The COVID Shot Was Three Vaccines, Not C & How We Can Heal From Them

Persistent mRNA, plasmid DNA in the nucleus, and shedding — why the spike p never stops, and what has actually worked for treating it

A MIDWESTERN DOCTOR

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Story at a Glance:

- **Throughout the development, production and distribution of the COVI vaccines, whenever a choice had to be made between safety and efficacy, won—a pattern which can be traced through the antigen chosen, the nanoparticles used to deliver it, the modifications made to the mRNA, a doses selected.**
- **Once the vaccines reached the public, a series of things happened which not supposed to be possible, the most significant being that the spike pr kept being produced for months or years after injection, and that unvac people around the vaccinated became ill in clear and reproducible patte**
- **For years I assumed this was simply the predictable result of a rushed ar profit-driven product. However, while researching the existing vaccine d learned that bringing foreign DNA into the nucleus of cells is already ar established vaccine technology—which not only offers a far more feasib explanation for the persistence, but suggests those designs were chosen what they would do.**
- **This matters because continual antigen production and spread through**

population are not accidents of these platforms. They are the longstandi of vaccination itself, and are now being made explicit by the next genera "replicon" vaccines which are designed to keep producing antigen long a injection.

- **Spike protein injuries have consequently become one of the most widesp and complex illnesses the population currently faces, yet there is almost mainstream research on them and no established protocols for treating which is why I am continually asked what can actually be done.**
- **This article is the result of a large project to answer that question. It cov treatments which have consistently worked, why the far greater number failures reveal so much about both the supplement industry and how ch illness is approached in general, and everything we now know about she**

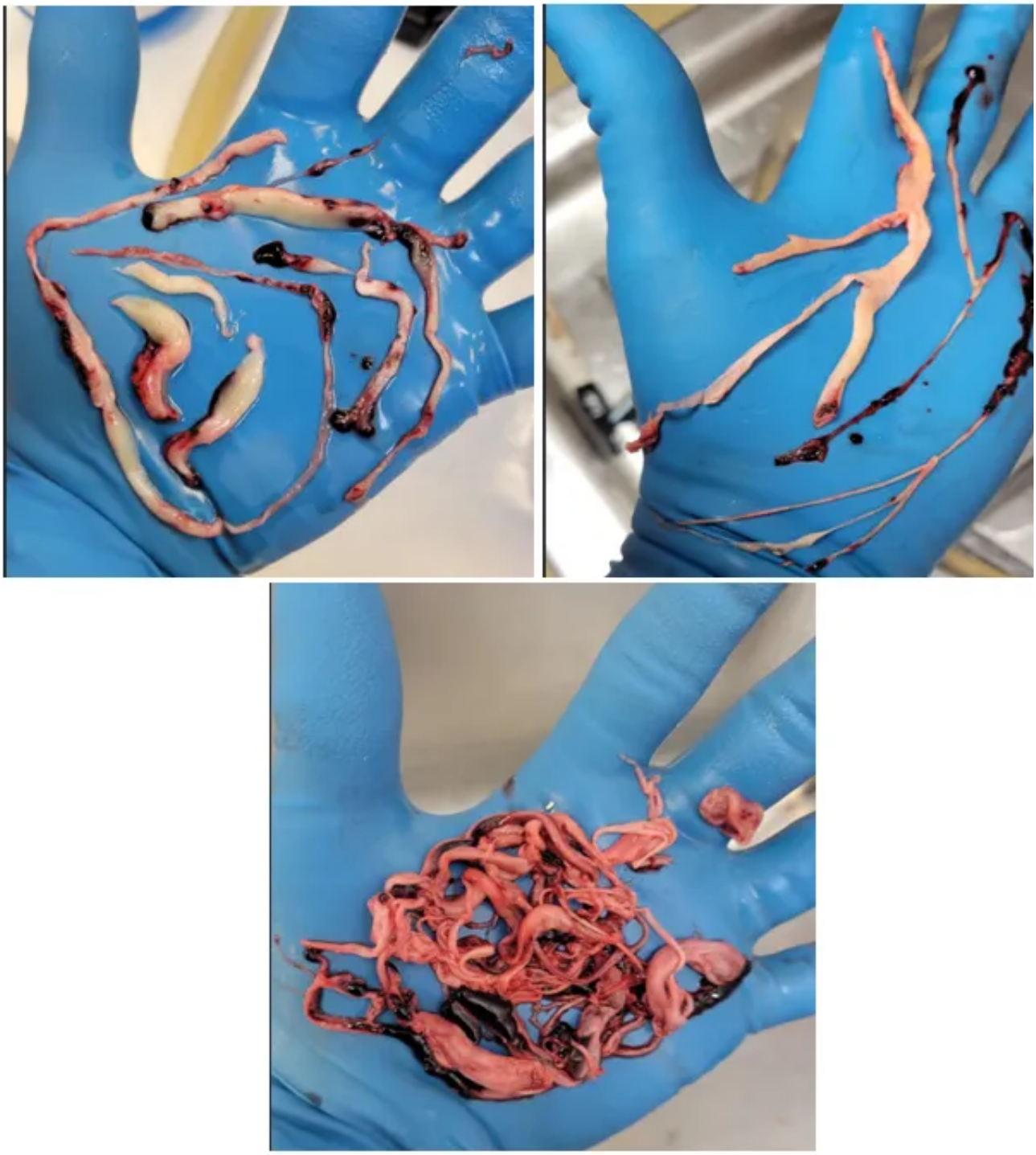
I have always been drawn to puzzles that contain large amounts of "unknown information" as this forces you to consider a wide range of possibilities, but simultaneously have the discernment to recognize which of those potential an the most probable and hence is less likely to backfire on you if you commit to

On one hand, many people have a total intolerance for anything uncertain or unsanctioned (which is why many medical professionals are unwilling to do ar slightly "unorthodox"—even if it is essentially a given that the existing conver options will lead to a bad outcome for their patient (e.g., death from an "incura illness). On the other end of the spectrum, many people will be too eager to co unsubstantiated answers, and in many cases (due to confirmation bias), collect of highly questionable evidence that supports their chosen possibility (which i case of the COVID vaccines, has resulted in numerous theories briefly going v which are completely at odds with reality—and often basic science).

This, in turn, has been the lens I've observed the COVID vaccines through, as

the mRNA gene therapies still being in the experimental stage when they were to the entire population, we saw a lot of very strange things occur which hence equally strange explanations for what was going on.

For example, since the vaccines came out, embalmers have been observing sci fiction-like massive rubbery clots coming out of the bodies of deceased indivi who had been vaccinated. A few citizen researchers, in turn, have been trying attention to this issue and have conducted numerous surveys of embalmers (w many professional organizations resisted) that were able to show those clots ir were being found, and recently were able to have the 2022-2025 results be pub a medical journal—where across 808 responses, 66% to 83% of embalmers repo finding these clots in roughly 19% to 27% of embalmed bodies.



These disconcerting findings in turn met a variety of expected responses rang
refusals to discuss the topic at all, to denials they existed (despite the extensiv
the citizen journalists did to reveal that they did) to a variety of shocking expla
being put forward to explain what they were (e.g., alien parasites or nanotechn

While I was trying to make sense of this topic, I came across a largely unnotic on COVID-19 that stated the spike protein causes fibrin (which the body uses long-lasting blood clots) to misfold. Since the body depends on a precise balar between enzymes creating and breaking down fibrin clots, if misfolded fibrin be formed, there was a high likelihood that the body's clot breaking enzymes v longer match it, and hence that the body would not be able to break these clot thereby allowing them to grow unchecked until they eventually became the m clots embalmers were finding, particularly since the study modeling this was a show (nowhere near as large) irregular fibrin clots formed by the spike protein were resistant to the enzymes the body used to break down clots—all of which detailed in this 2022 article. That model then became the accepted explanatio researchers were subsequently able to develop blood tests that showed the am (misfolded) fibrin clots were present in the bloodstream.

Malice or Malfeasance?

Whenever something bad happens on a large scale, a case can normally be ma was due to a deliberate desire to harm others, incompetence (and a tendency t double-down on one's mistakes), or simply a complete lack of concern for the cost of whatever they want to do. I tend to lean towards the latter explanation, strongest case frequently exists for it and it does not require ascribing (often u unknowable) motives to someone else.

As such, from early on with the COVID-19 vaccines, I formed the impression vaccine industry (and to some extent the US government) felt they needed to g vaccines to market as quickly as possible. For instance, leaders wanted a "wor vaccine to get to market as soon as possible (and ideally before the 2020 electi the economy could be opened up, Operation Warp Speed was effectively a win

take-all competition so whoever got the first vaccines to market would likely r
most of the money in it and there was a real likelihood the population would d
herd immunity to COVID-19 before the vaccines came out (negating the need
in the first place), which led not only to the vaccine being rushed along, but al
federal health leaders trying to stall the virus enough for the vaccines to still h
market (e.g., HHS insiders admitted many of the 2020 "containment" measure
done to isolate the population so herd immunity could be delayed,[1] and Scott
a recent FDA commissioner who became a Pfizer board member in 2019—adv
for lockdowns and publicly gave statements we were much further away from
immunity than what he privately told the CIA[1,2]). In contrast, African nations
did nothing for COVID-19 rapidly developed herd immunity to COVID and h
dramatically lower death rates than the Western Nations.
*Note: one of the most appalling aspects of this strategy was not only was herd immun
delayed to protect the vaccines, but the unnatural "immunity" the vaccines gave preve
population from being able to develop herd immunity to COVID-19, thereby turning
pandemic into a permanent seasonal infection. This was because the COVID vaccine
a very narrow immunity that locked the immune system onto the original strain (of a
mutating virus), thereby both provoking the rapid evolution of variants but also makir
locked onto the original virus less able to mount an immune response to the newer va
shown by both Cleveland Clinic Research[1] and countless Reddit reports of individuals
more likely to catch COVID the more shots they'd gotten[1] (and in many cases catch C
numerous times). While this was probably not intentional, it is notable that just two n
after the COVID vaccines hit the market, vaccine CEOs were already talking about th
COVID vaccine becoming an annual vaccination like the flu shot.[1,2,3,4,5]*

To expedite the vaccines, again and again, I identified how they appeared to h
the decision to cut as many corners as possible in each stage of its developmer
testing, production and distribution. As such, I long believed the fiasco we sav
simply due to a desire to make money and a complete lack of concern over the

consequences the actions taken would create. However, while researching the vaccine designs for a recent article, I came across a rather surprising piece of information that has changed my perspective on what actually happened with vaccines.

How Vaccines Work

When the body is exposed to a foreign invader, a series of defensive responses mounted. Some of these are relatively non-specific and hence can initiate imm while others are specific to the microbe and, though often more protective lat initially require time to become effective (as the tiny fraction of your randomly generated immune cells which match the invader must encounter them and th being activated, have time to reproduce enough that a sufficient amount of th are present to control the invader).

Note: life revolves around having DNA (or RNA equivalents in certain viruses) be tra by cellular enzymes into corresponding mRNA sequences, which is then transformed i corresponding protein sequences. Because of this, most organisms contain unique pro sequences that give them a "molecular fingerprint."

The theory of immunization, in turn, is that if you introduce the antigen (prot fingerprint) of the invader (without the invader also present), it becomes possi

the body to develop adaptive immunity to the antigen (and hence the pathoge
contains that antigen) without also having to survive a potentially dangerous i
As such, a variety of different antigens are routinely injected under the belief
will create immunity to disease—even though in reality this frequently does n
or creates a host of problems from unintended off-target "immunity." Howeve
the religious fervor around vaccinations, the medical field essentially believes
infallibility of this approach and continually tries to find every feasible way th
done.

As such, over the years, a variety of methods have been created to develop the
antigens.

Originally, the infectious microbe would either be cultured and then chemical
inactivated (e.g., killed), filtered or selectively bred (via repeated passages thro
cellular mediums) so that the microbe was made less dangerous (e.g., no longe
infectious) while still containing sufficient antigens to create an immune resp
(along with the microbe sometimes reproducing within the host and creating
more antigens to ensure the development of an immune response).

Later, once genetic engineering entered the picture, things would either be m
to produce the antigen so it could then be extracted (e.g., modified yeasts for M
HepB and HPV vaccines or moth cells for Novavax), or a virus would be modif
carry the antigen and then mass produced outside of the body so those antige
be delivered via the viruses (e.g., J&J or AstraZeneca's COVID vaccines).

Later still, genetic engineering made it possible to instead have the vaccine re
cells produce the antigen (thereby allowing a much lower initial dose of the va
be used). Many public health officials, in turn, pushed for this approach as it t
much less time to create the synthetic mRNA which did that than producing
traditional vaccine antigens, thereby making it possible to bring vaccines to m

a new infection much sooner (whereas with annual flu shots, they have to be p
before the flu season and frequently end up being for different strains than wh
circulating).

*Note: there are a variety of safety and efficacy issues with each of the vaccine designs
many of the "essential" ones on the market either provide almost no benefit or make t
infections worse) and when I went through all the standard ones, I could only identify
could make a good case provided a net benefit (along with a few non-standard ones li
after a bite). However, as mentioned before, due to the faith surrounding vaccines, ev
vaccine is assumed to be completely safe, effective and essential regardless of the actu
or logic underlying that assumption.*

Designing the mRNA Vaccines

The vision of mRNA vaccines that was sold to the public is:

- A carefully crafted sequence of mRNA is created and then manufactured a
- This mRNA is introduced into cells by injecting muscles with lipid nanop
containing the mRNA (which then travel into just the muscle tissue and th
in them).
- Once in the cells, mRNA is transformed by the cellular machinery within
cytoplasm into a foreign antigen which gradually travels out of the cell an
its surface, where the immune system can recognize the antigen and deve
immune response.
- Not long after, the immune system breaks the mRNA down and the entire
stops.

However, while that was the vision, it had major problems, and for decades att

find an acceptable balance between safety and efficacy failed (Dr. Malone, one pioneers, abandoned lipid-nanoparticle delivery in the 1990s after documentir profound toxicity[1]). This is best shown by Moderna, which raised billions from investors by selling the vision of life as software you could rewrite into health, could not deliver what was arguably the easiest mRNA therapy target on the n a rare disease needing a single missing liver enzyme — because no dose was b enough to be safe on repeat injection and high enough to work.[1,2] According t Moderna employees in 2017, this left vaccines as the only viable use of the tecl since a vaccine needs just one or two doses and the toxicity that made repeat c impossible never had a chance to accumulate.[1]

So, by the time COVID-19 arrived, both companies that would bring mRNA v to market were in trouble. Moderna had gone public in December 2018 in wha then the largest biotech IPO in history, raising $604 million at a $7.5 billion va —and then watched its stock fall more than 19% on its first day of trading.[1,2] I product, $60 million in revenue against $606 million in operating expenses, an accumulated deficit of $1.5 billion, and shrinking cash reserves, and it closed 2 $19.56 a share, below its $23 offering price.[1,2] BioNTech was in a similar posit had never taken a product past phase 2, its losses were widening, and its Octo IPO had to be cut from 13.2 million shares at $18–20 to 10 million at $15 befor could get done, closing its first day lower still.[1,2] One month before that IPO, t Melinda Gates Foundation had bought a $55 million equity stake in BioNTech to $100 million in total funding pledged), reportedly at around $18 a share, me the foundation was underwater the day the company listed.[1,2] In other words, two flagship companies entered 2020 needing exactly what a former Moderna employee had described three years earlier: a "miraculous, Hail Mary sort of s

Given this, I felt it was a given they would take advantage of everyone's desper get a viable vaccine to market by both cutting as many corners as possible and

leveraging the vast institutional support for the vaccine (e.g., liability protecti
oversight of clinical trials, and zealous media support for the vaccine—particu
since Bill Gates, a key investor in the technology, had also cultivated a vast spl
media influence through "donations" to many leading publications[1]). As such,
curious to see how they would solve the irreconcilable challenges with the mR
technology and hypothesized whenever a balance needed to be found between
and safety, efficacy would be chosen to expedite getting a COVID-19 antibody
producing agent to market (since the widespread faith in vaccines makes robu
antibody production one of the primary metrics regulators care about despite
having a poor correlation to clinical benefit).

What follows is an (incomplete) list of how that balance was struck:

1. **Choosing a toxic antigen:** The easiest target for a vaccine was the COVID-
protein since this was a novel part of the virus, needed for infection and highl
immunogenic, so both Pfizer and Moderna's vaccines were designed around c
cells to mass produce this protein (which was slightly modified so it could not
with cells and hence "safe" [1]) as this was by far the fastest way to reliably creat
antibody producing vaccine. However, there were a few problems with this ap

Chiefly, since the (**positively charged**) spike protein was inherently toxic in nu
ways (hence why it was so immunogenic), by mass producing it inside the bod
effect was created that was arguably worse than a COVID infection (particula
the individuals whose bodies could not clear the spike protein—which was sh
the distinguishing factor in a January 2023 study).

Furthermore, this design was predisposed to creating off target immunity. For
example, since the highly toxic antigen was expressed on the surface of cells, i
well-suited for provoking autoimmune responses—something made considera
more likely by the fact that the spike protein shares sequences with numerous

proteins.[1] A 2022 peer reviewed analysis identified a motif shared between the protein and thrombopoietin (where cross-reactive antibodies could produce th thrombocytopenia seen in these patients), along with another motif shared wi PRKG1, which is involved in platelet activation, and with tropomyosin, which to cardiac disease[1] (with the authors explicitly noting the implications of their for vaccine design).[1]

Note: beyond autoimmune disorders frequently being associated with the COVID vac pathologists who examined the bodies of individuals who died after vaccination foun inflammatory infiltration and immune destruction of normal tissue expressing spike p vaccine antigens (e.g., within the heart).[1,2]

Likewise, by forcing the body to lock onto a single antigen (the original COVI spike protein), pressure was made to rapidly mutate COVID to a different spik protein, thereby making immune systems locked onto the original strain less a respond to the new ones (which as said before is why I believe the vaccines pr us from developing herd immunity to COVID-19)—an issue sadly also seen wi other vaccines that use a small number of antigens.

Note: in 2022, I spoke to a few people who argued that China, knowing the US's appr vaccine development, may have designed COVID-19's spike protein so that the likely for it would be highly dangerous. While it's impossible to prove or disprove that hypot noteworthy that China's Sinovac instead used a traditional vaccine design (inactivati COVID-19 virus), was significantly safer than the mRNA designs and debatably offer comparable efficacy to the mRNA vaccines[1,2] (which rather than proving malice coul illustrate that the Chinese were intelligent enough not to pursue a bad vaccine strateg

2. **Choosing dangerous lipid nanoparticles**: as mentioned before, one of the unsolvable challenges in mRNA technology was making the lipid nanoparticle delivered them inside cells be both safe and effective (as since mRNA carries a

negative charge, a strongly positive lipid is needed to package it, but nothing i body is permanently **positively** charged, so those lipids damage whatever cell membranes they touch—and simultaneously, since most of the particles are di before they release anything, far more of them have to be injected than the bo tolerate). Curious how this would be solved, I read through regulatory docume leaked from the EMA (Europe's FDA) in December 2020, and noted that when nanoparticle design chosen (ALC-0159) was discussed, **only efficacy was highl as a rationale for it**—indicating, again, that since there were so few viable wa make these nanoparticles work, efficacy was prioritized over safety so the pro could be brought to market (while the only concern regulators raised was that metabolite was an acetamide and certain acetamides have been linked to liver this could potentially be an issue). As such, I felt it was likely these nanopartic would have toxicity and issues with spreading to unintended sites in the body was indeed what happened (e.g., confidential Pfizer documents were obtained a May 2021 Japanese FOIA showing the vaccine nanoparticles accumulated in ovaries).

Note: there are a few potential explanations for the significant clotting seen with CO and the vaccines (e.g., the previously mentioned amyloid clots or our observation the causes a high rate of the rare but severe autoimmune clotting disorder antiphospholip syndrome—likely due to it provoking the immune system into attacking the phospholi coating of spike protein expressing cells). However, my observation from the start of C is that the positive charges of both the spike protein and the lipid nanoparticles (whic more acutely) appear to be what is causing the rapid clotting (and microclotting) seen vaccines and why so much of my focus since 2020 has shifted towards restoring the pl zeta potential.

3. **Making mRNA resist degradation:** Since foreign mRNA was rapidly degrac cells, it was not possible to ensure enough would persist long enough to produ enough spike protein to generate the needed immune response. To address thi

than using uridine (one of the four building blocks of RNA), the synthetic mRI manufactured with a modified version of it, pseudouridine, as RNA containing pseudouridine both resists degradation and hides from the immune sensors th otherwise detect and destroy foreign RNA. In the body, this is a tightly regula process where specific enzymes modify specific sites on specific mRNAs, and day it is not understood well enough to predict what a given modification will Rather than attempt to replicate that, the manufacturers simply replaced ever in the sequence and did so with N1-methylpseudouridine, a synthetic molecul potent than the natural version which does not exist in the human body therel guaranteeing enough was done for the mRNA to persist long enough to work.

This however led to two major problems. First, since the process was overshot mRNA no longer merely lasted long enough to produce an immune response– persisted for months, continually producing spike protein the whole time. Thi first shown by a 2022 Stanford study that found vaccine mRNA and spike prot present in the lymph nodes of recipients 60 days after their second dose (the la point at which they looked),[1] and corroborated by a Massachusetts General Ho autopsy study that detected vaccine mRNA in the lymph nodes and heart mus patients who died within 30 days of vaccination,[1] another study which found r persisted in the blood of 37% of recipients for at least two weeks after vaccina along with being found in human blood, placenta and semen in many cases ov days since vaccination.[1,2] Second, the key reason pseudouridine allows the mR persist is that it hides it from the innate immune sensors (TLR7, TLR8, RIG-I PKR) which exist to detect foreign RNA and destroy it.[1,2] The long term conse of this immune suppression however were never tested, and hence may play a contributing role in the immune suppression and cancer being seen following vaccination.

Note: Codon optimization (which increases protein production from mRNA) may hav

caused the vaccine to excessively produce spike protein in the cells—once again illust that efficacy was chosen over safety.

4. **Excessive dosing:** with any substance, as greater amounts are taken, adverse reactions and severe ones become more common (to the point everything has a dose). For something to be viable as a medicine, the dose needed to create a therapeutic effect has to be below its toxic dose, and generally, the greater tha difference (the therapeutic window) is, the better the medication is (e.g., one o main reasons why I've been able to promote DMSO is because the therapeutic is so wide, most people who use it correctly have positive rather than negative whereas the narrower it is, the more high risk the medication is and the more its dosage has to be controlled (e.g., this is why chemo is frequently given at in centers). Further complicating this, the toxic dose (and effective dose) vary per person, so frequently, the medication's therapeutic window is narrow enough optimal dose exists for everyone, which results in the medical system throwing sensitive patients under the bus who can't tolerate the standardized doses the system revolves around.

With the mRNA technology, as mentioned above, a major problem was that th therapeutic window was too small for it to be a viable therapy (as doses high e work were also toxic), and while the therapeutic window widened when vaccin (rather than addressing a genetic defect) was the goal, the fundamental issue s remained that there did not appear to be an optimal way to dose the therapy. A was curious how this would be addressed, and immediately noticed Moderna u dose which was 3.3x greater than what even Pfizer would use (something I attr to Moderna at that point being desperate to bring a viable product to market). Remarkably, subsequent safety data showed Moderna's vaccine indeed had a h rate of side effects, but despite a dose toxicity relationship being demonstrate regulators never did anything to address it.

Producing the mRNA vaccines

One of the greatest challenges with bringing a pharmaceutical to market is sc
its production. So, as you might guess, a lot of corners were cut here as well to
to bring a viable product to market. These included:

1. **Vaccine mRNA rapidly degraded:** This was one of the primary regulatory c
with the vaccines (e.g., in the leaked EMA documents, numerous datasets wer
by regulators that showed the vaccine mRNA rapidly broke down into fragme
is, I believe, why when the vaccines were first launched, a huge deal was made
keeping them ultra-frozen until injection (e.g., Pfizer shipped at -90°C to -60°
Moderna shipped at -50°C to -15°C[1]). However, once the launch happened, th
gradually became forgotten (e.g., the vaccines were left out for long periods at
vaccination clinics and they switched to just refrigerating them).
*Note: when I initially learned about this, I was worried it would cause abnormal mR
fragments to form that could be a potential safety risk, but I now believe this actually
vaccine safer (as the more time they had to break down, the less active mRNA there w
to some extent, this was supported by an adverse event reporting analysis that found
lots distributed further away from Europe's manufacturing site (and hence having lon
break down) had a lower rate of adverse events, as did ones taken further away from t
manufacture.*

2. **Doctored Western Blots**: To assess if an intended protein is present, Weste
are one of the most commonly used tests, and in the pre-AI era, due to compu
generated ones being much less amorphous than natural ones, authors would
frequently get caught fabricating Western Blot tests (e.g., this caused billions
and years of Alzheimer's research to be wasted on the amyloid hypothesis and
only caught after the fact by an independent investigator who noticed the arti
blots). Given that it was a major question if the mRNA vaccines could actually

promised (especially given their tendency to rapidly break down) when we loo
it, we realized the blots needed to assess what was being produced were likely
fabricated.
*Note: while I assumed this was done to gloss over the fact the vaccines had poor quali
(with many not producing the promised product), from looking at all the available blo
another reliable researcher made the case they showed something else which was not
was in the vaccines too (and to this day, it has not been identified).*

3. **Vaccine contents varied lot by lot:** in addition to numerous VAERS analyse
published papers) showing the toxicity of COVID vaccine lots varied greatly, v
Ryan Cole examined the COVID vaccines under a microscope (as detailed on
Highwire), he found what was present in the vaccines varied greatly (and likew
Japan pulled 1.63M vials of Moderna's vaccine after visible metal particles wer
in them). Cole felt these observations indicated there were real quality control
with the vaccines, that properly mixing the vaccines was challenging and that
process for the vaccines was very poor (resulting in some individuals getting e
doses and others effectively getting saline shots—which mirrored our own
experiences). Remarkably, when the UK's MHRA was asked through a FOIA w
testing had been done to look for contaminants in the COVID vaccines, they c
that some vials had been sent for a visual inspection test, which consisted of r
them against two monochrome backgrounds to observe particulate matter visi
the naked eye, and explicitly stated the composition of the vaccine was not exa

Note: while Cole's explanation for this is the most probable explanation, it is also pos saline was given because not enough vaccine product was available to meet the comm orders.

4. **The production process was changed**. When the original COVID vaccines v made for the clinical trials, in Process 1, they were produced by:

•Starting with a circular plasmid that had the vaccine sequence on it.
•Using PCR to copy that sequence and turn it into linear DNA.
•Having T7 RNA polymerase make the vaccine mRNA from those linear
•DNA templates.
•Purifying the result so that, for the most part, what you had left was the mRN

The problem with this approach, however, was that it did not scale anywhere c the volume needed for the public roll-out. So when it came time to bring it to they cut corners and improvised a different way with Process 2:

•Starting with the same kind of circular plasmid and introducing them to E. c bacteria.
•Growing E. coli that now had that plasmid in them.
•Using an antibiotic to eliminate E. coli in the culture that did not have the pl

(as beyond producing a spike protein, the plasmid also contained a gene for ar
resistance).
•Once they had a pool of bacteria carrying the plasmid, they killed them and e
the plasmids which were then cut into linear DNA.
•Having T7 RNA polymerase make the vaccine mRNA from those linear DNA
templates.
•Purifying the result so that, for the most part, what you had left was the mRN

This shift, in turn, created a few key issues such as a different product being t
the clinical trials than what was given to the public. Of these, the greatest one
in Process 2, a different DNA plasmid was used, and that altered plasmid was
effectively purified from the final product. This, in turn, was discovered by Ke
McKernan, who having a background in genetic sequencing, decided to find o
was in the vaccines and discovered that not only was plasmid DNA present in
but they contained an undisclosed SV40 virus promoter sequence (which inclu
base pairs that were repeated). These results were eventually published in a 20
that also showed the rate of adverse reactions to the COVID vaccines had a co
to the presence of SV40 containing plasmids.

Note: McKernan's sequencing found fragments up to 3.5 kb in length[1] (which is many size of the SV40 promoter-enhancer region), and the same testing established that this sits inside the lipid nanoparticles, which shields it from the enzymes that would other break down loose DNA in the body.[1] Furthermore, the plasmid contamination he det corroborated by many other labs.[1]

The switch to Process 2 also changed the methylation of that DNA, as Process
PCR (which produces unmethylated DNA) whereas the bacterial strain used ir
2 methylates the exact bacterial signature sites our innate immune system evo
recognize as an invader. Industry is well aware of this, as CpG DNA deliberate
as a vaccine adjuvant is kept unmethylated—and McKernan suspects this is pa
why Pfizer resisted removing the residual DNA, noting their product contains
ten times more DNA than Moderna's at a third of the mRNA dose.[1]

The presence of the SV40 promoter understandably drew significant concern–
the virus this sequence comes from being strongly associated with cancer and
potential cancer triggering effects being associated with the sequence,[1,2,3,4] al
the vaccine plasmids being discovered in unusual aggressive cancers,[1] and rep
raise the possibility vaccine plasmids integrated into the DNA of cancers.[1,2,3]

Note: in 2004, Australia's TGA commissioned a review of the health consequences of

contamination of the polio vaccines, which dismissed the cancer concerns by arguing SV40 sequences being detected in human tumors were most likely laboratory contami as many of the reported positives carried a deletion mutation found in experimental p but not in the infectious virus. At the time this was a reasonable explanation, since th no other conceivable source of those plasmids. It is not reasonable now, as the same l dictates that a population injected with plasmids containing those sequences is a rou which they can reach human tissue.[1],[2]

Giving the benefit of the doubt to the industry, its presence was due to:

- The SV40 virus's enhancer being established as a potent way to bring fore into the nucleus of many different mammalian cells and have the cells the that DNA into mRNA (which then created the intended protein). As a 199 on the subject put it, the nuclear envelope is a major barrier to the uptake plasmids and one of the most significant unsolved problems in non-viral g delivery—and while various fragments of the SV40 region support nuclea to some degree, it is the "72-bp repeats of the SV40 enhancer" which facil maximal transport.[1]
- The SV40 enhancer being combined with a specific antibiotic-resistance g that it could be ascertained if mammalian (e.g., human) cells were taking u altered plasmids (as they became resistant to lethal antibiotic concentrati
- This package often being bundled with the sequences needed to grow and the same plasmid in bacteria, so that the same construct could be used fo mammalian and bacterial cell experiments without the cost of having to s between the two (and hence is frequently used in biomedical research)
- BioNTech choosing to use this dual package (which already contained the part) as the backbone for creating the plasmids used to make their vaccine not having any need for the SV40 part) because they already had easy acce (well-established) dual package and wanted to use something as quickly as

possible to scale up COVID-19 mRNA vaccine production rather than tak time to create a new backbone (much in the same way they did not take m robust measures to ensure residual DNA was consistently removed from t mRNA vaccines).

As such, while this is a bit jaw dropping, when I learned about it, I simply inte it as yet another example of speed and efficacy being prioritized over safety. N Moderna's vaccine plasmids did not contain SV40[1] (as they instead chose to us backbone without it), which again illustrates that there was no real justificatic Pfizer's decision to keep it there.

Furthermore, later FOIAs revealed that five months after McKernan revealed undisclosed plasmid contamination, Canada's Health Agency deemed it inapp for the SV40 sequences to be included in the plasmids used to manufacture th and requested for them to be removed—a request Pfizer disregarded (and rece sanctions for).

Mysteries of the COVID Vaccines

After the COVID vaccines came out, a variety of odd things were observed tha hard to make sense of, and I spent a while investigating them. Some of these I ultimately false (e.g., many of the alarming things individuals saw in the vacci under the microscope were actually normal findings). Others I ultimately did n what to make of (e.g., after many people online said the vaccines made them m I was able to find and evaluate one person who claimed this and noticed that h appeared to magnetize paramagnetic metals until they became magnetic, I fou Luxermbourg study , where 29/30 vaccinated [with both mRNA and non-mRN COVID vaccines] were magnetic while 0/30 unvaccinated were, but then also f larger study James Thorp MD conducted which found about 60% of both vacci **and** unvaccinated individuals were magnetic, leading Thorp to conclude that h have some degree of natural magnetism which had nothing to do with vaccina

However, there were also a few inexplicable observations I became increasing convinced of as time went on.

COVID Vaccine Persistence

When the COVID vaccines were originally pushed to the public, public health and the media promised a variety of things that were not supported by existing (e.g., that the COVID vaccines would stop disease transmission).
Note: a common tell for a con is if legitimate objections are addressed with rhetoric r than data—a pattern we saw through COVID-19.

As such, while reading through the Pfizer EMA leaks, I was very curious to se was being said in private about the three largest safety concerns about the vac (autoimmunity, fertility issues and cancer). To my initial surprise, this is all tha discussed throughout the documents:

> *Genotoxicity*: No genotoxicity has been provided. The components of the va

> formulation are lipids and RNA that are not expected to have genotoxic pot
> That being said, the novel lipids possess an acetamide moiety which is clas
> possible human carcinogen (IARC Group 2B) with debated genotoxic mech
> which should be discussed further (**OC**).

> Vaccination with modRNA is expected to induce robust neutralising antibo
> a concomitant T cell response to achieve protective immunity. Neverthele
> further discussion was provided regarding the risk of autoimmune respons
> induced by the modRNA. The Applicant is invited to further discuss the po
> that the mRNA vaccine can trigger potential autoimmune responses and ho
> plan to possibly evaluate their occurrence

Given that these issues—especially genetic damage **from an experimental ger
therapy**—were the largest concerns with the vaccines and hence most likely w
have been tested, I formed the hypothesis (in December 2020) that internal tes
shown there were serious issues with all three, and Pfizer had concluded their
option was to pretend to have never tested it so they could claim plausible den
once the issues were later discovered (or to sweep the independent evidence o
happening under the rug).

As the vaccines began to enter the market, I then began noticing countless me
outlets state that the vaccines could not change your DNA and that anyone wh
thought so lacked a basic understanding of science. However, rather than prov
evidence, they always referred back to "experts" like Paul Offit and Anthony F
who stated:[1,2]

1. The vaccines cannot enter the nucleus of the cell

2. mRNA from the vaccines breaks down rapidly in the cell, so it does not have
enter the nucleus and change your DNA.

3. mRNA is not DNA, and hence believing it can change DNA represents a fundamental lack of knowledge of biology.

Note: beyond the subsequently discovered SV40 plasmids, there were numerous other with these arguments such as the mRNA being deliberately modified to persist in the and already published studies contradicting their statements (e.g., an August 2021 pa showing vaccine spike protein concentrated in the nucleus, a May 2021 study showin endogenous LINE-1 retrotranscriptases were integrating COVID-19 RNA into huma and a February 2022 cell study showing the Pfizer vaccine's mRNA was reverse trans into DNA inside human liver cancer cells within six hours, likely via the LINE-1 mec

Beyond potentially causing cancer, one of the main reasons so many people w concerned about vaccine DNA integration was because this meant that the yo would perpetually produce the vaccine spike protein (rather than the process s once the mRNA broke down). In turn, we came across numerous clinical datas suggesting this was happening such as:

•Autopsy studies showing the tissue (of people who had died unexpectedly up months after vaccination) was flooded with spike protein.

•Spike protein antibody bloodwork (in vaccinated individuals) studies showin elevated spike protein levels for months if not years after vaccination (the leve which often roughly correlated with their clinical status) along with vaccine ir patients who clinically responded to spike protein binders months if not years vaccination (who then often regressed if the binders were not continued, sugg they were still being produced in the body).
Note: the only commercially available test (offered by Quest or LabCorp) measures ex antibodies to the spike protein receptor binding domain, and provides values anywhe 2,500 (Quest) or 0-25,000 (LabCorp) or higher than the test's maximum value (2,500 c Clinically, we've seen that on LabCorp's long COVID patients rarely get levels above

whereas in those with vaccine injuries, it can be anywhere from 0-25,000 with many l 25,000. In turn, a rough (and debateable) correlation exists between the antibody leve do not directly measure spike protein levels) and a patient's illness (along with its leve improving or worsening generally correlating to a patient's symptoms improving or w —with the strongest correlation existing between a level above 25,000 and subsequen developing an autoimmune neurodegenerative condition. Curiously, many patients d have their antibody levels decline with time (which is what you typically see after a C infection), which again suggests spike protein is being produced within the body that t stimulates an immune response. Conversely however, some of these cases may instead been from people who had antibody levels far above 25,000 who then had their antib decline (but this cannot be detected as they are still above the 25,000 cut off). Additio these observations have been corroborated by others (e.g., Alex Berenson has also sha reports of vaccinated individuals who've had spike protein antibody levels over 25,00 months after vaccination).

•When the spike protein could be directly measured (which requires specializ still not available to the public), long term persistence was observed. Currentl longest dataset (Yale's LISTEN study), showed it had persisted for over a year, longest case reaching 709 days of spike persistence at the time the study was f (which sadly has remained a pre-print because no journal will publish anythin of the vaccine program).

Total spike protein presence. "I" denotes if they also had a COVID-19 infection (so PVS-I is the most indicative group).

Because of this, a few schools of thought emerged on what was causing this persistence. These were:

•Genomic integration was happening (and hence that the nucleus was continu producing small amounts of vaccine mRNA).

•Rather than being due to a genomic integration (which would be rare enough unlikely to account for most of what was being seen) the persistence was due t vaccine mRNA not breaking down and hence continually producing spike pro *Note: the people I spoke to who I considered to be the most knowledgeable about mR*

technology tended to favor this explanation (as they felt it was by far the most probab

•The actual issue is not continual cellular spike protein production, but rather permanent dysregulation of the immune system (which can frequently happen autoimmune provoking stimulus). Numerous clinicians I know treating COVI vaccine injuries have gradually come around to this perspective (while others agree with it but feel a subset of vaccine injured people are still producing spi protein—mirroring the observations of Yale's study).
Note: some have also postulated the "persistence" may have resulted from the gut mic (e.g., endogenous E. coli) being transfected by vaccine plasmids and then producing sp protein which travels into the body. That said, to the best of my knowledge, no one ha tested if this is occurring. However, Pierre Kory spoke with researchers in Italy and G who developed a way to test for spike protein in the stools and urine and found that n people they tested (vaccinated or unvaccinated) had fragments in both which appeare from gut bacteria being transfected by the COVID virus (as it matched the virus rathe vaccine spike, and had bacterial modifications). Assuming this is true (and the data w collected and interpreted correctly), it indicates that there is widespread spike protein in the population.

Each of these explanations is compelling, and likely partially true. However, as recently realized, there is actually a much simpler explanation for what is hap

Vaccine Shedding

If a vaccine produces its antigens by replicating within the body, that vaccine ability to "shed" to others, as a tiny portion of it that reaches someone else can reproduce into a much larger amount within the other person, thereby produc enough of an antigen there to also provide them with immunity. This, in turn, viewed as one of the classic risks from using live viral vaccines (e.g., this is wel recognized with the polio vaccine and a case can be made it is the source of m

measles outbreaks) but simultaneously, by definition, is categorically assumed occur from any other vaccine type (with the exception of live bacterial ones—v is much less of an issue than with viral ones).
Note: there has been some other work into self-spreading vaccines (primarily for wildl also theoretically for humans), but despite some pushing for it (so vaccination can rea difficult to un-vaccinate populations), there has thus far been a general restraint on u technology.

Once the COVID vaccines came out, I began to hear numerous reports of indi who had made a point not to vaccinate then becoming ill after being around s who was vaccinated (particularly if they had recently been vaccinated or there prolonged close contact with them) and I quickly noticed there was a clear anc recognizable pattern to the symptoms experienced (e.g., menstrual abnormalit one of the most common patterns, to the point quite a few of my post-menopa friends began experiencing immediate and significant bleeding).

Since the COVID vaccines, by definition, could not shed, each time this point raised, it was gleefully debunked much in the same way Fauci and Offit explai it was impossible for the COVID vaccines to change your DNA. Given this, I f essentially a lost cause to ever expect it to be investigated, so (with Pierre Kory I collected a lot of provider data that had accumulated on this phenomena, pu call for readers to share shedding experiences (collecting over 2,000 of them), a searched the literature for everything known about this phenomenon.
Note: I ultimately received significantly more than 2,000 reports, but eventually stopp compiling them because they repeated the data seen in the earlier reports and our tim projects like this is finite (currently that time is allocated to collecting reader DMSO testimonials at that point—of which 7,600 have been collected).

From this whole project (which can be read here), it then became evident that and reproducible events could be seen with:

•Who was affected by shedding.
•What situations triggered shedding symptoms (including that while rarer, "se
shedding"—where someone exposed to a shedder then "shed" onto someone e
made them ill—did occur).
•What governed the severity of the symptoms experienced.
•How the symptoms could be prevented and mitigated.
•What symptoms were experienced—which resembled but had clear differenc
COVID-19, long COVID or vaccine injuries.
*Note: the most frequently reported shedding symptoms (in rough order of frequency) w
abnormal menstrual bleeding (which far outnumbered everything else), headaches, ras
like illnesses, tinnitus, fatigue, dizziness, nosebleeds, unexplained bruising, shingles, a
odor around the vaccinated, palpitations, coughs, sinus congestion, muscle pain,
gastrointestinal issues, and brain fog. Many others (e.g., swollen lymph nodes, hair los
neuropathy, chest pain, and viral reactivations) were reported less often but still recur
throughout the reports. A few of these (e.g., nosebleeds) were unique to shedding injur
not seen from other spike protein injuries. Additionally, many noticed "shedders" had
characteristic odor (and less frequently, a characteristic taste or feel), and a 2023 stud
that **COVID vaccination produces a distinct exhaled VOC signature** that can dis
vaccine recipients from unvaccinated controls with high accuracy (as did a 2025 one
found the sweat VOC profile shifted after vaccination), providing a plausible chemica
for the frequently reported odor around "shedders."*

It's also worth noting that the shedding experiences were quite common. For
after I described (in detail) everything which was known about shedding, read
shared:

Since medical phenomena are almost never accepted without a mechanistic ba
mRNA shedding was “mechanistically impossible”) I hence spent a long time
for every possible mechanism, and from the many potential candidates I ident
(each of which a case could be made for), I identified three I felt were the most
probable to be true.

1. **Exosome mediated shedding**: Since the mRNA vaccines worked by causing
to produce massive amounts of spike protein that eventually came out on thei

parts of the expanded cell membrane eventually blebbed off, causing exosome
(vesicles made from cell membranes) to be released which were studded with s
proteins that could then be exhaled or sweated out from the body and trigger
in others. Supporting this (in addition to it fitting numerous reports we receiv

•COVID-19 infections were repeatedly shown to alter the exosome system,[1,2,
long COVID (and more severe acute COVID) is characterized by the presence
protein studded exosomes,[1,2] (which have been found circulating a year after
infection[1]) and at the start of the pandemic, it was discovered that using thera
(healthy) exosomes produced dramatic results from severe COVID-19[1,2,3] (som
and many colleagues also observed)—all of which led me to believe the spike p
"poisons" the exosome system.
*Note: the spike protein has a high (heparin dependent) affinity for binding to the surf
exosomes. So, if it was not already there when the exosome initially formed, it can als
to exosomes traveling in the bloodstream.*

•One study showed the COVID vaccine's spike proteins also altered the exoso
system.

Note: a later case report detailed a man suffering from a significant COVID vaccine i
where spike protein coated exosomes were detected 1173 days post vaccination and v
mRNA containing exosomes were detected 1284 days post vaccination.[1]

•A 2023 peer-reviewed study found that unvaccinated children who were arou
COVID-19 vaccinated parents developed an immune response to the spike pro
was not seen in children with unvaccinated parents and spike protein antibod
found in surgical masks worn by the physicians. This led the authors to ***hypoth***
that antibodies were being directly transferred through the parent's breath to
children.

•Significant amounts of (RNA containing) exosomes can be found in your brea
like exosomes from other tissues in the body, lung derived exosomes vary depe
on the disease state of the lungs ("sicker" people have "worse" exosomes).[1,2,3]
Exosomes from COVID patients, in turn, are highly inflammatory,[1,2] potential

forming[1] and are taken up by the lung cells.[1]

Note: where the vaccine ends up in the body is highly dependent upon the charge of th nanoparticles (essentially if they are negatively charged, they match the biodistributic Pfizer provided, whereas if positively charged they go to the lungs—detailed here). As a significant subset of COVID-19 vaccine injured patients who developed lung issues subset of recipients who were the primary "shedders," I suspect this was due to the wi variability in COVID vaccine production causing some to receive positively charged l nanoparticles which ended up at the lungs.

•Since spike coated exosomes trigger an immune response to the spike protei inhaled vaccine was made from lung derived exosomes coated with spike prot (**they were lung derived so the lung cells would be more likely to absorb then** spike protein exosomes both generated an immune response and were absorb the body (and were repeatedly demonstrated, when injected, to effectively imn **nano-gram levels**[1,2]). Once absorbed, those exosomes travel to other tissues ar organs in the body, which (based on all the reports we've received and the pati we've seen) are known to be affected by shedding. Likewise, a 2021 review pap highlighted the feasibility of this approach and that numerous companies **wer developing exosome based COVID vaccines** which contained either COVID- antigens (e.g., spike protein) or mRNA to create them.

Note: exosomes are very similar to the lipid nanoparticles used to deliver the mRNA v (in fact, two studies detected vaccine mRNA within the breast milk exosomes of recen vaccinated mothers[1,2]—potentially explaining the shedding reactions breast feeding i developed), but to the best of my knowledge, their presence was never assessed in the l vaccine recipients.

2. Bacterial Transmission—if bacteria are transfected with the COVID-19 vac plasmids (and then reproduce), they will express the COVID-19 protein (and

potentially be able to alter bacteria they come in contact with so that they too same)—a process which has been shown to occur in the gut with other plasmi in turn, provides a way that the COVID vaccine could behave like a traditiona viral" or "live bacterial" vaccine that sheds. However, while this fits some of tl observations reported, it has never been directly assessed (the closest was that vaccination caused a 41-73% decrease in one of the most beneficial gut bacteri species[1,2] — which potentially could have been caused by spike protein appea other bacteria). As such, I feel it's worth raising the hypothesis (and have reacl to researchers who could evaluate this), but it remains a complete unknown.
Something quite close to this was documented by accident in 2020, when four asymptomatic lab workers repeatedly tested positive for COVID on the nuclec PCR but were negative for every other viral target—as what they were actually carrying was the plasmid they had worked with, which persisted in their nasal passages for up to three months after they stopped handling it, with the autho concluding either it had lodged in their nasal tissue or that E. coli containing colonized their noses (and a household member who never entered the lab alsc positive).[1]

Note: one (oral) COVID vaccine was created which engineered E. coli bacteria with p to either have spike protein on their surface (thereby creating both blood and mucosal immunity). Additionally, another was made which caused the bacteria to produce nar (tiny antibodies that bind a single domain) against the spike protein which were expel the bacteria within exosome like vesicles that then traveled through the gut lining to t and brain.[1,2]

3. **SARS-CoV-2 Shedding** — In a significant number of the reports I looked at being exposed to an (asymptomatic) shedder, the individual (and often multipl unvaccinated members of the group) became ill with one or more of the follow COVID-19, a COVID-like illness, a flu which may have been COVID, a severe

infection that hospitalized and sometimes killed them.

Yet in contrast, before the vaccine rollout, they never had this issue (e.g., norm never got sick, even around those they knew got COVID). This in turn means that a remarkable coincidence keeps on happening, or that the vaccine increas risk of transmitting COVID-19.

As it so happens, there are a few things that argue for the latter such as:

•The design of the vaccine does not create mucosal IgA immunity. This mean not prevent COVID-19 from colonizing the respiratory tract and hence makes able to spread COVID-19. Rather, the vaccine's design primarily reduces react the spike protein (i.e., COVID-19 symptoms). As such, vaccinated individuals infected with COVID-19 but not show symptoms of infection (which is also a issue with the pertussis vaccine many are erroneously forced to take to see the grandchildren).

•The vaccine is immune suppressing. On one hand, this causes individuals wh latent COVID infection to either start shedding the infection or become sever (which as I show here is a common but forgotten problem with vaccines). On t hand, it causes individuals who have been vaccinated to be unable to develop permanent immunity and, hence, continually catch it.
Note: I have received numerous reports of vaccination causing an existing minor CO infection to become life threatening,

In short, for some reason, individuals who do not get COVID will come down in the presence of a shedder, and in my assessment, this happens frequently en for it not to be a simple coincidence.

Based on all of this, the possibility exists that vaccinated individuals with CO

infections either excrete higher concentrations of the spike protein than those natural immunity, or have chronic infections they never clear (but show minin symptoms of—leading to many being exposed to them). However, the existing the length of infectiousness and viral counts in the noses of those infected wit COVID-19 (which may be biased) shows minimal differences between the vac and unvaccinated. As such, while it seems that vaccination causes certain indi to give others COVID, to the best of my knowledge data does not exist to supp claim and there may be some other process concurrently occurring which mak around a shedder more susceptible to catching COVID-19 from them.

As you might guess, of these three models, I believe the strongest case exists f first (exosome mediated transmission).

Note: Kevin McKernan [stated](#) that he was initially (and understandably) skeptical of shedding phenomenon because he felt there could not be a high enough exhaled dosag affect those who breathed it in (whereas I regularly encounter people who are that sen microdoses of a potent agent will still affect them). In turn, he shared that what chang opinion was the potential presence of plasmids in exosomes, as these could serve as a replicating vector that allowed a small amount to noticeably affect those exposed to i

DNA Vaccines

Since there is an irrational faith in vaccines, new designs are always being exp regardless of how unwise they are. Despite knowing this, I was quite surprised "DNA vaccines" (which use synthetic DNA to create mRNA which creates the cells then expel) existed, as this both seems to be a terrible idea, and directly contradicts all the messaging the vaccine industry has given that vaccines can change your genome.

Following this, I was then curious as to exactly how this technology worked (a I found out, when it was developed). Briefly:

- Plasmids are created from a standard industry backbone (which contains a sequence that transports DNA into the mammalian nucleus) along with th sequence that will become the target antigen.
- E. coli are transfected with that plasmid, the bacteria which took it up are and the plasmids are then separated from the bacteria to become the vacc product.
- The plasmids are injected into the body (typically with a jet injector or electroporation to force them into cells, but successful designs such as th one brought to market simply injected the plasmid into muscle).[1]
- Once inside a cell, the plasmid either enters the nucleus on its own (partic when the cell divides and the nucleus is more porous), or the plasmid has transport sequence that brings it into the nucleus regardless of which pha cell cycle it is in—where the cell's own machinery turns it into vaccine mI (and from there into the antigen).[1,2,3]
- This technology has been worked on for about 30 years[1] and there is now COVID-19 DNA vaccine[1] (licensed in India) along with several veterinary All of the licensed products use a CMV promoter (which was also used to J&J and AstraZeneca's adenovirus vector COVID vaccines)—however, the SV40 enhancer has been added to many experimental DNA-vaccine plasm because it helps get the plasmid DNA into the nucleus and because it can boost transcription once it is there.[1,2]

Once I realized this, it cast two of the questions I'd pondered since the start in completely different light.

First, it provides a completely different answer to the persistence problem, as

plasmids are being transported into the nucleus and then being transcribed to once there (but remaining separate from human DNA), this provides a much n feasible way for extensive production of the mRNA to occur, as it is effectively DNA" but at the same time, does not have to meet the high threshold of integ into the genome for this to happen (which is why many I spoke to had believe changes could not account for the majority of the spike persistence being seer importantly, this is not merely theoretical, as delivering plasmid DNA into the is a licensed and working vaccine strategy,[1] and it was made to work with far tools than the COVID vaccines had available, since those products rely on a C promoter and physical force rather than the two elements which most efficien this problem (the SV40 enhancer—which the DNA vaccine literature identifie sequence producing maximal transport of plasmid DNA into the nucleus,[1],[2] a nanoparticles). This is also McKernan's assessment, as he considers the focus genomic integration to be something of a limited hangout given that most pla operate episomally, and notes they can also be packaged into exosomes.

Second, while I still believe every bad choice made with the mRNA vaccines c attributed to pursuing profit with a complete lack of concern for how others w harmed, it's hard not to notice the chosen designs coincidentally mirrored exi vaccine designs (or that Pfizer refused to change them even when health regul pushed them to and Moderna was using a SV40 free plasmid). Given that the c approaches were well-established vaccine production techniques, I feel it is re to infer they were most likely aware of the expected effects of utilizing them. important as those "expected effects" dovetail with the core goals of a vaccina program.

Goals of a Vaccination Campaign

Since the faith of vaccination revolves around provoking the body to produce targeted immune response (e.g., antibodies), and since the profession has long

to validate itself by eliminating infectious disease and claiming victory over na
vaccine programs will inevitably err towards overstimulating that response to
as few people as possible have an insufficient one — which in turn requires ig
or dismissing the consequences of that excessive stimulation, rather than trad
partial reduction in efficacy for a significant improvement in safety. The regul
pathways are set up to support this, as the primary basis for approval is typica
consistently robust antibody response rather than a demonstration of safety.
*Note: I believe a major issue with the HPV vaccine came from the fact its antigen ha
overlaps with human tissue (which the immune system resisted forming an immune re
it), so a much stronger immune provoking adjuvant and massive antigen doses were n
the vaccine to work (e.g., Gardasil 9 contains 270 micrograms of antigen whereas the
recombinant hepatitis B vaccine contains only 20 micrograms[1,2]). This resulted in the
being heavily tipped to efficacy (rather than safety), and as a result, the HPV vaccine
extraordinarily high rate of causing autoimmune disorders.*

In this regard, one of the challenges vaccines face is that while natural immun
for a long time (e.g., it is often lifelong), the body will typically "resist" the effe
vaccine's artificial stimulation of select parts of the immune system, so over ti
vaccine derived immunity fades away (with the rate varying greatly depending
vaccine). Boosters, in turn, are given either because the original vaccine derive
immunity faded, or because the pathogen has mutated to a strain no longer co
the vaccine (resulting in the immune system being "locked onto" the incorrect

For this reason, one of the longstanding goals of the vaccine industry has beer
effectively mimic what occurs in nature (a continual low level boosting of the
population from individuals they encounter with minor infections).

One way to do this is to ensure the vaccine continually triggers a lighter immu
response long after injection—which both the persistent mRNA and nuclear p
(which produce mRNA) accomplish by ensuring a steady supply of spike prote

produced after vaccination. This was recently explicitly illustrated by Japan's r
generation "replicon" COVID vaccine (approved in 2023 and deployed in Octo
2024), as it is designed to extend antigen production, so in addition to the mRI
coding for the spike protein, it contains mRNA coding for an enzyme which c
that mRNA, so that it is continually replicated as it is broken down and hence
in the body far longer.[1] Its manufacturer's selling point, in turn, is that the effe
and in their Japanese trial, the antibody titer six months after the replicon vac
higher than the titer one month after Pfizer's, with high titers still present at c
Yet their own pharmacokinetic data showed the mRNA was largely gone from
muscle within 15-30 days and the spike protein undetectable by day 15—leavi
head of R&D to admit the mechanism behind a year of elevated antibodies is r
actually understood[1] (with a Japanese vaccine expert separately noting that th
term safety of this vaccine—which had already been given to 18,000 people wa
possible to know[1]).
Note: this vaccine was also subsequently licensed in Europe and the United Kingdom

In short, the same industry which insisted the original mRNA vaccines could
persist (despite the fact they do) has now built a product around making them
still cannot explain what its own product is doing, and has responded to the Ja
clinicians and nursing organizations raising these questions by threatening th
civil and criminal legal action.[1],[2]

This is a critically important point as the entire justification for a continually
produced antigen assumes doing so is both safe and effective (when in reality,
antigens often have a cumulative toxicity, while simultaneously, it has been re
shown that overstimulating the immune system to focus on one antigen reduc
ability to respond to other threats it encounters—which is why vaccines like th
COVID shot have been repeatedly shown to increase one's subsequent risk of
disease[1]). As such, a real possibility exists that the chronic illnesses seen after

injuries persist because vaccine antigen production persists as well.

Note: Arkmedic (an excellent researcher) recently made the case that the COVID vac not the first to be designed to get foreign DNA into cells.[1] Since every recombinant va manufactured with plasmids and residual plasmid DNA survives into the final produ matters is whether anything in the vial can carry that DNA across the cell membrane aluminium, the most widely used adjuvant in vaccines, turns out to be exactly that (as widely used vaccine components). A 2007 paper from ETH Zurich found aluminium nanoparticles transfected human cells more efficiently than any other metal oxide tes were the only ones to do so at calcium concentrations approaching those found in the Corroborating this, in 2012, HPV DNA was found bound to the particulate aluminiu adjuvant in Gardasil,[1] and the FDA has acknowledged the presence of residual DNA fragments in that vaccine since 2011 while maintaining they pose no safety risk.[1] Not Gardasil's competitor Cervarix uses a comparable aluminium-lipid adjuvant,[1] so this quirk of one manufacturer's formulation.[1] The only study the industry has ever offere this was a three-page 1999 communication co-authored by the Swiss vaccine regulato reported zero transfection from nine commercial vaccines — using a cell line with tw publications in the entire PubMed database and no control to establish the assay cou anything at all.[1] That said, some of this may simply be convergent chemistry, as a goo transfection agent is a positively charged or amphiphilic particle which binds nucleic disrupts membranes, while a good adjuvant is often a positively charged or amphiphi particle which concentrates antigen and disrupts membranes so the innate immune se If so, the situation is arguably worse rather than better, as it would mean the risk is in adjuvanted recombinant vaccines rather than an avoidable formulation choice—and leaves the question of why it is disclosed nowhere

Another is to ensure the vaccine is able to spread in the population, both supp continual source of external boosting to those who already got the vaccine and ensure those who did not vaccinate still are protected. The shedding observed

COVID vaccines (and the 2023 study showing a transfer of COVID immunity) demonstrates this was indeed happening, and the fact that the strongest evide exists for it being mediated through exhaled (or sweated) exosomes—which, li plasmid transfection, **was already an established vaccine technology**—sugges may have been an intentional feature of the mRNA vaccines rather than an ac (particularly since it is a given overproducing an antigen within a cell will cau release of exosomes containing the antigen).

Note: the more speculative mechanism I touched upon (self-spreading plasmid transfe bacteria), could have supported either goal (e.g., by having the gut microbiome produc continual internal production of it will repeatedly boost the recipient, while by having bacteria travel to others—something which routinely occurs with the human microbi would be possible for the vaccinated individual to stimulate the immune system of ot However, I must emphasize that this is a much more theoretical possibility as the rese needed to critically assess it has never been done (at least publicly).

That said, everything I have described here is simply my best guess to make se all the inexplicable things we have observed the COVID vaccines do and it is possible some of the inferences I made here from the existing data (e.g., the ex mechanisms or motives at play) are entirely incorrect. What's so frustrating is none of it needs to be guessed at as each of the scientific points I've raised cou assessed with currently existing technology—but they likely never will be beca many parties have too much to lose if the wrong answer is arrived at. As such, know the correct way to proceed, but I nonetheless feel real attention needs to brought to these issues, as otherwise, the industry will continue hurtling forw "safe" genetic technologies that have a wide range of known and unknown ris before long, we will be stuck with.

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Mitigating The Disaster

A common metaphor used to describe how the predatory ruling class enacts tl agenda is the boiling frog analogy (where a frog placed in hot water will jump one placed in water that is slowly heated will stay in until it dies).

Note: this is actually an urban legend, as frogs will still leave if the temperature is rais (something which unfortunately led to many cruel experiments as researchers sought t this claim). However, while the analogy does not hold for frogs, it does appear to hold again and again, changes which would have been fiercely resisted had they been impl all at once were instead accepted without much protest once they were introduced gra enough that no individual step seemed worth objecting to.

My longstanding view with the COVID vaccines, in turn, is that the industry h counting on exactly that gradual acceptance, as a wide host of issues exist witl mRNA platform (and the DNA vaccines which may follow it) that had been slo phased in over decades without much notice. What happened instead is that n longstanding agendas all rushed to use the pandemic to bring themselves to fr once, and because the antigen chosen to be mass produced by these injections spike protein (which is toxic to many different parts of the body), the problems the platform were common and severe enough that it was no longer possible t them under the rug. For example, had a less reaction provoking antigen been u highly unlikely enough people would have noticed effects like shedding and d

they be looked into. So, as horrific as the process was, it woke the public up to something being very wrong in the field of vaccinology in a way that another f years of incrementalism never would have.

If the Italian and German stool and urine findings hold up, spike protein expo now near universal rather than confined to the vaccinated, which means we ar post-spike world and the relevant question has shifted from how to avoid expo how to become resilient to it. For the subset who clearly cannot tolerate it (e.g affected by shedding), the question then becomes why—and my best guess is t comes down to their bodies not being able to effectively form neutralizing ant against it, as a 2023 study found this was the differentiating factor between adolescents who developed myocarditis after vaccination and those who did n

I say "best guess" because that is all anyone can offer. A novel protein was intr into essentially every human being on earth and is demonstrably capable of ca disease in a subset of them, so spikeopathy should by now be a recognized dis with its own researchers, diagnostics and literature. Instead, as Kory put it to are a handful of practitioners figuring it out independently while conventiona medicine maintains the illness does not exist.

Nonetheless, while the injuries the COVID vaccines created brought long ove attention to the dangers of this platform, they also created a disaster many of been struggling to fix ever since. In the final part of this article (which at reade request I have been working on for a few months), I will go through each of th approaches we have found work for the common subsets of vaccine injuries, h use of supplements there mirrors the issues we see when they are used for ma conditions, along with some of the less appreciated aspects of the higher-end treatments now coming into vogue (e.g., plasmapheresis) which are necessary getting the best outcomes from them, and address the questions I am most oft about shedding (e.g., how do you counteract it, and what has been learned abo

shedding and sexual intimacy).

Treating COVID Vaccine Injuries

A few situations are frequently encountered in medicine, particularly when w
with a complex illness that lack standardized treatment regimens are also rep
seen in when working with COVID-19 vaccine injuries (and long COVID):

- What each patient needs varies significantly, in part because they have di
facets of the disease, and in part because they have different underlying is
making them sick. Even with the most universally effective treatments, n
everyone responds, and the responses vary enormously (e.g., ivermectin m
treat one person's brain fog but not their fatigue, and the reverse in the ne
patient).
- Most practitioners are not familiar with how to target treatment to an ind
picture, so most patients essentially have to try numerous therapies until
better.
- Doctors are human and will inevitably inflate their results. We have seen
people claim they can treat almost everyone sent to them, but when we tra
outcomes of vax injured patients who went to see them, they typically do
improve (e.g., Pierre Kory eventually concluded practitioners just lack the
to objectively evaluate the results of their treatments because of how cons
he ran into this issue and the things he was emphatically told to use did n
actually work).
- Doctors default to what they already know. In watching how protocols ev
noticed many announced that a therapy they were already familiar with tr
vaccine injuries, and then became reluctant to switch even when a strong
existed for something else. Except for Pierre Kory's group (which essentia

everything and drifted over time towards what consistently worked), every I know with success treating these injuries—myself included—started fro framework they knew and modified it.

- The most profit is made from the most expensive therapies, so practitione an inherent interest in recommending them. Our experience has been tha more expensive therapies are often not the helpful ones, which becomes a problem when patients exhaust their savings on something they have pin hopes to.

Note: many practitioners "treat to lab values." While sometimes helpful, we find man popular labs poorly correlate with how sick someone is or how likely they are to benef treatment (much of which results from newer alternative tests being validated on sma populations). For this reason, the people who get the best results in complex illness typ order far fewer tests than their peers.

Why The Order Matters More Than The Therapy

When I compared notes with everyone I spoke to for this article (who I felt ha best results with treating these injuries within my network), it was notable eve had found that most of these therapies fail not because they don't work, but be they were given at the wrong point.

React19 put it in terms of mitochondria—if someone takes urolithin A while s inflammation or autoimmunity is still active, their mitochondria are impaired urolithin A simply will not work (which mirrors decades of experience in treat cell danger response). The clinician I spoke to who uses stem cells extensively if a patient is profoundly inflamed, he stabilizes everything else first, because cells then do far more. Likewise, the plasmapheresis specialist I know will not someone until confirming their mitochondria are functioning, spent a few we building up their trace minerals, and given a course of phosphatidylcholine an

chelation beforehand—because patients with weakened systems (e.g., severe f
can crash from the procedure itself.

Note: correctly sequencing therapies is critical for good outcomes (especially in compl severely ill patients). Since we often work this demographic (particularly Kory's practi needs to be done to ensure a good outcome than with a typical patient (so I made a p also include the experiences of a doctor who is treating more standard patients within insurance framework).

How The Spike Protein Makes People Sick

From what I have observed, the problems from the COVID vaccines and persi spike protein largely come from five issues:

- Blood flow obstruction
- Autoimmunity and inflammation
- An unresolved cell danger response
- Autonomic dysfunction
- Immune suppression

In turn, individuals working on the illness will often focus on one of these and others and often use different language to describe the same general things oc For example, one physician with a large practice treating these injuries descri same territory in entirely different terms, listing damaged mitochondria, an accelerated aging of the immune system through premature thymus involutio persistent inflammation ("inflammaging"), insulin resistance, shortened telom accumulation of senescent cells, and endothelial damage from spike antibodie

Furthermore, since these processes drive each other, it helps to explain why sy often map quite poorly onto mechanisms (fatigue can arise from any of them),

treatment aimed at one will often improve another, and why the therapies tha consistently perform best are "umbrella" agents with enough distinct mechan line up with whichever combination a given patient has.

Note: as Kory put it (like many other doctors before him who transitioned to treating illnesses), cases can present similarly while the underlying pathophysiology is entirely —normal organ systems only play a few notes.

Stage One: The Foundation

In all the data I reviewed (mirroring what has been found with chronic fatigue syndrome—a condition which interestingly has many overlaps with spleen qi deficiency), the interventions which help the most people are the ones that are promoted.

This is best shown by React19's survey of the fifty most common treatments u 453 vaccine injured, long COVID and ME/CFS patients, which scored each on where 3 was significant improvement, 1 mild improvement, 0 no real benefit c and negative values represented worsening. The top eight, in order (ranging fr to +1.4), were pacing strategies, an anti-inflammatory diet, prayer, brain retrai gluten free diet, a low histamine diet, low dose naltrexone, and avoiding exerc Likewise, in a later (non-surveyed) follow-up a few years later, the top universa was diet modification, followed by prayer and meditation, followed by pacing, supportive community ranking extremely highly throughout.

Note: with CFS (and patients trapped in the cell danger response), it is well known tha overdoing exertion or exercise is highly counterproductive (which is why pacing is ofte most helpful intervention that can be done) and this mirrors our experiences with ma vaccine injured patients. Despite this, a variety of graded exercise protocols are often for these patients, which while sometimes helpful if done correctly (e.g., we've seen go

in very light exercise paired with oxygen therapy or a VASPER type setup where ice p applied to the limbs during light cycling), these approaches are also ***often quite counterproductive****.*

React19's data on emotional wellbeing tells a similar story. When patients wer how various interventions affected the mental health consequences of their in two highest rated were online support communities and supportive family or f both above dietary change, meditation and cognitive therapy. Exercise or walk again had the largest proportion reporting it made things worse. Likewise, Ko assessment was that one of the most valuable (and appreciated) things his prac does is simply listening to patients, understanding them and empathizing wit situation—because nearly every other doctor they had seen gaslighted and dis them, which itself creates enormous physiological stress (which mirrors what seen in other integrative practices specializing in complex illness and what ot doctors treating COVID-19 injuries have reported).

Note: React19 reports that for suicide prevention in this population, the single highes protective factor remains a believing and supportive network of family and friends, w particularly noteworthing given how many of these patients have been dismissed by th medical system and in some cases by their own families, and frequently told their sym are psychiatric.

On the dietary side, no single diet outshone the rest. The most used were low histamine diets, followed by intermittent fasting (which we have also seen wor gluten free and paleo type diets, along with vegetarian approaches, eliminatin oils and eating organic—so what appears to matter is simply getting off the st American diet (the glyphosate, the sugars, the seed oils, and for many, the whe said, it is close to impossible to eat clean unless someone is cooking for you ar many people with these injuries, they simply do not have the energy to do that themselves (e.g., one person I spoke to said it took five years of meals made by

people before she was well enough to cook for herself), which again underscor critical it is to have support (which many vaccine injured patients sadly do not astutely put it, you cannot eat at McDonald's and expect a medication or an IV infusion to fix you; without dramatic dietary change, IVIG would not have don anything in her own body.

Finally (per an AI survey of online comments), of those who recover from thes many do not credit a specific therapy but rather they describe their (eighteen t six month process) being one of strict pacing, one dietary change, and the deci stop trying a new protocol every week.

Note: since spike protein toxicity is cumulative, most vaccine injured (and long COVI patients) quickly realize each subsequent vaccine will make them worse, in some cases infections do too, and in the most sensitive, shedding exposures worsen their conditio appropriate spike avoidance a critical component of their recovery).

Stage Two: Subtract Before You Add

The second stage is the one most likely to produce improvement at no cost, an almost never done, as it involves removing what the patient is already taking.

Supplementation

Supplements have been an incredible gift to the natural medical field and can extremely helpful for many diseases, but are often also quite counterproductiv commonly attributed to immense variation in ingredient quality—which is tru patients frequently do not respond to one brand of a supplement but do respo same thing made in a better manner by another company). However, we have l believed that is not the primary issue.

I first became aware of the actual issue from colleagues working with students

naturopathic college (in a damp climate) who shared that as students were con
learning about nutraceuticals, they would be inspired to try more and more
supplements on themselves and then become ill—developing the textbook pic
spleen qi deficiency (bloating, heaviness, loose stools, post-meal fatigue and m
fog), which resolved once they stopped. This is because in Chinese medicine, t
spleen is the functional system responsible for transforming food into usable
and it is understood to prefer dryness and be injured by dampness or mental
overexertion. Concentrated substances are difficult for the spleen to process, s
a weakened spleen to transform a large quantity of them produces more damp
rather than more nourishment.

*Note: when I queried AI about this issue, its synthesis of online reports (e.g., forum co
found that problems show up consistently once supplement stacks reach ten to twenty
daily, with bloating, fatigue and brain fog being the most common complaints, and m
people who cut back to three to five report feeling better within a couple of weeks.*

In practice, I and my colleagues often find the net effect of the supplements p
are taking to be negative, and that their conditions can be significantly impro
removing the ones we determine are counterproductive. As Kory shared with
when he evaluates vaccine injured patients who have not responded to treatm
attempts and they have long supplement lists (e.g., fifteen to twenty items), on
first things he does is cut it down—and in many cases they significantly impro
blunt version of this was that if you are on fourteen supplements and you are s
you should be asking why you are taking them.

The clearest single example is zinc. After COVID, much of the population beg
taking large daily doses and never stopped. Inspired by Russell Blaylock's wor
showing zinc at high doses acts as an excitotoxin, Kory cut many patients dow
the 20-50mg daily they had settled on and witnessed vaccine injured patients l
their symptoms fully resolve. In his words, almost everyone is taking too muc

more reasonable target being on the order of 15-20mg two or three times a we
notably, in React19's data zinc scored in the bottom third of the fifty treatmen
surveyed. The second is B vitamins, which Kory's assessment is that essentiall
everyone he tests is off the charts on. This matches what I found when I went
a year of comments in a large vaccine injury group—one of the only treatment
members repeatedly reported worked was B12, but only when testing showed
were deficient, and members reported it made things worse when they were n
in practice, colleagues have found B vitamins can be quite helpful if a clear de
exists).

*Note: React19 found that a standard multivitamin was the second lowest scoring of a
treatments (barely above zero) and that most individual supplements clustered in the
between "not much benefit" and "mild improvement" for vaccine injuries, with magn
being the only supplement to reach the upper portion of the list (which I've also seen
especially* LifeExtension's formulation*).*

Given this, I knew many would ask what threshold further supplementation sl
exceed, but as I had seen too much variation to feel confident naming a numb
polled the colleagues with the most experience in this area—and they too, due
variability, were unfortunately not sure. For example, some of their perspectiv
included:

- In healthy patients optimizing for longevity, more than three a week can
  counterproductive, especially as patients will not want to take too many
  supplements.
- Around seven is a reasonable ceiling, excluding special cases where patie
  clearly needed more (which can happen with sensitive patients, in which
  better calibration is needed).
- In many cases, supplements should be spaced out rather than taken daily

optimal results (e.g., once every two weeks, or daily but only for a few wee and this exact dosing schedule heavily depends upon the patient.

- Many of the issues with high supplement doses can be reduced or mitigat reducing the number of capsules taken, shifting to pure powders without or taking topical preparations that bypass the GI tract.

For this reason, it is important to either have a clear rational reason for taking supplement (e.g., a validated blood test shows you have a significant deficienc to see that the supplement makes you feel better.

Unfortunately, the pharmaceutical industry has conditioned Americans to bel health comes from a bottle, and as a result, it is very easy to market ingestible therapies that promise health. Since that same cultural mindset still exists wit natural health field, it is incredibly easy to market natural supplements that pr health as well, and as such, supplement marketing has essentially been the fou which has sustained the entire alternative medical field. Because of this, influ routinely convince patients they need to take significant numbers of supplem while some help, we continually run into people who are spending quite a lot on supplements that are not helping them but which they are extremely invest

Note: I can think of over a hundred supplements I could quickly write an article on ar an extensive and very convincing case they are essential for you to take. I mention thi it is almost certain you would not benefit from taking 100 supplements concurrently– within this paradigm, the justification for taking a supplement is often a question of research you have been exposed to (or how much something was studied) rather than i specific supplement is likely to objectively benefit your particular situation. For this r try to avoid generally promoting specific supplements (as there are not that many whi almost everyone) and instead restrict their mentions to conditions where we routinely make a tangible impact. To illustrate, in my own case, while I have taken many suppl

for short periods (when there was a specific indication for it), one of the only supplem routinely take is magnesium, as beyond there being a strong evidence base for it, I am noticeably better when I take it and it is specifically indicated for me because I drink osmosis water (which can predispose you to a magnesium deficiency). At the same tim however, I make a point of eating a varied diet which comes from healthy soil, and as I am able to get many of the essential nutrients individuals otherwise supplement for so without taxing my spleen).

Other Things Worth Removing

A few other agents came up repeatedly as actively counterproductive in this population:

- SSRIs, which were the highest offender for negative effects in React19's d (scoring essentially zero benefit across their fifty treatments), though som patients still swear by them.
- THC, which has created serious problems in chronic users, with patients developing hyperemesis that became further out of control than their orig vaccine injury.
- CBD, which makes many patients considerably more POTS-y, so while it provide symptom relief, it works against the underlying problem.
- Older GLP-1 drugs, which produced poor results in Kory's experience and he would not use in a thin, sick patient (though as discussed later, both th cell community and physicians successfully treating these injuries report opposite with the newer ones).
- Common over the counter analgesics, which scored near the bottom of Re list—Tylenol, Advil, Benadryl and other NSAIDs all sat in the range wher patients reported almost no benefit.

*Note: benzodiazepines occupy an unusual position here. They are thrown at these pat candy, which is generally not good (these drugs have a lot of issues)—but at the sa they do effectively reduce many of the symptoms vaccine injured patients experience was acknowledged in React19's surveys), and in a **small** number of cases practitioners are necessary, as life would simply not be manageable without them.*

Stage Three: Heal Underlying Issues

Once the foundation is in place and the counterproductive inputs are gone, th stage is correcting deficiencies and imbalances—which one of the doctors I sp said the bulk of his results actually come from (and likewise in my own practic to awknowledge this is the area I primaril focus on rather than empiric treatm protocols). Asked what has made the biggest difference in his practice, his ans optimizing hormones and nutrient deficiencies, exosomes, stellate ganglion bl some chelation, and Patricia Kane's phosphatidylcholine protocol (which som matches our experiences).

- **Underlying triggers** which pre-dated the illness. If you look for it, in almo anyone you can find multiple signs of disease or injury that "need" to be a (which vary depending on which medical system you are using), and while those problems can provide immense improvement, you will also encount numbers of people who have them and are entirely well. Because of this, c key skills which differentiates advanced practitioners from standard ones ability to not only spot these issues, but to know when there is merit in tr each one present, and which ones the patient is ready to have treated.
- **Micronutrient deficiencies**, one common underlying trigger, can be ident through targeted testing (e.g., a SpectraCell or organic acids test) rather th guessed at, since it is quite easy to go overboard here. The Born Free Prot builds on this approach—correcting what the testing shows, then optimiz

vitamins, then rehabilitating the gut with a good fiber supplement and fis and has been relatively helpful for some patients who were thoroughly de and who other approaches did not work for.

- **Hormonal imbalances**, particularly if they are raised via diet and exercise than hormonal injections, although in some cases supplemental thyroid o progesterone really helps, and in some cases testosterone does too. Which hormones however matter is ultimately patient dependent.
- **Sleep**, restored and then maintained through consistent sleep hygiene.
- **Heavy metal burden**, where an underlying one exists, via chelation. Low c EDTA (which also improves circulation) is the usual starting point, with D added if mercury is high. Clinically, the symptom chelation most often im brain fog.
- **Toxic scars and overly activated ganglia** disrupting the autonomic nervou (with neural therapy). In certain cases, weak ligaments also need to be trea with prolotherapy or neural therapy), as vaccine injuries tend to lead to lig weakening.
- **Gentle bodywork, lymphatic drainage, or acupuncture** from a skilled pra that addresses an underlying issue in their system (which like other items list, can be extraordinary for some patients but completely useless for oth
- **Underlying emotional trauma**, being recognized and released (e.g., with t emotion code).
- **Chronic toxicity**, detoxified (which often needs to be done quite slowly).

Note: these underlying issues often linger in the background with no apparent clinical consequence, and then come to the foreground once the body is placed under significa and no longer has the strength to counteract them (e.g., many of the issues individuals as they age can be traced to injuries or diseases they had when they were younger whi

assumed had fully healed and forgot about). Likewise, in chronic inflammatory disord of the places the disease first shows up are sites of old inflammation, injuries or surge this is commonly reported with Lyme disease), and one of the initial reasons I knew th COVID vaccine was going to be a huge problem was that within a week of it reaching market, a large number of patients reported exactly this.

For "sensitive" patients (which are commonly seen in chronic illnesses), all of to be done at a much slower and lighter pace, as if their symptom picture is ha the way it would be in a standard patient, it will overwhelm them and set them However, while some practitioners are familiar with treating these types of ca of those who were funneled into needing to treat COVID vaccine injuries did this background and hence (at least initially) overtreated the people they work —much of that sensitivity being due to the body being trapped in the cell dang response.

At the same time however, while each of those could be extremely helpful for person, they also often didn't help, and with both COVID vaccine injuries (and other similar chronic illnesses) I have seen more people than I can count who years pursuing most of the above with minimal benefit.

Stage Four: Affordable Core Therapies

These are the treatments which, across the practitioners I spoke to, most cons produce responses. Kory's practice, for example, over four and a half years of t has trialed at least thirty-five approaches in thousands of patients, and found six rise to the top in terms of consistent responses, while everything else work some people and not others—which is particularly unfortunate with the exper ones patients put their savings into (and is why he favors trialing cheaper ther first).

- **Ivermectin.** Kory considers this first line for essentially everyone and alm always helpful to some degree, and it was the highest scoring non-lifestyl LDN therapy in React19's rankings. Ivermectin had a strong affinity for th original spike protein, which is why in critically ill COVID patients you c often see rapid and profound improvements in their vital signs, as it woul the circulating spike protein and allow normal circulation to resume (whi believe was the common thread behind most of the COVID-19 therapies v produced rapid and dramatic improvements). As COVID mutated it becar progressively less effective for infection, but it remains highly suitable for injuries, since the spike protein produced there matches the early variant affinity for. In practice, most but not all patients benefit to some degree, t symptomatic improvements can be completely different person to person some patients can wean off it and sustain their gains while others have to permanently remain on it.
  Note: IVM has many other therapeutic mechanisms which also account for some benefits in spikeopathy, so it is much more than it simply binding the spike prote

- **Daily low dose sublingual ketamine.** This is one of Kory's single highest r therapies (and the one he was the most insistent I helped draw attention t Critically, this is not how ketamine is normally given—rather than the hig infusions used in the standard protocols (which he considers generally the way to pursue this), it is compounded into sublingual drops or troches, an titrated up to the minimally tolerable dose. His rationale is that the under problem is a neurological imbalance which corrects over time at these dos the regrowth of brain synapses, BDNF secretion and remyelination follow that, and the targets are brain fog, cognitive dysfunction, emotional labili sometimes neuropathy. Improvements accrue over roughly a six month pe treatment often runs for years, after which patients can frequently wean o his words, a lot of diseases medicine cannot treat are transformed by it.

Note: another therapy those with vaccine injuries have reported promising results microdosing psilocybin (provided microdoses are used), and as many of these ben appear to overlap with low dose ketamine—which is more precise, better titrated better understood—so we believe ketamine is preferable.

- **Sulodexide.** This orally absorbable heparin-dermatan sulfate mixture is u protect the endothelium and reduce clotting, is sold in Europe and Russia rates it immediately behind ketamine, particularly for endothelitis and dysautonomia, and the clinicians using it have found it to be one of the fe that is consistently helpful (e.g., one who is very experienced told me it ap overall be the most helpful treatment for the illness).
  Note: I strongly suspect its benefits are in part due to it being sulfated and hence the physiologic zeta potential.
- **YTE.** A protein extracted from fertilized eggs which has been used in No decades, and which Kory described as having quickly risen to a foundatio therapy in his practice—within three or four patients he was seeing many things, and he now gives it to essentially everyone (with my limited experi matching his). Like ketamine and ivermectin, there is no reliable way to p what it will help; energy is the most consistent, with brain fog and mood a common.
- **Low dose naltrexone.** This blocks the body's endogenous opioids, thereby the body to increase them, and integrative practitioners discovered early t was quite helpful for vaccine injuries (particularly the autoimmune issues accompanied them). It remains the top pharmaceutical in React19's patien across both their surveys, typically paired with H1 and H2 blockers, and w only medication to rank among their top eight interventions overall. Kory heavily and has now largely replaced it with ketamine, having found the s benefits to a greater degree. I have been less enthusiastic than many abou as while helpful, I frequently encounter people who are too depleted (or se

to tolerate the initial endorphin blockade.

- **Lumbrokinase.** At the start, proteolytic enzymes were assumed to be the s to the amyloid clots since they break them down. However, our experienc been that the most commonly used one, nattokinase, does not substancial an assessment Kory arrived at independently, and he found bromelain like unhelpful. Initially I advocated for NeprinolAFD, as it was the most helpf proteolytic enzyme formulation we had found for heart disease, but over t perspective shifted to lumbrokinase appearing to be the best for eliminati problematic clotting in vaccine injuries—which perhaps could mean it is enzyme best suited to breaking down the misfolded amyloid clots in the b Sadly, since lumbrokinase is significantly more expensive than nattokinas not found in most of the commercially available formulas people use for s protein issues.
- **Vedicinals 9.** A botanical mix of phytonutrients designed to support many systems spike protein injure, which Pierre Kory's group, in turn found wa very helpful for treating spike protein pathology (although like the other mainstays, the effects varied person to person). Many other similar botani preparations exist which they have tried, however this is the one that prov consistent improvements.
  Note: this company has also developed a formulation which appears to address b within the gut, that hopefully will available here in the near future.
- **DMSO.** Since I have extensively discussed the benefits of DMSO, quite a f readers have tried it for vaccine injuries, of whom 18 reported it helped (1 COVID vaccines, 2 for the shingles vaccine, 3 for COVID vaccine sheddin none of whom said it did not. That said, since readers primarily reach out when something worked (along with the variability in what DMSO helped not think that data set can be interpreted to mean there is a high success DMSO for specific vaccine injury symptoms—which is corroborated by cl

who've used it saying it sometimes helps and sometimes does not. Howev
oral DMSO's effects are inconsistent on the core facets of spikeopathy, in
it is frequently extremely helpful for the pain, soreness and musculoskelet
seen concurrently with it (although it seems to be hit or miss on neuropat
React19 likewise considers DMSO emerging and promising, but does not
enough patients using it to analyze properly.

*Note: the specific reader DMSO reports were as follows—four had neuropathy (t
Shingrix) ease or resolve[1,2,3,4]; two with multi-system injuries (POTS, MCAS, gas
edema, insomnia, tremors) or dysautonomia improved after weeks of oral use[1,2];
post-shot brain fog or memory loss lift[1,2,3]; two regained hearing, one's low-tone l
returning to the normal range on audiometry[1,2]; three describe cardio-respiratory
severe breathlessness, shortness of breath from Moderna-related heart damage, a
recovery after two strokes and a heart attack[1,2,3]; two had shedding symptoms (ne
blindness, menstrual bleeding) resolve[1,2]; one recovered smell and taste[1]; one stop
needing emergency visits every three days for booster-linked seizures[1]; and one re
that a vaccine-injured friend found it helped more than anything else he tried[1].*

Lastly, since some of these therapies (e.g., YTE) are quite difficult to procure, I
Kory's partner set up a website (https://spikeproteintest.com/) where patients a
patients can procure them and requested I include the link so their medical pr
not deluged with inquiries from individuals who want those supplements but
plan to be prospective patients. For that reason, I am including the link here (w
explicit disclosure I have no financial conflicts of interest in sharing a link to t
store).

Stage Five: Matching Treatment To Presentation

Beyond the core therapies, a fair amount can be targeted to the dominant pres
and in many cases, will only work if they are used in an applicable situation (w

fairness can often be difficult to discern since so many different things could l occurring—which is why we often favor using umbrella therapies with numer different therapeutic mechanisms).

Note: one of the few blinded treatment RCTs conducted in this field (for BC007—wh autoantibodies against G-protein coupled receptors) found BC007 showed no benefit placebo for long COVID (which lead to the therapy being abandoned). However, a be seen when it was subsequently only tested long COVID patients with these autoantib (which are also observed in post vaccination syndrome[1,2]), which again illustrates the importance of correctly selecting the appropriate therapy.

React19's most recent data is the most useful source here, as it reflects what la numbers of patients are actually using now rather than what was theorized ea

- **Autonomic dysfunction** (**POTS and dysautonomia**)**:** salt loading and com garments, which patients rate highly. The majority of this group also turn be autoimmune and ends up on some autoimmune protocol. Stellate gang blocks (discussed below) are the most effective intervention I know of her Additionally, for the hyperadrenergic subtype specifically (standing norepinephrine around 600pg/mL or above, or prominent tremor, anxiety flushing on standing), guanfacine at 0.5-1mg at bedtime reduces sympath outflow centrally rather than blocking it peripherally, which is a distinctio frequently missed.
- **Post-exertional malaise:** pacing above all, plus red light therapy, salt load urolithin A and astaxanthin.
- **Cardiac involvement:** colchicine or the *Cardio Miracle* nitric oxide supple
- **Autoimmunity and inflammation:** low dose naltrexone with H1/H2 block remains the backbone, often paired with resveratrol. Notably, antihistami among the better performing medications in React19's rankings, with Zyr Pepcid both scoring in the upper third.

Note: a newer option here is C1 esterase inhibitor (Ruconest, 50 U/kg IV), which complement and contact system activation, and which has produced striking resu narrow subset—inflammatory markers dropping sharply, with CRP, interleukins, and hormone production normalizing. It remains investigational, is expensive an impossible to get covered, and candidacy appears to require demonstrated compl bradykinin pathway activation, so it is best understood as a therapy that transfor right patient rather than a general option.

- **Recurrent infections and immune suppression:** ultraviolet blood irradiat ozone are both well suited here, as beyond improving circulation and redu inflammation, both improve immune suppression. Chlorine dioxide is ver for the recurrent acute focal infections these patients experience, though clear whether it benefits the underlying disease (e.g., Kory found it more b than benefit in vaccine injured patients specifically, as it is difficult to titr dose correctly, while the oxidative stress it creates can be too much for so patients). Separately, one colleague treats this as a thymus problem rather infection problem on the basis that the virus can directly infect thymic ep cells and accelerate the thymus involution which normally occurs with ag thereby reducing the supply of naive T cells and leaving patients less able respond to new pathogens. His approach is to attempt thymic regeneratio thymalin and thymosin alpha-1 paired with growth hormone releasing pe (based on Greg Fahy's TRIIM trial[1,2] but the legally riskier human growth hormone being substituted).
  Note: For the subset with elevated EBV or HHV-6 titers, antivirals have been use some success, such as valganciclovir (900mg twice daily for roughly three weeks, daily) and the Lerner valacyclovir protocol. Additionally, we have also found Sta Process's Thymus PMG to be quite helpful for this type of immune deficiency (es in chronic illnesses).
- **Neuropsychiatric involvement:** low dose ketamine is the primary tool. Re

also reports considerable success with very low dose tricyclics—doxepin a which is a powerful antihistamine with high sigma-1 affinity thought to r brain inflammation, and nortriptyline compounded into a liquid at aroun (though they avoid it due to its tachycardic effects). Doxepin has become a powerful tool for post-vaccine psychosis; React19 relayed a case this sumr patient who was about to commit herself to a psychiatric ward, tried it ins and described being "back in her own skin."

- **Mast cell activation:** the mast cell groups continue to rave about low dose agonists (tirzepatide), despite the drawbacks. React19's hypothesis, which plausible, is that these work by creating something resembling the metab environment of intermittent fasting—which is itself among the better sco interventions in their data.
  Note: many other detailed mast cell protocols will be discussed in a future article the reasons patients react to too many supplements or medications is because tha excipients (non-drug components) often exacerbate mast cell disorders.
- **Nervous system regulation:** vagus nerve toning, which in practice means humming and singing, along with cold exposure where tolerated.
- **Severe, largely bedbound patients:** lymphatic massage.

Note: there are many other therapies I use for these situations, but I wanted to keep t to focused to what people are doing for these cases and reporting success with.

Since, nicotine has become an increasingly popular therapy for these illnesses should note that both I and Dr. Kory have not been a fan of it because (beyond addictive), we have seen numerous sensitive patients who tried it get worse an relatively few who benefitted. That said, we have also occasionally seen partia improvements from it, and within the larger vaccine injury community, it has reported to help, provided much lower doses are used than those typically recommended. My own belief at this point is that the theory behind the thera

wrong (it has been presented as an antidote to the spike protein). Rather I beli simply is a helpful agent for improving energy levels and cognitive impairmen (especially as you age and if given at low spaced out doses)—as that was our cc experience with it prior to COVID-19 ever existing, and this describes most of benefits people have experienced.

Note: red light therapy and blood flow restriction training both also help some patien neither is expensive or risky, which makes them reasonable things to try.

Lastly, as circulatory complaints are central to COVID vaccine injuries, there treatments I and a few colleagues have utilize that I believe have merit but als less independent corroboration:

•Zeta Aid: this is one of the simplest ways to restore zeta potential (which whe disrupted, such as by the spike protein, cause microclotting) and we have seen significantly help quite a few COVID vaccine injured patients. However the d of preparation (as it's more work than just taking a pill) has made us use it on people than other modalities, so while I believe it's helpful, I cannot quantify t magnitude of benefit.

•Earthing: this simple practice (electrically connecting to the earth, such as by standing barefoot on the ground or sleeping in a conductive sheet attached to grounding outlet) has become a very popular holistic therapy, and I have made here it works by restoring zeta potential. Given this, I've asked numerous vacc injured patients to try it, quite a few of whom reported success, so I believe th merit (but again I do not feel confident in the denominator for efficacy).

•Chelation therapy: this is typically done to remove metals (which can be appl some patients) but when EDTA is used, it improves circulation as well. Classi is thought to result from EDTA decalcifying the arteries, but we believe (espec

low doses with aluminum free preparations) it is a potent zeta potential restor agent. Many, in turn, have reported (inconsistent) success using EDTA for CO vaccine injuries, and I believe this is in part due to if it was indicated and how administered. Clinically, the most common spikeopathy symptom it appears t with is brain fog.

•Sanum Mukohel: At the beginning of the pandemic, we discovered that this preparation (which is built on the model of correcting the microbiome in the l was helpful for post-COVID clotting and vaccine injuries and became a fan of it offered results for a very low cost (but at the same time, we did not have a la enough sample size to have a clear sense of its efficacy).

•Antiphospholipid syndrome can cause severe blood clotting and is frequently after COVID vaccination. It can be evaluated for with the AVISE test, and if d typically has to be treated with conventional anticoagulants.

•Ultraviolet Blood Irradiation: I am a big fan of this therapy, and like DMSO, diverse range of therapeutic mechanisms which address the core facets of CO vaccine injuries (e.g., both improve circulation)—which matters as oftentimes cases has different pathologic processes at work which is why "umbrella" ther crucial as they have enough mechanisms to line up with the highly variable ne patients have. That said, in practice, while I have seen this help (and often pro significant relief) the effects often fade, which makes it not ideal for many pat who are very limited by their budget, but at the same time, also often worth tr which point a decision can be made if the costs justify the benefits).
Note: UVBI's sister therapy, (that is typically a bit cheaper) ozone, has also shown pro COVID vaccine injuries. However, it is easier to overdose with ozone therapy than U this route is pursued, it is important to start gently with it (rather than immediately sc to the most expensive full blood EBOO ozonization machines). Additionally, beyond circulation and reducing inflammation, both UVBI and ozone are well suited for imp

immune suppression, so further consideration should be given to them in these cases.

Stage Six: Escalation For Refractory Cases

There are some more costly therapies which many have found to extremely he these illnesses. That said, due to the need to do these with a practitioner (who correctly identifies if you are currently a candidate for it) and their cost, it is n in your best interest to do the others first (although we have seen plenty of dra recoveries from one of these alone without anything else being done).

- **Stellate ganglion blocks.** Neural therapy works by temporarily anesthetiz overactive nerve or ganglia so that when it wears off, the normal function The stellate ganglia (in the neck) is one of the primary control points in th for the sympathetic nervous system, and we have noticed that when it is t with a preservative free block, it significantly improves the dysautonomia circulatory impairments seen in spikeopathy, along with the system's predisposition to remain in the cell danger response (because the sympath spikes that provoke that pathway are reduced). The clinician who uses the extensively described the effects as close to global—increased blood flow everywhere, improved gut health, and an immune system that becomes le hypersensitive so that it stops overreacting every time it encounters a mir This approach normally requires a course rather than a single treatment, around eight over six months
- **IV phosphatidylcholine (e.g., the Patricia Kane protocol).** This is given a phenylbutyrate, and the mechanism as explained to me is that it cleans ou endoplasmic reticulum and throws off the misfolded proteins accumulate Since the ER sits adjacent to the mitochondria and the two are physically a healthier ER permits healthier mitochondrial function. Clinically it is m useful for the brain fog and fatigue presentation, where it noticeably incre

energy and vitality, and it appears to help a wide range of conditions—pa neurological ones—for reasons that are not fully understood. It is also the preparation used to prepare patients before plasmapheresis. Notably, the practitioner who described this to me raised that some patients appear to "spike protein factories" stuck in a persistent inflammatory response, tha are their hardest vaccine injury cases, and that when the ER recovers they improve.

- **Exosomes.** Our success with using exosomes to treat COVID-19 made us for long COVID, where we saw rapid and dramatic improvements (it seem though the body suddenly "turned on"), and then for COVID vaccine inju where we saw similar improvements albeit not as dramatic. Following thi realized the exosomes were likely serving as a rapid signal to terminate th danger response and restore normal function to the cells, along with decr autoimmunity and likely counteracting spike protein poisoning of the bo endogenous exosome system (with many of my colleagues having similar making exosomes one of our preferred therapies for this illness). Others r highly divergent results, and I am more positive about this therapy than K who classes exosomes and stem cells as hit or miss. My working hypothes divergence is that better results come from selecting the most appropriate candidates (e.g., those stuck in the CDR), using amniotic fluid derived exo rather than the cheaper stem cell derived ones, and doing something befo (e.g., a few months of HCQ) to make the body more prepared for them. Ho even with this, I still do not think it explains the immense variation being
- **Stem cells.** The colleague using these most systematically stabilizes inflar first, because the cells then do far more, and then gives exosomes togethe Wharton's jelly derived cells—three doses within a week, repeated at six m The source matters, as umbilical cord blood stem cells are predominantly immune cells while Wharton's jelly derived cells can do more.

Note: many of the benefits seen with stem cells are also seen with exosomes (as st release "healthy" exosomes).

- **IVIG.** This is genuinely life saving for a subset, of patients and React19 na multiple patients who would not be alive without it, including one who ha life flighted seven times before starting it. Their view is that in some patie autoimmunity is so strongly programmed that it needs an enormous instr knock the autoantibodies down. However, it is hard on people—headache migraines and poor tolerance of higher doses (which to some extent can b mitigated with subcutaneous injections but this is rarely offered)—and Ko experience is that patients spend days in misery, then get about two week improvement, which makes it a rocky rollercoaster that is rarely practical with the fact it is typically nearly impossible to get costly IVIG covered by insurance for a vaccine injured patient).
- **Plasmapheresis.** This therapy has a lot of merits (particularly for detoxific and longevity) and since it "cleans the blood" many have logically conclud worth using for COVID-19 spike protein injuries. However, the most expe clinician using plasmapheresis I know has shared that plasmapheresis do help long COVID, and that he only considers it in patients with genuinely autoantibodies. Furthermore, because it removes roughly half the circulat patients with antibody driven disease need five to seven treatments over t weeks, after which the antibodies return within three weeks to a few mon to aberrant clones—so it must be followed with IVIG (so the body does no compensatorily restore it), or with exosomes in very inflamed patients (wh almost never done). He also noted that mildly toxic patients do well, wher sicker patients often do not feel much different and that it is often necess run it fairly slowly (which most physicians do not do due to it requiring ac costly nursing time). Corroborating this, React19's experience has been th therapy only offers temporary relief, and likewise Kory is not a fan, citing

having seen patients get significantly worse after it (as most providers do the extra steps needed to make plasmapheresis work for sensitive patients Additionally, two newer approaches (which are still highly investigative fo COVID vaccine injuries) provide an alternative approaches for addressing Immunoadsorption strips IgG and autoantibodies selectively rather than removing plasma wholesale, while FcRn inhibitors (e.g., efgartigimod) low circulating IgG pharmacologically instead of mechanically. For the micro specifically, H.E.L.P. apheresis (available at select US centers) removes fib Lp(a) and amyloid-fibrin microclots directly, while INUSpheresis in Europ Japan targets immune complexes.

Note: recently, attention has been drawn to a COVID vaccine therapy where pat went to Japan to get plasmapheresis and stem cells (which has definitely worked of the people who tried it). My suspicion is that most of the benefits could have b obtained without plasmapheresis (as the responses they described matched what repeatedly seen with exosomes), so it is likely not necessary to do the costly and a to Japan for this therapy.

- **Iliac vein stenting.** In some patients, vaccine injury symptoms suddenly o of the blue and primarily affect the lower half of the body. Recognizing th be due to a weakened illiac vein collapsing under the pressure of the iliac few physicians began stenting open these veins in vaccine injured patient saw dramatic improvements (detailed here) Since this therapy can produc dramatic results (e.g., it has been transformative in dozens of his patients, results ranging from modest improvement to being completely resurrecte normal) they always keep an eye out for when this is applicable to the pati situation.
- **Monoclonal antibodies.** The one effective Operation Warp Speed treatme COVID-19 was the monoclonal antibodies which blocked the spike protei both support groups and among the people I spoke to, this was one of the

therapies that actually helped vaccine injury. The effects were temporary
required repeated infusions, and React19's early survey found that while r
half did really well temporarily, about a third got substantially worse. The
longer available, as the Biden administration revoked their EUA (causing
to rapidly dispose of them) on the grounds that they were outdated and nc
bound the current COVID-19 variants—thereby denying vaccine injured p
access to this therapy (while the same logic was never extended to the vac

*Note: when I learned about the nanobody "vaccines" (bacteria which are engineered t
tiny antibodies which travel throughout your body and bind a chosen antigen [1,2]), it o
me that this could potentially be an implementable population wide treatment for spi
if the bacteria instead secreted anti-spike antibodies (as it could be quickly engineere
produced it is easy to scale up production of, in theory would only need one applicati
provide permanent protection, and in time could spread through the population to pr
everyone). Conversely, I can see a variety of reasons why this might be a very bad idea
mention it because it's one of the few things I've come across that could provide a rea
to these issues.*

The Anti-Aging Framework

One physician I corresponded with (who works in a standard insurance based
approaches all of this through the lens of accelerated aging rather than spike t
on the basis that the disease process involves seven distinct things—each of w
identifies with a specific test or history and then treats.

•**Damaged mitochondria**, which is treated with astaxanthin, urolithin A and C
along with the SS-31 peptide elamipretide at 5-10mg subcutaneously daily, MC
5-50mg weekly, and low dose methylene blue at 0.5-4mg/kg daily to support
cytochrome C oxidase function.

•**Immunosenescence from accelerated thymus involution**, which is recognize historically rather than by testing—the patient reports recurrent viral or infec illnesses every few weeks, which is the pattern of someone whose immune sys aged prematurely. As mentioned above, this is treated with sermorelin and tesamorelin (two growth hormone releasing peptides) plus thymus peptides— in cycles two or three times a year, and thymosin alpha-1 sublingually twice w

•**Persistent inflammation** (”**inflammaging**”), identified with a high sensitivity (which he prefers) or an ESR. The Vectra DA panel is the better tool but becan impractical once LabCorp acquired it and the price spiked. Treated with low c intermittent rapamycin at 6-10mg once weekly, paired with spermidine daily.

•**Insulin resistance**, identified by calculating a HOMA-IR score from fasting g and insulin, with anything above 2 treated as significant. Treated with retatru third generation triple action GLP-1, GIP and glucagon agonist, at 4-8mg wee (which can also be quite helpful for inflammatory issues).

•**Insufficient telomere length**, identified through a metabolic age panel or the seeming older than their stated age. Treated with epitalon (100mg divided acr doses over a month, two or three times a year) and TA-65.

•**Accumulated senescent cells**, which the same metabolic age testing will sug when biological age substantially exceeds chronological age. Treated with a se taken for two days at the start of each month.

•**Endothelial damage and microclotting from spike antibodies**, identified by spike antibody levels. Treated with augmented NAC twice daily and lumbroki daily.

Finally, regardless of which is the case, umbilical cord mesenchymal stem cell exosomes at 4.5ml IV plus Wharton’s jelly stem cells at 1ml IV, both every six

are the centerpiece of each protocol (which are typically given after the other a
have been stabilized, as inflammation in particular blunts what the cells can d

Note: on the metabolic age testing, he uses panels which calculate a biological age frc routine blood markers rather than a specialized assay, and Function Health (which ru through Quest) offers around 150 tests for $365, which makes this considerably more than most of what is discussed in this space.

While this protocol is different from how I approach this disease, I feel it bear mentioning, both because it fits much better into the conventional framework practitioners operate within, and because the patients it was used on are mucl representative of the typical patients one will see in practice (rather than the challenging cases which end up with providers like Dr. Kory).

Shedding

Since I have covered shedding in depth elsewhere, I will not repeat that case h beyond the mechanisms already discussed. What follows are the practical que: am most frequently asked.

Am I being affected by it?

Most people who are sensitive to shedding have already worked it out, as the p usually obvious once you look for it: becoming ill in the same situations (churc week, a crowded commute, a vaccinated partner returning from a trip), sympto starting either immediately or 6-24 hours after an exposure, and in many cases able to identify a specific "super shedder" who consistently makes you ill. Abr menstrual bleeding is by far the most common signal, followed by headaches, illness, nosebleeds, fatigue, rashes, tinnitus, sinus congestion and shingles. M

report a distinctive odor around recently vaccinated people, most often descri
sickly sweet, metallic, or like decomposition.

Three groups are most affected. The first are sensitive patients—those who al
react to chemicals, EMFs, mold or pharmaceuticals—who tend to react to the
exposures. The second are people already sensitized to the spike protein throu
vaccine injury or long COVID, whose sensitivity often increases over time. Th
are those who cannot effectively form neutralizing antibodies to the spike pro
which is the mechanism I believe underlies most of this.

*Note: exposure strength matters. Recently vaccinated or boosted individuals shed mos
the young and healthy (children most of all), and exposures are strongest in enclosed s
with prolonged contact, or with skin to skin contact. Shedding also spikes after each b
campaign and then declines.*

What can be done about it?

In practice, shedding responds to the same things vaccine injuries do, so the s
laid out above applies—though usually at the lighter end of it, since these are
more superficial injuries. Ivermectin is the most consistently useful, and Kory
found treating an asymptomatic shedder in the household (e.g., a vaccinated h
with a vaccine injury protocol frequently improves the patient far more than a
done for the patient directly. Beyond that, the spike protein binders discussed
help to varying degrees, and in my experience the most important thing is usu
restoring the physiologic zeta potential.

Some sensitive individuals have had success simply reducing the exposure itse
both UV light and chlorine dioxide inactivate the spike protein, and a few hav
disinfecting their respiratory tract (e.g., with nebulized hydrogen peroxide or a
containing a disinfectant) makes a significant difference.

Note: nicotine is frequently recommended for this, and I would be careful with it. I ho numerous asymptomatic patients who started taking it out of concern about shedding developed complications from the nicotine itself.

What about intimacy?

Sexual contact appears to be the strongest shedding exposure that exists, so so people who tolerate a vaccinated partner's presence without issue will still rea intercourse. The reports I have received here are among the saddest in the ent dataset—including partners who vaccinated specifically to protect their unvac spouse and made them chronically ill in the process, and relationships ended v regret once the pattern became clear.

That said, vaccinated partners frequently cause no issues at all. My view is tha something to be aware of rather than a rule: go slowly with a new partner so y observe how you react, be alert to whether you notice the odor in close proxim recognize that many sensitive people simply lose their attraction to shedders, tends to resolve the question on its own.

Is the blood supply safe?

This is raised constantly and I think the concern is overstated. Red blood cells cannot produce protein from mRNA, white cells are typically removed before transfusion, and the lipid nanoparticles are unlikely to still be present or intac time blood is drawn and stored. Across my own practice, colleagues, and thou reader reports, I know of only a handful of plausible transfusion injuries, and appear to have been acute reactions to spike protein in blood from someone re vaccinated rather than anything lasting.

Note: I have nonetheless avoided transfusions where possible since long before the va the blood supply carries other contaminants and repeated transfusions are associated