Slide 1

Slide 2 We are a group of six women including a mother whose daughter died after receiving the Gardasil vaccine and another whose daughter suffered adverse reactions. Over the last three years we have committed our time to research, educate and communicate what we have come to believe are the potential dangers of the HPV vaccines. We represent a growing global community of parents, who are dedicating energy, time and knowledge to assist those families desperate to understand what happened to their daughters, and to bring out the truth about Gardasil and Cervarix so there will be "one less" instead of "one more" innocent victim.

We speak on behalf of families around the world to bring justice to the thousands of adversely injured girls and the estimated hundreds of girls who have died from Gardasil and Cervarix.

Slide 3 Webinar Researchers & Participants

Slide 4 Not a day goes by that one of us receives an email from a parent whose daughter was affected by the vaccination. They all have so many questions. We are going to address what we feel are the most common and widespread concerns.

Slide 5 The international stories, spreadsheet and graphs that have been prepared represent a sample of the injuries occurring to adolescent girls globally.

As we all know Gardasil is administered in the United States. It is now licensed for use under the name Silgard in 120 more countries. In Spain, the Netherlands and in over 100 countries Cervarix is administered. In many countries both vaccines are licensed.

When reading the many reports of girls adversely affected it becomes quickly evident that the symptoms they are experiencing are part of a pattern of events that are similar *wherever* the HPV vaccines are administered around the world.

The occurrences are happening months to years post vaccination.

The handouts and in particular the graphs demonstrate this very point.

Slides 6 The HPV vaccines were developed with the purpose of preventing cervical cancer in women who have not been previously exposed to the HPV types in the vaccines.

Slide 7 To achieve maximum benefit vaccination should occur before sexual debut. -

Section I

Slide 8 **My daughter is now sick after the HPV vaccination and has warts on her hands and feet. Is HPV really only an STD?**

The next series of slides will address whether HPV is transmitted solely via sexual contact.

Slide 9 In the first research paper there is growing evidence that HPV infection is acquired through non-sexual routes and that one potential route is mother-to-child transmission in the perinatal period; referenced as vertical transmission.

In the second paper, it was noted that HPV's have been detected in virgins, infants/children, and juvenile Laryngeal papillomatosis was shown to be caused by these viruses. It has been acknowledged that HPVs may be transmitted by other non-sexual routes as well.

Slide 10 Another scientific paper authored by Rintala, Marjut A M (2005) found high risk types of human papillomavirus (HPV) DNA in oral and genital mucosa of infants during their first three years of life. *Experience from the Finnish HPV Family Study. Clinical Infectious Diseases 41(12)*

The research papers in the Journal of Medical Virology from scientists at King's College, London indicate additional points of concern. The first link entitled "High prevalence of human papillomavirus type 16 infection among children" raises a very important statement: "Before immunisation programmes can be designed, however, it is necessary to know the age of acquisition and all routes of infection for these viruses."

This important statement demonstrates that infection can occur without sexual contact.

This paper also documented that HPV-16 DNA was detected by nested PCR in 138 of 267 (51.7%) samples.

More than half of the samples that were taken were HPV 16 positive.

The second paper from King's College entitled "Buccal exposure to human papillomavirus 16 is a common yet transitory event of childhood." This paper cites two groups of children being tested. In the first group there were a number of children who were tested as being negative. 30 months later, a second oral swab was collected from each child. On this second testing, 40% of the HPV16 positive group had no detectable HPV 16 DNA; conversely, 63% of children who were originally HPV16 negative had now acquired the virus. The overall conclusion is that HPV16 DNA in the oral cavities of children is a transient event and is most probably acquired through their peers.

These infections may pass quickly enough through the bodies of these young children but if they are vaccinated while infected then the reality is "If infected then not protected."
What is not known is whether the HPV could lay dormant similar to the Chicken Pox virus which later in life causes shingles?

SECTION II

Slide 11 **My daughter has received an irregular pap test two years after the vaccination series. I thought the vaccine was supposed to prevent this?**
According to the National Vaccine Information Center there are 272 events reported to VAERS for HPV, HPV2 and HPV4 when the query is smear cervix abnormal.

Slide 12 The research that was carried out in this paper submitted to the FDA was on young women who tested positive for the HPV strains 16 or 18. The facts speak for themselves; the table indicates that the efficacy of Gardasil after vaccinating infected young women dropped to a staggering minus 44.6%. This not only left these women completely vulnerable and without any protection but also has put them in our opinion at greater risk of getting HPV CIN/3 lesions in later life. Using only the Gardasil group this breaks down to 20 out of every 100 women will have CIN 2/3 or worse.

The risk of introducing a vaccine concurrently with an infection is unfortunately the trigger to more serious problems in the future.

Slide 13 As you can see in this slide, participants that were both PCR positive and seropositive for the HPV types in the vaccine have a 33.7% greater chance of cervical cancer.

There is no reason to believe that this will not also apply to Cervarix. The small print on GlaxoSmithKline Cervarix product insert states: "Cervarix does not prevent HPV-related lesions in women infected with HPV 16 or HPV 18 at the time of vaccination and has not been shown to have a therapeutic effect." This statement cannot be much clearer.

Slide 14 Above data shows that Cervarix has a negative efficacy similar to Gardasil. If a participant was DNA positive and seropositive they are 32.5% more likely to acquire cervical lesions in our opinion.

They even state that the vaccine did not show a therapeutic effect in subjects HPV DNA positive.

Slide 15 **C**onclusions: Evidence detailed here regarding the poor efficacy of both Gardasil and Cervarix on already infected women has to be investigated further. If this is occurring in established infected groups of women then what will be occurring in the bodies of adolescent girl's who in many cases may already be sexually active and be infected at the time of vaccination? In the United States and United Kingdom, HPV SCREENING DOES NOT TAKE PLACE TO DETERMINE IF HPV INFECTION IS ALREADY PRESENT.

Pap screening does not start in the United States until the age of 21; Scotland at the age of 20 and in England/Wales at the age of 25. The American College of Obstetricians and Gynecologists "ACOG's new guidelines, state that women 30 and older should be screened for cervical cancer whether by conventional or liquid PAP test once every 2 years, instead of annually as was previously recommended."

It has recently been reported in the UK that teenagers as young as 14 are sexually active; are becoming pregnant and that medical people are encouraging 16 year olds and older to be vaccinated *even though* they may be sexually active. Great risks are being taken with the future of our young people. The promise has been made by Merck and GlaxoSmithKline that in most cases those who are vaccinated will be protected from the HPV strains which cause cervical cancer. The figures presented now state quite clearly that this is not the case.

Slide 16 The information presented thus far indicates that the majority of young girls and women will fall under the category of negative efficacy or no efficacy with regard to the HPV vaccines.

Considering that both manufacturers reported negative efficacy if positive, there is now the very real risk that these females now have the potential for cervical lesions and cancer at earlier ages than previous studies have determined. When initial pap screening takes place for a woman in her early 20's, an 11 year old who may already have HPV anti-bodies present has the chance of HPV infection prior to the availability of screening. If this infection is not caught early it could lead to cervical lesions and possibly cervical cancer.

We are now receiving emails regarding females who have irregular cells detected 2 to 3 years after receiving the vaccination series.

Section III

Slide 17 **Why is my daughter so sick now when she was always so healthy before the vaccination?**

This is a resounding concern expressed by all the parents that we have been in contact with over the years. The next series of slides addresses this concern.

Slide 18 First of all, the placebo used in the Gardasil trials was not a *true saline only placebo*. What is referenced as a placebo in these studies is actually the carrier solution of the vaccine.

When analyzing the first table it shows that 73.3 percent of participants that received Gardasil acquired a new medical condition; from flu-like symptoms to paralysis. The concern is that approximately ¾ of the female target population will suffer from some type of "new" medical condition as a result of these vaccines - increasing medical costs for families including uninsured medical visits and diagnostic, and lab testing.

In table 32 almost 60% of the participants experienced some type of systemic adverse reaction within 15 days. The concern is that some systemic adverse reactions can vary per individual and may not truly manifest until 30 days post vaccination. The percentage in this table could have the potential to be much higher if the evaluation period is at least one month.

Slide 19 Please note the HPV column. Over 35% of the participants suffered from fatigue, over 31% suffered from headaches (it is unknown whether some of them could have been of migraine intensity but did not stop normal activity) and 31% suffered from myalgia.

The concern is that these are "termed solicited" meaning that approximately one third of the participants were expected to suffer from these adverse events.

Break down: the total HPV group had 18,544 doses and three doses administered to an individual there were 6119 participants. 2020 participants or approximately 1⁄3 of the participants suffered from these "expected" conditions in the study group.

The 'other general' category includes 16,964 doses administered to 5598 participants. 1847 participants or approximately 1⁄3 had a reaction. 31% suffered from myalgia as a solicited symptom.

Slide 20 In this table the Gardasil numbers reflect day 1 to 15 for the reporting time period. Cervarix numbers only reflect day 1 to 7 for the reporting time period. No numbers were available for day 1 to 15 for Cervarix. If the reporting was for an extended period of time similar to Gardasil, probability dictates these percentages may be much higher.

For the most part Cervarix elicits a much higher percentage of adverse events in the initial days after inoculation over Gardasil. The comparison suggests that Cervarix is much less safe than Gardasil.

High percentages of fatigue, headache and myalgia may also be initially construed as the flu and not Cervarix related and therefore would not be reported as an adverse event related to the vaccination until the symptoms persists past the one week time frame for flu.

Slide 21 Population numbers from the 2007 and 2008 census were taken along with the percentages from the CDC document to ascertain the approximate number of adolescents vaccinated. The chart indicates that 6,533,460 received at least one dose of Gardasil (HPV4). 17.9% or 1,877,190 received all three doses. Subtract that from the total that received at least one dose and the balance indicates that 4,656,270 girls never completed the series.

The average the difference in the total number indicates that 71.3% did not finish the series. This percentage is in direct contrast to the 73.3% that is listed in TABLE 79, New Medical Conditions After Day 1 in Studies HPV-007, -013, -015, -016, -018 in the Safety Population (Final Close-out data). (Already presented in slide 10).

The concern is that this population of young women could have developed a 'new medical condition' and therefore discontinued the series. There are many parental accounts to back up this theory. An immediate follow-up by an independent entity must be enacted to determine if indeed the series was discontinued on the basis of the development of adverse reactions.

The percentages presented in the previous slide regarding the potential high adverse

reaction rates for Cervarix has the potential for an even higher discontinuation rate. These two facts directly impact the health care system and a family's personal finances. This has the potential be an economic catastrophe in the making.

Section IV.

Slide 22 **After reporting my daughter's reactions to VAERS (Vaccine Adverse Event Reporting System) I became curious to see how many other girls are like my daughter. There are so many I am now afraid my daughter will not get better.**

Slide 23 An analysis of the VAERS database from 6/1/2006 – 10/26/2009 compared 100% of all reports filed for all 80 vaccines listed including UNKNOWN with 100% of all identifiable HPV reports filed during the same time period shows disturbing differences. Gardasil statistics in VAERS do not appear to be comparable to other vaccine adverse events.

As demonstrated in the next tables, the report classification was used to compare the total reports to VAERS to only the HPV reports after June 1, 2006. These percentages are disturbingly high in comparison and show an increased trend of injury related to the HPV Vaccine.

In the 3 and ½ years the Gardasil vaccine has been on the market the total number of reports to VAERS makes up 21.7% of ALL reports submitted on or after June of 2006 to present.

The first graph is titled "Life Threatening" events. If the HPV reports are subtracted from all the vaccines, a yearly trend indicates that there would be 27 reports for all vaccines (excluding the HPV vaccines) compared to an annual trend of 90 reports of "Life Threatening" events for HPV only.

This suggests that there will be an approximate 329% increase in life threatening reports of adverse reactions solely due to the HPV vaccines.

The second graph, "ER Visits", shows an annual trend of 1321 or 86% more reports due to the HPV vaccines.

Slide 24 In the first graph, Hospitalized, there is an annual trend of 229 reports for all vaccines without the HPV and an annual trend of 504 reports for only HPV.

This is an increase of a 220% annual trend of Hospitalized reports because of the HPV vaccines.

The second graph, Extended Hospitalizations there is an annual trend of 38 more reports due to the HPV vaccines. This is an increase of 265% due to the HPV vaccines.

Slide 25 The first graph, “Did Not Recover” shows an annual trend of 428 or an increase reports for all vaccines (HPV excluded) and an annual trend of 869 reports or an increase of 203% for only the HPV vaccine

The second graph, “Disabled”, shows an annual trend of 128 more reports or a 372% increase due to the HPV vaccines.

Slide 26 The last graph, “Vaccines Deaths” there is an annual trend of 6 reports for all vaccines (excluding HPV) and an annual trend of 12 reports or 184% for only HPV.

As suggested in these graphs, since June of 2006, the HPV vaccine injuries and deaths have exceeded the total amount of all other vaccines. With the approval of Cervarix and the vaccination of adolescent men in 2009 the trend of adverse events is expected to increase exponentially.

Slide 27 The purpose of this graph is to show the dominance of Gardasil (HPV4) in VAERS compared to other vaccines. This graph contains the number of VAERS reports of injuries from a single vaccination. Gardasil (HPV4) has a clear lead for the number of reported adverse events for the same time period.

Slide 28 The purpose of this graph is to show the dominance of Gardasil (HPV4) in VAERS compared to other vaccines. This graph contains the number of VAERS reports of injuries from multiple vaccinations. Gardasil (HPV4) has a clear lead for the number of reported adverse events for the same time period.

Slide 29 This slide compares the rates of adverse events reported pre and post Gardasil. The numbers highlighted in dark blue signify more males reporting than females. The red box signifies the target population for the HPV vaccines.

Prior to the introduction of Gardasil on 05 / 31/ 06 adverse events reported by 11 to 13 year old females was only 3.8% greater than males.

After 06 /01 /06 the adverse event reporting by females increased to 44.7% more than males.

It is understood that this could be the result of more efficient reporting but it is not logical for it to be the sole reason. The dramatic increase in adverse reactions between females and males can only be attributed to the inclusion of the HPV vaccine Gardasil. A similar increase in adverse event reporting is apparent in all age groups receiving the HPV vaccination.

Slide 30 Numbers highlighted in blue reflect more males reporting than females.
This analysis of the VAERS numbers per annum suggests that with the advent of Gardasil the rates of reporting drastically increase.

Example: in the 11 – 13 year old group there are 23.9% more males reporting in 2005 than females. With the introduction of Gardasil into the market in 2006, the rate in adverse reactions in males decreased 11.4%.

In 2007 there is a drastic increase of 41.5% more females reporting adverse events than males. This increase is also evident in 2008 and it is projected that in 2009 the reports will be between 36% and 40%.

It is evident that since Gardasil was approved the same dramatic increase is seen throughout the analysis.

The concern is that Merck has applied for approval to expand the vaccination age group for females to 27 to 36 year olds. We already see that from 2006 through 2009 there are over 55% more females reporting adverse events than males. There is a real possibility of a significant projected 50% increase in reporting as evidenced in the present target population of females.

This new target population of females more than likely will be mothers with small children and/or who provide a second income for the family. Adverse reactions in this group would be devastating to their families if they become part of the 73.3% that acquired a "new medical condition."

Approval for this age group should be delayed until further studies by an independent party are performed.

Section V

Slide 31 **I am 18 and my friends and I received the Gardasil series. Why do I have an autoimmune disorder and they do not?**

Slide 32 In the three years we have been researching Gardasil we have been in contact with hundreds of parents via phone, personal email and message boards. WE have been able to ascertain that the majority of the girls injured or who died were athletes with a high GPA. Many of the girls had no pre-existing conditions and some had a family history of medical issues mainly allergies.

Slide 33 Subgroups of females affected from the Gardasil vaccine are those who are athletic and therefore had a higher 24 hour testosterone secretion.

Slide 34 This data in this slide suggests that testosterone levels in female athletes increases by 24% pre-event and 49% during the competition. This further emphasizes that the higher level of testosterone could play a vital role in adverse events reported after vaccination by athletic females.

Slide 35 Subgroups of females affected from the Gardasil vaccine are those that are overweight. The relationship between this group and the athletic girls is once again testosterone. During the course of our interactions with overweight females it has been noticed especially with dark haired females that they would have a certain amount of facial hair. This could be evident with a few strands on the chin or a mild mustache. Many have hair extending from above the ear to just above the jaw line. This is known as Hirutism and is caused by hormone imbalance.

The publication from the Johns Hopkins University they mention "greater circulating levels of testosterone" as an important contributor to certain disease conditions. This elevated testosterone level in females could also be a contributing factor to why some of the girls affected by Gardasil happen to be overweight.

Slide 36 Menarche is a very fragile time in an adolescent girl's time. In fact, it is the most fragile time of her life. There are many factors that determine the strength of the endocrine system and how well it will adapt to its environment. Studies have shown that menarche is occurring at a younger and younger age. In addition adolescent girl's reproductive hormones are active up to two years prior to first menstruation. It must be noted that both the immune and endocrine system are bombarded with many more environmental toxins than in the past. Many of these toxins emit estrogen mimickers that upset a woman's hormone balance. Menstrual cycle evaluation and hormone balance must be considered during for a vaccination program for any age group of women. Inoculation of the 9 to 26 age group poses many dangers as cited in the following studies on menstrual cycle evaluation.

Slide 37 Stress and the menstrual cycle phase are crucial factors in regards to immune response. As this study notes Gender and menstrual cycle phases affect the predisposition of individuals for certain diseases. Vaccination during the premenstrual (luteal) phase may indeed predispose a young woman to more severe adverse reactions. Of great concern is the immature endocrine system in young adolescents when ovulation may take place from day 1 after menses or day 101. Until ovulation occurs it is impossible to determine when the luteal phase begins. Stress levels are also elevated during vaccination – and a young woman's "fear" of needles and/or injection.

Study 2 – emphasizes that understanding sex differences in stress regulation has important implications for understanding basic physiological differences in the male and female brain and their impact on vulnerability to sex differences in chronic medical disorders associated with stress response circuitry.

Study 3 suggests that (1) NK cytotoxicity was higher in the follicular than in the luteal phase of the menstrual cycle. The study underlines the importance of evaluating when a woman's body may be able to tolerate an injection of foreign substances into her body.

Slide 38 Many of the girls adversely affected by the HPV vaccines have been diagnosed with PCOS. This study links that condition with high levels of testosterone. It is suggested that high levels of testosterone are responsible for this demographic of high achieving adolescents are at higher risk of adverse reactions from the HPV vaccine.

Hair loss amongst the girls adversely affected – and those who died have been a major concern. The Mayo Clinic cites that among other issues – **Alopecia areata**; classified as an autoimmune disease - **cause unknown**. People who develop alopecia areata are generally in good health. A few people may have other autoimmune disorders, including thyroid disease. Some scientists believe that some people are genetically predisposed to develop alopecia areata and that a trigger, *such as a virus or something else in the environment, sets off the condition.*

Slide 39 In this study on mercury's influence on luteinizing hormone (LH) Dan R. Laks with the Mental Retardation Research Center, David Geffen School of Medicine, at UCLA cites that LH is the only hormone with a rare and well characterized, high affinity binding site for mercury. On its catalytic beta subunit, LH has the structure to preferentially bind inorganic mercury almost irreversibly, and, by that manner, accumulate the neurotoxic element. Mercury is abundantly found in the environment and food sources including infant formula and corn syrup. Ingestion of mercury is not uncommon for most of the population.

In his next study on aluminum and the endocrine system, aluminum deposits in the pituitary, parathyroid, and adrenals has been demonstrated to interfere with parathyroid hormone secretion, insulin like growth factor and T3 levels, and the reproductive system. This study suggests that aluminum may be affecting normal endocrine system functioning and the reason why this demographic is experiencing annovulatory cycles – especially at a time when the endocrine system is immature and developing its own regulatory pattern.

This study demonstrates that diagnosis and *reduction* of an increased heavy metal body load improved the spontaneous conception chances of infertile women.

In the study on Hormone Allergy, the authors suggest a connection between symptoms
Slide 40 associated with hormone changes to a hormone antibody response.

Page 37 of the NATO Life Sciences book "Immunological Adjuvants and Vaccines," states studies that demonstrate "aluminum causes stimulation of the production of anaphylactic antibody (IgE) in the mouse", and that "the effect of aluminum on the IgE response in humans *does not appear to have been investigated. "*

The study on Histamine Metabolism During the Menstrual Cycle is of grave concern since L-Histadine is in Gardasil. This study cites that estrogen already releases the natural amino acid. At mid-cycle an increase in the urinary excretion of histamine metabolites was

sometimes evident and a statistically significant correlation could be established between MeHi (methylhistamine) and estrogen in urine. These results may support previous findings of histamine release by estrogens in uterine tissue but may also reflect an elevated histamine formation. The allergic woman excreted constantly increased amounts of histamine and its metabolites, especially when her allergic symptoms became aggravated premenstrually.

Other studies listed in the handout cite menstrual cycle evaluation for other women's health issues. To date an independent study on menstrual cycle evaluation and vaccination has not been conducted. The need for this assessment should have been considered in the initial studies on potential adverse reactions for both HPV vaccines.

SECTION VI

Slide 41

How do the side effects my daughter is experiencing compare with other children?

Gardasil Girls give the Silent Faces of Autism a Voice

Slide 42 Many of the adverse reactions experienced by girls affected by the vaccine mirror reactions those of children who become autistic. The difference is that the autistic child has lost the ability to speak. Suggested parallels:

Head banging by an autistic child could mean that they have a migraine which is one of the symptoms of an adverse Gardasil reaction.

Constant rubbing of legs by the autistic child could mean that they are experiencing tingling or numbness. This is also a complaint by girls afflicted by the vaccine.

Loss of speech by the autistic child. The difference here is that the Gardasil Girls have mastered speech so they do not lose this ability but many have a difficult time concentrating, retaining information and complain of "brain fog".

When comparing these two population sets the possible similarities become of great concern.

Slide 43 In women with Polycystic Ovarian Syndrome PCOS, androgens are typically elevated, increasing oil secretion and hair growth contributing to many of the symptoms the young girls experience; acne, increased facial hair growth and male pattern hair loss. The imbalance of hormones frequently affects the menstrual cycle by preventing ovulation and causing irregular cycles.

Many of the VAERS reports and comments from parents in regards to their daughters often mention circulation issues. The most referenced are drops in blood pressure and fainting. Quite a few of the parents that we are in contact with have mentioned that they constantly monitor their daughters because when this happens the girls have breathing issues that could require CPR.

The other symptom of interest is migraines. Many of the girl's migraines are so bad that they become unable to perform normal everyday functions. Some do experience photophobia and confine themselves to their bedrooms until the migraine subsides. Towards the end of this presentation we will address why this could be happening to these females.

SECTION VI

Slide 44 **Why Did My Daughter Die?** Not a day goes by that our family does not mourn the loss of our beautiful daughter, Megan Hild. My oldest daughter, Shauna is traumatized by the fact that she encouraged Megan to get Gardasil.

I will not live with a cause of death unknown on her autopsy report. I will not tolerate the "expert's" who told me that Megan was ready to leave this life. I spoke with my daughter two hours before she died. She was vibrant, beautiful, healthy, and embraced her life, her future – her family and her boyfriend.

Slide 45 In and of it self, 61 reports are not many considering how many females received the HPV vaccination. What is of grave concern is what is stated in many of those reports. Except for the last three items they all reference the heart.

We want to bring your attention to these last three causes of death. In essence the cause of death is undetermined. In the next slides we have done an analysis based on these reports of young women who are now disabled or have new medical conditions.

Slide 46 What brought the heart to our attention was an autopsy report voluntarily sent by a parent of a young 18 year old female. In the opinion section several items caught our attention and that had to do with the heart. This young woman's heart was enlarged. This was referenced in this report as "the most significant finding."

The report goes into more detail as to the possible reason for this condition. It was determined that arrhythmogenic right ventricular dysplasia (ARVD) was a possible cause. The diagnosis of this report was "Undetermined Cause of Death".

When you read the symptoms of ARVD and the other heart conditions referenced in the previous slide the symptoms reflect what we are hearing from the Gardasil Girls. Also, if you go back to the VAERS reports listed are events that could be heart related like drop in blood pressure and fainting. Our investigation into this matter brought us some startling results.

Slide 47 The mother of this young woman sent us a report about the medical issues that preceded her daughter's death.

After the third vaccination the circulatory symptoms of pins and needles and tingling in her hand started.

One month later she started to have night sweats, concentration and memory issues. The

night sweats can be attributed to a disruption of the endocrine system via the brain stem brought about by chemical menopause.

Four months after the third vaccination there are complaints of chest pain and heart palpitations along with a sore and achy back and abdominal pain.

One year after the first vaccination this young woman died in her sleep.

Slide 48 Many of the parents of girls adversely affected by the vaccine tell us that their daughters are suffering from intermittent chest pain and difficulty breathing. This is of great concern to them because they are afraid that their daughter could die.

Gardasil is the first vaccine to use L-Histidine as a buffer agent to keep the pH at 6.0-6.2. Studies into the relationship between a Histidine injection causing too much Histamine has not been performed.

With that being said we have to do something that we are very uncomfortable with and that is propose a "what if" scenario.

What if, a young woman receiving an injection with Histidine already has a family history of allergies which pre-disposes them to elevated levels of histamine? The additional Histidine could result in the release of large amounts of histamine H2. This would cause vasodilation and a stimulation of the heart's H3 receptors which could cause arrhythmia. This could also cause Myocardial Ischemia.

Slide 49 Now that there is the initial overload of Histamine causing dilation of the circulatory system, there is now an excess of norepinephrine and the H3 (Histamine 3) receptors to offset the abundance of H2.

In essence there is the initial dilation of the circulatory system which accounts for the fainting within minutes of the vaccination and reports of very low blood pressure.

Then there is the excessive H3 release that can trigger a sensation of tightness of the chest or difficulty breathing (cardiac dysfunction and arrhythmias) which is evident in the VAERS reports.

The concern is that silent damage to the heart is occurring after the first vaccination. Then the circulatory system is re-challenged two more times potentially causing permanent damage to the heart (Myocarditis, ARVD or Cardiomyopathy).

This is a real possibility because of the two reports presented in slides 39 and 40.
It is known that cardiac issues leading to arrest can be silent and do not occur overnight. They happen over a period of time and are unique to the individual. This could account for the time frame differences of the 18 year old (ten months after first vaccination) and the 19 year old (one year after first vaccination).

Slide 50 The initial vaccination is the challenge. With the HPV vaccines there are two more shots with the same ingredients called the re-challenge. The basic understanding of the challenge and re-challenge is: with the first vaccination you are priming the pump so to speak. With the second inoculation (re-challenge) the pump goes into overdrive. With the third inoculation (re-challenge) the pump now goes into hyper drive.

Once again because this area has not been studied a "what if" scenario needs to be explored.

A young woman receives her first HPV vaccination. She feels dizzy so she is required to lie down for 15 to 20 minutes. This is the challenge. A few days later she feels tired, achy and just unwell. She attributes this to the flu and dismisses the symptoms.

She receives the second HPV vaccine and again she feels dizzy but this time she faints. This is the first re-challenge. Again she has flu-like symptoms which are accompanied by a rash. These symptoms are also dismissed as anxiety and the flu. The only difference is that the flu-like symptoms do not totally go away.

Now she goes back and receives the third vaccine. Once again she faints but also experiences tonic/clonic movements of her body. This time it is noted that her blood pressure is low but recovers after a period of time. This is the second re-challenge.
In the following weeks and months she not only has the flu-like symptoms return but she starts feeling confused, has sporadic feelings of not being able to breathe properly and her menses stop.

As time goes by her state of confusion increases making it difficult to do normal tasks. The tightness in her chest increases and is accompanied by some pain. She is also experiencing abdominal and back pain. This is dismissed as stress related.

This is what is being reported by mothers of adolescent girls and young women.

The concern is that because of the activation of the inflammatory histamine by IgE during The immune response to histamine is damaging the various organs and circulatory system causing damage to the brain stem and spinal cord where histamine receptors are also found.

Immune response to the vaccine has been studied for 36 months and shows high levels of anti-bodies. What is not known is how long the IgE is active in the body because of the re-challenge by the vaccines. If the IgE is still active 2 months to 2 years after vaccination there may be ongoing damage being done to the CNS and other organs of the body because of histamine activation.

We feel that this may be the reason for the prevalence of auto-immune diseases and the reason why it takes many females a prolonged period of time for more disabling medical conditions to manifest.

Slide 51 Resources cited in determining the cause of events in regards to histamine and IgE involvement.

Slide 52 There are several physiological issues that are responsible for the dramatic increase in adverse event reports for the HPV vaccines.

During the follicular phase of the menstrual cycle, the production of estrogen releases histamine. During the luteal phase the protective effects of estradiol sharply decline, the production of progesterone increases and the immune system becomes more easily compromised; succumbing to the overdose of histamine from three sources: L-Histidine in the vaccine, increased amounts of estradiol in the body from natural production plus environmental toxins (estrogen mimickers) and the body's own natural production of histamine. The rise and decline in hormones; the rise and decline in immunity and the overproduction of histamine – may be a factor as to why the health of the girls adversely affected by the HPV vaccines is not improving.

Both HPV vaccines are VLP's (virus like particles). This can be termed 'molecular mimicry' and when an antigen in a vaccine is structurally similar to an antigen in the host antibodies are produced that react with the host's normal tissue.

Allergy sufferers with moderate to severe asthma have IgE levels greater than 1,000 U/ml. Normal serum IgE levels in individuals without allergies is less than 70 U/ml. An increase in IgE means more free IgE is available for binding to the activated mast cells. More mast cell activation and degranulation may lead to an increased release of inflammatory histamine. This reaction also leads to TH2 cytokine and leukotriene secretion, resulting in systemic anaphylaxis in the form of allergy.

This proves an increased risk of injury due to an overload of histamine being released from the mast cells causing a more severe inflammatory response throughout the body. Tissue damage due to this process can cause hypertrophy of smooth muscles. Smooth muscles are evident in the heart. With the rechallenge to an already active immune response we could have more smooth muscle damage especially to the heart and damage to the Central Nervous System.
With all our research completed, due to the lack of safety testing in regards to hormone, histamine and IgE level effects due to challenge and rechallenge on the female and male physiology the risks of the HPV vaccines outweigh the benefits.

Slide 53 On behalf of the parents around the world we are asking that more studies be conducted on Gardasil and Cervarix before the vaccines are administered to more healthy, innocent and young women and men.

Slide 54 On behalf of all the parents whose daughters have died or who have been adversely injured from the HPV vaccines, we want to thank you for your interest and participation in the FDA sponsored "listening session."