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Hepatitis C Transmission

BLOOD TRANSFUSIONS & VACCINE CONTAMINATION

Summary:

The Hepatitis C epidemic is discovering what was. In 1988, 242,000 Hepatitis C infections were reported annually. These high figures were reported from the 1960s throughout 1980s. **Since 1989 and mandatory heating or washing of blood products, the annual number of new infections had declined more than 80 percent by 1998.**

The conditions that existed during the Vietnam & Cold War era for processing blood, blood products and vaccines were indefensible. The blood was not heated despite hundreds of warnings from federal scientists to do so. The arm pits of foreign countries, skid row USA and prisons supplied over fifty percent of the nations blood supply during this time. Scientist began to scream **"HEAT THE BLOOD"** as early as **1968**. Needless to say their warnings were ignored.

In **1948**, The government began **experimentation on prisoners with hepatitis**, as a result, prisons have been in epidemic status since 1963. The facilities and other questionable sources, **supplied at least fifty percent of the blood processed here and 30% of the blood processed in Canada** (Krever Commission Report). The products sold to Canada were turned into immune globulin vaccines & freeze dried (lyophilized) blood and blood products. These products were resold back to the US military. The products were not processed according to the strict standards in place today.

The blood supply is responsible for HBV/HCV/HIV/HPV and other blood borne pathogen epidemics. The high infection rates reported, decreased 80%, once effective detergents were added to blood products that couldn't be heated.

The military personnel infected **shared toothbrushes**, **manicure** items, **razors** and **rags**. They had **surgery**, **dental** or **medial**, and received **injections** with **reusable needles**. All had **finger sticks** with **reused lancets by technicians that did not wear gloves**. Everyone was **vaccinated by jet injection and many with reused bifurcated** (two-pronged) needle that is dipped into the small pox vaccine solution, a blood based product.

In **1959 a test was developed** to detect elevated liver enzymes. Another test, the **HB Core Test was developed in 1972,** and commercially available since **1975**. Nether test was used until **1986**. Why? Because the **collectors had to pay for the test and then reject donors that tested positive.** It would have cost billions of dollars to implement testing.

Click on the titles to view articles

Oct. 2008 **The hazards of blood transfusion in historical perspective**- Harvey J. Alter1,*, and Harvey G. Klein1,* ...over the course of almost 3 decades... Retrospective testing showed that only 25% of TAH was hepatitis B–related... 75% of cases tentatively classified as non-B hepatitis ... In 1975, ...NIH discovered the hepatitis A virus (HAV), and we immediately tested stored sera from our non-B hepatitis cases. Surprisingly, not a single case was due to HAV, the only other known hepatitis virus at that time. Hence, the origin of the designation "non-A, non-B hepatitis,"...

- **1948 Experimentation with Hepatitis**
  April 5, 1948 letter from C.J. Watson, M.D., Army Epidemiological Board to Dr. McLeod, with a copy to Dr. Stokes and others

  Dear Dr. MacLeod: I have given careful consideration in the past few weeks to **the matter of using volunteers in penal institutions for experimentation, with particular reference to hepatitis**.

- **The Blood, Plasma, and Related Programs in the Korean War** A plasma program was also developed which later had to be discontinued because of the risk of serum hepatitis associated with plasma infusions (p. 776). The production of human serum albumin was substituted for the production of plasma and was supplemented by the production of plasma expanders (the so-called blood substitutes of World War II).

- **1995 Philadelphia Inquirer**
  final Section: EDITORIAL REVIEW & OPINION Page: E01 SUNDAY April 16, It is one of the little-known stories of World War II. **Had more attention been paid** to it, hemophiliacs in the United States might not be dying now at the rate of one a day. It was 1944, five years into the war

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- **1969 New York Times** Washington, July 28 -- The 59-year old doctor, whose companies have been blamed for the repeated use of dangerous methods and inadequate equipment, is estimated to have produced the plasma for about a fourth of an important byproduct that is widely used to protect people exposed to infectious diseases.... An executive of Cutter Laboratories once acknowledged, for instance, that gross contamination was apparent in the areas where the largest blood plasma operations were conducted. The rooms were "sloppy," he observed...When a Government doctor asked why Cutter continued to reward such an enterprise with hundreds of thousands of dollars' worth of business, the executive explained that the Stough group enjoyed crucial "contacts" with well placed officials. .....

  With neither Government nor industry intruding, with most of their records held in secret, with officials passing the problem on to someone else, Dr. Stough prospered at his work throughout the nineteen-sixties. .....

  The gamma globulin from most donors contains enough antibodies against such diseases as measles and hepatitis to be effective when it is reinjected into a person who has been exposed to those diseases. ....Groups of donors receive vaccinations to build up the antibodies in the gamma globulin intended to treat these illnesses. The result is known as hyperimmune gamma globulin, and much of the plasma Dr. Stough extracted was used by manufacturers to produce this serum. It can be a hazardous process. ..... By April, 1963, five months after Dr. Stough had opened his

plasmapheresis center at Kilby, the incidence of viral hepatitis an often fatal disease of the liver, was climbing sharply. .....At Kilby, for example, 28 per cent of the men who participated in Dr. Stough's program came down with the disease. For those who did not take part, the rate was only 1 percent. .....
.

The Food and Drug Administration, citing regulations of the Department of Health, Education and Welfare, refused requests by The Times to examine its records on Dr. Stough. A spokesman for the agency said, however, that since 1963 the physician has carried out some 130 investigational studies for 37 drug companies. Other types of tests and work by an associate involved 45 additional programs. .....The F.D.A. declined to disclose the names of the drugs that Dr. Stough examined or the names of the companies for which he worked. Some of the information has been obtained from other sources, however. .....Dr. Stough incurred no Federal disfavor for the hepatitis epidemic in three states because **the disease apparently was routinely killed out in the manufacturing process that turned his plasma into gamma globulin. .....**." (see this link)

What about the communicable disease center, which traced the hepatitis epidemic directly to Dr. Stough's programs? That agency, a spokesman said, is only a consultant to the states. Enforcement is up to the state authorities. .....

CUMMING PRISON

The FDA has suspended plasma production at the Arkansas Department of Correction facility at Grady, where an average of 550 to 600 inmates have been giving plasma since 1967, but now is setting an April 23 deadline for the prison system to seek a hearing on the proposed permanent revocation.

-Overbleeding of inmate donors;
-Using donors previously disqualified because of a history or symptoms of hepatitis, which can be transmitted through plasma;
-Inadequate storage of plasma to prevent contamination; and
-Failure to note on the plasma whether testing had been done for signs of hepatitis and syphilis.

- **American Society of Microbiology** June, 1999 Several Huge Lawsuits Pending Over Tainted Blood in Canada One available source of such plasma was Health Management Associates (HMA), a private company which ceased operations in 1994. ...acquired blood plasma from prisoners, ... had been officially terminated in 1971 in Canada-- and in 1982 in the United States ....NOT SO ... prison plasma pumped through 1994 in BOTH Arkansas and Louisiana under Liddy Dole's "revamped" blood system].

  Nonetheless, prisoners at the Department of Corrections unit in Grady, Ark., some of whom had symptoms ... were still permitted to donate plasma. **"Unbelievably, the U.S. Food and Drug Administration] allowed the high-risk plasma to be exported to Canada .....**

  - **BLOOD BROKER INVESTIGATED BY FBI**
    IN 1974 - Foundation for 1980s Tainted Blood Scandal Washington Weekly 4/18/99 By Ricki Magnussen **"The procedure started a few months ago when in New York the FBI found out that this firm violated the law.** Bureau of Biological (BB) states: FDA is keeping a close eye on their plasma, they have tested so far about 20 lots, of the last six lots four were found to be HB [hepatitis B] antigen positive.

  - **FDA DEFENDS EXPORT OF HIGH-RISK BLOOD**
    February 12, 1999 The Associated Press Canadian tainted-blood victims are demanding an inquiry into why the **FDA continued to license prison blood centres despite evidence that prisons were hotbeds of HIV and hepatitis C infection.**

  - **The Attack Dog: The Role of The FDA** 1970 FDA Commissioner Dr. Herbert **Ley blows the whistle on the FDA and its corrupt relationship with the medical and pharmaceutical cartels.** It is ignored by an intimidated government. Ley is forced out and replaced.

- **THE BLOOD BROKERS: HOW BLOOD, THE 'GIFT OF LIFE,' BECAME A BILLION-DOLLAR BUSINESS**
  Gilbert M. Gaul, Inquirer Staff Writer
  PHILADELPHIA INQUIRER; FINAL Page: A01
  SUNDAY September 24, 1989

  First in a series

  The potential for fatal mistakes is "a ticking time bomb," said Frank E. Young, commissioner of the Food and Drug Administration.....No one - not the federal government, not the blood banks themselves - knows for sure how much blood is bought and sold on the open market. There are no requirements that sales be reported; no government agency keeps track.....All of which should be of grave concern to Americans, for the very safety of the nation's blood supply is at stake..... Blood collectors say they have done everything possible to ensure the safety of the blood supply. Yet confidential documents show the industry ignored or delayed using readily available tests and procedures to make blood and transfusions safer.

  * At a time when AIDS was showing up in the blood supply in the early 1980s, the FDA reduced its inspections of blood-collecting facilities from once a year to once every two years.

  * Thousands of pints of suspect blood and other blood components have been released by blood banks and commercial plasma centers as a result of testing errors, computer problems and other mistakes.

  This haphazard system exists because the United States has failed to develop a comprehensive blood program that ensures adequate, safe supplies to all regions of the country at fair prices.....The United States is one of only a handful of Western nations that leave the collection and distribution of blood scattered among a patchwork of private and quasi-public groups....."What we have is not so much a system as a non-system," said Norman R. Kear, administrator of the Red Cross' blood center in Los Angeles. "Blood-collecting groups like the Red Cross cooperate when it is in their interest to cooperate, and when it's not in their interest, they fail to cooperate."

- **Philadelphia Inquirer**
  April 16,1995 “On the Trail of Tainted Blood-gives an in-depth report of our Governments knowledge of Hepatitis transmission. “A 1976 government report recited this U.S. Food and Drug Administration definition of safety for biologic products: **"Safety means the relative freedom from harmful effect to persons affected by a product when prudently administered, taking into consideration the character of the product in relation to the condition of the recipient at the time.**

“Thomas C. Drees says hepatitis was considered an unfortunate but unavoidable downside of the business…. In an interview, said that when he joined the industry in 1972, "it was sort of accepted that all of the workers in our plant were positive for hepatitis B, and so were all the hemophiliacs, and it was accepted that all the hemophiliacs would probably die of hepatitis at some time in their lives." "But when AIDS came on the scene . . . **then they started heat-treating - and, son of a gun, it got rid of most of the AIDS," Drees said. Had the government demanded heating earlier to kill hepatitis B, he said, "I think that would have saved the game"** when AIDS erupted.” “One published study, performed by federal health researchers from 1968 to 1971… concluded that hepatitis B was a common occurrence in plasma-industry workers. Similar studies already had been done at blood banks and hospitals.”

- **AFIDAVIT OF THOMAS DREES**
  This is the AFFIDAVIT OF THOMAS DREES STATE OF CALIFORNIA Thomas C. Drees Sworn Dec. 15, 1988: He has been retained as an expert witness in the case of John Doe v. Cutter He is an expert in the area of the manufacturing, marketing, safety, supply, and processing of blood products. He was the Chief Executive Officer of Alpha Therapeutics, one of the Defendants in this case, from 1978 to November 1983.

He states he has seen "documents which indicate fractionators in conjunction with Dennis Donohue of the FDA and the AABB and ARC **conspired to prevent the use of the HB Core Test from being implemented to prevent having to incur the expense of the test to avoid having to reject donors who were positive for the test." "**It is now clear to me that the HB Core Test should have been used from the time it became available through Abbott Laboratories in 1975." "there was such resistance to the use of the HB Anti Core Test by the blood industry, and the blood industries resistance to take the most obvious and needed precautions to the AIDS epidemic convinces me that there was a concerted effort by the influential leaders of the blood industry to save dollars at the expense of lives, even when it was clear beyond any doubt that there was widespread contamination of the blood supply.

- **THE GLOBE AND MAIL**
  THURSDAY, FEBRUARY 27, 1975
  Federal regulations violated Contamination problems danger of infection reported at Connaught-Among the most serious were the **"grossly inadequate" quarters for control testing of Sabin polio vaccine.**

- **Blood Money**
  1976 Maclean's Magazine December 27,1976 Health The Arkansas prison system has been in near-perpetual crisis since at least 1970, 'The plasma program began in the 1960s as a way for inmates and the prison system to make extra money. " they would say, **'No, I've just given plasma.' It was clear they were sick."**

1971 June Daily Colonist
Friday 25, Victoria, BC **"All blood distributed by the Red Cross transfusion service in BC is being tested** for an elusive form of hepatitis, the origins of which have been discovered only during the past two years."

1971 The Vancouver Sun Jan. 14
"Red Cross **Jail blood barred in health fear**" states in 1971 the Canadians band the use of Prison blood because of the high hepatitis infection rate of the prisoners.

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1969: On June 9, 1969, Dr. D.M. McArtor, then Deputy Director of Research and Technology for the Department of Defense, appeared before the House Subcommittee on Appropriations to request funding for a project to produce a synthetic biological agent for which humans have not yet acquired a natural immunity. Dr. McArtor asked for $10 million dollars to produce this agent over the next 5-10years. The Congressional Record reveals that according to **the plan for the development of this germ agent, the most important characteristic of the new disease would be "that it might be refractory [resistant] to the immunological and and therapeutic processes upon which we depend to maintain our relative freedom from infectious disease".** AIDS first appeared as a public health risk ten years later.

In 1970, a study by researchers at the National Institutes of Health, published in the Journal of the American Medical Association, warned that just **one unit of hepatitis-contaminated plasma could contaminate an entire pool. Diluted 10 million times, it still was infectious.**

1969~1974 - VA - Anicteric **hepatitis [HCV] has developed four times [400%]more frequently than icteric [HBV] hepatitis, the total incidence for all 6 years being 11.3%**. There is indirect evidence to suggest that an undefined agent is responsible for the majority of instances of post-transfusion hepatitis occurring presently. PMID: 1235478

1973 - **Should we try to prevent epidemic hepatitis at present?** PMID: 4360123

1975 "A General Accounting Office (GAO) study of FDA revealed that **150 FDA officials owned stock in the companies they were supposed to regulate."** -Barry Lynes, _The Healing of Cancer_, Marcus Books, Box 327, Queensville, Ontario, L0G 1R0, Canada, 1989, pg. 22

"Since 1965, federal **executive orders and implementing regulations have prohibited employees from engaging in outside activities** that are not compatible with the full and proper discharge of the duties and responsibilities of their government employment. The prohibition includes activities that involve the acceptance of a fee or anything of value in circumstances in which acceptance may result in or create the appearance of conflict of interest or that may result in the appearance using public office for private gain." (United States General Accounting Office, GAO/GGD-92-34 Employee Conduct Standards, February 1992). Despite this, FDA has a documented history of conflict of interest.

"In 1964, Congressman Melvin Laird (Wisconsin), demanded from FDA data concerning the number of FDA officials who left the agency to take their next job with FDA-regulated industry. FDA responded that **one in ten (83 of 613) who left FDA** between 1959 and 1964 had done so."

-Omar Garrison, _The Dictocrats_, ARC Books, New York, 1970
"A study conducted by the US Congress in 1969 revealed that 37 of 49 top FDA officials who left the agency moved into high corporate positions with the large companies they had regulated."

-Barry Lynes, _The Healing of Cancer_, Marcus Books, Box 327, Queensville, Ontario, L0G 1R0, Canada, 1989, pg. 22

1977, the World Federation of Hemophilia **called on the makers of clotting concentrates to kill viruses in their products**

1978 - Transfusion hepatitis: **the blood label could make you liable.** PMID: 703480

1980 - Post-transfusion hepatitis B: a presently treatable problem? PMID:7428649

1980 - Post-transfusion hepatitis: can the problem be solved today? PMID:7353503

1982 Transfusion Plasma derivatives and viral hepatitis. Gerety RJ, Aronson DL 347-51
"The risk of hepatitis B associated with plasma derivatives is reduced … by HBsAg screening of donors"

1983 A dry-heat process for cleansing blood is developed in the U.S. Internal **documents evidence that the blood products companies knew it was unsafe but marketed it nonetheless** until lawsuits forced a halt around 1987.

11/20/92 – Newsday 1983-Dr. Thomas Drees forced out as President of Alpha Therapeutics Co. because he believes the blood products they produce are dangerous.

March 1983: The CDC reports that AIDS seems to have spread among hemophiliacs through unheated blood products. The U.S. Food and Drug Administration approves a heat-treated blood product developed by Travenol Co., now Baxter World Trade Co.

1984 - 1994. The center **continued to draw prisoners' plasma for another decade and finally closed its doors in 1994 for a simple reason. It could no longer find a buyer for its controversial product.**

Krever Commission Report

On November 26, 1997, Health Minister Allan Rock, on behalf of the federal government, released the final report of the Commission of Inquiry on the Blood System in Canada (Krever Commission).

On November 25, 1998, the Health Minister observed the first anniversary of the report by reaffirming the federal government's commitment to blood safety. He added that Health Canada took action concerning each one of the commission's final recommendations that concerned the Department.

Volume 1- Introduction
The Scope and Nature of the Inquiry

A nationwide public health calamity occurred in Canada during the late 1970s and the 1980s. The national blood supply was contaminated with two infectious viruses, one causing a newly emerging disease, the other causing a

disease that had existed for many years but had not previously been identified precisely. The first of these infectious agents was the human immunodeficiency virus (HIV), which causes acquired immune deficiency syndrome (AIDS). It contaminated the blood supply in the late 1970s and early to mid-1980s. More than 1,000 persons in Canada were infected with HIV through the bloo.....Others became infected after using factor concentrates, blood products used to treat hemophilia, that were made from the pooled plasma of many thousands of donors. Persons with severe hemophilia depended on these blood products for their health and used them as often as several times a week.....Suspicion was focused immediately on the only element that was common to all their histories, the use of blood products. That suspicion became a certainty in 1984, ...

Volume II
The Risk in Factor Concentrates

Volume III
International Responses

Appendix A

In 1993 testimony before a House subcommittee, FDA Commissioner David A. Kessler said that he believed his **agency had erred in its relationship with the blood industry.** The FDA's reliance upon voluntary compliance was "emblematic of our collegial approach to regulated industry at that time," he said. "Those days are behind us" he states.

Note: This is the same excuse given for the Vioxx scandal in 2005.

Disease spread as blood test was delayed
Link includes original communication memos and letters.

By KAREN DILLON
2003 The Kansas City Star

WARNING SIGNS: In the 1970s, about 1,500 hospital patients participated in the Transfusion-Transmitted Viruses Study. **Researchers concluded that ALT testing could slow the spread of hepatitis** C. However, the blood testing was delayed for years. The infected blood from the study is stored at BBI Biotech in Gaithersburg, Md., for future research.

Special to ABCNEWS.com
A simple blood test might have prevented hundreds of thousands of cases of hepatitis C.... **A study back in 1959 showed that blood donors with raised ALT levels were three to five times more likely to transmit hepatitis** "Perhaps Congress should investigate why ALT testing was not implemented until 1986." " might want to inquire why the Food and Drug Administration never issued a formal regulation requiring ALT testing and how blood industry representatives who sat on government health committees may have influenced decisions about testing." **"Is this a typical example of what governments do after they miss an opportunity to prevent the spread of an illness, and is the government liable in this case?**

1999

COMMITTEE OF TEN THOUSAND

What we have discovered over the years of investigating this issue said Kuhn is "nothing short of shocking and represents the worst medical scandal in US history". Even after the CDC warning, these practices continued unabated according to COTT President, Corey Dubin, who stated that **"blood product manufacturers such as the Bayer Corporation, Baxter Healthcare, and Alpha Therapeutics continued to purchase and use for the manufacture of blood products prison plasma that they knew was contaminated with HCV and HIV".**

2002

Criminal Charges laid in Canadian Blood Scandel

It validates (the knowledge) that my infection was not brought on by God but by a man-made decision that placed money over my safety," said McCarthy, on the verge of tears.

The RCMP blood task force charged:

The Canadian Red Cross Society,
Dr. John Furesz, former director of the bureau of biologics at the federal government's health protection branch,
Dr. Wark Boucher, former chief of the blood products division of the bureau of biologics at the health protection branch,
Dr. Roger Perrault, former director of the Canadian Red Cross Society's blood transfusion service,
Armour, a Bridgewater, N.J., pharmaceutical company,
Dr. Michael Rodell, former vice-president of Armour

2003

Red Cross Under Fire

FDA inspectors found more than 200 safety violations.....**The Red Cross shipped infected blood, failed to screen out risky donors, even some who admitted having HIV, and lost track of more than a thousand units, including small amounts infected with HIV or Hepatitis C.** And some Red Cross employees were told to skip safety steps or falsify records to allow infected blood to be released. Despite years of violations, the Red Cross has insisted things can't be that bad because not many people are getting sick from transfusions.

The FDA needs to, if not take over, heavily oversee a re-design of the blood system. And in some cases they need to start from scratch," Paul Cololery, editor in chief of Non-Profit Times tells Attkisson.

A Bait-and-Switch Charity - The Scandalous History of the Red Cross-Charity Navigator gives the Red Cross a Five Star Rating - **yet the history of this corporatized organization tells a story of unparalleled corruption.** ...The leading administrators and officials of the Red Cross are almost always drawn from the corporate boardroom or the military high command. Among the past chairs and presidents of the Red Cross are seven former generals or admirals and one ex-president.

2008 Red Cross penalties more than $19 million in recent years The Food and Drug Administration has fined the Red Cross an additional $4.6 million for the distribution of "unsuitable blood products," bringing penalties against the organization to more than $19 million in recent years.

New 2008 Problems Persist With Red Cross For 15 years, the American Red Cross has been under

a federal court order to improve the way it collects and processes blood. Yet, despite $21 million in fines since 2003 and repeated promises to follow procedures intended to ensure the safety of the nation's blood supply, it continues to fall short

Lawsuit Says Companies Sold Tainted Blood
Cutter goes to trial ☺
Plaintiffs' claims arise out of the **most egregious misconduct in the history of the pharmaceutical industry, which resulted in the killing of thousands** of hemophiliacs worldwide, with a continuing death rate of hundreds of victims per year. Defendants are American corporations which manufactured blood products known as "Factor VIII" and "Factor IX" for the treatment of hemophilia, and sold these products to hemophiliacs worldwide, despite knowledge that the products were manufactured from sick, high risk donors and/or known to be contaminated with the viruses that cause AIDS and Hepatitis C (now known as HIV and HCV respectively). Defendants continued selling these products to hemophiliacs abroad even after the products were no longer being used in the United States due to the known risk of AIDS and Hepatitis C transmission. Plaintiffs are hemophiliacs from countries outside the United States who contracted HIV and/or Hepatitis C through use of Defendants' contaminated products.

2005

CLINTON'S SCOTTISH COURT WARNING The Daly Record (UK)
31 October 2005 FORMER US President Bill Clinton may be forced to appear in court over a medical scandal which claimed the lives of innocent Scots. Many haemophiliacs were infected with hepatitis C after tainted blood from American prisoners was imported into the UK.

Immunoglobulins- used as starter material for many vaccines.

Three generations of immunoglobulin
1986 The first purified human immunoglobulin G (IgG) preparation used clinically was immune serum globulin (ISG), which was prepared in the 1940s by E. J. Cohn's group. It was originally formulated in water with 0.3 M glycine at pH 6.8 and was 70%-80% monomeric.

Immunoglobulin Transmits Hepatitis C. True or False?
Intramuscular immunoglobulin preparations are prepared according to the Cohn fractionation process, which separates the fraction containing antibodies that neutralize various infectious agents. The resulting preparations are highly concentrated (16% in solution and containing 160 mg of protein/mL). Other manufacturing procedures do not ensure the same safety.

The safety of HCV-RNA-positive Intramuscular immunoglobulin preparations can be attributed to several factors:

(1) partitioning of viruses away from immunoglobulin,

(2) inactivation of viruses by the fractionation process, and

(3) a high concentration of neutralizing antibodies

Human Immunoglobulins for Intravenous Use and Hepatitis C Viral Transmission

Cohn's method number 6 was particularly amenable to largescale use. This method results in five major fractions: fraction I (fibrinogen), fractions II and III (gamma globulins), fraction IV (alpha and beta globulins), and fraction V (albumin). As expected, differences in fractionation and purification processes between manufacturers exist ...Variations of the original Cohn method (30, 52, 72), combined with more subtle adjustments in precipitation and filtration conditions, make it difficult to generalize about a cold alcohol procedure.

Outbreak of Hepatitis C Associated with Intravenous Immunoglobulin Administration — United States, October 1993–June 1994

Safety and availability of immunoglobulin replacement therapy in relation to potentially transmissable agents Clinical & Experimental Immunology Volume 118 Issue s1 Page 29 - October 1999... However, the role of partitioning of viruses cannot be taken in isolation; when antibodies to HCV were removed following the introduction of screening, the amount of recoverable HCV-RNA in the various Cohn fractions changed dramatically as a result of the virus no longer being complexed with antibody. [28] ...As Cohn–Oncley fractionation is not sufficient to remove lipid-coated viruses, additional antiviral inactivation steps are required.

INTRAVENOUS (HUMAN) Rho(D) IMMUNE GLOBULIN
For transfusion related sensitization, treatment is recommended for Rh-negative children and women of childbearing age who received Rh-positive red cell containing components

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Drug Company Admits Unsafe Vaccines Were Used inoculated in the 1960s and 1970s with toxic whooping cough vaccines

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Did the Shots Cause HCV
"Intramuscular immune globulin is safe and has never transmitted hepatitis C or any other infectious disease as licensed in the United States," said Miriam Alter, the CDC's chief hepatitis epidemiologist.

Hepatitis C Origin
Points to Possible Military Link Copyright 1999 by Forward Times- DOCUMENTS RAISE QUESTIONS ABOUT VIETNAM ERA EXPERIMENTS ED WENDT-Documents obtained by Forward Times under the Freedom of Information Act, for an investigation of the hepatitis C epidemic, reveal that U.S. servicemen were used to test experimental vaccines while they were in Basic Combat Training during the Vietnam Era" " blood samples of American servicemen taken in 1948 were recently reviewed during a study. Those samples detected the hepatitis C virus."

1999 - **Benefits and risks due to animal serum used in cell culture production.** The use of contaminated cells for vaccine production may result in contaminated vaccines, which may lead to seroconversion or disease in the vaccinated animal. Contaminated serum or cell cultures may also interfere with the diagnosis of viral infections. **PMID: 10404869**

Citizens Against Legal Loopholes

A Speech Before the Citizens Against Legal Loopholes Rally, The Capitol Mall, Washington, D.C., Labor Day Weekend, 1996 By Leonard G. Horowitz, "So I began by investigating the Centers for Disease Control and Prevention's (CDCs) official investigation reports on the case. And to make a long story short, I found the reports to be scientifically bogus. I later learned that the government had covered-up key evidence in the tragedy in an effort the maintain the case an unsolvable mystery. In essence they had committed scientific fraud and misconduct and, in the process, concealed the most incriminating evidence against the dentist--a very bright, scientifically trained, ex-military dentist, who believed he was dying of a virus that the government had created. Yes, you heard me correctly, a virus that the government had created."

EMERGING VIRUSES

1996 by Leonard G. Horowitz AIDS & EBOLA: Nature, Accident or Intentional" Tetrahedron Inc. Rockport, MA . Foreword written by W. John Martin, M.D., Ph.D. The mixing of vaccine viruses with others found in the cells and tissues used to develop the vaccine can potentially lead to the development of new recombinant mutants that are more adaptive and have wider host range than either of the original viruses. This can especially happen when a live viral vaccine produced in cells from one species is then given to another species.

Vaccine Dangers

Although the public has heard about side effects of vaccines, most people are clueless about the manufacture of vaccines. Few people know that viruses used in vaccine production need to be grown on animal parts like monkey kidneys, or in chicken embryos, or in human and fetal “cell lines.” Harvesting viruses in human cell-lines can be perilous because some human cell lines are derived from cancer cells. Most people assume vaccines are “sterile” and germ free. But sterilizing a vaccine can destroy the necessary immunizing protein that makes it work. Thus, contaminating viruses or viral “particles” can sometime survive the vaccine process.

MORATORIUM ON VACCINES

THE SAN FRANCISCO MEDICAL RESEARCH FOUNDATION RECOMMENDED BY NATION OF ISLAM'S HEALTH MINISTER Further, Dr. Horowitz cites evidence that Food and Drug Administration (FDA) officials, in charge of testing and approving vaccines for drug makers, have known of these contamination problems since the early 1970s”

MATILDE KRIM'S AIDS-ORIGINS-THEORY
Strangely Mum Since Her 1980's Comments; Krim speculated that AIDS could have originated from virus-contaminated batches of "gamma globulin" which were inoculated into gay men for the purpose of protecting them from hepatitis virus inflection. Krim is a well-known AIDS expert and cancer virologist associated with Sloan-Kettering Hospital in Manhattan. She is also co-chairperson of the American Foundation for AIDS Research (AmFar).

The 1994 Rockefeller Report
Examining Biological Experimentation on U.S. Military. Participation in military research is rarely included in military medical records, making it impossible to support a veteran's claim for service-connected disabilities from military research

The History of the Development of AIDS
"Special Operation-X." (The SOX) program served as the immediate prototype program for the Special Virus program to begin in 1962

Man-Made AIDS for Bio Warfare When conspiracy-minded critics raise questions about the origins of the variety of new diseases and medical syndromes that "emerged" in the 1970s and '80s, they often point to the so-called MacArthur testimony as a putative smoking gun.

Trends in hepatitis C and HIV infection among inmates entering prisons in California, 1994 versus 1999
"the approximately one in three male and one in four female inmates infected with HCV represents a serious public health concern."