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Does The COVID Vaccine Cause Long Term Medical Issues?

The COVID vaccines have been administered to millions of humans. Data overwhelmingly shows that it saves lives - especially of the elderly and very young. It is not a perfect vaccine, and individuals still can catch the SARS2 coronavirus and exhibit symptoms of COVID but usually do not require hospitalization or die. In many individuals, their injection site may get warm, red or tender and in others they get a mild flu-like syndrome responsive to Tylenol. A small percentage of young men have developed inflammation of the heart muscle or pericardium the sack around the heart. This inflammatory response is treated with non-steroidal anti-inflammatory drugs and subsides in a few days.

It is important to note that the actual COVID infection causes more pericarditis and myocarditis in patients than the vaccine does, and it is more severe. Yes, there are even a few cases of the neurological disorder myasthenia gravis which is also treatable. The overwhelming data shows the benefit of taking the vaccine outweighs the risks of adverse reactions.

Despite these facts, the new Cabinet level Secretary of the Health and Human Services Department, Robert F Kennedy Jr, and the Governor of Florida Ron DeSantis plus his Surgeon General have all said that the vaccine is harmful and we should avoid taking it.

Akiko Iwasaki, PhD, an immunobiologist at Yale University, with great international respect and credentials, has decided to clinically and scientifically investigate this issue. She is in the preliminary stages of evaluating 42 individuals who believe they have Post COVID Vaccination Syndrome. Their symptoms mimic the symptoms of individuals who have the after COVID infection Long COVID Syndrome. They complain of fatigue, inability to exercise, brain fog, dizziness and ringing in the ears. If you analyze their blood, you find prolonged presence of the coronavirus spike protein and different proportions of body defense system cells. These patients tend to have reactivation of the previously dormant Epstein Barr Virus which is associated with mononucleosis and chronic fatigue syndrome.

Similar age healthy patients do not have these changes in their blood. It is noteworthy that the symptomatic patients were all far less healthy at the start of the COVID pandemic than the controls. The overlap of symptoms and clinical and lab findings in the 42 post-vaccination syndrome patients and long COVID patients is eerily striking.

At this point, Dr. Iwasaki is expanding the investigation to large groups of patients. Her current sample size is just too small by her own team's admission. The only conclusion they have reached is that the 42 sick individuals all have changes in their blood. They do not know if these changes are due to a previous pre-COVID infection with SARS2 or to one of the many coronaviruses we all catch during our life and present as a nagging cold? She does not know if there is something in the vaccine which causes this syndrome?

What is known is that with her credentials and experience, the investigation will be thorough, professional and critiqued by experienced and accepted experts who will give us the answers we are searching for rather than fighting over it on social media.

Tylenol, Ulcers and GI Bleeding

Acetaminophen is the generic chemical name of Tylenol. For decades physicians have been told it is safer and with little risk of GI bleeding and/or ulcers than Aspirin, Ibuprofen, naproxen and diclofenac non-steroidal anti-inflammatory drugs. In addition to being kinder to the stomach and having a low risk of contributing to gastric ulcers, it is supposed to have a low risk of causing bleeding spontaneously in the skull and brain and systemically. Doctors and patients recognize that it is very good in lowering an elevated temperature but really provides far less pain relief from headaches as well as aches and pains than the other products.

J. Kaut, PhD, MPH and associates at the University of Nottingham in England published an article in *Arthritis Care and Research* questioning the safety of acetaminophen. They used data from the British National Health Service Data Bank to examine acetaminophen usage and complications in 180,483 users and 402,478 non-users of acetaminophen after two prescriptions for acetaminophen were used. The patients were senior citizens with the mean age of 75-years-old. Sixty percent were women.

They found that the risk for peptic ulcers, bleeding from ulcers and any other type of GI bleeding was increased in the acetaminophen users the from 20-36% compared to the non-users. They also found increased rates of overall health problems including heart failure, chronic kidney disease and high blood pressure.

There is no free lunch. Every chemical put into our bodies for the right reason has the possibility of causing adverse events.

If the study was conducted on younger individuals would the same adverse events and risks of bleeding and ulceration be found? That type of study needs to be conducted needs to take a look at the pre acetaminophen health of the participants.

A mathematical technique known as propensity matching is supposed to level the playing field but the researchers admitted that the acetaminophen group “took opioids, NSAIDs, aspirin and other medications at a much higher rate than non-acetaminophen users. They were more likely to be overweight or obese and to be current or former smokers”

The conclusion is that acetaminophen is a weak pain reliever which in senior citizens can cause ulcers, GI bleeding and other health problems. It is sold without a prescription in the USA so senior citizens need to consider the implications fully.

Measles – Its Forgotten Deadly Sequela

We live in an era where political passions and social media influences have given rise to legions of individuals attacking public health measures and vaccinations as being the cause of illness rather than a scientific shield or miracle.

Claire Paosian Dunavan, MD is a professor of medicine and infectious diseases at the David Geffen School of Medicine at UCLA and former president of the American Society of Tropical Medicine and Hygiene. She discussed our lack of familiarity with measles in an article in *MedPage Today*, an online publication. Her words were directed at vaccine hesitant parents and young modern physicians who have never seen a case of measles and tend to downplay its importance.

Measles is a highly contagious viral illness accompanied by high fevers, malaise, cough, runny nose, conjunctivitis and rash. Following exposure, 90% of unvaccinated individuals will develop measles. The disease had been eradicated in the Unites States through the childhood MMR vaccine, but unvaccinated children have led to a revival of infection. The incubation period is 6 - 21 days with a median of 13 days. It enters our body through respiratory cells or the eye conjunctivae, then replicates and spreads through the blood stream. Contagiousness

is estimated to begin five days before the appearance of the rash and last at least four days after the rash appears. Clinical improvement begins four to five days after the rash appears.

Complications occur in about 30% of infected individuals including pneumonia in one out of twenty children, encephalitis in one in 1,000 children and death in three per 1,000 infected children. The disease causes immune system amnesia so if you survived previous childhood diseases that normally convey lifetime immunity, those antibodies and protection disappear or are severely impaired. Diarrhea leading to malnutrition is becoming common. Blindness due to lack of Vitamin A is seen in poorer countries. Immune system amnesia is also causing increases of malaria, typhoid and other infections.

Dr. Dunaven introduced her colleague, Pam Nagami, MD who wrote a book about a student of hers who contracted subacute sclerosing panencephalitis (SSPE) 20-years after surviving measles. In these cases, the wild measles virus infects the brain and lays dormant for years to decades and then activates and eats away the brain resulting in visual abnormalities or loss, convulsions, myoclonic jerks, stuttering and speech impairment and cognitive decline. Over time, these patients become mute with spasticity, eventual coma and death. Dr. Nagami described performing spinal taps twice per week over a ten-month period to administer an antiviral medication into the spinal canal directly in an unsuccessful attempt to save the girl's life.

James Cherry, MD, MSc is a pediatric infectious disease expert who is awaiting the release of his ninth edition of his pediatric infectious disease textbook. He has spent decades caring for children injured by vaccine preventable infections. In a discussion on NBC News this year he talked about how this complication of measles is ten times more common than previously believed based on research he did in collaboration with the California Department of Public Health. This is not some complication seen only in poor Third World nations. His data is based on measles in California.

Much will be said in the next few months about mandatory vaccinations for infants, school age children and young adults in colleges and universities. Unless you have seen these diseases, and cared for their complications, you have no basis to understand how big a threat anti-vaccine campaigns are to the health, safety, and quality of life of all of us.

Regular Dental Tooth Flossing Tied to Lower Stroke Risk

Physicians, dentists, and hygienists are always trying to convince our patients that preventing tooth and gum disease, with regular oral hygiene, reduces the risk of serious health issues. Souvik Sen, MD, chairperson of the Department of Neurology at the University of South Carolina School of Medicine, studied the effects of flossing on strokes. Previous research has suggested that flossing and gum health reduces your risk of myocardial infarction (heart attack).

Flossing involves using a string between the teeth and to the level of the gums to remove retained food particles which are not removed even with thorough tooth brushing. By removing the food particles, you are reducing inflammation which is believed to be the catalyst for atrial fibrillation and then strokes and heart attacks.

Dr. Sen used data from the ARIC study, beginning in 1987, of 6,278 enrollers with no history of stroke or atrial fibrillation. If the participants flossed once a week, they were considered "flossers". If they saw the dentist once a year, they were considered current on regular dental care.

Of the study's participants, there were 4,092 (65%) "flossers" with an average age 62. The majority were women. There were twice as many African Americans in the non-flosser group as in the flosser group.

The participants were followed for 25 years with 434 strokes reported during that period. The study indicated that flossing reduced the number of ischemic strokes. Researchers believed flossing reduced inflammation, which reduced the development of atrial fibrillation and eventual strokes.

Dental flossing is an inexpensive method of reducing the number of ischemic strokes and heart attacks. The study highlights the need for improved education regarding oral hygiene both at the school level and community level.

Playing the Inpatient Versus Outpatient Observation Game

As a board-certified internist, with previous certification in Geriatric Medicine, I care for a great many adults with chronic illnesses, that have multiple physicians and are taking many prescribed medications (polypharmacy). Since I reside and practice in an affluent resort community, many of these senior patients have winter homes locally and summer homes with another set of physicians located north of the Mason-Dixon line.

Years ago, the Center for Medicare Services (CMS) altered its categories of hospital admissions to try and reduce the length of stay and costs. At the same time Congress authorized payment for private firms to review medical records and recover funds they felt were spent on unnecessary hospital length of stay. Observation status was created to accommodate patients who showed up at the emergency department ill, but no one was quite sure how ill, what the cause was and if you required a prolonged hospital stay or not. Observation status meant you were not admitted to the hospital even though you were receiving daily hospital care. The bills were paid through Medicare Part B with the patient responsible for 20% of the costs. In addition, the patient was not entitled to any post-hospital treatment or benefits. If they needed post stay physical, occupational or speech therapy it was an out-of-pocket non-reimbursable expense.

The result is that if a patient falls and fractures their pelvis and cannot stand or walk but does not require surgery, their post hospital physical and occupational therapy designed to get them up and walking will not be covered by Medicare. If the patient were admitted to the hospital with inpatient status and spent three days or two midnights in the hospital, the patient would be covered by Medicare Part A and the patient would be responsible for an annual deductible of $1,260 with the rest of the costs being covered. If the patient spent three days or two midnight in the hospital, they would be covered for post hospital care in a rehabilitation facility and therapy all covered in a rehab facility, in their home or in a rehab office setting.

The hospitals make more money by using the observation status. The patients and families are covered for more services with inpatient status.

The problem is most of the physicians in the hospital are now employees of the hospital. While legally it is the physician who must make the decision of inpatient versus outpatient status, it is really hospital administration through their non-medical case managers who make the decision. If the employed physician opposes the case manager's decision, they find themselves unemployed when contract renewal approaches. This control in billing is seen at hospitals which are part of for-profit health systems and in the previously more charitable nonprofit facilities. These same facilities have worked diligently over the last few years to discourage independent physicians from treating their patients in the hospital setting leaving that job to the more controllable employed physicians.

The system would be much more equitable if the hospital were required to be transparent by printing out and presenting to the patient and attending physician the costs to the patient, the facility and post hospital services available as an inpatient versus "outpatient observation" status prior to the patient being discharged.

We read about illness and health care costs being the leading cost of personal bankruptcies. This inpatient versus outpatient hospital stay status contributes to this situation.

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