Common CC BY-NC 4.0 license.*

Negative Efficacy

6 studies have demonstrated that COVID-19 vaccination increases your risk of SARS-CoV-2 infection.

Shrestha et al (Cleveland Clinic) – The risk of COVID-19 increased with the number of vaccine doses received. Individuals with one prior dose had a 107% higher risk (HR = 2.07, 95% CI: 1.70–2.52), while those with more than three doses faced a 253% higher risk (HR = 3.53, 95% CI: 2.97–4.20).

Feldstein et al (CDC) – Children vaccinated with Pfizer-BioNTech without prior SARS-CoV-2 infection were 159% more likely to get infected (HR = 2.59, 95% CI: 1.27–5.28) and 257% more likely to develop symptomatic COVID-19 (HR = 3.57, 95% CI: 1.10–11.63) compared to unvaccinated children without prior infection.

Ioannou et al – Vaccine effectiveness (VE) against documented SARS-CoV-2 infection was -3.26% (95% CI, -6.78% to -0.22%), meaning vaccinated individuals had a statistically significant higher infection rate than the unvaccinated control group.

Nakatani et al – Vaccinated individuals had an 85% increased odds of infection compared to the unvaccinated (OR = 1.85, 95% CI: 1.33–2.57).

Eythorsson et al – Those who received two or more doses had a 42% higher risk of reinfection than those with one dose or less (95% CI: 1.13–1.78).

Chemaitelly et al – The effectiveness of Pfizer-BioNTech (BNT162b2) against symptomatic BA.1 and BA.2 Omicron infections dropped from 46.6% and 51.7% (1–3 months post-dose) to -17.8% and -12.1% (≥7 months). Moderna (mRNA-1273) declined from 71.0% and 35.9% to -10.2% and -20.4% over the same period.

DNA Contamination

11 reports have found DNA contamination in COVID-19 vaccines, documented across multiple manufacturers, vaccine platforms, and geographic regions, with levels exceeding regulatory thresholds by up to **65,500%**.

The discovery of large amounts of residual plasmid DNA, including Spike-coding sequences and the SV40 promoter/enhancer, in COVID-19 vaccine vials raises serious concerns about **potential genome integration, prolonged Spike protein expression, and carcinogenicity.**

Researcher	Affiliation, Country	Pharma Company	# of Vials	First reported	Methods	DNA/dose (limit 10 ng)	DNA/RNA ratio (limit 1/3030)	Concerns	Publication
McKernan, K. [33-35]	Medicinal Genomics, US	Pfizer, Moderna	a dozen	2023-04	Electrophoresis (Agilent)	2250 ng – 3390 ng*	1/8 – ½	Adverse events, Gene integration	Reported to FDA Presented at FDA Presented at WCH Reported by Epoch times Found gene integration in OvCar3 cancer cells transfected by Kämmerer Found SV40 in tumors
					Fluorometer (Qubit)	312 ng – 843 ng*	1/47 – 1/8		
					qPCR/RT-qPCR	12 ng	1/161 – 1/43		
		Pfizer, Moderna, Daiichi-Sankyo (Japan)	5	2023-11	Fluorometer (Qubit)	17.5 – 61.8 ng (after Tritton-X/RnaseA)			
					qPCR	88.8 ng (Pfizer)			
Nitta, T. [36]	Tokyo Univ, Japan	Moderna	1 or 2	2023-06	qPCR/RT-qPCR	0.1 ng**	1/1,000,000	No Problem	No publication
Buckhaults, P. J. [37, 38]	USC, US	Pfizer, Moderna	some	2023-07	qPCR	0.6 ng -- 18.7 ng		Adverse events, Gene integration	Presented in South Caloraina Senate Presented gene integration to normal human epithelial stem cells
		Pfizer 2020, Pfizer 2023, Moderna 2020, Moderna 2023	4	2024-04	qPCR	7.7 ng (SV40, Pfizer) 4.5 -- 5.5 ng (Neo/Kan, Pfizer) 1.5 -- 9.0 ng (ORI, Pfizer) 2.5 -- 18.7 ng (Spike, Pfizer) 0.002 -- 0.004ng (ORI, Moderna 2023)			
König, B. Kirchner, J. O. [39]	MMD, Germany Indep., Germany	Pfizer, Moderna	4	2023-09	Fluorometer (Qubit)	3600 ng – 5340 ng	1/12 -- 1/7	Adverse events, Gene integration	Reported to the German Ministry of Health Reported by local public broadcasting MDPI peer-reviewed paper
Speicher, D. J. McKernan, K. [40]	University of Guelph, Canada Medicinal Genomics, US	Pfizer, Moderna	27	2023-10	Fluorometer (Qubit)	1896 ng – 5100 ng		Adverse events, Gene integration	Presented at WCH
					qPCR	0.22 ng -- 2.43 ng (Spike) 0.01 ng -- 4.27 ng (ORI)			
Speicher, D. J. [41]	University of Guelph, Canada	Pfizer, Moderna (Australia)	3	2024-06	Fluorometer (Qubit)	451 ng – 1420 ng (after RNaseA/DNaseI)		Adverse events, Gene integration	Reported to Therapeutic Goods Administration (TGA) Under litigation
					qPCR	6.46 ng -- 163.68 ng (Spike) 0.54 ng -- 12.97 ng (ORI) 3.70 ng -- 14.69 ng (SV40, Pfizer)			
Raoult, D. [42]	Aix-Marseille Univ (Former Prof), France	Pfizer	some	2024-11	Fluorometer (Qubit)	216 ng (Avg) 5160 ng (Avg, after Triton-X-100)		Gene integration	Preprint
Kämmerer, U. [43]	Univ. Hospital of Würzburg, Germany	Pfizer	4	2024-12	Fluorometer (Qubit)	2712 – 3683 ng (after Triton-X-100) 32.71 -- 42.09 ng (after Triton-X-100/RNaseA)		Adverse events, Gene integration	Peer-reviewed paper of Science, public health policy and the law. Transfection to HEK293 cells
Wang [44]	Centreville High School, US	Pfizer	6	2024-12	Spectrometer (Nanodrop), Fluorometer (Qubit)	3450 – 6550 ng (Nanodrop), 41.4 – 109.5 ng (Qubit)		Adverse events, Gene integration	Peer-reviewed paper of the Journal of High School Science. Work performed in FDA lab.

*Table 2. Verifications of mRNA Vaccine DNA Contamination in the World. Red boxes indicate DNA contamination exceeding the regulatory limit of 10 ng per clinical dose. *Multiplied the value by 300 for ul. **From the description of DNA 44x10fg to mRNA 400 ng, the calculation for Moderna 1-dose as mRNA 100 ug. Credit for table creation and data extraction: Dr. Kenji Fujikawa, PhD, Institute of Medical Statistics, Information, and Communications, Japan.*

Widespread and Unified Calls for the Market Withdrawal of COVID-19 Vaccines

>81,000 Physicians, Scientists, Researchers, and Concerned Citizens

240 Elected Government Officials

17 Professional Public Health and Physician Organizations

17 Republican Party County Committees

6 Scientific Studies

2 State Republican Parties

All call for the market withdrawal of COVID-19 vaccines.

Figure 3. Organizations that Called for COVID-19 Vaccine Market Withdrawal.

Conclusion

I expect that calls for an immediate moratorium on COVID-19 vaccines will continue to increase until a critical mass is reached, and the products are finally removed from the market.

Excess mortality, negative efficacy, and widespread DNA contamination associated with COVID-19 vaccines have been sufficiently demonstrated. The FDA's criteria for a Class I recall have been far exceeded.

No large-scale, conclusive, randomized, double-blind, placebo-controlled trials have demonstrated reduction in infection transmission, hospitalization, or death as primary endpoints. Thus, the COVID-19 vaccines are not proven to be effective in reducing important clinical outcomes.

A position supporting COVID-19 vaccination goes against good medical practice and violates the Hippocratic Oath to above all, do no harm.

Immediate removal of COVID-19 vaccines from the market is essential to prevent further harm to the fewer than 20% of the population still receiving booster doses.