COVID-19 Vaccines Are NOT Safe nor Effective* and CANNOT be Added to Vaccine Schedules

Warning: Very Harmful to Your Health

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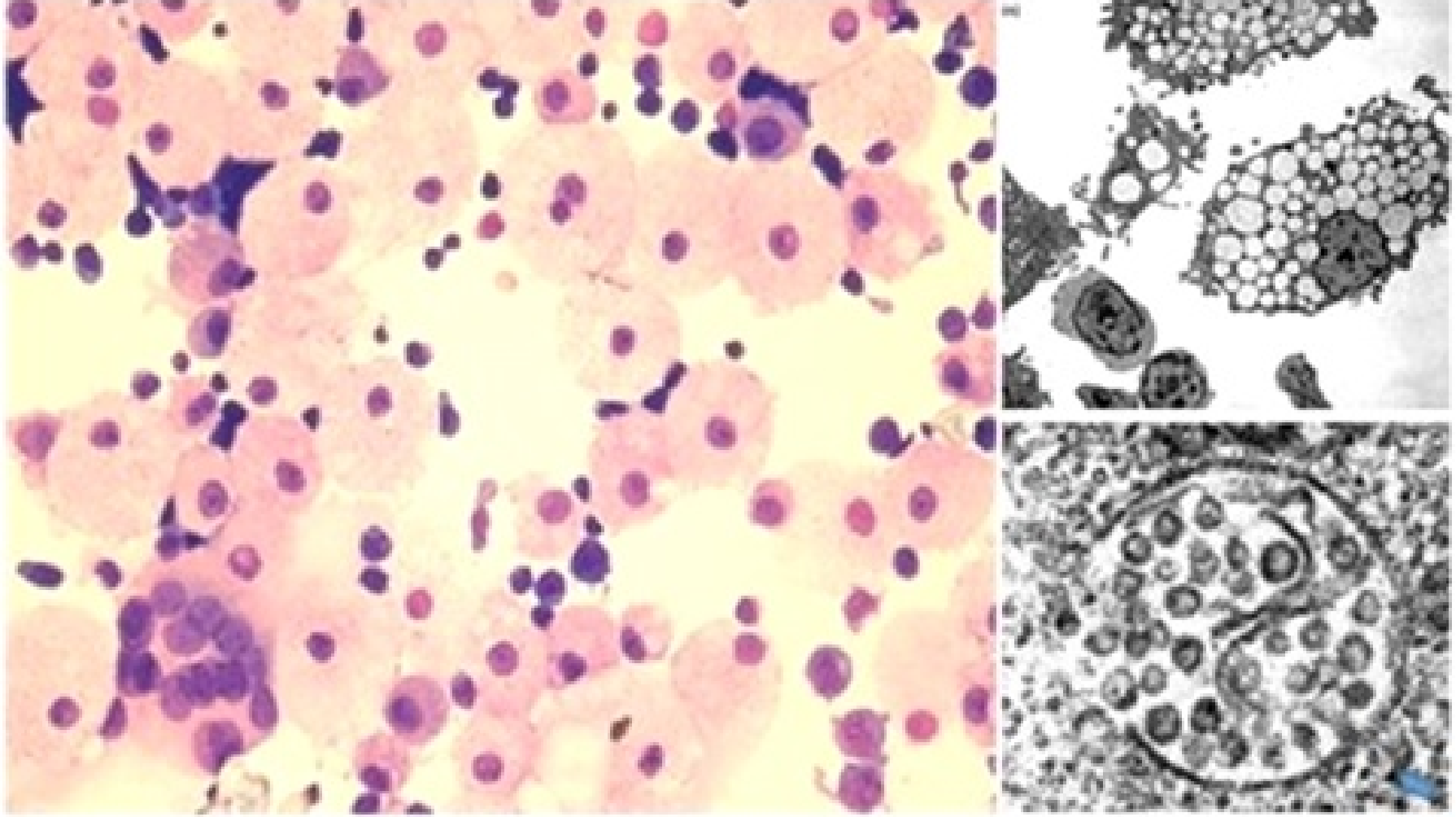

Figure 1. HERV-K102 is a Protector Foamy Retrovirus Unique to Humans Produced in and Generates Foamy Macrophages, Where Particles are Released by Lysis [from Laderoute, 2018].
The particles once released putatively stimulate innate T and B cells that recognize HERV-K102 Env where the latter involves broadly neutralizing antibodies active against viruses including RNA pandemic viruses needed to help establish herd immunity.

Laderoute MP. Trained immunity involving HERV-K102 activation may promote recovery from COVID-19 providing a new vaccination paradigm against pandemic RNA viruses, ***submitted*** July 26, 2022.

Abstract

The successful development of safe and effective vaccines against pandemic RNA viruses has been largely impeded by the phenomenon of antibody dependent enhancement (ADE) of infection which redirects the virus into macrophages associated with progression. During natural infection with SARS-CoV-2 the development of antibodies to spike protein is associated with progression to severe COVID-19 and not protection, directly implicating ADE in mediating severity. There may be two forms of ADE that occur during SARS-COV-2 infection *in vivo*; 1) classical ADE involving FCGR2A in the upper respiratory tract (URT) targeting lipid body negative foamy macrophages (LB-FMs) identified as sebocytes; and 2) a novel form of ADE in the lower respiratory tract (LRT), whereby the spike:ACE2 (primary receptor) switches to spike:BSG (the secondary receptor). The latter does not appear to select for variants but mediates infection into the ACE2 negative, BSG positive, LB-FMs associated with severity. On the other hand, the former could mediate selection of variants if vaccinal antibodies to spike protein are pre-existing. In the LRT, the LB-FMs correlated with recovery from moderate disease but were depleted with onset of severe COVID-19. Based on differentially expressed genes, SARS-CoV-2 appears to target sebocytes (URT) and LB-FMs (LRT) producing the human endogenous retrovirus K102 (HERV-K102) protective foamy virus particles. Of significance, HERV-K102 replication was previously associated with resistance to HIV-1 acquisition in an HIV-1 exposed seronegative (HESN) cohort. Moreover, SARS-COV-2 infection induces HERV-K102 expression *in vivo*. Evidence is also presented which suggests the second dose of the adaptive mRNA COVID-19 vaccines may have selected for the alpha and delta SARS-CoV-2 variants. **Accordingly, a new vaccine paradigm is proposed against pandemic RNA viruses namely, the induction and boosting of trained (innate) immunity involving HERV-K102 particle production in LB-FMs to avoid the problems of ADE.**

IMAGE 1.

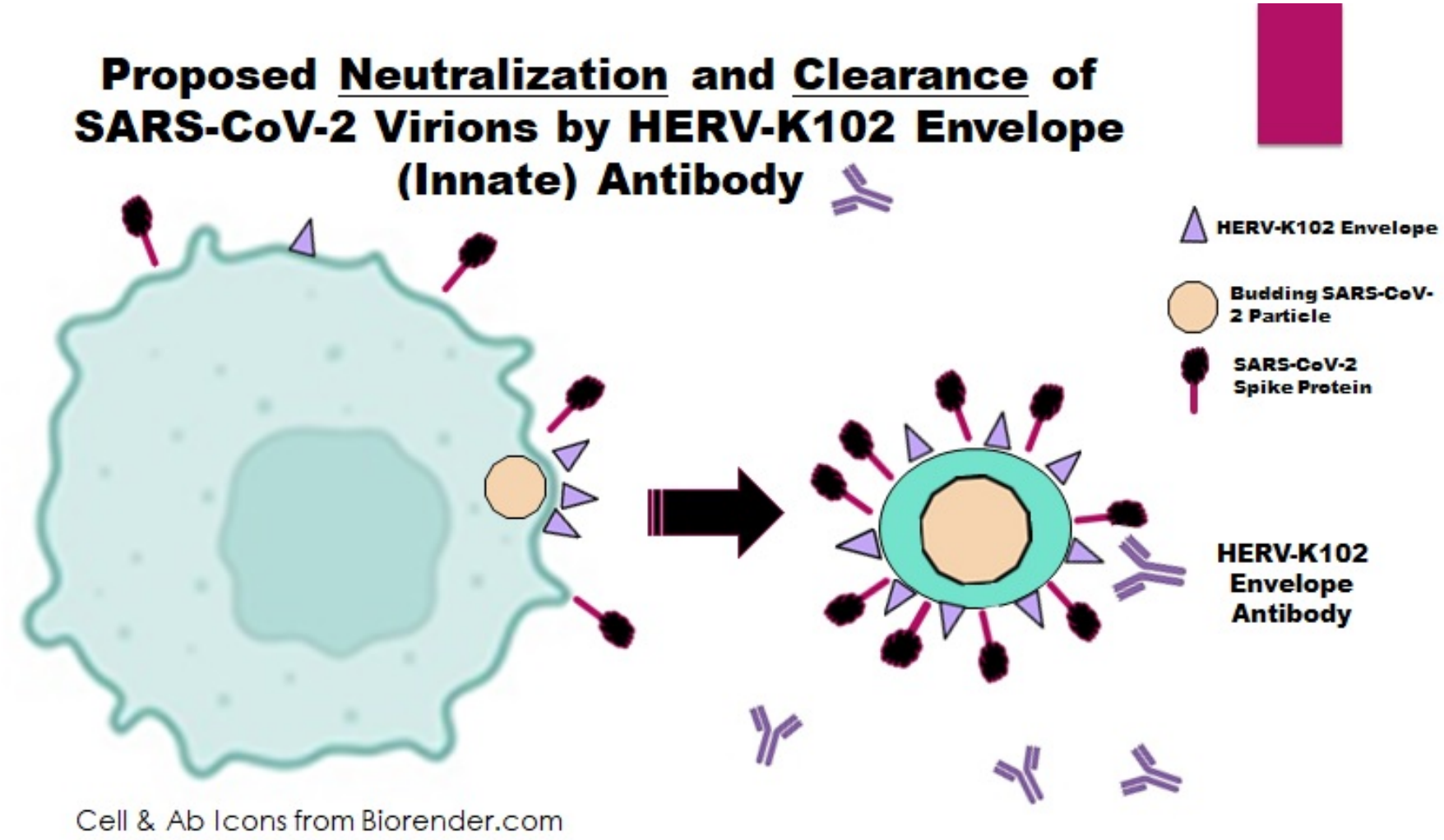

Figure 2. **Antibodies to HERV-K102 Envelope May Neutralize and Clear SARS-CoV-2 Virions**

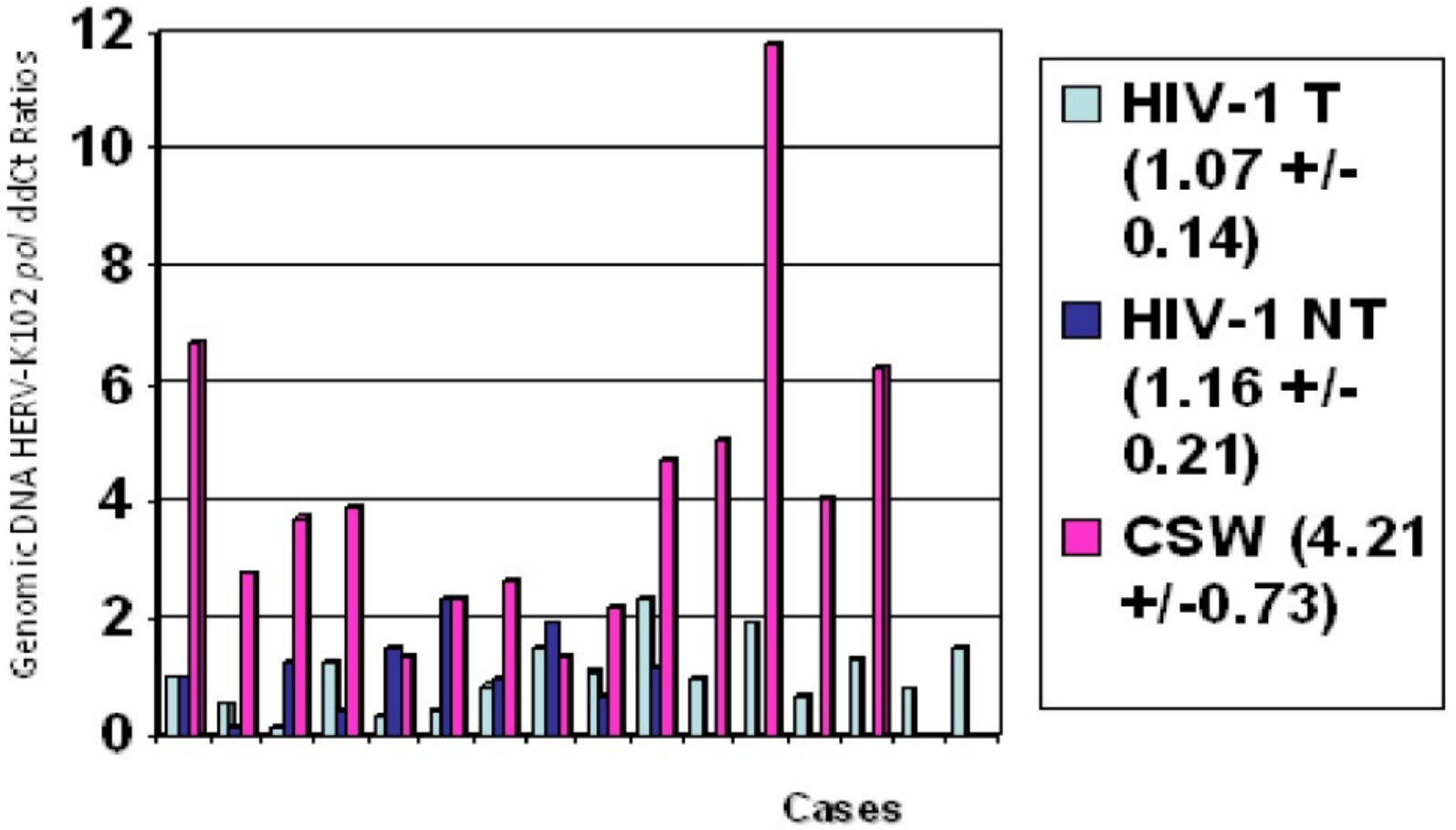

Figure 3 **Increased proviral copies of HERV-K102 *pol* may be associated with resistance to HIV-1 acquisition.** DNA was extracted from plasma and the HERV-K102 *pol* ddCt ratio was performed with respect to 18S RNA as previously described [3] on UNG treated templates to ensure genomic DNA and not particle associated cDNA was assessed. Individual ddCt ratios were plotted: **Light blue** = 16 Canadian HIV-1 patients on antiretroviral therapy (HIV-1 T) with a mean genomic copy ratio of 1.07 +/- 0.14. **Dark blue** = 10 Canadian HIV-1 patients not on antiretroviral therapy (HIV-1 NT) with a mean of 1.16 +/- 0.21. Note there was no statistical difference in the genomic copy ratios of HERV-K102 *pol* between the Canadian HIV-1 infected patients whether or not they were on therapy and neither group alone or together was statistically different from normal. **Pink** = Commercial Sex Workers (CSW) who had shown at least 3 years of HIV-1 resistance to transmission despite daily exposures to HIV-1 [15,16] with a mean genomic copy ratio of 4.21 +/-0.73. This was significantly elevated above normal (0.88 +/-0.37; $p<0.0005$) and above the 2 standard error cutoff of 1.62 (N=30, data not shown).

TABLE 1. Office for National Statistics (ONS) UK Mortality Rates per 100,000 Person-Years and Vaccinated (Vax) to Unvaccinated (Unvax) Ratios for January 1, 2021 to May 31, 2022 for Both Sexes and All Ages*

From ONS TABLE 1.

		All-Cause Mortality				COVID-19 Mortality				Non-C19 Mortality			
		RATE Unvax	Actual RATE Ever Vax	Ratio of Vax/ Unvax Rates	p value	RATE Unvax	Actual RATE Ever Vax	Ratio of Vax/ Unvax Rates	p value	RATE Unvax	Actual RATE Ever Vax	Ratio of Vax/ Unvax Rates	p value
2021	Jan	2508	3484	1.39		1187	1526	1.29		1320	1958	1.48	
	Feb	5262	3205	0.61		2174	457	0.21		3087	2689	0.87	
	Mar	3308	4193	1.27		5919	284	0.05		2716	3909	1.44	
	April	2298	5040	2.19		146	184	1.26		2153	4855	2.25	
	May	1719	8583	4.99		46	85	1.86		1673	8426	5.04	
	June	1590	10060	6.33		56	88	1.58		1534	9916	6.46	
	July	1611	10307	6.40		218	225	1.03		1392	9960	7.16	
	Aug	1712	10341	6.04		404	403	1.00		1307	9266	7.09	
	Sept	1665	8639	5.19		368	520	1.41		1297	7884	6.08	
	Oct	1624	12456	7.67		322	569	1.76		1302	11845	9.10	
	Nov	1708	15547	9.10		421	721	1.71		1287	14155	11.00	
	Dec	1879	16974	9.04		521	1122	2.16		1358	15501	11.41	
2022	Jan	1812	19998	11.04		585	2311	3.95		1227	16417	13.38	
	Feb	1385	12474	9.01		259	1128	4.36		1126	11346	10.08	
	Mar	1232	10257	8.33		184	764	4.16		1048	9445	9.01	
	April	1205	12423	10.31		205	801	3.91		1000	11622	11.62	
	May	873	8246	9.45		78	262	3.37		795	7914	9.95	
average by row		1964	10131	5.16	0.0001	770	673	0.87	NS (0.8)	1507	9242	6.13	0.0001

ONS UK Data Released July 6 2022

https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsinvolvingcovid19byvaccinationstatusengland/deathsoccurringbetween1january2021and31may2022

Era	C19 Ratio Vax/Unvax	p value
C19 Entire Period	0.87	NS (0.8)
Oct 1 2021-May 31, 2022 (3rd Dose)	2.98	0.01
Jan 1 2021- Sept 30 2022 (1st & 2nd Dose)	0.36	NS (0.3)

NS=not significant