

Coronavirus Pt. 6: The COVID Vaccines

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1 Online source.

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Part I

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VAERS data sets for COVID Vaccine Injuries can be found, downloaded and searched here.

VAERS report of injuries as of Feb. 4, 2021: **563 deaths – 12,697 injuries**

VAERS report of injuries, as of Feb. 18, 2021: **1095 deaths – 19,907 injuries**

In December 2020, the first vaccines for coronavirus disease were granted an EUA – Emergency Use Authorization – by the Food and Drug Administration (FDA) and recommended by the Advisory Committee on Immunization Practices (ACIP). Vaccine administration began immediately. Were you first in line? I hope you were not, and I hope no one you care about ran to get this injection either.

This is not “just another vaccine” and this is not “just like getting a flu shot.” The ingredients are experimental and the mRNA is coded to produce a protein that CAN modify your genes.

2 What We Know About the COVID Vaccines

According to the Coronavirus Vaccine Tracker, as of Dec. 26, 2020, 83 vaccines are in Phase 1, 2 or 3 human and animal clinical trials, with 18 approaching the final stages of testing. Never before have so many companies tested so many different vaccines at the same time, against a virus that has not been isolated. Of those in the trials, five vaccines are now early use, with three vaccines approved for clinical use Pfizer, Moderna and AstraZeneca. Here’s what we have been told, so far:

2.1 Pfizer/BioNTech (BNT162b2)

Pfizer's vaccine – given the tentative name Comirnaty – has been approved for persons 16 years of age and older. The mRNA vaccine consists of two doses (30mcg solution in 0.3cc) given intramuscularly 21 days apart. The vaccine must be stored at -94F (-70C). mRNA is an unstable molecule, which is why it needs to be wrapped in lipid nanoparticles for storage and transportation. But the lipid nanoparticle is exquisitely sensitive to temperature; hence the reason that the vaccine must be stored and transported at extraordinarily low temperatures.

The ingredients found in Pfizer's vaccine include the following: (CDC, slide 20)

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- nucleoside-modified mRNA encoding the viral spike (S) glycoprotein of SARS-CoV-2
- Lipid: (4-hydroxybutyl) azanediyl)bis(hexane-6,1-diyl)bis(2-hexyldecanoate)
- Lipid: 1,2-Distearoyl-sn-glycero-3-phosphocholine. [DSPC]
- Lipid: 2-[(polyethylene glycol)-2000]-N,N-ditetra-decylacetamide
- Lipid: cholesterol
- potassium chloride
- potassium dihydrogen phosphate
- sodium chloride
- disodium hydrogen phosphate dihydrate
- sucrose

Note that none of the ingredients are listed with milligrams dosage. Look at the first three excipients. *Not one of these has ever been used in a previously approved vaccine.* Have they been tested for synergistic toxicity? Has there been stability testing for the breakdown of each ingredient when warmed to room temperature? And what about all those allergic reactions being reported? Have ANY of these chemicals been tested for allergic responses, in humans or even in animals? Pfizer gives explicit instructions on how to mix and administer this injection. See the specific instructions [here](#).

While Pfizer and the FDA have no idea if this vaccine will prevent infection or even if the antibodies will persist long-term, Pfizer expects to manufacture over 1.3 billion doses worldwide by the end of 2021. For more on how this vaccine works, go [here](#).

2.2 Moderna (mRNA-1273)

Like Pfizer's vaccine, Moderna's vaccine also uses mRNA as its vehicle for inducing antibody responses to the spike protein. Approved for those 18 years of age and older, the vaccine is given in two doses, (100 mcg in 0.5 cc intramuscular injection) with the second dose given one month (28 days) later, or as close to the recommended interval as possible. This vaccine can be stored for up to six months at -4F (-20C) temperatures.

The ingredients in the Moderna vaccine have now been listed on the Moderna Fact Sheet for providers: Moderna COVID-19 Vaccine is a white to off-white suspension for intramuscular injection to be injected 28 days apart. Each 0.5 mL dose of Moderna COVID-19 Vaccine contains: (CDC, slide 20)

- Messenger RNA (mRNA) encoding the pre-fusion stabilized Spike glycoprotein (S) of SARS-CoV-2 virus, 100 mcg
 - IMPORTANT: The Moderna patent states that another mRNA may be present that encodes for the protein, flagellin, an unapproved vaccine adjuvant used to stimulate the pro-inflammatory Toll-like receptor 5 (TLR5)
- Lipid: (4-hydroxybutyl) azanediylbis(hexane-6,1-diyl)bis(2-hexyldecanoate)
- Lipid: 1,2-Distearoyl-sn-glycero-3-phosphocholine. [DSPC]
- Lipid: 2-[(polyethylene glycol)-2000]-N,N-ditetra-decylacetamide
- Lipid: cholesterol
- tromethamine, 31 mg – this is a prescription medication used to treat metabolic acidosis
- tromethamine hydrochloride, 18 mg
- acetic acid, 0.42 mg
- sodium acetate, 0.12 mg
- sucrose, 43.5 mg

Are you willing to be injected with something unknown and never tested before in humans? For more on how this vaccine works, go here.

Buried deep inside the Moderna patent is a section that has been ignored by the media and is not mentioned on the Moderna provider fact sheet. The mRNA in the Moderna vaccine has been coded to transcribe a protein, flagellin, that is used to enhance the cytokine response of the macrophages.

Either of the currently authorized mRNA COVID-19 vaccines can be used when indicated; ACIP does not state a product preference. However, these two vaccines are not interchangeable and both doses of the series should be completed with the same product. However, if two doses of different mRNA COVID-19 vaccine products are inadvertently administered, no worries! Additional doses of either product are not recommended.

Remember that both vaccines are completely protected from all liability by the 2005 PREP Act. So, if the nurse gives you the wrong shot, and you have a serious reaction, even death, there will be no repercussions for the nurse and no compensation for you.

2.3 One more candidate: AstraZeneca (AZD1222) (ChAdOx1 nCoV-19)

AstraZeneca's AZD1222 coronavirus vaccine candidate, formerly known as ChAdOx1 nCoV-19, is made from a weakened version of a common cold virus, hence its original name. While it can cause infection in chimpanzees, the virus was genetically changed so it cannot reproduce/ replicate in humans.

The manufacturer released only a cursory list of ingredients, without including the microgram or milligram amount of each chemical. One 0.5cc injecting includes:

- COVID-19 Vaccine (ChAdOx1-S* recombinant) 5×10^{10} viral particles (vp)
 - *This product contains genetically modified organisms (GMOs)
- Recombinant, replication-deficient chimpanzee adenovirus vector encoding the SARS CoV 2 Spike (S) glycoprotein
- Genetically modified human embryonic kidney (HEK) 293 cell
- List of excipients – unknown amounts:
- L-Histidine
- L-Histidine hydrochloride monohydrate
- Magnesium chloride hexahydrate
- Polysorbate 80
- Ethanol
- Sucrose
- Sodium chloride
- Disodium edetate dihydrate
- Water for injections

This vaccine candidate is of interest because the clinical studies, done in collaboration with the University of Oxford, were widely publicized as the first and most promising vaccine. However, in May 2020, it was reported that all the vaccinated monkeys treated with the Oxford vaccine became infected when challenged. Then, why did the company press forward with the renamed, AZD1222

vaccine candidate? Because even though the vaccine did not protect the animals from infection, it did moderate the disease. Watch for this type of logic as the 80+ COVID vaccines try to make their way into the multi-trillion-dollar vaccine market.

But not to let all that research and money go to waste, researchers now believe the shot will be effective against a new viral variant emerging in Britain. To find out more about how this vaccine works, to here.

For details on all of the current vaccines clinical trials, go to the Coronavirus Vaccine Tracker found here (subscription required to NYTimesOnline to view)

Part II

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3 Vaccine-induced Spike Antibodies: Havoc on the Lungs

When the coronavirus vaccine is injected, the mRNA contains “instructions” for building the spike protein that has been identified on the surface of the SARS-CoV2 virus. The cell’s reverse transcriptase enzymes are called into action, leading to the mass production of the spike (S) protein, the protein thought to play a vital role in its infectivity.

However, is this a good thing?

The 2019 study by Liu, Li et al, *“Anti-spike IgG antibody causes severe acute lung injury by skewing macrophage responses during acute SARS-CoV infection”* is worthy of your time to read and study.

The investigation was undertaken to study the effect vaccine-induced, spike-protein antibodies have on preventing SARS-CoV infections and to examine the possible effect the spike-protein antibodies have on the immune system.

What the researchers discovered was startling.

Sixteen macaque monkeys were given two injections; half of the animals received a modified vaccinia virus with an inserted spike protein (ADS-MVA) or a control vaccine made with a modified vaccinia virus without the spike protein antigen (ADC-MVA). Three healthy, non-vaccinated monkeys were included as additional controls.

The animals were sacrificed between weeks 9 and 21, after receiving the second injection; the vaccine containing the spike protein induced very high antibody responses to the spike protein (anti-S-IgG). Although the antibodies had reduced the viral load in the upper respiratory tract, they caused a serious, antibody-enhanced injury in the lungs. In fact, there was a direct and positive correlation between

the level of antibody in serum and the degree of lung injury. The tissues had evidence of diffuse alveolar damage (DAD), with various degrees of exudate (pus-like fluid) and hemorrhage (bleeding).

Even more, the lungs were large filled with large quantities of macrophages (pus) that had been weakened and inactivated.

MACROPHAGES ARE A TYPE OF WHITE BLOOD CELL THAT ENGULF, DIGEST AND ELIMINATE MICROBES AND FOREIGN PROTEINS THROUGH A PROCESS CALLED PHAGOCYTOSIS. THERE ARE TWO PRIMARY TYPES OF MACROPHAGES. THE M1 CELLS KILL PATHOGENS BY SECRETING PRO-INFLAMMATORY MEDIATORS AND THE M2 CELLS, WHICH HAVE AN ANTI-INFLAMMATORY FUNCTION AND REGULATE WOUND HEALING. ANTIBODIES FORMED AGAINST THE SARS-CoV SPIKE PROTEIN BINDS TO THE SURFACE OF M2 MACROPHAGES AND WEAKEN THEIR FUNCTION, ALLOWING THE M1 MACROPHAGES TO RELEASE UNCHECKED QUANTITIES CYTOKINES. INSTEAD OF HEALING AND REPAIRING THE INFECTED LUNG TISSUES, THE ANTI-S-IgG ANTIBODIES STIFLE THE M2 CELLS AND PROMOTE M1-CAUSED INFLAMMATION. THE RESULTS ARE A DISASTER.

3.1 A Summary of The Study's Findings:

- We present evidence of a detrimental role of the anti-S-IgG (anti-spike protein antibody) and acute lung injury during a SARS-CoV infection.
 - Vaccine-induced, spike-specific antibodies resulted in severe acute lung injury in SARS-CoV infected Chinese macaques
- Anti-S-IgG antibody failed to prevent SARS-CoV lower respiratory tract infection (pneumonia) and amplify (increase) M1 macrophage infiltration and accumulation in the lungs.
- Anti-S-IgG causes severe acute lung injury (ALI) when the lungs become re-infected and/or re-exposed to coronaviruses by removing the inflammation-resolving work of the M2 macrophages.
- Animals who died of SARS-CoV infection had an accumulation of pro-inflammatory M1 macrophages and an absence of wound-healing M2 macrophages in their lungs.
- Histological examination [the lung tissue of the sacrificed animals] in 6 of the vaccinated macaques revealed acute diffuse alveolar damage (DAD) with various degrees of severity. Most of the macaques in the control group given the non-spike protein vaccine showed only minor to moderate lung inflammation. (Note: alveoli are the tiny air sacs in the lungs that oxygenate the blood.)
- Without the presence of the anti-S-IgG antibodies, M2 macrophages began healing the lungs within two days of infection.

4 Evidence Ignored

The above study was very recent (2019) but is it one of MANY dating back to 2002 documenting how damaging the COVID vaccine(s) are going to be once a person is vaccinated and then is re-exposed to circulating coronaviruses.

But that's not the only problem caused by the COVID-19 vaccines.

Most garden-variety respiratory viruses cause infection by binding to specific receptors on the surface of the host's cells. To block this attachment, antibodies formed from previous infections or by vaccines bind the circulating virus and neutralize it. This stops, or at least weakens, the progression to a full-blown infection.

However, in some viruses, the antibodies formed against them bind only loosely to the viral surface proteins. Instead of stopping an infection, this mechanism promotes invasion into the cell, enhancing the infection instead of stopping it.

4.1 Antibodies: Neutralizing vs Non-Neutralizing

A neutralizing antibody is shaped like the letter Y. The upper arms are called the Fab fragments and the stem is called the Fc fragment. The Fab fragments bind to an invading pathogen. The Fc fragment then binds to an Fc receptor on the surface of white blood cells, such as macrophages, lymphocytes, natural killer (NK) cells and others. Normally, this signals the white blood to release tiny bits of inflammatory chemicals to destroy the microbes

However, when the spike protein antibody (anti-S-IgG) engages with the Fc receptor on the surface of the cytomembrane, the "door opens" and allows the complex to enter host cells. And, if the Fab fragments of the antibody are only weakly bound to the surface of the pathogenic protein, the antibody acts like a Trojan horse. The loosely bound protein material "escapes" from the end of the Fab fragments, it hijacks that reverse transcriptase enzyme system and begins to replicate, enhancing the infection rather than stopping it.

This is the process of how antibody derived enhancement, or ADE, works. It's like having an "on button" on a replicator but no "off button." As the mRNA replicates, more and more non-neutralizing antibody is produced, leading to accelerated autoimmune diseases, primarily affecting the lungs, liver and kidneys. ADE may even play a role in the development of fulminant ARDS (Acute Respiratory Distress Syndrome) after patients have recovered from COVID.

ADE has been identified in more than 40 kinds of viruses including HIV, Dengue, West Nile and coronaviruses. There are seven or the 36 circulating coronavirus strains (LINK) are known to infect humans.

5 Every Animal Tested

In a 2012 study of mice, ferrets, hamsters, and Cynomolgus monkeys, using various coronavirus proteins and various adjuvants, researchers reported immunopathology in every animal that had been vaccinated and then re-exposed to a SARS-CoV virus.

Researchers clearly stated the following:

This combined experience provides concern for trials with SARS-CoV vaccines in humans. Clinical trials with SARS coronavirus vaccines have been conducted and reported to induce antibody responses and to be “safe.” However, the evidence for safety is for a short period of observation. The concern arising from the present report is for an immunopathologic reaction occurring among vaccinated individuals on (re)exposure to infectious SARS-CoV, the basis for developing a vaccine for SARS.

Researchers concluded the following:

The SARS-CoV vaccines all induced antibody protection against infection with SARS-CoV. However, [viral] challenge of the mice given any of the vaccines led to the occurrence of Th2-type immunopathology suggesting hypersensitivity to SARS-CoV components. Caution in proceeding to application of a SARS-CoV vaccines in humans is indicated.

6 Unanswered questions

We know so little about the COVID vaccines.

- Does the vaccine prevent the infection or only lessen a patient’s symptoms?
- Does it keep them from spreading the virus? If so, why do we still need to distance and wear a mask?
- How long will the antibody last? In otherwords, how long to we have to worry about viral re-exposure?
- What if you already have a co-morbidity such as an autoimmune disease?
- How well does it protect the elderly, many of whom have received a flu vaccine?

We are only a few weeks into this mass global vaccination campaign, and thousands of side effects are already being reported.

With all the evidence being ignored, is avoiding an infection with a 99% survival rate, worth the risk of the vaccine?

My vote will be unequivocally no.

1-5-2021: UPDATE: In less than 1 month and with 1M doses delivered, the latest data from the Department of Health and Human Services (HHS) shows there have now been 40,433 adverse events REPORTED from the Covid19 vaccinations in the USA. . . .AND THERE MAY BE THOUSANDS MORE UNREPORTED

Look at the list of side effects: [HERE](#)