OPINION

From cancer to psychosis: New data analyses paint grim picture of COVID jab effects

When it comes to the legitimacy of the COVID vaccines, the worst is yet to come. The intensity and range of bad health impacts will become a horror story in coming years.

mRNA vaccines

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Tue Feb 21, 2023 - 3:28 pm EST

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(LifeSiteNews) — What most people have heard about deaths and illnesses caused by COVID vaccines is just the tip of the iceberg. Medical research articles keep rolling out on a host of health impacts from the vaccines. Here a number of new articles are cited to better reveal how unsafe these vaccines are.

An important part of the message for the general population should be this: All the new research on vaccines comes from just two years of use. Thus we still do not have good information on the long-term health impacts. There is a reasonable probability that the negative health impacts will become even worse as more time for impacts on bodies and for research increases.

Another point is that even though the percent of people impacted may seem quite low, it is important to remember that there are huge numbers of people vaccinated, hundreds of millions of people, in fact. This means that very large numbers of people may be impacted by a host of diseases that at first seem minor.

Lastly, it is possible that some people may become victims of several vaccine-caused health problems. Just another factor to consider when high excess death rates continue to be observed nearly everywhere.

Cancer

There has been limited analysis and data on cancers being caused by the COVID mRNA vaccines. Now comes a creative new analysis by Ronald Kostoff. The article title is: *Are COVID-19 Vaccine-Induced Cancer Rare Events?*

Here is one statement that caught my attention: “Applying the URF [unreported fraction] of ~100 from the Harvard Pilgrim Health Care study, and the 1/3 fraction from the autopsy results to the post-COVID-19 vaccine VAERS cancer-related numbers yields a total of about 83,000 cancer-related events post-COVID-19 vaccination (so far).”

Here are a few excerpts:

COVID-19 vaccine-induced cancer has been judged a 'rare' event by the major promoters of these vaccines (caveat: these injections prevent neither infection nor viral transmission, so they are not vaccines in the classical sense). To ascertain the frequency of COVID-19 vaccine-induced cancers, we have examined the Vaccine Adverse Events Reporting System (VAERS) database for reports of cancers. Since cancers tend to have a long latency period, we have also addressed the issue of Early Warning Indicators that could identify COVID-19 vaccine-induced cancers on or over the horizon. Finally, we have compared cancers reported following COVID-19 vaccines with those reported following influenza vaccines for similar numbers of vaccine doses delivered.

While imperfect (as are most publicly-available vaccine adverse events reporting systems), VAERS is a reasonable system for identifying safety signals related to vaccines. One major VAERS deficiency is that only a small fraction of vaccine-related adverse events is reported to VAERS. A study by Harvard Pilgrim Health Care, using electronic tracking, showed that 'fewer than 1% of vaccine adverse events are reported.' This is an average value over all adverse events; it may be far worse for cancer.

Before presenting the numbers, we need to define what is a cancer-related event reported in VAERS. Is it 1) a biomarker associated with the eventual emergence of cancer, 2) a group of biomarkers reflecting pre-clinical cancer, 3) a newly-diagnosed cancer, 4) a cancer that has been exacerbated, or 5) a cancer death? While all five are valid candidates, the present study concentrates on items 3) and 4).

This restriction to items 3) and 4) substantially under-reports the COVID-19 vaccine adverse events that may eventually result in cancer, because it excludes abnormalities in cancer risk biomarkers.

There were ~330 different cancer-related adverse events reported in VAERS for the COVID-19 vaccines, with ~2500 total number of events. Converting these VAERS entries to real-world numbers of COVID-19 vaccine-induced cancers requires three major assumptions, and some minor ones. The major assumptions are 1) the cancers reported in VAERS following the administration of COVID-19 vaccines is, in fact, caused in part or in whole by the COVID-19 vaccines, 2) the under-reporting factor (URF) to be used for cancer scale-up to real-world numbers can be approximated for very conservative estimation purposes by the Harvard Pilgrim Healthcare URFs, and 3) the fraction of the VAERS entries to which the URF should be applied can be approximated by autopsy results for fraction of post-COVID-19 vaccine deaths that can be attributed to the COVID-19 vaccine.

Assumption 1) is based on mechanistic studies that show the COVID-19 mRNA vaccines (those distributed most widely in the USA) destroy the innate immune system, including those components that surveille and control the growth of cancers. One of the specific mechanisms demonstrated in very recent mechanistic studies (https://www.science.org/doi/10.1126/sciimmunol.ade2798 and https://pubmed.ncbi.nlm.nih.gov/36713457/) is that the COVID-19 mRNA vaccines increase the fraction of IgG4 antibodies and decrease the fraction of IgG3 antibodies, and the effect increases as the number of vaccine doses increase. This IgG3/IgG4 ratio shift is favorable for increasing tolerance to allergens but can also support increased malignancy. Based on the above and many other recent study results, the question we should ask about the COVID-19 vaccines should not be i) why would we expect that these vaccines contribute to cancer development, but rather ii) **why would we expect they would not contribute to cancer development, given their demonstrated destruction of those components of the innate immune system responsible for controlling the development of cancer!**

Assumption 3) is based on the observation that autopsy results for COVID-19 vaccine-induced deaths showed about 1/3 of all the VAERS entries for deaths could be attributed to the vaccine. Whether this fraction is applicable to vaccine-induced cancer is unknown.

… All the major cancers are represented, with breast, lung, prostate, brain, and colon cancers being the most frequent. Placing these results in context is a separate study in itself. We do a simple comparison of the highest frequency cancers reported here with their counterparts for the influenza vaccines reported in VAERS. We selected influenza, since it is a respiratory viral disease and has a number of features in common with COVID-19.

New estimate of vaccine deaths

A very innovative analysis is presented in the new article: *Age-stratified COVID-19 vaccine-dose fatality rate for Israel and Australia.* What is noteworthy is that the detailed analysis for Israel and Australia leads to a generalization applicable to the United States. The paper points out that **“it is not unreasonable to assume an all-population global value of vDFR = 0.1 % [vaccine dose fatality rate].” This is for vaccine doses.** For the U.S., 670M doses have been given, so the estimate is 670,000 people have been killed by the COVID vaccines in the U.S.

Here are a few excerpts:

It is well established that the COVID-19 vaccines can cause death, as seen from detailed autopsy studies (Choi et al., 2021; Schneider et al., 2021; Sessa et al., 2021; Gill et al., 2022; Mörz, 2022; Schwab et al., 2022; Suzuki et al., 2022; Tan et al., 2022; Yoshimura et al., 2022; Onishi et al., 2023), adverse effect monitoring (Hickey and Rancourt, 2022), a recent survey study (Skidmore, 2023), studies of vaccine-induced pathologies (e.g., Goldman et al., 2021; Kuvandik et al., 2021; Turni and Lefringhausen, 2022; Edmonds et al., 2023; Wong et al., 2023), and more than 1,250 peer-reviewed publications about COVID-19 vaccine adverse effects (React 19, 2022).

In particular, a study of the Vaccine Adverse Event Reporting System (VAERS) data for the USA showed that the COVID-19 injections can be understood as individual challenges to the body, and that “toxicity by dose” is a good first-order model of the phenomenon for the adverse effect of death (Hickey and Rancourt, 2022). An exponential increase of lethality with median age of those dying following injection was observed (Hickey and Rancourt, 2022).

…

Our all-population value of vDFR of approximately 0.05 % (Figure 3, Tables 1 and 2) implies that in the USA, following the administration of approximately 670 million COVID-19 vaccine doses to date (669.60 million doses, up to January 31, 2023, Our World in Data),2 ***approximately 330,000 USA residents would have died from the COVID-19 vaccine***s (1 in 1,000 on a population basis), assuming that elderly and vulnerable individuals are not more abundant or more aggressively targeted than in Australia or Israel. This number is comparable to the 278,000 fatalities found by Skidmore (2023) in his survey study for the USA. Our number of 330,000 is probably an underestimate, in light of the exponential dependence of vDFR with age that we have demonstrated and the known exceptionally large pools of highly vulnerable residents in the USA (Rancourt et al., 2022b).

…

…it is not unreasonable to assume an all-population global value of vDFR = 0.1 %. Based on the global number of COVID-19 vaccine doses administered to date (13.25 billion doses, up to January 24, 2023, Our World in Data),3 ***this would correspond to 13 million deaths from the COVID-19 vaccines worldwide.***

Psychosis

Two medical research articles presented evidence for vaccine-caused psychosis.

The title of the first article is: *Can new-onset psychosis occur after mRNA-based COVID-19 vaccine administration? A case report.*

Here is a key part of the article:

> A 31-year-old, single Hispanic male without past medical or psychiatric history, was brought to the emergency room by police because of erratic and bizarre behavior. He was found to be anxious, guarded, superficial and grandiose. He reported becoming 'clairvoyant,' being able to talk with dead people, hearing 'people drumming outside his house' and the constant voice of a co-worker whom he believed to be a paramour- it was later confirmed that there was no romantic relationship. All these symptoms began one month ago, after receiving the first dose of an mRNA-based COVID-19 vaccine, and markedly worsened three weeks later after receiving the second dose. Previously, he was asymptomatic, working full-time as an office manager. Although functional in adolescence and adulthood, he described himself as a loner, with an inclination to overly spiritual ideas, and able to communicate directly with God. He had a few close friends and romantic relationships.
>
> His-vital signs, blood chemistry, urine toxicology, urinalysis, and chest radiograph were within normal limits, except for moderate leukocytosis with left shift, and erythrocyte sedimentation rate of 48 mm/h. His-COVID-19 PCR was negative. Non-contrast head computerized tomography with- and without-contrast showed hyperintensities throughout the subcortical and periventricular white matter. Magnetic resonance imaging (MRI) also revealed focus of FLAIR hyperintensity in the left peritrigonal white matter, with multiple nonspecific punctate hyperintensities throughout the subcortical and periventricular white matter and focus of susceptibility in the right lateral thalamus. The patient was admitted to the neurology service, where a video electroencephalogram (EEG) was negative. He refused a lumbar puncture. The following day he was wandering the unit talking to himself, stating that the 'EEG machine was communicating with him.' The patient demonstrated poor insight into his symptoms. He was started on risperidone 0.5 mg po qhs and placed on one-to-one observation. The next day, risperidone was increased to 0.5 mg qam and 1 mg qhs, and the patient was transferred to the psychiatric ward. He engaged in milieu treatment, and the hallucinations and delusions resolved after two days. He was discharged on the same medication regime five days later, with good insight about his symptoms. One week after discharge he was taking medication, asymptomatic and back to work.

> This is the first report of psychotic symptoms after receiving a COVID-19 vaccine. SAR-CoV- 2 is known to trigger a powerful immune response, which includes the release of large amounts of proinflammatory cytokines. As of January 2021, 42 cases of psychosis associated with COVID-19 infection have been reported. It has been hypothesized that a COVID-19-triggered cytokine storm may increase the risk of psychosis. Coincidentally, schizophrenia has been linked to a pro-inflammatory status (Goldsmith et al., 2016).

The title of the second paper is: *First Episode of Psychosis Following the COVID-19 Vaccination – A Case Series.*

Here is the key summary:

> We report the case series of three patients who developed psychotic symptoms after the COVID-19 vaccination. Considering the evidence in the literature of an association between altered immune function and psychosis, the negative family and personal psychiatric history of our patients, the clinical presentation, and the close temporal relationship between the COVID-19 vaccination and the presenting symptoms, we hypothesize that the COVID-19 vaccine may play a role in the etiology of their symptoms. Since the COVID-19 vaccine has been shown to be safe and effective (Sultana et al. 2022), and the development of psychosis after vaccination is very rare (Reinfeld et al. 2021), we firmly believe that this case series should not discourage the use of the COVID-19 vaccine. Rather, future systematic studies should be conducted with adequate control of confounding variables to establish coincidence, association, or causality between reported psychotic symptoms and the COVID-19 vaccine.

Shingles

Here is the abstract:

> Introduction: Varicella zoster virus (VZV) reactivation has been reported following vaccination for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), but the real extent remains unknown. Methods: We conducted a systematic review to summarize evidence of VZV reactivation or infection following SARS-CoV-2 vaccination. Episodes after coronavirus disease-2019 (COVID-19) were also identified. Related articles were identified in PubMed and EMBASE databases till December 31, 2021, using the terms “varicella zoster” and “COVID-19".

Results: The search revealed 314 articles, of which 55 met the inclusion criteria. VZV manifestations were documented in 179 (82.1%) subjects following SARS-CoV-2 vaccination and in 39 (17.9%) patients with COVID-19. Among the vaccinated, median (IQR) age was 56.5 (42–70) years, and 56.8% were female. Twenty-one (16.8%) were immunosuppressed. The median (IQR) latency time after vaccination was 6 (3–10) days, and 84.4% received mRNA vaccines. VZV reactivation occurred following a first dose (68.2%), a second dose (12.8%) or a booster (0.6%). The most important VZV manifestation was dermatome herpes zoster rash, which accounted for 86.4% of events in vaccinated subjects. Twenty patients (11.3%) presented serious VZV events after vaccination, with Herpes Zoster ophthalmicus (5.6%) and post-herpetic neuralgia (3.4%) predominating. No VZV pneumonia or deaths were recorded. Antiviral prescriptions were made in 96.2% of vaccinated subjects. No significant differences between vaccinated and infected subjects were found. Conclusion: This study indicates that the occurrence of VZV reactivation is clinically relevant.

Multisystem inflammatory syndrome

The title of this article is: *Reported cases of multisystem inflammatory syndrome in children aged 12–20 years in the USA who received a COVID-19 vaccine, December, 2020, through August, 2021: a surveillance investigation.*

Here are parts of the summary:

Background

Multisystem inflammatory syndrome in children (MIS-C) is a hyperinflammatory condition associated with antecedent SARS-CoV-2 infection. In the USA, reporting of MIS-C after vaccination is required under COVID-19 vaccine emergency use authorizations. We aimed to investigate reports of individuals aged 12–20 years with MIS-C after COVID-19 vaccination reported to passive surveillance systems or through clinician outreach to the US Centers for Disease Control and Prevention (CDC).
Findings

Using surveillance results from December 14, 2020, to August 31, 2021, we identified 21 individuals with MIS-C after COVID-19 vaccination. Of these 21 individuals, median age was 16 years (range 12–20); 13 (62%) were male, and eight (38%) were female. All 21 were hospitalized: 12 (57%) were admitted to an intensive care unit, and all were discharged home. 15 (71%) of 21 individuals had laboratory evidence of past or recent SARS-CoV-2 infection, and six (29%) did not. As of August 31, 2021, 21 335 331 individuals aged 12–20 years had received one or more doses of a COVID-19 vaccine, making the overall reporting rate for MIS-C after vaccination 1·0 cases per million individuals receiving one or more doses in this age group. The reporting rate in only those without evidence of SARS-CoV-2 infection was 0·3 cases per million vaccinated individuals.

Interpretation

Here, we describe a small number of individuals with MIS-C who had received one or more doses of a COVID-19 vaccine before illness onset; the contribution of vaccination to these illnesses is unknown. Our findings suggest that MIS-C after COVID-19 vaccination is rare. Continued reporting of potential cases and surveillance for MIS-C illnesses after COVID-19 vaccination is warranted.

Conclusion

When it comes to the legitimacy of the COVID vaccines, the worst is yet to come. The intensity and range of bad health impacts will become a horror story in coming years.

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