A third open letter to Dr. Grace Lee, ACIP Chair - Oral Comments: David Wiseman ACIP Jan 5 2022

The last wackamole of boosting in an omicron environment of negative quasi-vaccine efficacy and possible immunological addiction. Transparency concerns remain.

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Josh Guetzkow PhD, Hebrew University, Jerusalem, Israel Hervé Seligmann PhD

Docket CDC-2022-0002 tracking ky5-1kzn-vopm www.regulations.gov/comment/CDC-2022-0002-0002

January 7 2022
Comment Tracking Number: (added after submission:)

Dear ACIP Chairperson Dr. Lee

Once again, this hastily arranged meeting without agenda or docket number last night deepens concerns about opacity and suppression of diverse views, the subject of our now two unanswered open letters,(1,2) the latter still not appearing on the December 16 meeting docket until after the January 5th meeting. We submit this letter to the docket but request your response as to your corrective actions.

To facilitate transparency and informed consent, we distinguish the classical vaccines from this novel class meeting FDA's definition of gene therapy products by the term "quasi-vaccine" (q-vaccine). We similarly use the FDA term - nucleoside modified mRNA or modRNA.

Because of ambiguity in the deadline for submission of these written comment (the regulations.gov site showing January 7,[1] and the Federal Register showing January 12th,[2], we are submitting these preliminary remarks today, pending further analysis.

As always, we invite constructive critique of our analysis.
Respectfully etc,

1. Transparency Concerns

1.1. Concerns shared by others

Similar concerns about the compromise of transparency were expressed by committee members as well as some of the public comment speakers. I am pleased to acknowledge progress on one aspect, namely that the ACIP email notification system now appears to be working, as I have just received a message regarding the upcoming January 12th meeting which deals with non-Covid topics. Further, unlike the last two ACIP meetings, an agenda has been posted today, i.e. five days in advance of the meeting.

1.2. Key presentation not announced or posted

There are other transparency issues. Speaker presentations were not posted until around the commencement of the meeting, some of them well into the meeting. The inclusion of the presentation of Dr. Alroy-Preis (Israeli-Ministry of Health) still does not appear on the official agenda (see section 8) or the listing of meeting materials. I have included them here (see section 7), taken from screen shots. The transparency issues this raises are concerning enough, without considering the revelation by FDA's Dr. Marks at the Jan 5th ACIP meeting that one of the main drivers of FDA's decision to authorize the Pfizer booster in 12-15 year olds and no doubt the shortening of the boosting interval for both Pfizer and Moderna q-vaccines to 5 months. Data this pivotal must be open, and the lack of a VRBPAC meeting to discuss it speaks to opacity on the part of FDA.

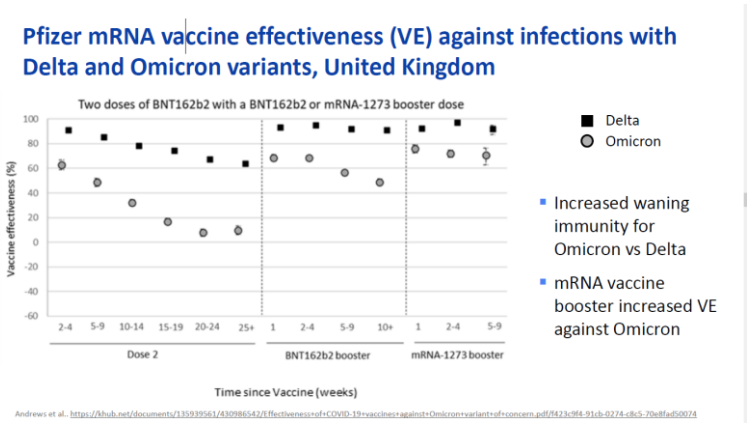
1.3. Fair speaker selection?

Lastly, we question the basis for speaker selection. The posted agenda indicates that thirty minutes had been allotted for the public comment period which heard from a total of five speakers. In contrast, for the December 16 2021 ACIP meeting, a total of six speakers provided oral comments, with only a 20-minute public comment period allotted (see section 8). With the same three-minute slots, the 30 minutes allotted period would be ample time to accommodate 8 or 9 speakers and yet only five were selected. We therefore conclude that there were no other requests for speak. However, in additional to myself, I have been made aware of three other people whose requests to speak were declined. They share views broadly similar to mine, in contrast to four of the five selected speakers. The fifth selected speaker expressed a view abut natural immunity with which we would agree, although his broader views could not be discerned from his comments.

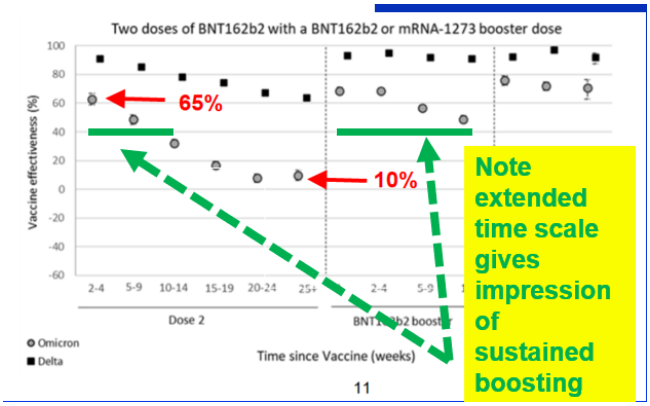
2. How is the Pfizer q-vaccine justified with negative efficacy and waning boost effect?

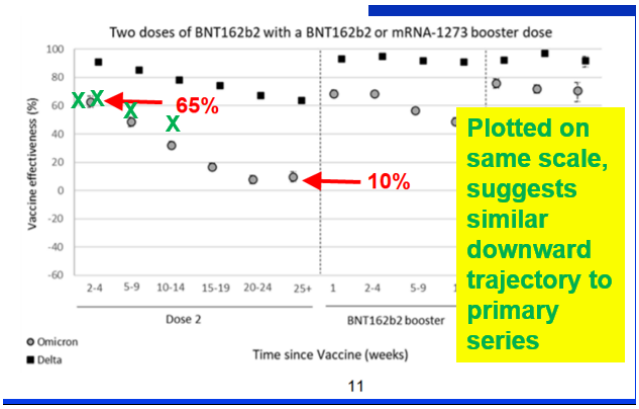
Data from the UK(3) were presented by CDC's Dr. Oliver which shows waning of VE against omicron from about 65% to about 10% about 15 weeks after the primary series. This is apparently restored by a Pfizer booster.

[1] www.regulations.gov/document/CDC-2022-0002-0001
[2] www.federalregister.gov/documents/2022/01/06/2022-00123/advisory-committee-on-immunization-practices-acip



The graph, (identical to the original report) is misleading as to the effect of the booster. The extended time scale gives impression of sustained boosting, when in fact, when plotted on the same scale as the leftmost panel suggests a downward trajectory similar to the primary series.





More concerning are other reports that not only confirm reduced VE of the Pfizer q-vaccine against Omicron, but suggest that VE becomes negative.

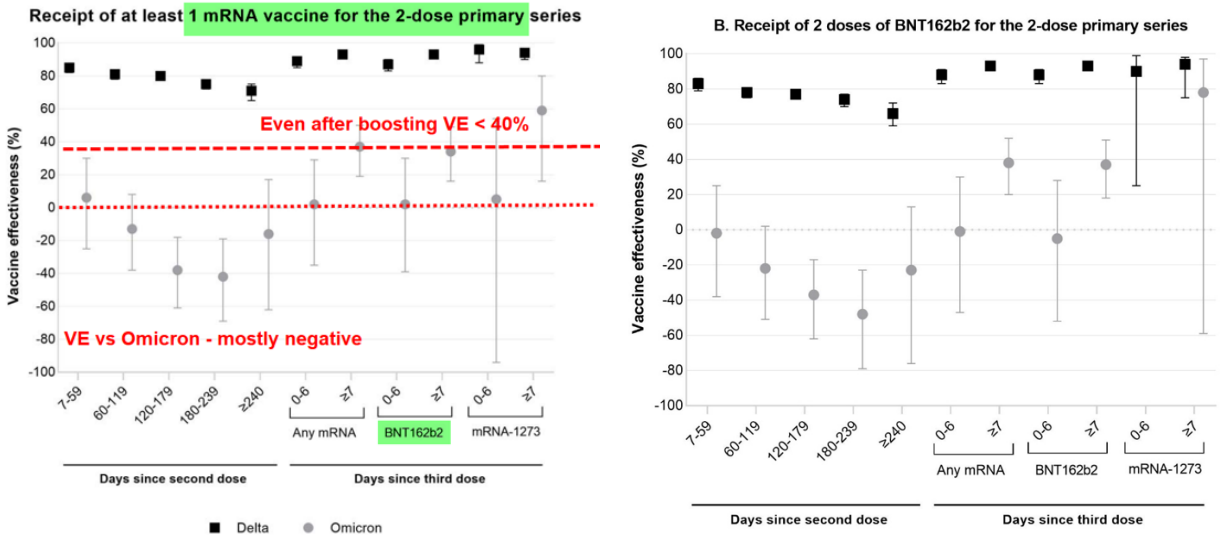
This Danish study shows a negative VE of -76.5% by day 90 after primary series(4), well before the new 5 mmonth boosting interval.

Table Estimated vaccine effectiveness for BNT162b2 and mRNA-1273 against infection with the SARS-CoV-2 Omicron and Delta variants during November 20 – December 12, 2021, Denmark.

	Pfizer – BNT162b2				Moderna - mRNA-1273			
Time since vaccine protection	Omicron		Delta		Omicron		Delta	
	Cases	VE, % (95% CI)	Cases	VE, % (95% CI)	Cases	VE, % (95% CI)	Cases	VE, % (95% CI)
1-30 days	14	55.2 (23.5; 73.7)	171	86.7 (84.6; 88.6)	4	36.7 (-69.9; 76.4)	29	88.2 (83.1; 91.8)
31-60 days	32	16.1 (-20.8; 41.7)	454	80.9 (79.0; 82.6)	8	30.0 (-41.3; 65.4)	116	81.5 (77.7; 84.6)
61-90 days	145	9.8 (-10.0; 26.1)	3,177	72.8 (71.7; 73.8)	48	4.2 (-30.8; 29.8)	1,037	72.2 (70.4; 74.0)
91-150 days	2,851	-76.5 (-95.3;-59.5)	34,947	53.8 (52.9; 54.6)	393	-39.3 (-61.6;-20.0)	3,459	65.0 (63.6; 66.3)
1-30 days after booster vaccination protection	29	54.6 (30.4; 70.4)	453	81.2 (79.2; 82.9)	-	-	5	82.8 (58.8; 92.9)

CI = confidence intervals; VE = vaccine effectiveness. VE estimates adjusted for 10-year age groups, sex and region (five geographical regions). Vaccine protection was assumed 14 days post 2nd dose. Insufficient data to estimate mRNA-1273 booster VE against Omicron.

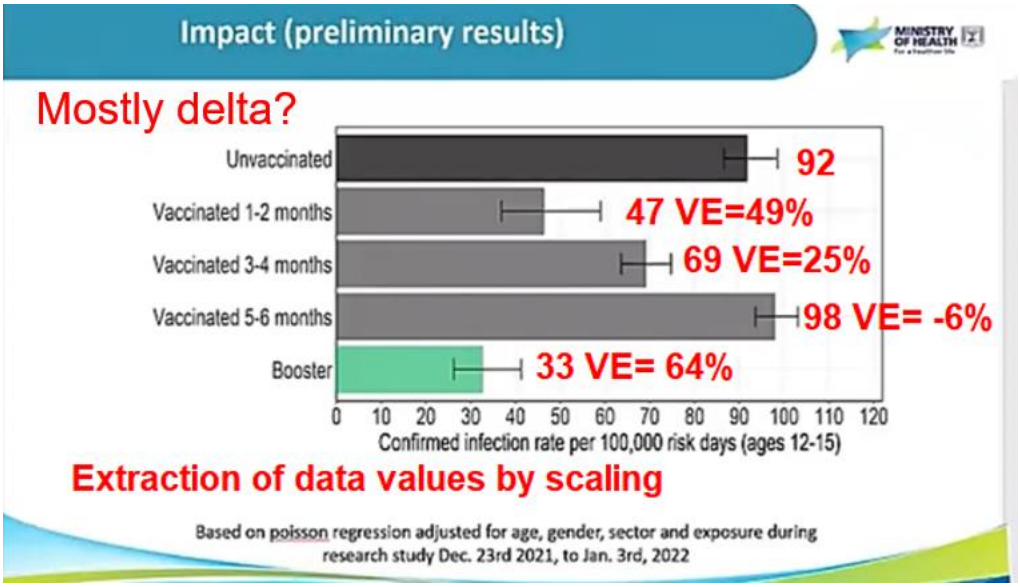
Even more concerning is almost immediate negativity in a Canadian study(5), shown here for either modRNA q-vaccine, as well as the Pfizer product alone.



Here the negative VE of -40% can be boosted to about 40%, but with no information as to its sustainability. The encouraging news is that persons who received their primary series >240 days, may start to recover their ability to counteract omicron.

Finally, the data presented by the Israeli MoH were equally concerning. From the bar graph presented, we extracted the data values to compute crude estimates of VE. Given Israel's earlier adoption of boosters in July 2021, the data (unclear if this was just for 12-15 years, or all population) related mainly to the delta variant, although the comments from Dr. Alroy-Preis suggested that some omicron component was involved. Again the lack of detail for these data raises transparency concerns.

Nonetheless, this analysis suggests a much lower VE of only 49%, waning to a negative 6% from 5-6 months. It is unclear as to whether "unvaccinated" includes subjects with only one primary dose, or with 2 rpaimry doses 6 or more months previously.



How long any of boosting last for is unknown.

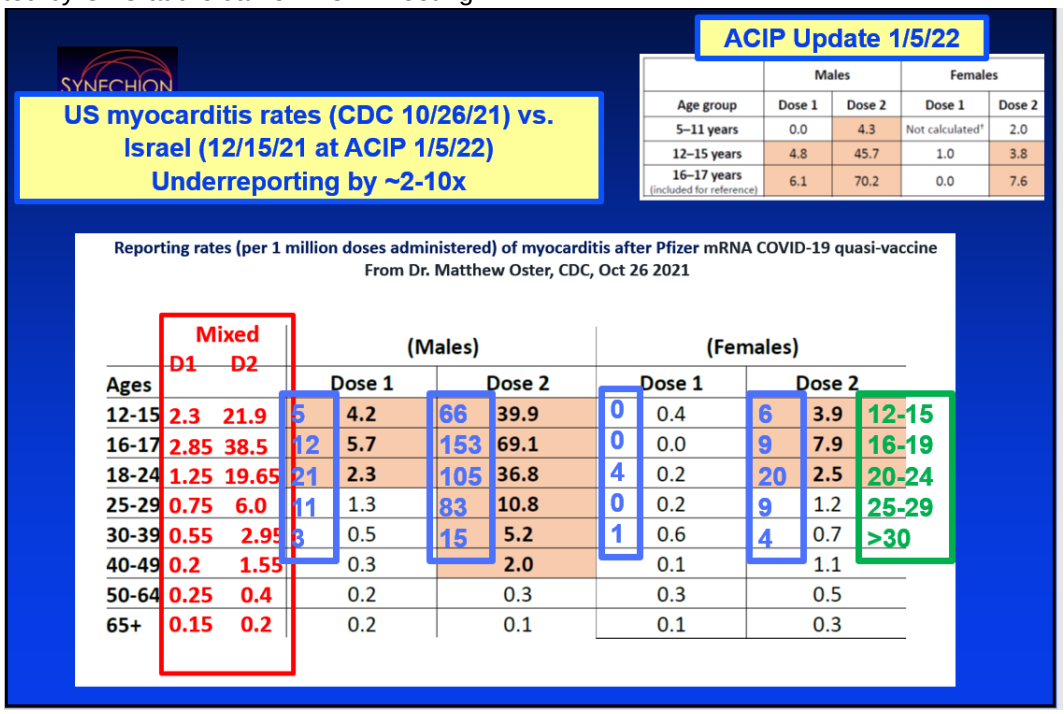
This dangerous situation unlikely to be manageable given FDA and CDC's failure to prevent over 9300 VAERS reports of age-inappropriate dosing, more likely some 46000 events given FDA's acknowledged underreporting factor of 4.8.

3. How can boosting be justified without cumulative toxicity data?

There are still no genotox, cancer or, male fertility studies. Were there studies in juvenile animals implied by the Australian TGA report?(6)

4. How can any q-vaccine be justified with AE rates far exceeding the 0.57/million threshold set by the issuance of the Janssen TTS contraindication?

VAERS Deaths for the primary series in all three are between 37-66/million people with <1 dose. Serious AE rates for thrombosis and myocarditis far exceed the TTS thresholds. How can these any longer be justified, especially given their 6.5 fold underreporting, revealed in CDC's recent report.(7) Despite CDC encouragement, only 2 of 13 already motivated vsafe participants reported their hospitalizations to VAERS. Ignoring one error this yields a 6.5 fold underreporting. This is similar top the 4.8x underreporting for myocarditis inherent in FDA's risk benefit analysis for 5-11 year olds, and the estimates of 2-10x underreporting suggested by a comparison of updated Israeli and US data presented by CDC at the Jan 5th ACIP meeting.

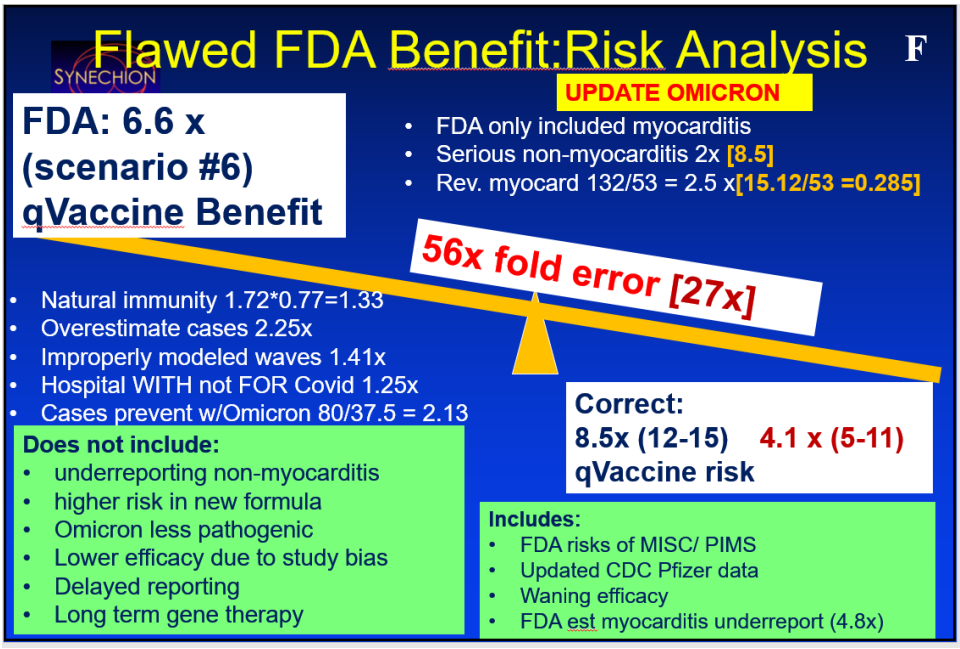


5. Surely all q-vaccinations must be paused to allow for immune recovery:

Our(2) and other's data suggesting early and delayed all-cause mortality associated with the q-vaccines should be examined along the VE negativity with omicron. We cannot put people at reduced benefit with greater risk by attempting to boost our way out of omicron in the immunological equivalent of heroin addiction. Here the Canadian(5) study suggests that VE negativity may clear at some time 8 months after the primary series.

6. Conservatively updated for Omicron our examination of FDA's risk benefit analysis in 12-15 year olds finds a 56 fold error yielding 8.5 times greater risk than benefit.

Using the latest figures provided by CDC, we updated our previous analysis of FDA risk benefit analysis in children that showed a 26 fold error and a 4x risk>benefit (2). For 12-15 year olds we calculate an 8.5x and 4.1x risk>benefit ratio for 12-15 and 5-11 year olds respectively.



There are still no data for subclinical myocarditis and no rate for omicron-related myocarditis. FDA and CDC have failed to comment on the intense safety signals for non-myocarditis events we have previously described.(2)

Pfizer's clinical data remains suspect due to unaccounted for evidence of bias related to exclusions and the effect of the changed formulation on effective dose, distribution, safety and efficacy is still questioned.

ACIP members commented on how preliminary the various data presented were Much of the data presented related to pre-omicron periods and estimates of harms after a third dose are subject to selection bias.

It is bad enough that adults now appear to be immunological addicts based on VE negativity. Don't impose that on our children. ACIP member Dr. Long commented that the use of boosters is not sustainable and that this is our "last wackamole." The sooner FDA and CDC realize this the better.

7. <u>Slides presented by Dr. Alroy-Preis, Ministry of Health, Israel, at ACIP January 5, 2022</u>

12-15 y/o Booster Vaccination Data from Israel

Sharon Alroy-Preis, MD, MPH, MBA
Israel Ministry of Health

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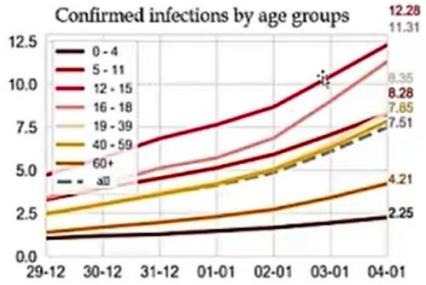
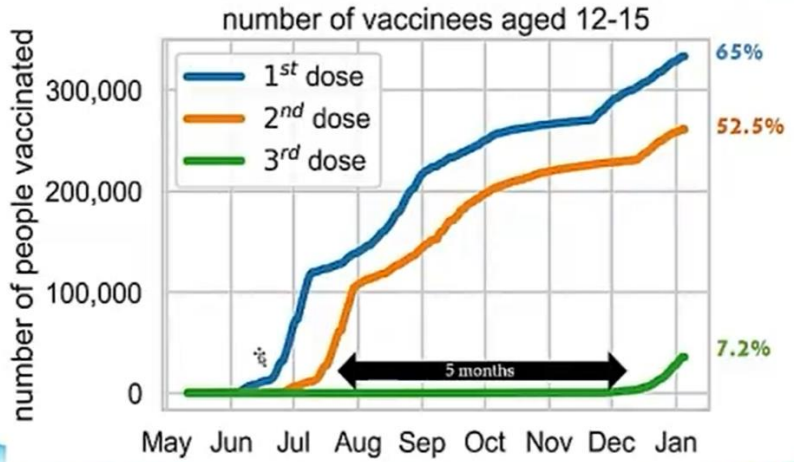
Why?



Age group 12-15 is the leading group in confirmed infection

Vaccine coverage 12-15 y/o (updated Jan 5,22)

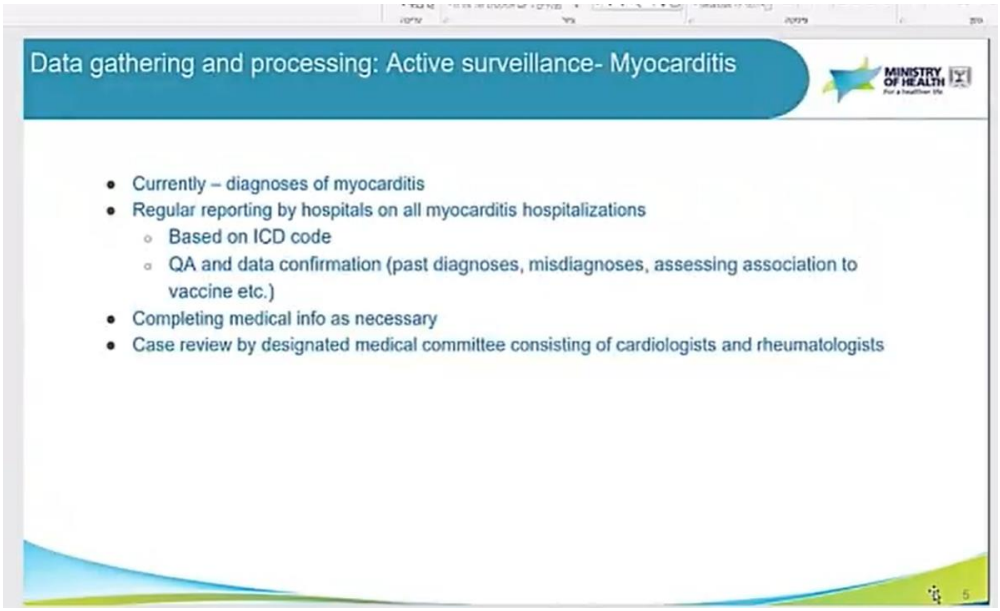


Safety Methods of gathering data

- Passive surveillance- reports from medical staff
- Active surveillance of Myocarditis/Perimyocarditis
- The majority of 3rd doses administered with Pfizer vaccine - AE reported are following booster with Pfizer vaccine only

Data gathering and processing: Passive Surveillance

- Reports from medical staff in the community/hospitals
- Cross-referencing data with vaccine registry & confirming appropriate time range
- Completing missing data from HMOs/hospitals
- Reviewing medical files to verify medical background and differential diagnoses
- Serious AE review by designated medical committee
- Data processing and statistical analysis
- Data presentation:
  - Data anonymization
  - Content presented in a way that is accessible to the public (easy to read and understand)


Data gathering and processing: Active surveillance- Myocarditis
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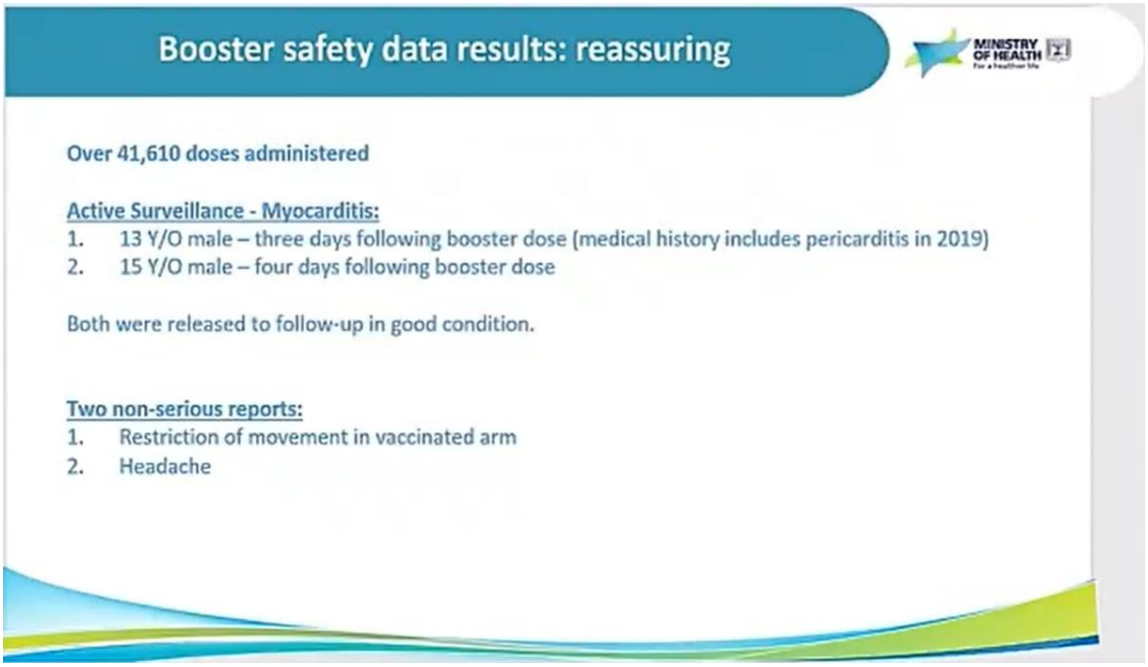
Currently – diagnoses of myocarditis
Regular reporting by hospitals on all myocarditis hospitalizations
Based on ICD code
QA and data confirmation (past diagnoses, misdiagnoses, assessing association to vaccine etc.)
Completing medical info as necessary
Case review by designated medical committee consisting of cardiologists and rheumatologists
5


Booster safety data results: reassuring
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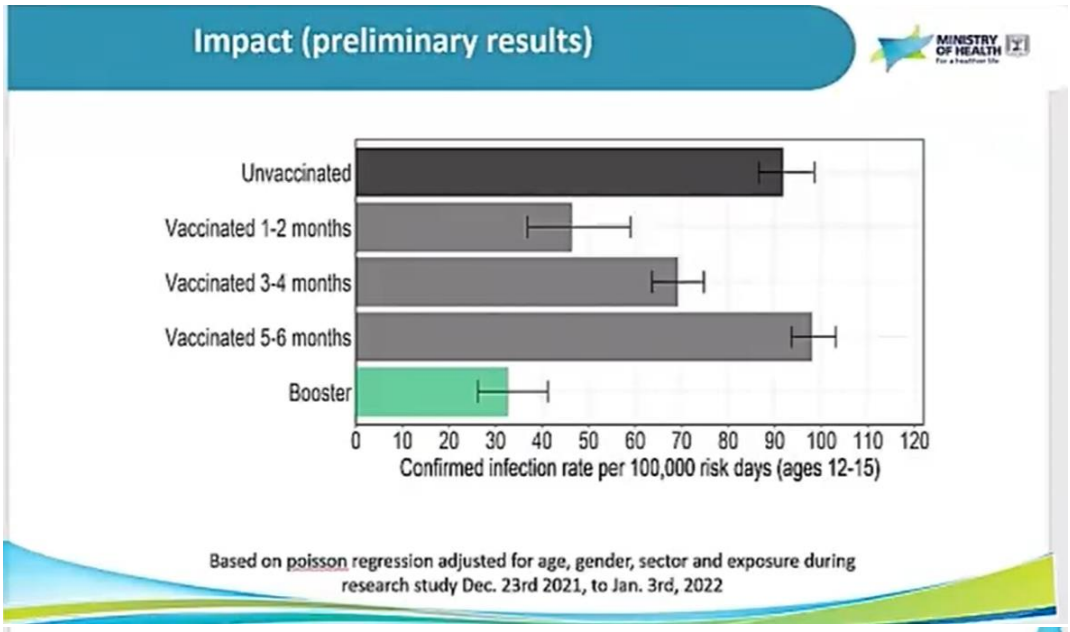
Over 41,610 doses administered
Active Surveillance - Myocarditis:
1. 13 Y/O male – three days following booster dose (medical history includes pericarditis in 2019)
2. 15 Y/O male – four days following booster dose
Both were released to follow-up in good condition.
Two non-serious reports:
1. Restriction of movement in vaccinated arm
2. Headache


Impact (preliminary results)
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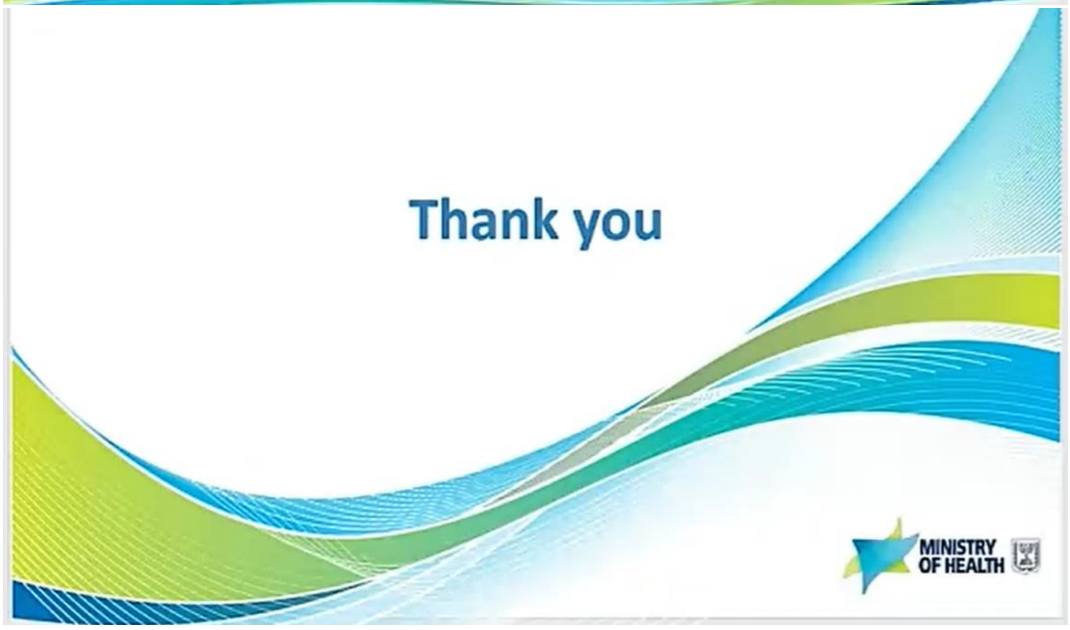
Unvaccinated
Vaccinated 1-2 months
Vaccinated 3-4 months
Vaccinated 5-6 months
Booster
0 10 20 30 40 50 60 70 80 90 100 110 120
Confirmed infection rate per 100,000 risk days (ages 12-15)
Based on poisson regression adjusted for age, gender, sector and exposure during research study Dec. 23rd 2021, to Jan. 3rd, 2022


Thank you
MINISTRY OF HEALTH

8. Agenda Excerpts for the ACIP meetings of December 16, 2021 and January 5, 2022

January 5, 2022

MEETING OF THE ADVISORY COMMITTEE ON IMMUNIZATION PRACTICES (ACIP)
Centers for Disease Control and Prevention
Atlanta, Georgia 30329
January 5, 2022

Wednesday, January 5, 2022

1:00	**Welcome & Introductions**	Dr. Grace Lee (ACIP Chair) Dr. Melinda Wharton (ACIP Executive Secretary, CDC)
1:15	**Coronavirus Disease 2019 (COVID-19) Vaccines**	
	Introduction	Dr. Matthew Daley (ACIP, WG Chair)
	Updates to COVID-19 vaccine safety: VAERS	Dr. John Su (CDC/NCEZID)
	Updates to COVID-19 vaccine safety: v-safe	Dr. Anne Hause (CDC/NCEZID)
	Updates to COVID-19 vaccine safety: VSD	Dr. Nicky Klein (KPNC)
2:15	***Break***	
2:30	**Public Comment**	
3:00	**Updates to Clinical Considerations**	Dr. Evelyn Twentyman (CDC/NCCDPHP)
	Updates to the EtR Framework: Pfizer-BioNTech COVID-19 vaccine booster doses in adolescents 12-15 years of age	Dr. Sara Oliver (CDC/NCIRD)
	Discussion	
	VOTE	
	COVID-19 vaccine booster doses	Dr. Sara Oliver (CDC/NCIRD)
5:00	**Adjourn**	

December 16, 2021

MEETING OF THE ADVISORY COMMITTEE ON IMMUNIZATION PRACTICES (ACIP)
Centers for Disease Control and Prevention
Atlanta, Georgia 30329
December 16, 2021

Thursday, December 16, 2021

12:00	**Welcome & Introductions**	Dr. Grace Lee (ACIP Chair) Dr. Melinda Wharton (ACIP Executive Secretary, CDC)
12:15	**Coronavirus Disease 2019 (COVID-19) Vaccines**	
	Introduction	Dr. Matthew Daley (ACIP, WG Chair)
	Updates on Thrombosis with Thrombocytopenia Syndrome (TTS)	Dr. Isaac See (CDC/NCEZID)
	VaST summary	Dr. Keipp Talbot (VaST Chair)
	Updates to the benefit/risk assessment for Janssen COVID-19 vaccines: Applying the Evidence to Recommendation Framework	Dr. Sara Oliver (CDC/NCIRD)
	Discussion	
2:00	***Break***	
2:10	**Public Comment**	
2:30	**VOTE**	
	Janssen COVID-19 Vaccine: Updated recommendations for use	Dr. Sara Oliver (CDC/NCIRD)

9. References

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https://www.regulations.gov/comment/CDC-2021-0125-0003.)

2. Wiseman D, Rose, J, Guetzkow, H, Seligmann H. Why limit contraindication to Janssen? Using same criteria revisit EUA/BLA for all C19 quasi-vaccines. Transparency: Emergency ACIP Meeting Dec 16 2021: A second open

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3. UKHSA. SARS-CoV-2 variants of concern and variants under investigation in England Technical briefing: Update on hospitalisation and vaccine effectiveness for Omicron VOC-21NOV-01 (B.1.1.529) 2021 Dec 31. 2022 Jan 2, at https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1044481/Technical-Briefing-31-Dec-2021-Omicron_severity_update.pdf.)

4. Hansen CH, Schelde AB, Moustsen-Helm IR, et al. Vaccine effectiveness against SARS-CoV-2 infection with the Omicron or Delta variants following a two-dose or booster BNT162b2 or mRNA-1273 vaccination series: A Danish cohort study. medRxiv 2021:2021.12.20.21267966. Epub Dec 23 2021 http://doi.org/10.1101/2021.12.20.21267966

5. Buchan SA, Chung H, Brown KA, et al. Effectiveness of COVID-19 vaccines against Omicron or Delta infection. medRxiv 2022:2021.12.30.21268565. Epub Jan 1 http://doi.org/10.1101/2021.12.30.21268565

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7. Hause AM, Baggs J, Marquez P, et al. COVID-19 Vaccine Safety in Children Aged 5-11 Years - United States, November 3-December 19, 2021. MMWR Morb Mortal Wkly Rep 2021; 70:1755-60. Epub 2021/12/31 http://doi.org/10.15585/mmwr.mm705152a1