Shedding Part 3 - Can You Absorb Lipid Nanoparticles From Being Exposed To a Vaccinated Person?

I review all the routes of entry into the human body that mRNA vaccine nanoparticles can take.. and the ease in which they do so. The most troubling is via inhalation.

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NOV 1, 2023

In this post, I will review the ways in which the synthetic lipid nanoparticles (LNPs), used in the Covid mRNA vaccines (as well as natural LNPs called exosomes) can be absorbed into the body.

First, a summary of the data presented in my first 2 posts here and here:

1. The Covid mRNA vaccines meet the regulatory definition of a gene therapy product
2. Gene therapy products are required to undergo both animal and human shedding studies (the latter were not done and

the results of the former have not been made public by Pfizer).

3. Shedding studies are required because the mRNA is delivered to the cell via lipid nano-particles and LNP's are distributed widely in the body
4. Pfizer specifically excluded subjects who could be closely exposed to a trial subject that had already received the vaccine.
5. The gene therapy product called Luxterna has a warning on its insert that the product can be shed via tears and nasal secretions.

Where is the evidence that LNP's from vaccinated folks can be transmitted to and subsequently enter our bodies? From this review of nanoparticles (i.e LNPs/exosomes) they state:

> *As far as the exposure of humans to NPs is concerned, they can enter the body through inhalation, ingestion, skin uptake, injection, or implantation. It is also interesting to note that NP uptake could be intentional or non-intentional.*

Non-intentional? From the article: "Some exposures are unintentional, such as pulmonary inhalation of NPs in the environment or at manufacturing sites."

This figure illustrates the various routes of absorption and dissemination throughout the body:

Figure 1

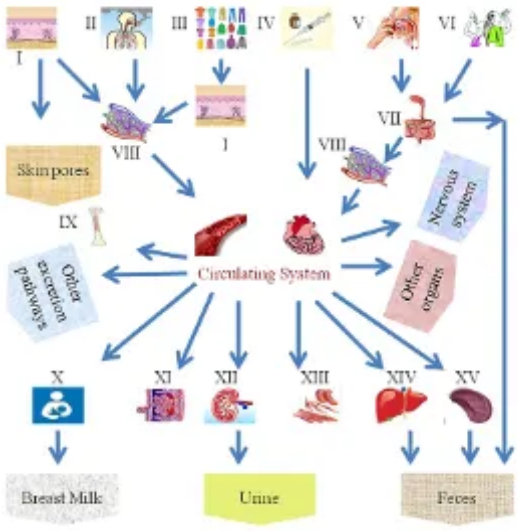


FIGURE 1. Scheme of the different exposure routes of nanoparticles in the human body. (I) Skin, (II) inhalation, (III) fabric, (VI) intravenous injection, (V) food intake, (VI) water intake, (VII) gastrointestinal tract, (VIII) lymph, (IX) bone marrow, (X) breast milk, (XI) placenta, (XII) kidney, (XIII) muscles, (XIV) liver, and (XV) spleen.

Here is where we are: synthetic LNP's like the Covid vaccines contain modified mRNA. Natural exosomes can take up released modified mRNA as well as the spike protein. LNP's and exosomes distribute widely throughout the body. But can they be released from the body? If released via body fluids or exhaled breath, can they then be absorbed by others who are exposed to these fluids/vapor?

A major concern is that this study found that vaccine mRNA is present from day one and persists in the bloodstream for at least 2 weeks after injection; its concentration starts to decrease after

4 days. Note this is much longer than was claimed by the manufacturers on the basis of brief studies in rats.

From the conclusion of the study:

> *In conclusion, we showed that BNT162b2 vaccine mRNA remains in the systemic circulation of vaccinated individuals for at least 2 weeks, during which it likely retains its ability to induce S-protein expression in susceptible cells and tissues.*

So mRNA can stay in the blood for up to two weeks. However, in my now almost two year clinical experiences treating both Long Vax and Long Covid, it is clear that the spike protein is the most worrisome given its severe pathogenicity and toxicity.

Let's start with what we know about distribution of spike protein to organs and body fluids (this would be required in order to support the fact that shedding can occur):

In July of 2021 a page on the website of the Infectious Disease Society of America noted that the lifespan of spike in the bloodstream is "unknown and may be a few weeks." That page no longer exists. This might be because of the publication of numerous studies showing not only wide dissemination but also the persistence of spike protein in the body:

For example, this research team reported that the spike protein persists for a long time in free form: full-length spike is detected up to day 15, with a peak at 62 pg/mL. After the 2nd dose, free spike is no longer detected as *it would be* bound to antibodies (but the study did not look for antibody-spike immune complexes).

Another study found that vaccination with mRNA and translation of the mRNA induces the production of exosomes carrying the spike protein and circulating in the blood 14 days after injection and **up to 4 months after**.

Another group similarly found that the spike protein concentration rapidly increases in blood after vaccination (within 1 to 3 days) and persists in the bloodstream for more than a week. Although they report that the spike is completely eliminated within 1 month a more recently published study which looked much more carefully, found spike protein circulating in the blood up to 187 days after vaccination (after which they stopped testing and finished their study).

In the Parry et al review paper on "spikeopathy", they include a table summarizing the persistence of various vaccine products in various organs as in the below bottom left (image taken from William Makis's review of the paper on his Substack called Covid Intel):

biomedicines

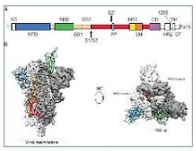
MDPI

Review

'Spikeopathy': COVID-19 Spike Protein Is Pathogenic, from Both Virus and Vaccine mRNA

Biomedicines **2023**, *11*, 2287

Peter I. Parry [1,2,*], Astrid Lefringhausen [3], Conny Turni [4], Christopher J. Neil [5], Robyn Cosford [3], Nicholas J. Hudson [6] and Julian Gillespie [3]



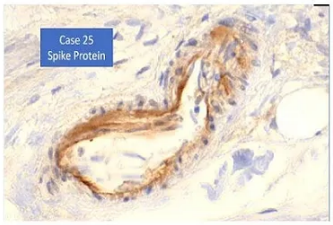


Figure 8. Spike protein in blood vessel wall from Burkhardt (2022a) [47].

Table 1. Studies demonstrating persistence of vector-based vaccine constituents and/or derivative spike protein.

Author	Constituents/Tissue Type/Assay Technique	Duration Measured
Animal		
Pfizer (Japanese MoH) 2020 [46]	Radiolabelled LNP in plasma and tissues	140 h–14 days
Human		
Ogata et al. (2021) [52]	Spike protein and S1 subunit (assay)	3 days
Bansal et al. (2021) [57]	Spike Protein	4 months
Fertig et al. (2022) [50]	LNPs and mRNA	15 days
Röltgen et al. (2022) [53]	mRNA and Spike Protein in ipsilateral lymph nodes; 2–7 days post dose in blood	60 days
Yamamoto et al. (2022) [58]	Spike Protein in skin	3 months
Yonker et al. (2023) [54]	Spike Protein in blood	1–19 days *in cases of myocarditis*
Castruita et al. (2023) [51]	mRNA in plasma	28 days

Table 4-2. Mean concentration of radioactivity (sexes combined) in tissue and blood following a single IM dose of 50 µg mRNA/rat

Sample	Total Lipid Concentration (µg lipid equiv/g (or mL))						
	0.25 min	1 h	2 h	4 h	8 h	24 h	48 h
Adipose tissue	0.057	0.100	0.126	0.128	0.093	0.084	0.181
Adrenal glands	0.27	1.48	2.72	2.89	6.80	13.77	18.21
Bladder	0.041	0.130	0.146	0.167	0.148	0.247	0.365
Bone (femur)	0.091	0.195	0.266	0.276	0.340	0.342	0.687
Bone marrow (femur)	0.48	0.96	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
Eyes	0.010	0.035	0.052	0.067	0.059	0.091	0.112
Heart	0.28	1.03	1.40	0.99	0.79	0.45	0.55
Injection site	128.3	393.8	311.2	338.0	212.8	194.9	164.9
Kidneys	0.39	1.16	2.05	0.92	0.59	0.43	0.42
Large intestine	0.013	0.048	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)	0.064	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	1.366
Muscle	0.021	0.061	0.084	0.103	0.096	0.095	0.192
Ovaries (females)	0.104	1.34	1.64	2.34	3.09	5.24	12.26
Pancreas	0.081	0.207	0.414	0.380	0.294	0.358	0.599
Pituitary gland	0.339	0.645	0.868	0.854	0.405	0.478	0.694
Prostate (males)	0.061	0.091	0.128	0.157	0.150	0.183	0.170
Salivary glands	0.084	0.193	0.255	0.220	0.135	0.170	0.264
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	1.279	1.302	1.472
Spinal cord	0.043	0.097	0.169	0.250	0.106	0.085	0.112
Spleen	0.33	2.47	7.73	10.30	22.09	20.08	23.35
Stomach	0.017	0.065	0.115	0.144	0.268	0.152	0.215
Testes (males)	0.031	0.042	0.079	0.129	0.146	0.304	0.320
Thymus	0.088	0.243	0.340	0.335	0.196	0.207	0.331
Thyroid	0.155	0.536	0.842	0.851	0.544	0.578	1.000
Uterus (females)	0.043	0.203	0.305	0.140	0.287	0.289	0.456
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	0.815	0.515	0.550	0.510	0.555	0.530	0.540

Clinical and pathologic evidence abound as well: a case report of an autopsy done in a man who died of multifocal necrotizing encephalitis three weeks after the vaccine found vaccine spike in numerous organs (heart, brain, muscles, germinal centers etc.). Further, they emphasized the finding of high concentrations in the walls of capillaries. One sentence in that report jumped out at me:

> *"The family of the deceased requested an autopsy due to ambiguous clinical signs before death."*

That is exactly the patient population autopsied by a team of pathologists led by senior German pathologist Arne Burkhart (unfortunately he is recently deceased but many of us Covid dissidents co-lectured at conferences with him - he was a brilliant, courageous, and kind man).

Know that in order to establish the vaccine as the cause of death on autopsy, you have to use a special stain to identify the spike protein embedded in the organs or vessels, something that nearly all "system" coroners across the world did NOT do. As the independent pathologist Ryan Cole has said "you can't find what you don't look for." It was clear to all of us Covid "dissidents" that from the outset there was a concerted, global effort to avoid looking for disseminated spike protein in the bodies of the deceased.

This is why the findings of Burkhart's team are so alarming (and censored) They began systematically performing "2nd opinion" autopsies staining for the presence of spike protein in people who died where the family was convinced the vaccine was the cause (and the primary coroner had not performed these special stains).

Although not yet published, he has presented their findings in multiple invited lectures. He reported that out of the first 50 autopsies performed, in 80% of cases where the family suspected

the vaccine as the cause of death, spike induced organ damage was determined to be the proximate cause of death.

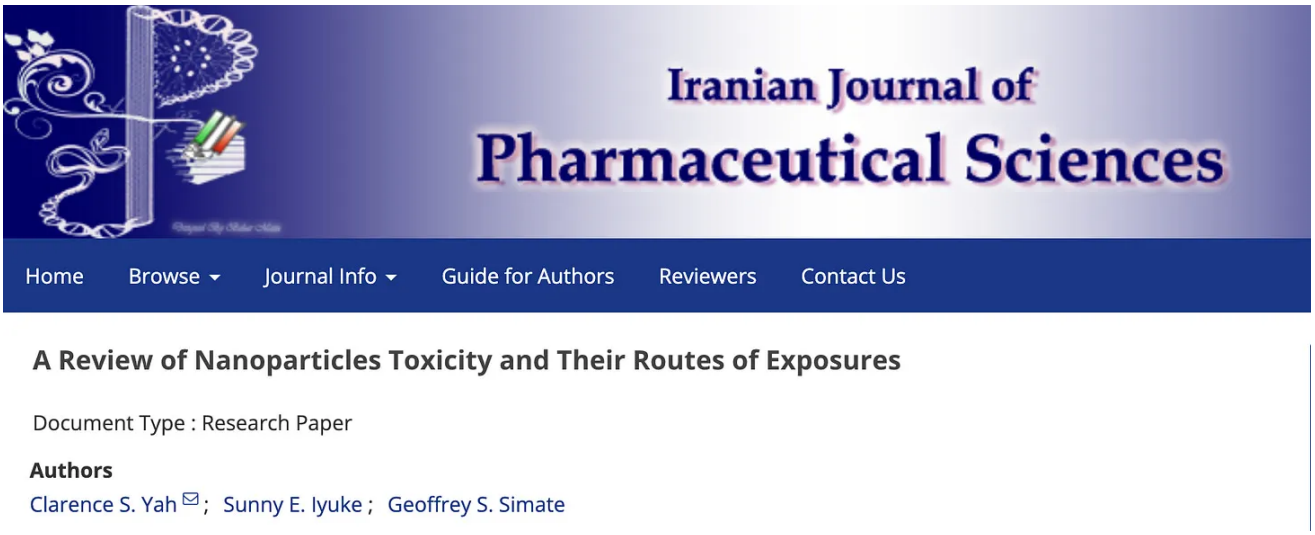
In that lecture, Burkhart showed slides of properly stained tissues demonstrating not only widespread dissemination of the spike protein, but also widespread spike-induced damage to tissues and vessels (i.e. vessel walls, heart muscle, brain tissue, kidneys etc).

More recently, another group of publicly vocal Covid "dissident" scientists including Peter McCullough, Harvey Risch, Mark Trozzi, and others performed a systematic review of autopsies where the spike protein was stained for. The spike was found to be the cause of death in 74% of cases. Unsurprisingly, the paper was nearly immediately retracted off of a… pre-print server. It just doesn't stop.

So, LNPs, naked mRNA, naked spike and spike containing exosomes are disseminated in the bloodstream and to tissues as long as 187 days from vaccination (know this is not a limit, it is just the longest they followed the patient for). The dissemination of spike protein can cause immense organ damage leading to death.

Now, are the vaccine product containing exosomes/LNP's capable of being transmitted ("shed") and then absorbed by the

bodies of unvaccinated individuals in contact with freshly vaccinated individuals? [In this paper they state:]



> *... "these ultrafine particles are capable of entering the body through skin pores, debilitated tissues, injection, olfactory, respiratory and intestinal tracts. These uptake routes of NPs may be intentional or unintentional. Their entry may lead to various diversified adverse biological effects. Until a clearer picture emerges, the limited data available suggest that* ***caution must be exercised when potential exposures to NPs are encountered.***
>
> ***These nanosized particles are likely to increase unnecessary infinite toxicological effects on animals and environment; although their toxicological effects associated with human exposure are still unknown.***

Again, based on the above, it is apparent that we humans are again proliferating novel technologies without fully understanding their risks.

There is a large and growing body of research in the development of a rapidly increasing amount of "LNP nanoparticle therapeutics" (i.e. using LNP's to deliver drugs and/or corrective genes). Reviewing these studies, it becomes quickly apparent that the LNP's can be delivered into the body via numerous routes and successfully impact biologic activity (i.e. they have confirmed the successful impact on biologic activity by measuring production of the desired gene product and/or the therapeutic effect of the drug cargo or the achievement of an immune response in nanoparticle vaccine experiments).

Currently, therapeutic nanoparticles have been successfully administered transcutaneously (here, here, and here), transdermally, transfollicularly, intranasally, via inhalation and then excreted via urine, feces, saliva, breast milk, exhaled breath, and sweat. About that last one, Banoun points out:

> *What is unfortunate about that is an increase in sweating after the COVID vaccine has been noted [33] and people who have received the vaccine have complained of increased sweating, particularly at night [34].*

In regards to nasal absorption, a close colleague of mine who is a clinical expert in exosome therapy, reported a case of rapid return of smell after intranasal administration of cord blood derived stem cell secreted exosomes.

In my original draft of this post, I explored the studies behind each of the transmission routes above in a too-long yet detailed manner, I subsequently decided to focus almost solely on the science behind respiratory (inhalational) transmission of LNP's. Why did I do that?

Two reasons; the first is that although LNP's/exosomes can be absorbed by all of the above routes, in each study or example, the researchers were treating with therapeutic doses and/or using designed applicators (concentrated fluids, creams, or nebulizers containing the LNP's).

Thus I used to think it was doubtful that in routine, daily, social life, sufficient body fluids could be exchanged between the vaccinated and unvaccinated outside of sexual intercourse, kissing (saliva), or accumulated exhaled breath vapor in close proximity.

Although no study on sexual transmission/shedding exists, in Part 7 of this series, I provide two examples of typical vaccine adverse effects which developed after one form of sexual

intercourse. Although I placed Part 7 behind a paywall due to their sensitive nature, in Parts 6 and 8, I present over two dozen clinical descriptions of shedding events from both our practice and from people who have written to me or posted in the comments section. Two of them describe symptoms and/or focal bruising developing in an extremity placed in proximity to a vaccinated persons extremity for a prolonged period. So, ultimately, I don't know if their are limits to transmission.

Thus it is my opinion that based on our clinical observations and treatment of shedding "injuries" that the lungs would be the ***primary (but not only) route of transmission*** (i.e. the inhalation of exhaled breath from a vaccinated person which contains free spike/free mRNA, and/or natural or synthetic LNP/exosomes containing spike or mRNA).

(*Here I will break to make an appeal for paid subscribers to support my time and work, thanks for considering).

ABSORPTION VIA INHALATION

The findings in this paper from 2005 are terrifying in my view:

> *When inhaled, specific sizes of NSPs (nano-sized particles, i.e. LNP's/exosomes) are efficiently deposited by diffusional mechanisms in all regions of the respiratory tract. The small size facilitates uptake into cells and transcytose across epithelial and endothelial cells into the blood and lymph circulation to reach potentially sensitive target sites such as bone marrow, lymph nodes, spleen, and heart.*

This randomized, double-blind controlled trial in *The Lancet* found that in humans, liposomal DNA gene therapy loaded nanoparticles administered locally by nebulization transfected airway cells. This was validated by the fact the cystic fibrosis patients treated in this manner experienced a stabilization of lung function, while the placebo group experienced a decline.

So this study found that DNA encased in the LNP integrated and became active in the recipient. Again, the LNPs were nebulized using a therapeutically sufficient dose which may not mimic real world risks. However it certainly does not exclude the possibility.

Clinical trials for influenza prevention have shown the efficacy and safety of inhaled mRNA vaccines:

The paper above reported that bare mRNA or mRNA enveloped in lipid particles (especially PEG-based as in the anti-COVID mRNA vaccines), are able to be inhaled in an aerosol and transfect lung epithelial cells.

Finally, extracellular vesicles by inhalation (ongoing trial against Alzheimer's disease) is being studied.

Finally, from Banoun:

> *Nebulization of exosomes for inhalation therapy has been tested against COVID-19. Clinical trials are underway to deliver aerosolized anti-viral therapies in EVs in COVID-19. Currently, over sixty clinical trials are underway to study the effects of MSCs (mesenchymal stem cells) and EVs (containing these MSCs) in COVID-19 patients. A phase 1 clinical trial to evaluate the safety*

> *and efficacy of inhaled exosomes derived from MSCs for the treatment of COVID-19 pneumonia has been completed.*

At this point of my deep dive into shedding, I find the above propositions insane - unless in a hermetically sealed room or waring a P100 respirator (does that even filter out nanoparticles?), anyone administering the aerosolized nanoparticle vaccine or in proximity will unwittingly receive the "vaccine."

Also this study reported 3 clinical trials that used aerosol as the route of administration. In 2022, this study showed that exosomes were effective via nebulization therapy in COVID-19 patients:

Similarly, in our private practice specializing on both Long Covid and the treatment of Covid mRNA vaccine injury syndromes (Long Vax), my partner Scott Marsland and I have treated a select cohort of (generally refractory) patients with stem

cell derived exosomes delivered via nebulizer, intranasal spray, and intravenously. Since we used multiple routes simultaneously, we cannot clinically differentiate which routes had the most impact.

It is important to note that the Covid mRNA vaccines were injected and not inhaled. This presents a higher risk of mRNA and/or DNA to be transmitted given the amounts of mRNA that were injected. From **Banoun:**

> "Huge amounts of mRNA are injected compared to the circulation of a virus during a natural infection: up to 7 to 10 times more, according to Professor Jean-Michel Claverie [27].").

This is likely not a good time to remind us of the DNA plasmids contaminating the vials.

Links to all the other already active posts in this series is after the subscribe button below.

P.S. I just want to say thanks to all my subscribers, especially the paid ones! Your financial support is greatly appreciated as it allows me to devote what is often large amount of time I spend researching and writing my posts, so again, thanks. - Pierre

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“Shedding” Part 1- Shedding of Covid mRNA Vaccine Components and Products From The Vaccinated to the Unvaccinated - Part 1

“Shedding” Part 2 - The Bio-Distribution and Excretion Potential of Covid mRNA Vaccine Products

“Shedding” Part 3 - Can You Absorb Lipid Nanoparticles From Being Exposed To a Vaccinated Person?

“Shedding” Part 4 - Evidence of Placental and Breast Milk Transmission of Covid mRNA Vaccine Components

"Shedding" Part 5 - Evidence of Shedding Causing Illness In Others

“Shedding Part 6- Clinical Case Notes Describing Shedding Phenomena Among Leading Edge Clinic Patients

“Shedding” Part 7 - Shedding Via Sexual Intercourse - Clinical Reports

“Shedding” Part 8 - A Deluge of Clinical Reports Pour In

“Shedding” Part 9 - More and More Clinical Case Descriptions of Shedding Pour In

P.P.S - Proud to report that my book is gaining Best Seller status on Amazon in several countries and is climbing up the U.S Amazon rankings… Link:

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WITH **JENNA MCCARTHY**

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Lidia Nov 4

Dr Kory, thank you so much for tackling this issue! I was waiting for someone to finally address this. When vaccine mandates camein May of 2021 to colleges in US - I was working in one as a molecular lab manager. Im molecular biologist and worked in that field for over 30 years. At that time - summer of 2021, I worked with numerous students daily in the lab setting, in close proximity to 5-10 freshly vaccinated students at any time. M-F 9-5. I refused to be vaccinated. In a matter of days since the vaccine mandates rolled out I started to feel sick. Migraine, low grade fever, dizziness. After two weeks my body began to hurt. After a month I was literally incapacitated, couldn't raise my arms to comb my hair or brush my teeth. Joints im my upper body were on fire. Intense, burning, throbbing pain, constant. Went to ER and was promptly diagnosed with polymyalgia rheumatica (PR). I knew at that point that it was vaccine shedding. I observed that after a day

of close contact with several young healthy adults who just got vaccinated a few days prior- my symptoms were most severe. Pain was subsiding on weekends. I asked students about dates of their vaccination. They got it anywhere from 3days to a few weeks before and vast majority was Pfizer. I was myself faced with decision to get vaccinated or lose my job. I chose the latter, I retired early. My health was my priority. I went to rheumatologist who promptly put me on massive doses of prednisone. I ask him how many new cases of PR he usually gets per year. Answer - maybe 2. How many since vaccines rollout, half a year ago? 24!!! I said- you realize that I'm vaccine injured? He asked me to find another doctor.

I took a test offered by dr Bruce Patterson for long covid. My score was 10.5 which is very high. Except I had covid a year and half prior and recovered within two weeks.

I went to my FP and asked for some blood tests. My inflammation markers CRP and ESR were very high. I took a d-dimer test and it was "borderline ".

My FP told me to accept the fact that I'm getting older and need to stay on prednisone for the rest of my life. I am a very healthy, active, now 66 years old, no medical conditions, no medications.

There is so much more to this story, I'm trying to be brief. As a scientist I found myself observing my symptoms carefully and decided to stay away from mainstream medicine. Now I'm almost completely recovered- combination of supplements, PEMF therapy, acupuncture, therapeutic massages. I took ivermectin,

NAC, nattokinase, etc. I will be happy to share more information with anyone interested.

God bless you Dr Kory for addressing this! I knew I wasn't crazy but your articles are so reassuring for me.

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1 reply

The BarefootHealer Nov 3

Re the 187 days, there are 2x preprints, the most recent was this year-2023. Both showed persistent spike presence long past 187 days. The most recent being 28 months.😐😐🤐

sigh my personal assumption is that they wanted a sure fire "airborne" vector. But current technology only allowed it to reach target respiratory transfection AFTER inoculation saturation point had been reached. Essentially though, I feel they underestimated nature's adherence to balance and preservation of equilibrium. BTJMO😉🤷‍♀️

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2 replies by Pierre Kory, MD, MPA and others

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