RESEARCH STUDIES

Challenging the Mainstream Narrative

COVID-19 VACCINES

Prepared By:

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WHAT IS THIS GUIDE?

Hi! My name is Jessica and I'm the Quick Conservative. You can find me on QuickConservative.com or Instagram at @QuickConservative.

This guide is my attempt to increase access to scientific literature so that patients can make informed treatment decisions regarding COVID-19 vaccination.

THIS GUIDE IS NOT...

- ✗ Medical advice
- ✗ Written by a doctor
- ✗ Intended as a comprehensive literature review

The following pages highlight research that the mainstream media ignores – not because I think individuals should only listen to these studies and reject all others; but because I believe balance is desperately needed.

Certain facts are currently being shouted louder than others. It is my hope that this guide will serve, in some small way, to balance the presentation of data – empowering patients to make truly informed healthcare decisions.

As the Journal of Medical Ethics reminds us:

"...the technical knowledge of healthcare professionals does not include the ethical qualifications and prerogative to decide for others."

Kottow, M. (2004). The battering of informed consent. Journal of Medical Ethics, 30(6), 565-69.

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GENERAL

COVID DATA TRACKER (2021)

MANAGED BY: Centers for Disease Control and Prevention (CDC)

GENERAL

AS OF **AUGUST 18, 2021**, THE CDC'S 'COVID DATA TRACKER' LISTS:

Cases: 37,097,850
Deaths: 621,344

Vaccines Administered: 358.6M

Fully Vaccinated People: 169.2M

Case Survival Rate (By Age)

5-17: 99.9%
18-29: 99.96%
30-39: 99.86%
40-49: 99.63%
50-64: 98.64%
65-74: 94.8%
75-84: 87.21%
85+: 74.58%

National Average: 98.3%

ON **APRIL 13, 2021**, THE CDC'S 'COVID DATA TRACKER' LISTED:

Cases: 31,015,033
Deaths: 559,172

Vaccines Administered: 190M

Case Survival Rate (By Age)

5-17: 99.9%
18-29: 99.96%
30-39: 99.87%
40-49: 99.66%
50-64: 98.72%
65-74: 95%
75-84: 87.6%
85+: 75.7%

National Average: 98.2%

NOTE: Demographic data (for age analysis) was not available for all cases, which accounts for any discrepancy between the national average (calculated by total cases and deaths).

https://covid.cdc.gov/covid-data-tracker

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VACCINES

VACCINE ADVERSE EVENTS REPORTING SYSTEM (VAERS) COVID-19 VACCINE DATA

CO-MANAGED BY: Centers for Disease Control and Prevention (CDC) and the U.S. Food and Drug Administration (FDA)

ADVERSE EFFECTS

WHAT IS VAERS: VAERS accepts reports of adverse events and reactions that occur following vaccination. Healthcare providers, vaccine manufacturers, and the public can submit reports to the system. While very important in monitoring vaccine safety, VAERS reports alone cannot be used to determine if a vaccine caused or contributed to an adverse event or illness. According to the VAERS website: "The strengths of VAERS are that it is national in scope and can quickly provide an early warning of a safety problem with a vaccine. [...] VAERS is designed to rapidly detect unusual or unexpected patterns of adverse events, also known as 'safety signals.'"

AS OF **AUGUST 6, 2021**, 'VAERS COVID VACCINE DATA' LISTS:

Reports: 571,830
Deaths: 12,791
Hospitalizations: 51,242
Urgent Care: 70,666
Office Visits: 95,887
Anaphylaxis: 5,282
Bell's Palsy: 4,461
Shingles: 6,784

Miscarriages: 1,505
Heart Attacks: 5,590
Myocarditis/Pericarditis: 4,371
Permanently Disabled: 16,044
Thrombocytopenia/Low Platelet: 2,554
Life Threatening: 13,140
Severe Allergic Reaction: 24,305

https://www.openvaers.com/covid-data

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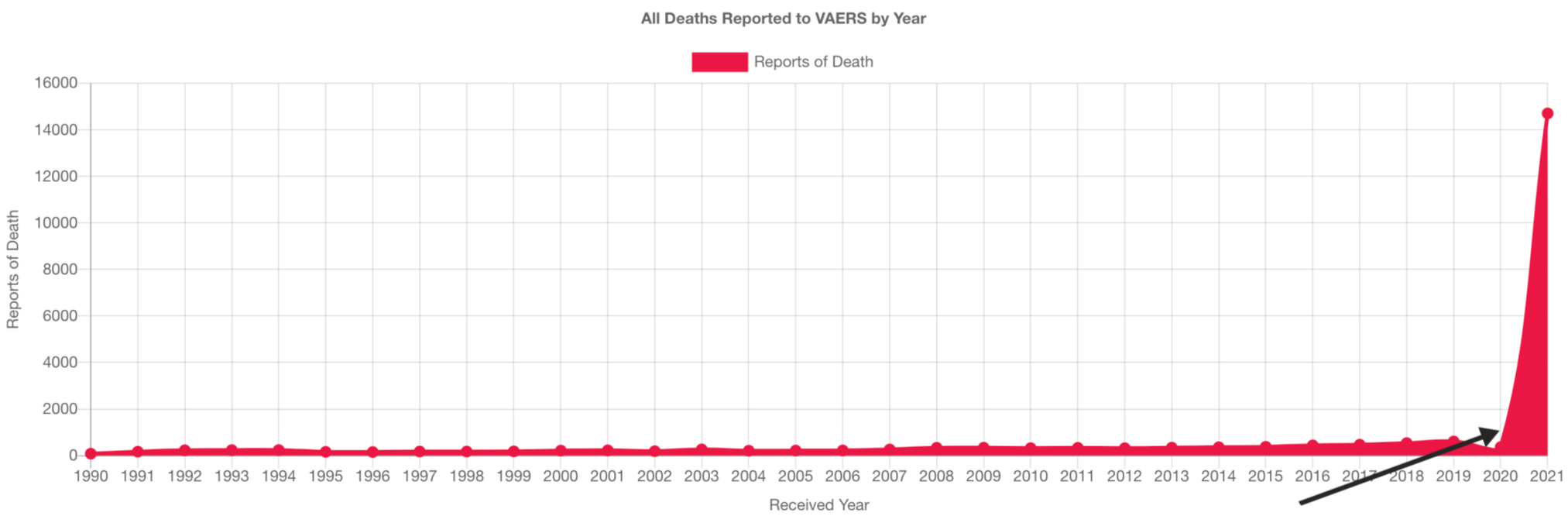
VACCINES

VACCINE ADVERSE EVENTS REPORTING SYSTEM (VAERS) COVID-19 VACCINE DATA

CO-MANAGED BY: Centers for Disease Control and Prevention (CDC) and the U.S. Food and Drug Administration (FDA)

ADVERSE EFFECTS

ALL DEATHS REPORTED TO VAERS (FOLLOWING ALL VACCINES COMBINED)



COVID-19 VACCINE STARTS

July 1, 1997 - Dec. 31, 2013

All Vaccines Combined

(16+ Years)

Vaccine Doses: ≈ 2 billion

Deaths Reported to VAERS: 2,149

Death Report Rate: 1 in 930,665

Dec. 14, 2020 - Aug. 13, 2021

Just the COVID Vaccine

(8 Months)

Vaccine Doses: ≈ 363.9 million

Deaths Reported to VAERS: 13,068

Death Report Rate: 1 in 27,848

https://www.openvaers.com/covid-data

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VACCINES

DEATHS REPORTED TO THE VACCINE ADVERSE EVENT REPORTING SYSTEM, UNITED STATES, 1997-2013 (2015)

AUTHORS: Moro, P.L., Arana, J., Cano, M., Lewis, P. & Shimabukuro, T.T.

JOURNAL: Clinical Infectious Diseases

✓ PEER-REVIEWED: Yes

ADVERSE EFFECTS

SUMMARY: Study authors searched the Vaccine Adverse Event Reporting System (VAERS) for U.S. reports of death after any vaccination from July 1, 1997 through December 31, 2013. During that time, VAERS received **2,149** death reports.

NOTES: A VAERS search for reports of death after the COVID vaccine during the first four months of 2021 alone (January 1 - May 6, 2021) yielded **3,525** results.

That means 1,376 more reports of death were filed, following COVID-19 vaccination, in roughly four months than reports of death following all types of vaccination **combined** over a **15+ year period**.

The first U.S. COVID vaccine was adminstered on December 14, 2020. Eight months later (August 18), VAERS-recorded deaths following COVID vaccination has reached **12,791.**

HOW TO SEARCH VAERS: Visit https://www.openvaers.com/openvaers. Click "search VAERS reports." Enter "COVID19" under "vax name." Customize based on your search goals.

https://www.doi.org

10.1093/cid/civ423

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VACCINES

INFORMED CONSENT DISCLOSURE TO VACCINE TRIAL SUBJECTS OF RISK OF COVID-19 VACCINES WORSENING CLINICAL DISEASE (2021)

AUTHORS: Cardozo, T. & Veazey, R.

JOURNAL: International Journal of Clinical Practice

✓ PEER-REVIEWED: Yes

ADVERSE EFFECTS

SUMMARY: The aim of the study was to determine if sufficient literature exists to require clinicians to disclose the specific risk that COVID-19 vaccines could worsen disease upon exposure to challenge or circulating virus.

QUOTES: "COVID-19 vaccines designed to elicit neutralising antibodies may sensitise vaccine recipients to more severe disease than if they were not vaccinated."

"Vaccines for SARS, MERS and RSV have never been approved, and the data generated in the development and testing of these vaccines suggest a serious mechanistic concern: that vaccines designed empirically using the traditional approach (consisting of the unmodified or minimally modified coronavirus viral spike to elicit neutralising antibodies), be they composed of protein, viral vector, DNA or RNA and irrespective of delivery method, may worsen COVID-19 disease via antibody-dependent enhancement (ADE). This risk is sufficiently obscured in clinical trial protocols and consent forms for ongoing COVID-19 vaccine trials that adequate patient comprehension of this risk is unlikely to occur, obviating truly informed consent by subjects in these trials."

https://www.doi.org

10.1111/ijcp.13795

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VACCINES

OUTBREAK OF SARS-COV-2 INFECTIONS, INCLUDING COVID-19 VACCINE BREAKTHROUGH INFECTIONS, ASSOCIATED WITH LARGE PUBLIC GATHERINGS — BARNSTABLE COUNTY, MASSACHUSETTS, JULY 2021

AUTHORS: Brown, C.M., Vostok, J., Johnson, H., Burns, M., Gharpure, R., Sami, S. Sabo, R.T.,... Laney, S.

SOURCE: CDC (MMWR) Morbidity & Mortality Weekly Report

X PEER-REVIEWED: No

VACCINATED CASES

SUMMARY: In July 2021, following multiple large public events in a Barnstable County, Massachusetts town, 469 COVID-19 cases were identified among Massachusetts residents who had traveled to the town during July 3–17; 346 (74%) occurred in fully vaccinated persons. Testing identified the Delta variant in 90% of specimens from 133 patients. Cycle threshold values were similar among specimens from patients who were fully vaccinated and those who were not.

Among the 469 cases, 346 (74%) occurred in persons who were fully vaccinated; of these, 301 (87%) were male, with a median age of 42 years. Vaccine products received by persons experiencing breakthrough infections were Pfizer-BioNTech (159; 46%), Moderna (131; 38%), and Janssen (56; 16%). Among persons with breakthrough infection, 274 (79%) reported signs or symptoms. Among fully vaccinated symptomatic persons, the median interval from completion of ≥14 days after the final vaccine dose to symptom onset was 86 days (range = 6–178 days). Among persons with breakthrough infection, four (1.2%) were hospitalized, and no deaths were reported.

https://www.doi.org

10.15585/mmwr.mm7031e2

VACCINES

COMPARING SARS-COV-2 NATURAL IMMUNITY TO VACCINE-INDUCED IMMUNITY: REINFECTIONS VERSUS BREAKTHROUGH INFECTIONS (2021)

AUTHORS: Gazit, S. Schlezinger, R., Perez, G., Lotan, R., Peretz, A.,, Ben-Tov, A., Cohen, D., Muhsen, G.C., & Patalon, T.

SOURCE: medRxiv (pre-print)

X PEER-REVIEWED: No

VACCINATED CASES

SUMMARY: Researchers conducted a retrospective observational study comparing three groups: (1)SARS-CoV-2-naïve individuals who received a two-dose regimen of the BioNTech/Pfizer mRNA BNT162b2 vaccine, (2) previously infected individuals who have not been vaccinated, and (3) previously infected and single dose vaccinated individuals.

QUOTES: "SARS-CoV-2-naïve vaccinees [people whoe received the vaccine] had a 13.06-fold increased risk for breakthrough infection with the Delta variant compared to those previously infected, when the first event (infection or vaccination) occurred during January and February of 2021. The increased risk was significant for symptomatic disease as well."

"This study demonstrated that natural immunity confers longer lasting and stronger protection against infection, symptomatic disease and hospitalization caused by the Delta variant of SARS-CoV-2, compared to the BNT162b2 two-dose vaccine-induced immunity."

https://www.doi.org

10.1101/2021.08.24.21262415

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VACCINES

REINFECTION RATES AMONG PATIENTS WHO PREVIOUSLY TESTED POSITIVE FOR COVID-19: A RETROSPECTIVE COHORT STUDY (2021)

AUTHORS: Sheehan, M. M., Reddy, A. J., & Rothberg, M. B.

JOURNAL: Clinical Infectious Diseases

✓ PEER-REVIEWED: Yes

IMMUNE SYSTEM

SUMMARY: Of 150,325 patients tested for COVID-19 infection, 8,845 (5.9%) tested positive and 141,480 (94.1%) tested negative. 1,278 (14.4%) of the positive patients were retested after 90 days, and 62 had possible reinfection. Of those, 31 (50%) were symptomatic. Of those with initial negative testing, 5,449 (3.9%) were subsequently positive and 3,191 of those (58.5%) were symptomatic. Protection offered from prior infection was 81.8% (95% confidence interval 76.6 to 85.8), and against symptomatic infection was 84.5% (95% confidence interval 77.9 to 89.1). This protection increased over time.

QUOTES: "Prior infection in patients with COVID-19 was highly protective against reinfection and symptomatic disease. This protection increased over time, suggesting that viral shedding or ongoing immune response may persist beyond 90 days and may not represent true reinfection."

https://www.doi.org

10.1093/cid/ciab234

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VACCINES

SARS-COV-2 REINFECTION RISK IN AUSTRIA (2021)

AUTHORS: Pilz, S., Chakeri, A., Ioannidis, J. P., Richter, L., Theiler-Schwetz, V., Trummer, C., Krause, R., & Allerberger, F.

JOURNAL: European Journal of Clinical Investigation

✓ PEER-REVIEWED: Yes

IMMUNE SYSTEM

SUMMARY: This is a retrospective observational study using national SARS-CoV-2 infection data from the Austrian epidemiological reporting system. Scientists recorded 40 tentative re-infections in 14,840 COVID-19 survivors of the first wave (0.27%) and 253,581 infections in 8,885,640 individuals of the remaining general population (2.85%), translating into an odds ratio (95% confidence interval) of 0.09 (0.07 to 0.13).

QUOTES: "In this study in the whole general population in Austria with a follow-up of over half a year, those individuals with a previous SARS-CoV-2 infection had a significant reduction by 91% for the odds of a re-infection versus the odds of a first infection in the remainder general population."

"Protection against SARS-CoV-2 after natural infection is comparable with the highest available estimates on vaccine efficacies."

https://www.doi.org

10.1111/eci.13520

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VACCINES

ANTIBODY STATUS AND INCIDENCE OF SARS-COV-2 INFECTION IN HEALTH CARE WORKERS (2021)

AUTHORS: Lumley, S. F., O'Donnell, D., Stoesser, N. E., Matthews, P. C., Howarth, A., … Oxford University Hospitals Staff Testing Group

JOURNAL: New England Journal of Medicine

✓ PEER-REVIEWED: Yes

IMMUNE SYSTEM

SUMMARY: Studying 12,541 health care workers in the United Kingdom, scientists performed a prospective longitudinal cohort study to assess the relative incidence of subsequent positive SARS-CoV-2 PCR tests and symptomatic infections in health care workers who were positive for SARS-CoV-2 antibodies and in those who were negative. The presence of anti-spike or anti-nucleocapsid IgG antibodies was associated with a substantially reduced risk of SARS-CoV-2 reinfection in the ensuing 6 months.

QUOTES: "No symptomatic infections and only two PCR-positive results in asymptomatic health care workers were seen in those with anti-spike antibodies, which suggests that previous infection resulting in antibodies to SARS-CoV-2 is associated with protection from reinfection for most people for at least 6 months."

"Evidence of postinfection immunity was also seen when anti-nucleocapsid IgG or the combination of anti-nucleocapsid and anti-spike IgG was used as a marker of previous infection."

https://www.doi.org

10.1056/NEJMoa2034545

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VACCINES

NECESSITY OF COVID-19 VACCINATION IN PREVIOUSLY INFECTED INDIVIDUALS (2021)

AUTHORS: Shrestha, N.K., Burke, P.C., Nowacki, A.S., Terpeluk, P. & Gordon, S.M.

JOURNAL: medRxiv (pre-print)

IMMUNE SYSTEM

✗ PEER-REVIEWED: Not yet (as of August 15, 2021)

SUMMARY: Cumulative incidence of COVID-19 was examined among 52,238 employees in an American healthcare system. COVID-19 did not occur in anyone over the five months of the study among 2,579 individuals previously infected with COVID-19, including 1,359 who did not take the vaccine.

QUOTES: "This study shows that subjects previously infected with SARS-CoV-2 are unlikely to get COVID-19 reinfection whether or not they receive the vaccine."

"...credible reports of previously infected persons getting COVID-19 are rare."

"When such reinfections occur, it would be purely speculative to suggest that a vaccine might have prevented them."

Also addressed the Denmark/Lancet study that concluded natural infection cannot be relied on: "[That] study did not compare vaccinated and unvaccinated people, and it is therefore an assumption to consider that a vaccine would have provided better protection in that particular population."

https://www.doi.org

10.1101/2021.06.01.21258176

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VACCINES

PRIOR SARS-COV-2 INFECTION IS ASSOCIATED WITH PROTECTION AGAINST SYMPTOMATIC REINFECTION (2021)

AUTHORS: Hanrath, A. T., Payne, B., & Duncan, C.

JOURNAL: The Journal of Infection

✓ PEER-REVIEWED: Yes

IMMUNE SYSTEM

SUMMARY: The study authors previously defined a cohort of over 11,000 healthcare workers (HCWs) with documented evidence of previous infection status during the first wave of the SARS-CoV-2 pandemic, from March to April 2020. A second wave of SARS-CoV-2 transmission occurred in their setting from October to November 2020. Researchers undertook a retrospective analysis of HCW testing data during this second wave, to address the question of whether previous SARS-CoV-2 infection was associated with protection.

QUOTES: "Protection against short term reinfection has been observed in a non-human primate model of SARS-CoV-2. A small clinical study was also suggestive. Immunity to seasonal coronaviruses is maintained for up to 12 months."

"Despite 290 symptomatic infections in 10,137 non-immune HCWs, there were no symptomatic reinfections in over 1,000 HCWs with past infection. We conclude that SARS-CoV-2 infection appears to result in protection against symptomatic infection in working age adults, at least in the short term."

https://www.doi.org

10.1016/j.jinf.2020.12.023

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VACCINES

SARS-COV-2 INFECTION RATES OF ANTIBODY-POSITIVE COMPARED WITH ANTIBODY-NEGATIVE HEALTH-CARE WORKERS IN ENGLAND: A LARGE, MULTICENTRE, PROSPECTIVE COHORT STUDY (SIREN) (2021)

AUTHORS: Hall, V. J., Foulkes, S., Charlett, A., Atti, A., Monk, E., Simmons, R., Wellington, E., Cole, M. J., Saei, A., Oguti, B., … SIREN Study Group

JOURNAL: Lancet

IMMUNE SYSTEM

✓ PEER-REVIEWED: Yes

SUMMARY: A large, multi-centre, prospective cohort study was done, with participants recruited from publicly funded hospitals in all regions of England. Enrollment lasted from June 18, 2020 to December 31, 2020; 25,661 participants were included in the analysis.

QUOTES: "A previous history of SARS-CoV-2 infection was associated with an 84% lower risk of infection, with median protective effect observed 7 months following primary infection. This time period is the minimum probable effect because seroconversions were not included."

"This study shows that previous infection with SARS-CoV-2 induces effective immunity to future infections in most individuals."

"This study supports the hypothesis that primary infection with SARS-CoV-2 provides a high degree of immunity to repeat infection in the short to medium term; with similar levels of prevention of symptomatic infection as the new licenced vaccines for working-age adults."

https://www.doi.org

10.1016/S0140-6736(21)00675-9

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PROTECTION OF PREVIOUS SARS-COV-2 INFECTION IS SIMILAR TO THAT OF BNT162B2 VACCINE PROTECTION: A 3-MONTH NATIONWIDE EXPERIENCE FROM ISRAEL (2021)

AUTHORS: Goldberg, Y., Mandel, M., Woodbridge, Y., Fluss, R., Novikov, I., Yaari, R., Ziv, A., Freedman, L., & Huppert, A.

JOURNAL: medRxiv (pre-print)

IMMUNE SYSTEM

✗ PEER-REVIEWED: Not yet (as of August 15, 2021)

SUMMARY: Researchers analyzed an individual-level database of the entire population of Israel to assess the protection efficacy of both prior infection and vaccination in preventing subsequent SARS-CoV-2 infection, hospitalization with COVID-19, severe disease, and death due to COVID-19. Vaccination was highly effective with overall estimated efficacy for documented infection of 92.8%; hospitalization 94.2%; severe illness 94.4%; and death 93.7%. Similarly, the overall estimated level of protection from prior SARS-CoV-2 infection for documented infection is 94.8%; hospitalization 94.1%; and severe illness 96.4%.

QUOTES: "This study suggests that both the [Pfizer] BNT162b2 vaccine and prior SARS-CoV-2 infection are effective against both subsequent SARS-CoV-2 infection and other COVID-19–related outcomes."

"Moreover, the effectiveness seems similar for both cohorts [Pfizer BNT162b2 vaccine and prior SARS-CoV-2 infection]. This puts into question the need to vaccinate recent (up to six month) previously-infected individuals."

https://www.doi.org
10.1101/2021.04.20.21255670

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VACCINES

RECONCILING ESTIMATES OF GLOBAL SPREAD AND INFECTION FATALITY RATES OF COVID-19: AN OVERVIEW OF SYSTEMATIC EVALUATIONS (2021)

AUTHORS: Ioannidis, J.

JOURNAL: European Journal of Clinical Investigation

✓ PEER-REVIEWED: Yes

COMPARISONS

SUMMARY: Researchers analyzed six systemic COVID-19 evaluations - each covering data from 10 to 338 studies (spanning 9-50 countries).

QUOTES: "Allowing for such residual uncertainties, reassuringly the picture from the six evaluations assessed here is relatively congruent: SARS-CoV-2 is widely spread and has a lower average infection fatality rate (IFR) than originally feared, and substantial global and local heterogeneity. "

"...even 'common cold' coronaviruses have an infection fatality rate ~10% in nursing home outbreaks."

"Global infection fatality rate [of COVID-19] is approximately 0.15% with 1.5-2 billion infections as of February 2021."

NOTE: A British Medical Journal study describes 0.5% as "the upper [IFR] range seen for seasonal influenza" (Garske et al., 2009), while the World Health Organization (2020) puts the average "below 0.1%." Using CDC data from 2010/11-2018/19 (excluding asymptomatic cases), AAP fact-checkers (2020) put a "crude [flu] IFR at 0.13%." These figures suggest an influenza IFR range of <0.1% to 0.5%.

https://www.doi.org

10.1111/eci.13554

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INFECTION FATALITY RATE OF COVID-19 INFERRED FROM SEROPREVALENCE DATA (2021)

AUTHORS: Ioannidis, J.

JOURNAL: Bulletin of the World Health Organization

✓ PEER-REVIEWED: Yes

COMPARISONS

SUMMARY: Researchers analyzed included 61 studies (74 estimates) and eight preliminary national estimates to determine the infection fatality rate (IFR) of COVID-19.

QUOTES: "Infection fatality rates ranged from 0.00% to 1.63%, corrected values from 0.00% to 1.54%. Across 51 locations, the median COVID-19 infection fatality rate was 0.27% (corrected 0.23%)."

"The inferred infection fatality rates tended to be much lower than estimates made earlier in the pandemic."

NOTE: A British Medical Journal study describes 0.5% as "the upper [IFR] range seen for seasonal influenza" (Garske et al., 2009), while the World Health Organization (2020) puts the average "below 0.1%." Using CDC data from 2010/11-2018/19 (excluding asymptomatic cases), AAP fact-checkers (2020) put a "crude [flu] IFR at 0.13%." These figures suggest an influenza IFR range of <0.1% to 0.5%.

https://www.doi.org

10.2471/BLT.20.265892

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INFECTION FATALITY RATIOS FOR COVID-19 AMONG NONINSTITUTIONALIZED PERSONS 12 AND OLDER: RESULTS OF A RANDOM-SAMPLE PREVALENCE STUDY (2020)

AUTHORS: Blackburn, J., Yiannoutsos, C. T., Carroll, A. E., Halverson, P. K., & Menachemi, N.

JOURNAL: Annals of Internal Medicine

✓ PEER-REVIEWED: Yes

COMPARISONS

SUMMARY: This study aimed to estimate infection fatality ratios (IFRs) among noninstitutionalized (that is, community-dwelling) populations by using the first U.S. statewide random-sample study of SARS-CoV-2 prevalence.

QUOTES: "Indiana's [COVID-19] IFR for noninstitutionalized persons older than 60 years is just below 2% (1 in 50). In comparison, the ratio is approximately 2.5 times greater than the estimated IFR for seasonal influenza, 0.8% (1 in 125), among those aged 65 years and older."

"The overall noninstitutionalized IFR was 0.26%. Persons younger than 40 years had an IFR of 0.01%."

NOTE: A British Medical Journal study describes 0.5% as "the upper [IFR] range seen for seasonal influenza" (Garske et al., 2009), while the World Health Organization (2020) puts the average "below 0.1%." Using CDC data from 2010/11-2018/19 (excluding asymptomatic cases), AAP fact-checkers (2020) put a "crude [flu] IFR at 0.13%." These figures suggest an influenza IFR range of <0.1% to 0.5%.

https://www.doi.org

10.7326/M20-5352

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TIPS

"Follow the science" does not mean "follow the narrative."

The very nature of science necessitates debate and a constant evolution of ideas - which means scientists are going to disagree with scientists, doctors are going to disagree with doctors. This is a GOOD THING, because it pushes the field forward.

✗ Don't assume that one study "proves" anything

✗ Don't be surprised if someone counters your study with another study

✗ Don't be bullied (a study doesn't become less valid just because a prominent scientist or doctor disagrees it - keep in mind: the original study author probably disagrees with HIM!)

✓ Stay open-minded (change your position if new evidence supports it)

✓ Keep your arguments grounded (no need for exaggerated claims): "No, we can't say anything for sure - but the data highlights concerns that require more research..."

To find any of the cited studies, visit https://www.doi.org/ and enter the number in the yellow box under "resolve a DOI name."

Studies typically have an abstract that you can access/print even if you can't view the full article. Abstracts break down the study's highlights, so the main information you need is all there!

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