

Waking Up the Nation,
One Reader at a Time...

PUBLIC HEALTH ALERT

Biological Warfare Experiment on American Citizens Results in Spreading Pandemic

CDC-Created Epidemic Now Spreading Down East Coast of U.S.

Doctors Prevented from Treating Patients by Biowarfare Arm of the CDC (Epidemic Intelligence Service) Working with the IDSA in Phase II of the CDC's Infamous Tuskegee Experiment



by Jerry Leonard

"Who could imagine the government, all the way up to the Surgeon General of the United States, deliberately allowing a group of its citizens to die from a terrible disease for the sake of an ill-conceived experiment?"

--Commentary on the Tuskegee Experiment

"How tragic would be the

irony if an agency established to control and find cures for diseases caused instead their proliferation."

Comment on Plum Island's Biological Warfare Research, quoted in Lab 257

"A much more discreet, diabolical and effective method of disabling a country would be to employ a moderately infectious organism, or combination of organisms (Russian Doll Cocktail), which would pass slowly through the population unnoticed."

- Marjorie Tietjen, Lyme researcher

Americans are under attack from an insidious biological warfare agent perpetrated by agencies within our own government. This attack is centered on the American East Coast, but nobody should feel safe.

Shockingly, I am talking about Lyme disease¹,

an affliction that the uninformed may believe is nothing more than arthritis caused by a tick bite. But according to the CDC, this "multisystem, multistage" illness is capable of inducing disorders² including "chronic inflammatory arthritis, chronic muscle pain, heart disease and/or neurological (brain and peripheral nerves) disorders." So many disabling afflictions are caused by Lyme that it has earned the disease the nickname "The Great Imitator."³

The highly complex bacterium that causes Lyme disease⁴ has the ability to infect nearly every organ in the body, often in spite of antibiotic administration, by changing into various self-protective forms⁵. This often happens without initially being detected by the victims themselves or by the woefully inadequate, indirect⁶ diagnostic tests^{7,8}.

These attributes of Lyme disease have inspired

researchers to call it a "pleomorphic stealth pathogen." And with the exception of the American Northeast, ground-zero for the outbreak, a crippling national (and worldwide) epidemic has largely spread "under the radar"⁹.

In this article I describe exactly how and why the CDC has allowed this catastrophic epidemic to spread on behalf of the pharmaceuticals industry using an orchestrated disinformation campaign led by CDC-manufactured "thought-leaders". This criminal program has enabled large-scale human experimentation (the Tuskegee Experiment, Phase II) under the cover of biowarfare research to implement a step-by-step vaccine marketing agenda outlined in a cold-blooded CDC marketing strategy published in 1999.

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"...we are dealing here with a formidable 'smart stealth' type of bacteria that is hard to eradicate-one that does extreme damage to psyche and soma if not treated aggressively over the long term when missed in the first days following inoculation by the vector..."

-- Dr. Virginia Scherr

Lyme disease is spreading rapidly up and down the East Coast of the US. In fact, it is the most common tick-borne disease in the Northern Hemisphere accounting for more than 95% of all vector-borne diseases reported in the United States. Even worse, the very same Centers for Disease Control and Prevention that investigated the disease and its myriad induced disorders is home to a secretive biowarfare defense infrastructure that prevents people not only from understanding the devastating nature of the disease (due to its complexity and often nonspecific symptoms), but also from getting treatment for it.

Many thousands of Lyme patients who are desperately ill cannot get a doctor to diagnose them properly, let alone treat them-even in admitted endemic areas. In some cases this is because of pure ignorance, where a doctor diagnoses arthritis or heart trouble without discovering that the underlying cause is really Lyme, which then goes untreated. In egregious cases, knowledgeable doctors won't admit that the patient has Lyme despite all the signs, and they refuse to

treat it. In outrageous cases, knowledgeable doctors realize that the patient has Lyme, but they aren't allowed to treat it or they are punished if they do.

What is behind this travesty¹⁰?

"It seems everywhere I go, someone comes up to me to talk about how Lyme disease has severely impacted their lives or someone they know."

--Congressman Chris Smith (R-NJ), 2011

The Curious Lyme-Biowarfare Connections

In a previous article, I related that Lyme disease is named for the unfortunate town in Connecticut where it first broke out, just 20 miles from the nation's top-level biowarfare test facility (Plum Island Animal Disease Research Center) that conducted outdoor tick experiments and has a history of pathogen-leaks from its internal labs.

The connections between Lyme disease research and biowarfare are stunning¹¹. A quick review:

The bacterium that causes the disease is named after a biowarfare researcher who, decades previous in a biowarfare lab, injected *Ixodid* ticks-the same type of ticks that spread Lyme, with *Borrelia* bacteria-the same type of bacteria that causes Lyme disease¹². The first researcher to overcome the difficult process of culturing the Lyme bacterium worked in this same biowarfare lab

and now directs his own biowarfare lab. The defense-contractor researcher who "discovered" the *Ixodid* tick vector that causes Lyme disease, and led the early efforts to deny victims treatment for it (under numerous, fraudulent pretexts), was then a recent graduate of the CDC's biowarfare defense program. The researcher whose publication is universally used to institutionalize this treatment-denial philosophy for Lyme disease was also a graduate of this CDC biodefense program and now also directs his own biowarfare lab.

Moreover, the lead author of the highly controversial treatment guidelines for Lyme disease, which use this publication as a justification¹³, travels around the country lecturing on biological warfare treatments¹⁴. Press releases prepared in 2005 to announce the opening of a government-funded biowarfare lab at the University of Texas admitted Lyme disease was one of the numerous bioweapons to be studied at the facility, then were mysteriously edited to scrub only the references to Lyme disease¹⁵.

Are you getting the picture?

"As of 2007, not a single U.S. government researcher had been prosecuted for human experimentation, and many of the victims of U.S. government experiments have not received compensation, or in many cases, acknowledgment of what was done to them."

-Wikipedia.org (Unethical human experimentation in the United States¹⁶)

The Tuskegee Experiment Continues

My research into the horrific politics behind Lyme disease have led me to believe that the Lyme Epidemic is the result of Phase II of the CDC's infamous Tuskegee Experiment, only this time conducted under the protection of biowarfare research. (This is covered in my July 2011 article in the Public Health Alert¹⁷.)

The original Tuskegee Experiment was designed to monitor the destruction that syphilis would cause over the long term in untreated controls so that treatments and preventive strategies could be tested. Thus, in Phase I of this experiment, geographically isolated black men and their families were systematically denied treatment against syphilis for decades, so that the "natural course" of the disease and its spread could be monitored through the patients' deaths and subsequent dissections in carefully arranged post-mortem examinations¹⁸. Even though the experiment was proving fatal almost immediately¹⁹, the deadly experiment would go on for decades²⁰.

I believe Phase II of this deadly experiment is being conducted by the CDC with a weaponized variant of a *Borrelia* spirochete-a bacterium of the same phylum as the syphilis spirochete that was the subject of the

first Tuskegee Experiment. (The Lyme spirochete is actually much more complex than the syphilis spirochete and the infection more deadly and less understood²¹.)

You need to arm yourself with information to protect yourself and your family. As will be shown below, the CDC clearly isn't going to do it²².

"Lyme disease patients frequently endure extensive delays in obtaining an initial diagnosis, have poor access to healthcare and suffer a severe burden of illness."

-- Johnson, Aylward & Stricker, (Health Policy, 2011)

No One Is Safe

Lyme disease spares no level of society²³. George W. Bush caught it while serving as president²⁴. Lyme also has afflicted Senator Charles Schumer of New York²⁵. They may have been spared the awful effects of misdiagnosis and denial of treatment because of their privileged positions, but millions of others haven't been so lucky²⁶.

In addition to crippling arthritis, this disease can cause severe and disabling neuro-cognitive symptoms that are difficult if not impossible to cure (depending on delays in diagnosis and treatment)-making it a grave national security threat, especially when it infects the Commander In Chief in time of war²⁷.

But the biology of the Lyme infection is only part of the problem. Another aspect of the epidemic is the manner in which it is being

politically perpetuated through the denial of the severity and geographical extent of the disease by the CDC and associated government agencies. This has resulted in many thousands of desperately ill patients being cruelly and systematically denied medical attention as they fall victim to the numerous symptoms of the disease.

The Tuskegee Experiment Was Worse Than We Thought

Even as the CDC's agents work to prevent Americans from getting treatment for this plague, we have recently learned that the CDC's infamous Tuskegee Experiment in treatment-prevention against an eerily similar bacterium (Treponema Pallidum) was far wider in scope and more deadly than we have been led to believe.

Indeed, instead of the experiment being limited to the prevention of treatment for syphilis in an isolated geographical area of Alabama, we have learned that the Tuskegee Experiment was international in scope and involved the deliberate infection of mental patients and prisoners through syphilis injections, scrapings and orchestrated exposure to carefully infected prostitutes.

Professor Susan Reverby²⁸ recently summarized:

"In this research program of a series of carefully delineated experiments, PHS doctors

exposed their subjects through the use of infectious prostitutes or directly through inoculums made from tissue from human and animal syphilitic gummas and chancres, or pus of gonorrhea or chancroid filled sores."

Dr. John C. Cutler, an assistant surgeon general in the Public Health Service who conducted these experiments in Guatemala with the syphilis spirochete, ultimately returned to the U.S. to conduct similar experiments in prisons²⁹.

"If this were fiction, the study's investigators would have been the archetypal mad scientists. But the study was conducted by no less prestigious a group than the United States Public Health Service³⁰ and funded by the National Institutes of Health (NIH)..."

--The Lancet, December 2011 (commentary on international syphilis injection experiments conducted by the U.S.)

As Reverby relates, these experiments with syphilis spirochetes were conducted by the Public Health Service to test vaccine prototypes:

"These prison studies were done to answer some questions about reinfection and whether having treated syphilis and then being provided with the "booster" of new disease created immunity to further infection."

In response to these horrifying revelations,

Francis Collins, the NIH director, tried to allay fears on ongoing experimentation:

"I want to emphasize that today, the regulations that govern research funded by the United States Government, whether conducted domestically or internationally, would absolutely prohibit this type of study³¹."

While such statements may offer comfort to the uninformed, I believe the NIH and the CDC are in fact conducting a modern Tuskegee Experiment in treatment denial for vaccine research against another spirochete disease that is very similar to syphilis.

I have referred to this ongoing medical crime as the institutionalization of the Tuskegee Experiment³². The treatment denial experiment is being orchestrated on a daily basis on a grand scale in a sophisticated manner at a very high level through the enforcement of treatment guidelines³³ and the selective NIH funding of guideline authors' research.

(This body of sponsored research gives the treatment guidelines undeserved credibility through an artificially contrived appearance of scientific consensus by manufactured thought-leaders³⁴.)

Through the increasing reliance on treatment guidelines, which often end up being "non-treatment" guidelines, the medical system can be used not only to conduct unethical experiments but also to wage biological warfare against an entire population through treatment denial. Indeed, it is not far-fetched to call this

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the "institutionalization of biological warfare"³⁵.

As was the case with the original syphilis study in treatment denial, the NIH is so intimately intertwined with the immoral research that it is impossible for them to conduct an impartial investigation into it³⁶. Thus, we need an informed public to demand a truly independent investigation into why many thousands of patients are being denied treatment for Lyme disease.

The Tuskegee-Lyme Link?

One of America's leading Lyme and biowarfare researchers, Dr. Alan Barbour³⁷ has written on the experimental use of bacterial disease agents known as "Borrelia" (the type of organism which causes Lyme disease) in syphilis treatment research.

Barbour has summarized bizarre studies in which Borrelia infections were induced in mice for subsequent inoculation back into humans, so the organisms could be studied as potential cures for syphilis (through deliberate fever-induction, or "pyrotherapy"):

"When using borreliae for pyrotherapy of neurosyphilis, the authors of this report recommended that no more than 30 to 40 passages in mice be made before inoculation of the strain back into humans³⁸."

Was this ongoing experimentation with deliberate human infection with live Borrelia spirochetes part of the ongoing Tuskegee study involving deliberate

human infection with syphilis spirochetes³⁹, so that vaccines and cures could be tested⁴⁰ in carefully controlled populations (some control populations getting no treatments)?

Let us establish quickly that Lyme disease and syphilis are similar organisms. Porcella and Schwan wrote in the *Journal Of Clinical Investigation*:

"... the Lyme disease spirochete, *Borrelia burgdorferi*, is amazingly similar to the spirochete, *Treponema pallidum*, that causes syphilis⁴¹."

The infections caused by the two disease agents are also similar. As summarized by Judith Miklossy:

"Both spirochetes are neurotropic and in both diseases the neurological and pathological manifestations occur in three stages. They both can persist in the infected host tissue and play a role in chronic neuropsychiatric disorders, including dementia⁴²."

Military researchers were investigating the use of Borrelia spirochetes in syphilis vaccine research because the infectious agents were so similar (providing hope for common antigens that could be used in vaccines and diagnostic tests⁴³), as were the infections they caused.

But there was more at stake than potential cures or tests for syphilis.

Barbour has also noted that Borrelia spirochetes were not only useful for studies in syphilis experiments. They were of "basic

biological interest⁴⁴" as well as a useful model for providing unique insight into the human immune response⁴⁵, a topic vital to vaccine research, in general. Thus, human experimentation with Borrelia bacteria would have major research benefits outside of syphilis research.

Notably, Barbour is a career biowarfare researcher, as are many of the so-called "experts" on the Borrelia organism that causes Lyme disease.

Borrelia and Biowarfare

The tie-in between Lyme disease, syphilis and biowarfare research may seem puzzling (see Appendix A for a summary of these connections). But there is a connection that makes perfect sense if you think about it.

The Tuskegee Experiment conducted from the 1920s to the 1970s by the PHS/CDC (a quasi-military institution formed during World War II⁴⁶ and involved in biological warfare activities⁴⁷) also had a military justification. The rates of syphilis infection in the public were hindering the American war effort as far back as World War I⁴⁸. Thus, efforts aimed at curing or preventing syphilis had a national security justification.

The degree to which Borrelia infections such as Lyme disease affects the readiness status of American troops is an ongoing area of government study⁴⁹. (American soldiers were even infected with relapsing

fever Borrelia through injections and tick bites in international experiments to understand the transmission of Borrelia diseases.⁵⁰) But the truth has been actively obscured from the public's view, much like the extent of the national epidemic and its premeditated nature.

"Three human beings, volunteer patients, have been infected with relapsing fever as follows:

- 1. The first by a subcutaneous injection of blood from a white rat which had been infected with relapsing fever by ...naturally infected ticks.**
- 2. The second by a hypodermic injection of a suspension of naturally infected ticks.**
- 3. The third by being bitten by naturally infected ticks."**

-- Bates, et. al., *Am. J. Trop. Med.*

In addition to affecting military readiness, research into disabling agents such as the Borrelia organism that causes Lyme disease had an offensive use as biowarfare agents.

Borrelia organisms were of interest to the military because of their ability to cause both mentally and physically disabling infections that were capable of relapsing, even after treatment with antibiotics. This was due to the organism's ability to not only rapidly evolve into different forms in a manner that frustrated

antibiotics administration⁵¹, but also to rapidly disseminate throughout every major organ in the body.

Another form of self-protection is the organism's ability to form protective "biofilms" and "cysts"⁵² when confronted with a hostile environment, only to reconvert from dormancy to active infection once a friendly environment was again encountered⁵³ (for example, when any administered antibiotics were gone⁵⁴). This protective dormancy capability, which is shared by anthrax (a biowarfare agent also studied by Barbour before Lyme broke out⁵⁵) and syphilis, would be highly useful for real-world biowarfare exercises⁵⁶.

In addition to weapons that could kill quickly, the Pentagon was interested in such weapons that could incapacitate⁵⁷.

The staggering benefits of Lyme disease as an incapacitating infection were summarized by researcher Mark Sanborne:

"Lyme's ability to evade detection on routine medical tests, its myriad presentations which can baffle doctors by mimicking 100 different diseases, its amazing abilities to evade the immune system and antibiotic treatment, would make it an attractive choice to bioweaponers looking for an incapacitating agent. Lyme's abilities as 'the great imitator' might mean that an attack could be misinterpreted as simply a rise in the incidence of different, naturally occurring diseases such as autism, MS, lupus and

chronic fatigue syndrome (ME). Borrelia's inherent ability to swap outer surface proteins, which may also vary widely from strain to strain, would make the production of an effective vaccine extremely difficult. ... Finally, the delay before the appearance of the most incapacitating symptoms would allow plenty of time for an attacker to move away from the scene, as well as preventing people in a contaminated zone from realizing they had been infected and seeking treatment⁵⁸."

Lyme and Syphilis: A Shared "Tuskegee Research" Rationale

The rationale of the PHS/CDC's Tuskegee syphilis experiment in denying treatment to individuals "to evaluate the effectiveness of programs of public health control" was explained in one journal from the beginning phases of the epidemic:

"... the facts relative to the occurrence of central nervous system syphilis, cardiovascular syphilis and congenital syphilis were well known from the point of view of diagnosis and pathological findings once the disease had become manifest. However, there was no accurate idea about the natural history of the disease leading-up to these complications. This information was necessary in order to evaluate the effectiveness of programs of public health control with a reasonable degree of understanding of the natural history of the disease⁵⁹."

The CDC was able to garner information about "the natural history of the disease" from its earliest phases by monitoring isolated communities of American citizens denied treatment for syphilis "from the beginning of the disease to the death of the infected person." This was viewed as an "opportunity ... to compare the syphilitic process uninfluenced by modern treatment⁶⁰."

Shockingly, the experiments were published in open medical literature over the years⁶¹ and yet the story did not break until 1972, when long overdue bad publicity forced the experiment to end⁶².

Is the ongoing effort behind treatment denial of Lyme disease allowing the government to conduct another long-term experiment on the public with a hidden agenda of biological warfare?⁶³ One which allows them to monitor the various chronic symptoms caused by such disabling agents in an untreated public, while generating a demand for vaccine research against them? If so, how much bad publicity will be required to shut this multi-decade experiment down?

"So far, we are keeping the known positive patients from getting treatment."⁶⁴

--Comment On Tuskegee Experiment, by U.S. Public Health Service Official

"Half of the [Lyme disease victim] respondents reported seeing at least seven

physicians before the diagnosis of Lyme disease was made. Nearly half had Lyme disease for more than 10 years and traveled over 50 miles to obtain treatment."

--2011 Medical Survey

Published by the California Lyme Disease Association

A Contrived Epidemic Proliferating Out of Control

Lyme disease is the most rapidly expanding vectored disease in the U.S.⁶⁵ Nationally reported cases of Lyme disease doubled from 1991 to 2007⁶⁶. An estimated 2,000 to 20,000 people per year contract Lyme. And even the higher number likely understates the number of cases.

Local levels are more alarming. On Long Island, next door to the Plum Island Animal Disease Research Center that conducted outdoor tick experiments, the "rate of infection among the construction workers who worked outdoors" is an incredible 13%.⁶⁷

The Boston Globe has summarized the spread of the disease northward from the New York/Connecticut "ground zero" area to Massachusetts:

"The number of Lyme disease cases reported in Massachusetts jumped by about 50 percent from 2004 to 2005, a single-year increase that prompted concerned state health officials to say they were stepping up efforts to educate the public about prevention of the disease."⁶⁸

Moving south from the Connecticut epicenter of the epidemic, Pennsylvania

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now leads the nation in the number of Lyme cases. More alarmingly:

"In the past five years the cases have doubled, and the population most at risk is kids, ages 5 to 10 and the over-40-year-olds who are in their backyards gardening."⁶⁹

Moving further south, in a major investigative reporting series, the Roanoke Times has just confirmed that the Lyme Epidemic is spreading down the East Coast to Virginia and North Carolina, and even to Florida.

The rapid increase in Lyme in Virginia (500% in some areas!) was reported by the Times:

"Lyme disease in Virginia is spreading west and south ... In Montgomery County, the number of reported cases jumped 500 percent from four in 2007 to 24 in 2008. [A] record 65 new cases have been documented this year in the Roanoke region -- where only a handful was reported just four years ago."

In fact, the rate of the epidemic's spread is likely worse than what Virginia officials belatedly acknowledge. Dr. Keri Hall, director of epidemiology at the Virginia Department of Health, cautioned: "it is highly likely that the state doesn't know about all instances of the tick-borne disease."⁷⁰

To address the escalating epidemic in Virginia, Gov. Bob McDonnell entered the fray, creating a Lyme Disease Task Force to aid the diagnosis, treatment and education among doctors

and the public at large. When the task force issued its recommendations, the chair, Michael Farris (eight out of ten of his family members have Lyme), stated, "I think it's the greatest health threat of our time."⁷¹

Why has this not been done at the national level⁷²? Tragically, because of the "political" environment created by the CDC, patients and doctors cannot rely on the CDC or the national medical infrastructure to get accurate information on how to treat Lyme disease. In fact, a systematic disinformation campaign, and a war on doctors and patients who see through it, is being waged by agents and agencies of the CDC.

This "controlled stand-down" of the CDC seriously inhibits doctors' ability to get assistance in treating victims at the state level.

Here is a case in point.

While volunteering at Virginia summer camp last year, Dr. Cathryn Harbor saw an astounding 10% of her campers come down with symptoms of Lyme disease, according to the *Roanoke Times*.⁷³

Dr. Harbor was unable to get cooperation from her state Department of Health, which dismissed her concern with contrived and deadly arrogance that has become typical of the so-called health experts who should be confronting the Lyme Epidemic, instead of actively denying it.

The CDC, working through the Infectious Diseases Society of America

(IDSA), has created a hostile political climate for state Departments of Health⁷⁴ like Virginia's. This adversarial climate prevents Lyme victims from even being acknowledged, let alone treated. The effects of this climate on Dr. Harbor's attempt to treat the children were relayed by the Roanoke Times:

"It's so politically contentious that when she called the Virginia Department of Health to say she was swamped treating campers with acute Lyme, the response was: You can't possibly have that many cases because the number of Lyme-carrying ticks in Western Virginia is insignificant and small."

"You can't have Lyme because the experts say it doesn't exist here." This is the devastating "party line" of circular reasoning that has been parroted the last 40 years because of staggering levels of disinformation put out by the CDC and its biodefense unit, the EIS (Epidemic Intelligence Service). This militant denialism is deadly for victims of a disease for which treatment delay by days or weeks can make the difference between getting well or facing a lifetime of suffering.⁷⁵

"As I have traveled throughout my congressional district, I have been struck by the lack of knowledge about Lyme by both patients and medical providers, even though this area has long been at the center of a Lyme epidemic." -- Congressman Frank Wolf (R, VA).

A similar state of affairs existed in the neighboring state of North Carolina. State health experts there have engaged in denials over the years about the prevalence, and even the existence, of Lyme disease. These deadly denials have recently been exposed as fraudulent by the Raleigh NewsObserver. Reports the Observer:

"After years of cautioning that people were unlikely to get Lyme disease in North Carolina, state health leaders are now advising that the tick-borne illness can, in fact, be acquired here."⁷⁶

Too bad for those in North Carolina unfortunate enough to have contracted Lyme when the official position was that it didn't exist! (Whose experts were those?)

The calculated denial of infection rates directly impacts the ability of patients to get diagnosed and treated. This reality in North Carolina was summarized by the *Raleigh NewsObserver*:

"Yet North Carolina health officials do not consider Lyme disease a perpetual threat -- a designation that would make it easier for doctors to diagnose Lyme based solely on a patient's symptoms ..."

Consequently, "for years patients insisted they had caught Lyme from tick bites in North Carolina and faced tremendous problems finding doctors to diagnose and treat them."

The Raleigh News Observer relates the case of

Angela Stott and her efforts to get her son diagnosed and treated for Lyme disease (similar cases are commonplace):

"This past summer, Angela Stott of Asheville said her son, Max, went several weeks without a diagnosis before he became so sick he could barely walk and had such excruciating headaches his eyes crossed.

"More than one doctor told her Lyme disease was not a factor in North Carolina. Even when a Lyme test came back positive, Stott said, doctors still questioned the diagnosis.

"It was nightmarish," she said."

The newspaper notes how "the state is now working to get the word to doctors, who for years were reluctant to even test patients for Lyme because it wasn't considered much of a possibility."

The Lyme Epidemic is also surging further south, in Florida. According to a recent article in the *Tampa Tribune*:

"Across Florida, Lyme disease cases have more than tripled since 2007, according to the Florida Department of Health's Office of Statistics and Assessments..."

Lyme disease cases have also tripled in states far from the East Coast, like Iowa.⁷⁸

"So using the CDC's own definition, physicians in Georgia and Missouri reported that they were seeing Lyme disease. But because the cases were in a

non-endemic area, the CDC tossed out these purely clinical diagnoses."

-Jonathan Edlow, Bull's-Eye

Even more alarming, the Times reports that "experts concede that incidence of Lyme is woefully under-reported and can be as much as 10 times higher than the numbers indicate."⁷⁹

The magnitude of the epidemic at the national level has been summarized in one article as follows:

"We're in the midst of a terrifying epidemic, although you wouldn't know it to talk to most doctors and health specialists. The disease is growing at a rate faster than AIDS. From 2006 to 2008 alone, the number of cases jumped a whopping 77 percent. ...If any other disease had stricken so many people, the medical community would be scurrying for knowledge, scrambling for cures or rushing to warn patients (think swine flu). But that's not the case with Lyme disease -- a disease carried by ticks."⁸⁰

"Our practice is restricted by higher authorities, like the CDC."

--Dr. Muddasar Chaudry

Lyme Doctors Eradicated

Although Lyme disease cases have doubled in the past five years, the number of doctors willing to treat them has dwindled. Medpage today reports that at ground-zero of the Lyme Epidemic, **only 2% of doc-**

tors in the state of Connecticut are willing to treat it:

"Only a very small number of physicians in Connecticut -- the epicenter of Lyme disease -- diagnose and treat patients with the controversial chronic form of this tick-borne infection, a survey found. Among 285 primary care physicians surveyed, only about 2% treat chronic Lyme disease..."⁸¹

As the authors of the award-winning Lyme disease documentary *Under Our Skin* recently reported in their blog:

"So, with Connecticut Lyme cases skyrocketing up 118% from 2006 to 2008, and the state desperately needing every Lyme specialist it can get, the children of Connecticut are the ones receiving a potential life sentence of suffering, if they acquire one or more tick-borne diseases."⁸²

The human consequences of this reality are hard to fathom for those not directly affected.

The Tampa Tribune related the story of Delores Claesson⁸³, and her struggle to get her daughter treated for misdiagnosed Lyme disease:

"In all," she said, "we saw about 20 doctors." None thought of Lyme disease.

"This is normal." Claesson said. "They don't know about it. They don't know the signs and symptoms. ... here in Florida, doctors don't know about it and don't know how to diagnose it. They don't know how to treat it."

Even more alarming, according to Claesson, the doctors are willingly ignorant of the epidemic:

"I want my kid fixed," she said. "Doctors here are like ostriches putting their heads in the sand. It's been 27 months of pure hell," she said.

"We're lepers," Claesson said. "We can't get any treatment. It's bankrupted people."

Virginia State Delegate Tom Rust, after investigating the Lyme Epidemic in his state, commented, "I have people coming to me saying their dog can get better treatment than they can."

As ludicrous as this sounds, it is a tragic fact that people are resorting to treatment by veterinarians. This phenomenon is not limited to the US. The Bolton News in the United Kingdom reported that a "toddler who was taken to hospital after a tick burrowed under his skin, ended up being treated by a vet." The child's father stated, "Daniel got better service there than at the hospital."⁸⁴

Why the failure to treat Lyme patients?

Dr. Muddasar Chaudry of Virginia, was specific in stating why he was unable to treat patients with required long-term antibiotics:

"Our practice is restricted by higher authorities, like the CDC."⁸⁵

Dr. Kenneth Liegner, an MD treating Lyme patients in Armonk, New York, goes even further:

"Physicians who

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have cared for persons with chronic Lyme disease have faced harassment at a minimum and for some, their careers have been ruined. Researchers who have seriously dedicated themselves to the scientific study of chronic Lyme disease in humans and/or animals have often found themselves attacked or marginalized. To persist in their researches would have resulted in virtual career suicide and some have been forced, by exigencies of survival, to leave the field."

The film-makers for the award-winning *Under Our Skin* described the punishment (supervised probation and a \$20,000 fine) meted out to Dr. Charles Ray Jones, a national hero known for successfully treating thousands of desperately ill children with Lyme disease in the Northeast.

"Last week the Connecticut Medical Examining Board (CMEB) voted to discipline Dr. Charles Ray Jones, the 80-year-old pediatrician featured in *UNDER OUR SKIN*, for technical violations in the way he diagnosed and treated three children suspected of having tick-borne diseases."

The film-makers noted the asymmetry in the establishment's malicious punishment of a well-respected Lyme doctor:

"...Last year the medical board punished 43 physicians for serious charges such as substance abuse, sexual misconduct, mental illness, and negligence; not one of these

physicians received a fine larger than \$5,000. And only one other physician, accused of drug abuse, received a longer supervised probation period than Dr. Jones - though this drug-addict doctor did not receive the additional \$20,000 in fines levied on Dr. Jones."

The film-makers also warned:

"The medical board's six-year investigation into Dr. Jones has sent a headline-grabbing message to every pediatrician in Connecticut - If you treat children with Lyme disease with more than four weeks of antibiotics, you may lose your medical license and be treated as a pariah among your peers."⁸⁷

According to attorney Richard Wolfram, this harsh treatment of Lyme doctors⁸⁸ has caused many to refuse treatment with long-term antibiotics, leaving patients abandoned:

...in the case of long-term treatment of Lyme disease, complainants estimate fewer than 150 physicians in the United States are willing to endure the pressures from the IDSA and from insurance companies (by their refusal to cover long-term antibiotic treatment). This number is down considerably from previous levels."

Unfortunately, it is exactly this type of embattled long-term treatment⁸⁹ that is often required to fight the Lyme infection.⁹⁰

"It is difficult enough for someone suffering debilitating symptoms due to late-

stage Lyme disease to get well with the judicious, but adequate, use of long-term antibiotics. Almost no one gets better without these. To deny patients access [to] this care is a travesty. But this happens all the time and patients often travel hundreds to thousands of miles to see one of the small numbers of Lyme experts in this country. How can that be?"

--Dr. Jon Sterngold

Observations of patients getting better under the expert administration of long-term antibiotics--only to relapse after their doctors are prevented from providing them--are routine in the Lyme treatment community. For example, the North Carolina state medical boards punished infectious disease expert Dr. Joseph Jemsek for prescribing long-term antibiotics to desperately ill Lyme victims. Consequently, many of his patients (including myself) relapsed because they were no longer able to get treatment from Jemsek or other doctors who were afraid of similar prosecution by the state medical mafia. As the mother of one such patient, who was recovering his sight under Jemsek's expert care, related:

"We've looked for other doctors, but nobody will deal with it here because they're terrified by what happened to Dr. Jemsek. All we want is for our son to be able to be home and get well. Dr. Jemsek did that for us. He gave us back our son's life."⁹²

Manufactured Doctor Shortage Enables Modern Tuskegee Experiment

Why would the medical establishment actively prevent doctors from effectively treating Lyme disease, and help destroy doctors who treat it?

I believe the CDC is conducting Phase II of its Tuskegee Experiment on an expanded scale for the same reason it conducted Phase I--the development, testing and marketing of pharmaceutical products to treat only symptoms of the disease. In fact, the treatment denial of the Phase I Tuskegee Experiment has become an everyday occurrence for thousands of Lyme patients because the experiment has become institutionalized within the mainstream medical system through the creation and enforcement of treatment guidelines to justify treatment denial. For added protection, the CDC is conducting this experiment in long-term treatment denial through the biowarfare infrastructure as a biodefense exercise.

The medical literature from the time of the original Tuskegee Experiment explained the experimental reasons for why patients with chronic diseases like Lyme or syphilis must be prevented from getting treatment over a long period:

"The prolonged nature of a chronic disease or a disease with a chronic stage, such as syphilis, necessitates long-term study

of the natural history (or pathogenesis) of the disease before the effectiveness of programs for the control of the disease can be evaluated properly."⁹³

In other words, a long-term baseline must be established as to how the chronic disease behaves in untreated patients (the "natural history of the disease"), so that the effectiveness of treatments or vaccines can be evaluated against this background.

Since syphilis and Lyme disease are caused by similar organisms and create similar multi-staged, chronic infections, a similar experimental rationale would apply to studies of Lyme disease treatments and vaccines.

Could the CDC really be conducting Phase II of the original Tuskegee Experiment? And could this explain the politics behind the non-treatment of the Lyme Epidemic?

Dr. Colin Ross, the intrepid author who obtained thousands of pages of FOIA documents on unethical government experimentation on its citizens, noted that:

"The Tuskegee Syphilis Study was eventually shut down in 1972 because of the efforts of an investigative journalist. ***There is no evidence to suggest that the government or the medical profession had any intention of closing the study as of 1972.***"

Ross also noted the precedent that the first Tuskegee Experiment set:

"It establishes that a large network of doctors and

organizations are willing to participate in, fund and condone grossly unethical medical experimentation into the 1970's."

The timing is curious in that just as the original Tuskegee Experiment was being wound down in the 1970s, the Lyme disease epidemic and a corresponding denial of treatment for it by "experts" (often associated with the CDC) was ramping up. In the 1970s, numerous congressional investigations also revealed that the American public had been subject to decades of human experiments with all manner of incapacitating agents through the CIA's MKULTRA project. According to the congressional reports, the government had engaged in "extensive testing and experimentation" on unwitting human subjects "at all social levels, high and low, native Americans and foreign."⁹⁴

The CDC's Secret Police: The Epidemic Intelligence Service

In the Lyme war, the establishment is waging a battle of ignorance and denial. Doctors in the field trying to treat the relapsing, chronic infection due to Lyme, and their desperately sick and relapsing patients, have opinions that differ drastically from the research selectively published by CDC and Ivy League "experts" who routinely deny the notorious "persistence" of so-called chronic Lyme disease, even after aggressive treatment.⁹⁵ As noted by the Roanoke Times:

"There is a gaping disconnect between scientific research and the experiences of people on the ground. Among the 420 New Englanders whom anthropologist Macaуда interviewed for his 2007 dissertation on chronic Lyme, 80 percent of the interviewees believed in the [chronic form of the] disease."

This "gaping disconnect" can be laid directly at the feet of the Centers for Disease Control's elite biowarfare defense unit, the Epidemic Intelligence Service, since their epidemiologists⁹⁶ and researchers are the ones downplaying the geographical extent and relapsing nature of the Lyme Epidemic.⁹⁷ And this downplaying of the infection-rate and chronic nature of the disease directly results in treatment denial.⁹⁸

The anonymity of the EIS belies its power to shape health policy from behind the scenes. Indeed, it would be hard to underestimate the power of the EIS in coordinating domestic health policy. Their graduates populate top positions in the health infrastructure (including the media⁹⁹). According to the ***American Journal of Epidemiology***:

"The current CDC Director (and two previous Directors) and a Deputy Director are graduates of the program, as are the directors of 9 of the 11 major CDC organizational units and much of the CDC leadership throughout the organization. Two alumni have served as Surgeon General of the United States."

International news articles report patients who are initially treated with disgust rather than with medicine by their nation's medical experts, only to get better when they traveled to a country that gave them proper tests and long-term antibiotics treatments.^{100,101}

The political power and disinformation network of the EIS would aid in coordinating treatment-denial policy on an international scale, as well. According to the *American Journal of Epidemiology*:

"Many EIS alumni are serving or have served in leadership roles for the World Health Organization, the Pan American Health Organization, the World Bank, and other international organizations and foundations."

"It's possible to see the modern history of Lyme as a string of events with an EIS member at every crucial node."

-Elena Cook, "Lyme Is A Biowarfare Issue"

The overall reach of the EIS in coordinating an "information exchange" would be substantial, as noted in the *Journal*:

"Although difficult to quantify, the networking and camaraderie among EIS graduates continues to strengthen the overall public health infrastructure by facilitating information exchange among alumni located in key public health positions throughout the nation and world."

Careful investigation

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supports the theory that the epidemic of ignorance and corresponding lack of treatment has been perpetuated by the CDC as part of Phase II of the deadly Tuskegee Experiment.

"Never would I have deemed it possible that a group of medical people would work so vigorously and with such malice against a group of desperately ill people But, here it is."

**-Lyme victim/activist
(requested anonymity for
fear of reprisal)**

Even worse, Phase II is being carried out by the CDC with the aid of its secretive biological warfare group. Where the Phase I experiment denied isolated patients from seeing non-CDC-approved doctors¹⁰², Phase II involves preventing doctors from treating patients (or even providing an accurate diagnosis--recall the Tuskegee diagnosis of syphilis as "bad blood"¹⁰³) outside of CDC-approved guidelines published by a medical society known as the IDSA (Infectious Disease Society of America), on an international basis.

The CDC's own history of the Tuskegee Experiment describes how the CDC worked with prominent medical societies to gain support for the multi-decade experiment in medical malpractice:

"1969 CDC reaffirms need for study and gains local medical societies' support (AMA and NMA chap-

ters officially support continuation of study)."

So the national agency that was supposed to be protecting the public from a deadly disease was actually in favor of letting it go untreated for experimental reasons and worked with prestigious medical societies to that end!

Tuskegee Phase II is being conducted in a similar manner, including the direct assistance of prominent medical societies through IDSA treatment guidelines¹⁰⁴ enforced by CDC insiders, who are regularly found to be on the payroll of the pharmaceuticals and insurance industries--both of which can profit enormously^{105,106} by not treating the many symptoms¹⁰⁷ caused by the disease.

"One way drug companies have marketed their products is by funding the implementation of guidelines..."

**--Civil Action No. 08
CA 11318 DPW**

The CDC has used the non-specificity of Lyme symptoms (except for those fortunate enough to manifest the Bull's Eye rash at the onset of infection¹⁰⁸) as an excuse to mislabel the disease and thereby prevent effective diagnosis and treatment.^{109,110} As Dr. Brian Fallon summarized:

"Incorrectly labeling these patients as having a functional illness, such as depression, hypochondriasis or a somatization disorder, may result in a delay in the initiation of antibiotic treat-

ment. Such delay may lead to further dissemination of the infection, and in some cases severe disability and possibly chronic neurologic damage."

The further dissemination of symptoms is highly profitable for pharmaceutical companies, while treating the root cause of the disease with off-patent antibiotics is not.¹¹¹

"Most blockbuster drugs got that way not by curing people but by treating chronic conditions ... that can require a lifetime of prescription refills."

**--Michael Gianturco,
Fortune**

The Steere Camp's War on Lyme Patients

Even more alarming than CDC complicity in spreading the epidemic¹¹² is the overlap between government personnel in biowarfare and regulatory agencies and private medical societies, universities and corporations involved in fueling the epidemic.

Notably, the lead author of the controversial IDSA Lyme disease treatment guidelines, pharmaceuticals consultant Dr. Gary Wormser, in his spare time lectures as a biowarfare expert.¹¹³

Pharmaceuticals consultant Allen Steere, influential researcher and co-author of the guidelines, is a CDC/EIS biowarfare officer. He also worked for the private Yale Corporation¹¹⁴ that worked closely with the biowarfare tick lab across the Long Island Sound from Lyme, Connecticut, and

which also controlled the initial response to the Lyme Epidemic in the Northeast.¹¹⁵

It was Steere's laughable ideology that antibiotics were ineffective against Lyme disease that was used from day one to deny patients this treatment.

The geographical clustering of the arthritis cases in the initial Lyme outbreak¹¹⁶, along with seasonal correlation of the outbreaks (arthritis symptoms typically increased in late summer and early fall), made it difficult to ignore the likelihood that insects were spreading the disease. Judith Mensch was a Connecticut housewife who, like Polly Murray, had voiced her concerns about the spreading arthritis epidemic to local health authorities (and even the CDC). She mentioned to Steere the first time they met that she suspected ticks might be the source of the disease.¹¹⁷ As part of the initial investigation into the mysterious epidemic, Yale sent out bulletins to the local community warning residents to be on the lookout for insects that might be spreading the disease.

While Steere was still prescribing toxic levels of "aspirin therapy"¹¹⁸ for Murray's desperately ill family, a man named Joe Dowhan walked into Steere's office and presented him with the "smoking gun." Dowhan had not only been bitten by a tick and suffered from Lyme symptoms. He had saved the tick, which turned out to be from the Ixodes Scapularis species.¹¹⁹

This vital clue would

allow Steere to become famous by publishing a paper documenting the transmission of the mystery disease by *Ixodid* ticks.¹²⁰ A case can be made for the argument that Steere used the prestige offered by this development to tragic effect over the ensuing years.

Indeed, Steere's institutional ties gave him undeserved influence as an "expert" on Lyme disease. Unfortunately, Steere's expertise seems geared toward finding reasons for why patients didn't have Lyme disease and therefore didn't need treatment. The *New York Times* summarized Steere's history:

"As the world's foremost expert on the illness, however, Steere did not believe many of them had Lyme disease at all, but something else ... and he had refused to treat them with antibiotics. Many doctors and insurance companies had followed his lead, and in turn, hordes of patients had started to stalk him."¹²¹

Over the years, this so-called Steere-camp group has invented a non-existent Lyme virus¹²² and a non-existent species of *Ixodid* tick¹²³ to justify the denial of antibiotics¹²⁴ to an expanding group of Lyme victims. (This camp currently searches for an auto-immune mechanism¹²⁵ which would explain chronic Lyme disease symptoms independent of an ongoing infection that might be cured through antibiotics¹²⁶ instead of treated with a lifetime of pharmaceuticals products.)

"To sum up the therapy of Lyme arthritis (Lyme disease), it appears that at this point only symptomatic treatment is feasible..."

**--Allen Steere et al.,
Hospital Practice 143 (April 1978)**

This fraudulent Steere-camp ideology has been institutionalized in the highly controversial, one-size-fits-all IDSA Lyme Disease Treatment Guidelines.¹²⁷ These "guidelines" were so draconian they were investigated by the Connecticut Attorney General, who found "undisclosed financial interests held by several of the most powerful IDSA panelists."^{128,129}

Steere originally worked for the corporation (Yale) that developed and licensed the first Lyme vaccine, Lymerix. He not only established the mythology that has kept his patients from getting effective treatment so that the vaccine could be developed and marketed, but he also personally oversaw the vaccine trials and associated tests¹³⁰ run by the company that licensed the vaccine from his previous employer.

Steere admitted in one technical paper how having blood samples from untreated controls throughout the progression of the disease was beneficial in mapping out the long-term immune response to the disease (this was critical for developing a vaccine to mimic the antibody response against the disease-agent):

"In two previous studies, we used a unique set of serial serum samples from untreated patients monitored throughout the course of Lyme disease in the late 1970s prior to the use of antibiotic therapy for this illness. Only with this set of serum samples is it possible to determine how the antibody responses to *B. burgdorferi* develop and change during the various stages of the illness."¹³¹

At the beginning of the epidemic, Steere systematically ridiculed the notion that antibiotics were effective against the Lyme disease bacterium¹³² that he erroneously assumed¹³³ was a virus.¹³⁴ His group at Yale said the same thing,¹³⁵ even as doctors around him were successfully treating patients with antibiotics.¹³⁶

"We remain skeptical that antibiotic therapy helps..."
--Allen Steere, et. al.

When they could no longer deny the obvious beneficial effects of antibiotics, Steere's camp suddenly switched to the other extreme, claiming that antibiotics were amazingly effective and therefore only extremely short courses of antibiotics would completely cure Lyme disease. The common thread in these two contradictory ideologies is that they are both rationales for denying patients effective, long-term antibiotic treatment.

These positions allowed Steere et al to conduct what he later termed as a "natural experiment" in

which the deadly symptoms ("sequelae") of the disease could be monitored over the long term (as the "optimal antibiotic therapies were still evolving"), just as they had been in the CDC's Tuskegee Experiment with a similar, but less complicated, syphilis spirochete. As Steere, who played an active part in discrediting "optimal antibiotic therapies" that other doctors with far more limited resources than Yale's finest had managed to develop,¹³⁷ shockingly admitted in 1994:

"We studied persons residing in an endemic coastal area of Massachusetts who were previously infected with *B. burgdorferi* in the early 1980s. They contracted Lyme disease while the clinical syndromes and optimal antibiotic therapies were still evolving, which offered a "natural experiment" for the identification of risk factors for Lyme disease sequelae."¹³⁸

In her book, Lyme research pioneer Polly Murray hinted at Steere's agenda in not treating Lyme disease, which was consistent with Tuskegee-like monitoring¹³⁹ of the progression of the damage induced by the disease:

"He told us that he felt that it was very important for him to follow all his patients on a continuous basis in order to know the stages of the disease."¹⁴⁰

Steere even took measures to ensure that the fraudulent ideology¹⁴¹ he created to maintain untreated controls was enforced. He personally testified against

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doctors who defied his carefully designed disease perpetuation paradigm. As related by the **New York Times**:

"To patients with Lyme disease perhaps Dr. Steere's most audacious gesture came in 1994 when he testified at a board of medicine hearing against Dr. Joseph Natole of Saginaw, Mich., who was treating patients for chronic Lyme disease. Because Dr. Natole had so many people on intravenous antibiotics, authorities charged him with medical malpractice and insurance fraud. Dr. Natole was ultimately stripped of his medical license for six months."¹⁴²

Steere has not only helped destroy the lives of Lyme doctors. He has systematically ridiculed Lyme patients over the years--especially women.¹⁴³ Echoing the manner in which Polly Murray was initially treated by the medical community,¹⁴⁴ Steere has taken the position that many Lyme patients want to be diagnosed with Lyme disease. He was quoted in the **New York Times**:

"I suppose Lyme disease is one of the few diseases that some people want to have, because it's defined. I think it's very difficult to have something that is not well understood."

On top of all this, Steere is a member of the Epidemic Intelligence Service, the CDC agency chartered with responding to biowarfare agents released on U.S. soil, as well as developing vaccines against them. (The EIS has boasted of its history in promoting vac-

cines.¹⁴⁵)

At this point, I should add that I do not think Steere has any power on his own. He, and other Ivy League Lyme "experts" like him, are simply being used as manufactured "thought-leaders" on behalf of the pharma-biowar establishment to sell profit-friendly Tuskegee policy to the public. His undue influence reflects no expertise whatsoever (other than milking government grants to reach the same conclusion year after year), just the reality that far too much unaccountable influence rests in too few hands at the top of the economic ladder.

"The controversy in the Lyme disease research is a shameful affair. And I say that because the whole thing is politically tainted. Money goes to people that have for the past 30 years produced the same thing: nothing."

--Willy Burgdorfer
[name-sake of Lyme bacterium]

The Blueprint Behind It All?

Could a vaccine agenda, under the pretext of biowarfare defense, explain why the EIS, and its point-man Allen Steere, were so heavily involved in controlling the non-response to the Lyme Epidemic, which started just outside a biowarfare lab?

It is certainly feasible that a two-step program was put into place with respect to a vaccine development and marketing agenda for Lyme disease.

Step-I would involve the leaking of the pathogen into the public,¹⁴⁶ with associated treatment-prevention and cover-up techniques subsequently employed by pharmaceutical companies using their influence over the CDC and other regulatory agencies. This would keep the public ignorant about the nature and extent of the disease, so that well-connected researchers (conveniently doubling as pharmaceutical consultants and military biowarfare experts) could monitor the immune response of the disease in untreated controls. This information could then be exploited to develop a vaccine.

Once this phase was complete, and a candidate vaccine developed, would come Step-II. The vaccine could be tested under the secrecy and human experimentation privileges afforded by the covert biowarfare research infrastructure, which has conducted decades of destructive experiments with impunity. The health crisis created through the "treatment-denial phase" of the vaccine-development experiment could then be used to generate demand and justify implementing the vaccine, despite predictable side-effects.

"The most serious and disappointing circumstance was when I caught the CDC red-handed trying to... masquerade opinion as data supported by objective and provable facts."

--Dr. Ed Masters, Lyme

researcher

The otherwise inexplicable policies of the Steere camp, which are more geared toward perpetuating the epidemic than halting it, can be viewed as implementing such a strategy. The Steere camp has created an environment conducive to developing and testing vaccines and also one for marketing them!

Such a strategy is not as far out as it may seem. The parameters that would lead to a favorable market for Lyme vaccines were outlined in a blunt CDC paper on the cost-effectiveness of a Lyme disease vaccine. According to the conclusions of the paper, vaccines against Lyme disease would only be cost-effective if the probability of contracting Lyme disease was increased significantly from the existing levels.¹⁴⁷ (Published 1999).

As Emma Hitt explained in **Nature Medicine**,¹⁴⁸ the cost-effectiveness argument for a vaccine ("savings per case averted") only made sense if nearly an order of magnitude increase in infection rates took place:

❖ "A cost-effectiveness analysis of the Lyme disease vaccine by the CDC indicates that the use of Lymerix vaccine is justified only in areas in which the incidence of Lyme disease is high.

❖ They found that the mean net savings of vaccination per case averted is \$3,377 if the probability of

contracting Lyme disease is estimated at 0.03. *However, the probability of contracting Lyme disease is, in all but a few areas, less than 0.005.*"

The CDC vaccine-marketability authors found that, within parameter values estimated to be accurate at the time when the first Lyme vaccine was being marketed, increasing the probability of Lyme disease to 1%-3% would make the vaccine appear cost-effective. The problem was that, except for a few isolated areas, this proposed probability of contracting Lyme was far higher than actual infection rates.

- ❖ Were CDC policies put into place to correct this?
- ❖ Were CDC-trained epidemiologists (EIS), such as Allen Steere, put in place to justify disastrous policies to make the vaccine cost-effective, as outlined in this CDC-authored publication?
- ❖ Does this explain the decades of outrageous CDC policies to the detriment of the public, allowing Lyme disease to spread generally and its effects to worsen individually beyond what they would have with proper treatment so that a vaccine could be justified from a financial standpoint?

"In recent years, drug companies have perfected a new and highly effective method to expand their markets. Instead of promoting drugs to treat diseases, they have begun to promote diseases to fit their drugs."

--Marcia Angell, New York Review of Books

The CDC vaccine-marketability study spells out how the "cost-savings of vaccination" against Lyme disease can be computed by examining "the effect of combinations of six inputs":

- ❖ cost of vaccination
- ❖ annual probability of contracting Lyme disease
- ❖ costs of successfully treating either early symptoms of Lyme disease or one of three sequelae
- ❖ probability of diagnosing and treating early symptoms
- ❖ probability of sequelae due to early infection

❖ probability of sequelae due to late, disseminated infection

Thus, this article reveals how a business case could be made to offset the costs of an expensive Lyme disease vaccine for each of these parameters, if

- ❖ the probability of contracting the disease increases
- ❖ the cost of treating Lyme disease increases
- ❖ the probability of correctly diagnosing it decreases
- ❖ the probability of effectively treating it decreases; and, correspondingly,
- ❖ the probability of devel-

oping short- and long-term complications (sequelae) from Lyme disease increases

I propose that this CDC article provides insight into the overarching principles behind the Steere camp's "Lyme Disease Cartel" (managed largely by CDC epidemiologists), and therefore provides a blueprint of the real goals behind decades of disastrous CDC Lyme disease policies.¹⁴⁹

Indeed, with this article as a backdrop, it should be obvious that the policies advocated by the Steere-camp pharmaceutical consultants that have resulted in abject misery for Lyme victims represent gain for vaccine interests.

The article explains:

- ❖ The perpetuation of mythologies (variations of the "hard to catch, easy to cure" myth) that allow the epidemic to spread more readily (the "easy to catch, hard to cure" reality) while keeping the public and the medical community in the dark as to the true nature and extent of the disease
- ❖ This increases the "probability of contracting Lyme disease"
- ❖ The promotion of notoriously inaccurate test methodologies over more effective ones, while grossly underplaying the effect this has on the burgeoning epidemic

❖ This decreases

the "probability of diagnosing and treating early symptoms" (while the epidemic is building)

❖ The promotion of ineffective, short-term antibiotic regimens over more effective, long-term antibiotic regimens that have been developed through years of careful, empirical research

❖ This increases the "probability of sequelae due to early infection; probability of sequelae due to late, disseminated infection"

❖ The systematic harassment of physicians who learn how to diagnose and treat the disease effectively by using these antibiotic treatments

❖ This both decreases the probability of effectively treating Lyme disease and increases the probability of generating short- and long-term disease symptoms, the expensive treatments for which make a vaccine look cost-effective by comparison

❖ The denial of the role of active infection in sustaining long-term or chronic Lyme disease and the associated symptoms

❖ This also decreases the probability of effectively treating Lyme disease at the source and increases the probability of generating long-term Lyme disease symptoms

❖ The downplaying

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of chronic or asymptomatic infections ultimately causing long-term symptoms also makes the vaccine trials easier to conduct (allows a shorter surveillance time with a shorter list of symptoms to monitor)¹⁵⁰

Indeed, the Lyme "vaccine marketability" argument could also explain other controversial tenets long held by the Steere camp, including the following:

❖ The overemphasis of the relatively fast-developing Bull's-Eye rash symptom (Erythema migrans) as an indicator of Lyme disease, when this occurs in only half (or less) of Lyme victims¹⁵¹

❖ The restricting of Lyme disease to an arthritic disease, while absurdly denying that numerous, debilitating symptoms (both short- and long-term) such as cognitive and cardiac problems are routinely induced by the disease.¹⁵²

Overemphasizing the prevalence of the Bull's-Eye rash and arthritis in Lyme disease cases has major benefits for vaccine development. By concentrating on only one or two of the "protean manifestations" of Lyme disease, a vaccine can be made to appear more effective by emphasizing short-term conditions and ignoring long-term ones. Additionally, the difficult and costly problem of running vaccine trials can be made much more manageable.

This is because, in addition to helping spread the infection for reasons described above, the insistence that Lyme disease is characterized by a fast-forming and easily recognized Bull's-Eye rash along with arthritis symptoms drastically shortens the surveillance time (and thus the required FDA approval time) in vaccine trials and eases the "surveillance criteria" defining a positive case of Lyme disease following experimental vaccination.

Indeed, according to the authors of one Lyme vaccine study, the long lead-time, late-stage disease manifestations of Lyme disease presented unique and significant problems¹⁵³ for vaccine trials, since they required longer and therefore more expensive monitoring periods:

"Late-stage disease, which can occur weeks to years following infection, may cause complex rheumatologic, neurological and cardiac manifestations. These variable manifestations can make definitive diagnosis problematic and present difficulties in determining case definitions for use in vaccine efficacy trials. The long latency period for the appearance of symptoms also has implications for a trial, since prolonged surveillance must be employed."¹¹⁵⁴ [emphasis added]

Thus, by ignoring symptoms that form over periods of months to years and which are difficult and expensive to diagnose and, by emphasizing symptoms that are easy to diagnose

and monitor, the ability to make experimental vaccine trials look more successful is enhanced.

This was the course taken in the trials for the first commercial vaccine against Lyme disease. In spite of the fact that researchers associated with SmithKline Beecham admitted the size of the vaccine trials "will not be sufficient to determine vaccine efficacy against rare manifestations of LD with comfortable precision," an IDSA meeting was used to make ridiculously overoptimistic statements regarding the vaccine's effectiveness against so-called asymptomatic manifestations. According to one optimistic synopsis of the vaccine trials:

"A study with Lymerix®, manufactured by SmithKline Beecham Biologicals, presented at the Infectious Diseases Society of America (IDSA) meeting in Philadelphia, showed that after three doses, Lymerix reduced the risk of asymptomatic Lyme disease infection by 100 percent."¹⁵⁵

Such absurd vaccine marketing claims may also explain why Steere himself has made so many statements trivializing these non-arthritic symptoms over the years, and has recently claimed that these asymptomatic cases are not only rare in American infections,¹⁵⁶ but form over a period short enough to have been monitored¹⁵⁷ in his vaccine trial.

"The pharmaceutical companies depend upon a lot of their profits for drugs and so

on to treat chronic illnesses. These are patients they think they are going to have for the rest of their lives. So it's a big profit center for them. ... They don't really like solutions to these illnesses because it cuts into their profits, long-term profits. So in that regard, they have not been our best friends."

--Dr. Garth Nicholson, former David Bruton Jr. chair in cancer research, Department of Tumor Biology, the University of Texas M.D. Anderson Cancer Center, Houston

The Unrivaled Destructive Power of "Big Pharma"

Is there a power center capable of manipulating the definition and treatment of a disease for such a nefarious agenda? If so, how does it work?

The pharmaceuticals industry certainly has the money and infrastructure to carry out such an agenda. They also have a history rife with such large-scale doings.¹⁵⁸

This vaccine-friendly agenda is largely accomplished by manufacturing thought-leaders¹⁵⁹ out of compliant academics and keeping them on retainer as consultants to write pharmaceutical-friendly treatment guidelines and publish pharmaceutical-friendly articles in pharmaceutical-dominated medical journals. Such thought leaders are also kept on retainer to serve as "expert witnesses" when doctors who buck the system are put on trial.¹⁶⁰

The rotating door between the pharmaceuti-

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icals industry, private medical societies and government health agencies facilitates the implementation of a vaccine-friendly agenda. This was no more evident than when former CDC director Dr. Julie Gerberding was recently selected to head Merck's vaccines division:

"As a pre-eminent authority in public health, infectious diseases and vaccines, Dr. Gerberding is the ideal choice to lead Merck's engagement with organizations around the world that share our commitment to the use of vaccines to prevent disease and save lives."¹⁶¹

Additionally, Dr. Carol Baker, past president of IDSA and head of the Lyme disease definition panel (hearing panel) on IDSA Lyme guidelines was appointed head of CDC advisory committee on vaccines. Conveniently "the 2009 IDSA international meeting focused on Lyme vaccine development."¹⁶²

These developments are consistent with the thesis of this article that personnel are being rotated through government health and military agencies (CDC), private medical societies (IDSA) and private pharmaceuticals companies (Merck and others) to carry out dangerous, vaccine-friendly human experimentation policies under the hidden agenda of biowarfare defense.

Also consistent with this hypothesis is a development reported by Dr. Merle Nass, who has been following the military's deadly anthrax experimentation on

the public. Nass reports that in addition to hiring directors from the CDC, Merck has hired a high-level military vaccine expert to help market vaccines. According to Nass, "retired Colonel John Grabenstein, Ph.D., who led the military anthrax vaccine program from 1999 through 2006, supervised multiple poorly conducted studies of anthrax vaccine safety, then moved to Merck Vaccine as a VP."¹⁶³

Of course all of this orchestration takes lots of money, planning, lobbying and media censorship. The pharmaceuticals industry has unrivaled power in this regard. It is the most profitable business on earth¹⁶⁴ and correspondingly has the most expensive,¹⁶⁵ extensive¹⁶⁶ and effective¹⁶⁷ lobby in the U.S. Its lobbying is so successful¹⁶⁸ that it routinely engages in illicit behavior, knowing the profits will far exceed any fines it is eventually hit with (which often set records). These fines are merely factored into the cost of doing business.¹⁶⁹

Conflicts of interest abound, with respect to pharmaceuticals' company influence over government regulatory agencies¹⁷⁰ - including the FDA,¹⁷¹ NIH¹⁷² and the CDC.¹⁷³ Other media outlets have reported that members of Congress own pharmaceutical stocks.¹⁷⁴

Alarming, the pharmaceuticals industry¹⁷⁵ has historically played a pivotal role in running the American biological warfare program.

This role would give the industry the ability to

create pathogens for which profitable symptom treatments could be sold in perpetuity. Since the pharmaceutical industry dominates the CDC, medical education,¹⁷⁶ medical press^{177,178} and mass media,¹⁷⁹ the industry is not likely to be held accountable for disseminating pathogens for which their well-placed consultants could ghost-write self-serving treatment guidelines^{180,181} (bolstered by ghost-written studies^{182,183}), and help intimidate doctors into compliance with them,^{184,185} to keep the profitable circle going.¹⁸⁶ The elite medical press has all but given up on preventing such profit-oriented conflicts of interest.¹⁸⁷

"Replacing medical education with industry promotion in the guise of scholarship causes demonstrable harm to trainees, the public and the profession."¹⁸⁸

--Dr. Amy C. Brodkey

Would pharmaceutical companies perpetuate research with deadly, "sham antibiotics regimens" (such as those short-term antibiotic regimens with ineffective drugs and doses typically recommended for Lyme disease) to make competing treatments that are a threat to corporate profits look less effective by deliberately under-dosing them?

Pfizer is accused of doing exactly this. It was sued in Nigeria for conducting a deadly, unethical drug experiment on children, without the permission of their parents.¹⁸⁹ According to an article in the

Independent:

The suit further contends that the researchers gave the other half a comparison drug made by Pfizer's competitor Hoffman-La Roche, but deliberately underdosed them to make their own product look better. Pfizer and its doctors "agreed to do an illegal act," the suit says, "in a manner so rash and negligent as to endanger human life".¹⁹⁰

The fact that Lyme disease under-treatment has been surrounded by so many researchers with biowarfare connections explains why their deliberately ineffective treatment regimens (using the wrong drug at the wrong dose for the wrong period of time to give the illusion of treatment while preventing it, as was done in the Tuskegee Study¹⁹¹) have not been widely exposed.

Unfortunately, this situation is only getting worse.

Sherwood Ross has reported on the increased collaboration between the pharmaceutical industry and academia in America's resurgent biowarfare program:

"In case you didn't know it, the White House since 9/11 has called for spending \$44 billion on biological warfare research, a sum unprecedented in world history, and an obliging Congress has authorized it. Thus, some of the deadliest pathogens known to humankind are being rekindled in hundreds of labs in pharmaceutical houses, university biology departments and on military bases.

...Besides the big

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pharmaceutical houses, the biowarfare buildup is getting an enthusiastic response from academia, which sees new funds flowing from Washington's horn of plenty." According to Francis Boyle, an international law authority at the University of Illinois, Champaign... 'American universities have a long history of willingly permitting their research agenda, researchers, institutes and laboratories to be co-opted, corrupted and perverted by the Pentagon and the CIA.'¹⁹²

Lyme Disease: The Stuff Dreams Are Made Of?

The Lyme disease epidemic has proved to be a lucrative opportunity for the biowarfare-connected corporate-linked academics who made their careers pretending to investigate and treat it. Perhaps this explains their reported excitement when the disease first broke out.

Polly Murray, the pioneer Lyme investigator who bore the brunt of the arrogance of the medical establishment that misdiagnosed her and her family,¹⁹³ records that the doctors present at her initial meeting with Steere at Yale were strangely enthusiastic about the burgeoning epidemic that was devastating her community. She records one doctor's strange comments on the newly discovered illness: "Isn't this exciting?"

The tell-tale rash that signaled the coming onset of symptoms associated with Lyme disease caused Steere camp "experts" as far back as the mid-1970s to

view Lyme disease as a model form of experimental arthritis. Stephen Malawista, who oversaw Steere's initial investigation into the cause of Lyme arthritis, saw the Bull's-eye rash as "the stuff that rheumatologists' dreams are made of."

As summarized by Jonathan Edlow, since "Lyme arthritis had a definable onset, marked by the rash, rheumatologists could study the joint inflammation in a way that they could not for, say, rheumatoid arthritis or lupus." (The fact that the disease was also caused by an infectious agent that could be modified for use in a vaccine was another plus.) Such considerations would also play into the ease with which post-vaccination rates of infections in experimental populations could supposedly be monitored in vaccine trials.¹⁹⁴

No doubt Steere's knowledge of the immune response to Lyme disease, gained from his "study of 25 untreated patients monitored longitudinally throughout the course of Lyme disease" came in handy when he was put in charge of an experimental Lyme vaccine trial, while working at Tufts University.¹⁹⁵ This trial was based on the vaccine agent that was licensed to SmithKlineBeecham by Steere's former employer (Yale). (The study was funded jointly by SmithKline Beecham Pharmaceuticals and the CDC.)

In fact, scientists from the vaccine manufacturer credited Steere with advising them on reducing

the background noise of adverse reactions (something he could claim to be an expert at, having carefully monitored the excruciating symptoms in numerous untreated patients throughout the course of their untreated disease).

Steere played a pivotal role in bringing the disastrous vaccine to market. As the "coordinating investigator," he "coordinated and monitored all laboratory activities, including assay validation, sample testing, and the reporting of results." He also advised the vaccine researchers on adverse reactions, "especially the serious adverse events." Steere's assistance in this matter was essential due to the fact that "the number of adverse events was so large that it could otherwise have been considered 'too much background noise.'¹⁹⁶

"We the people" need to ask this question: Did reducing this "background noise" involve suppressing negative findings in the form of "adverse events"?¹⁹⁷ Curiously, Steere's experimental vaccine, the world's first vaccine to prevent Lyme disease, was quickly pulled from the market in the face of multiple lawsuits once the public figured out that adverse reactions were inducing symptoms of the disease instead of preventing them.¹⁹⁸

Summary

The institutionalized Steere camp philosophy that Lyme disease is overdiagnosed and overtreated has been an epic disaster for

Lyme patient victims.²⁰⁰

The New York Times quoted Murray, the woman who conducted the first investigation of Lyme disease in Connecticut (until Steere took it over²⁰¹ and ran it into the ground), summarizing Steere's philosophy of denying the existence of chronic Lyme disease and the benefits of long-term antibiotic treatment:

"I am dismayed about Dr. Steere's position. He feels that it's overdiagnosed and overtreated, but I see people in the area who are having a real struggle with getting over Lyme disease. And some of them have responded to longer-term treatment."

Murray has provided us an illuminating glimpse into Steere's early investigation of Lyme disease. Her story, as one of the first victims unfortunate enough to fall under Steere's dismissive care (her husband was given the Tuskegee "aspirin therapy"²⁰² by Steere, et al at Yale), vividly illustrates the ongoing struggle with the arrogant Yale/CDC/IDSA aristocracy that has plagued the Lyme community from the beginning.²⁰³ This arrogance was described by a Navy doctor named William Mast who early on tried to inform Steere that antibiotics could be effective against Lyme disease:

"Allen [Steere] at that time was very adamant about antibiotics having absolutely no role in the disease. We left with some feelings of animosity at that point. And the academic people made us feel like we

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obviously didn't know what we were doing. And we knew from our observations that we did."

Murray, who at first naively trusted Steere, has given us a succinct summary of the "widening gulf" between reality and Steere's deadly myth:

"There was a widening gulf between what the patients were experiencing and what most of the medical literature was reporting that Lyme disease should be like. Patients were becoming confused and frustrated by the dilemmas in diagnosis. Dr. Steere seemed to be less receptive to what patients were describing, and I felt it more difficult to understand his position on diagnosis, treatment, re-infection and sero-negative patients."

Dr. Ed Masters, a Lyme doctor from Missouri who more recently caught the CDC red-handed conducting a fraudulent investigation to justify denying the existence and necessity of treatment of Lyme disease in the Southeast, gave a blunter summary of the establishment's disastrous-yet-strident positions on the nature of Lyme disease:

"First off, they said it was a new disease, which it wasn't. Then it was thought to be viral, but it isn't. Then it was thought that sero-negativity didn't exist, which it does. They thought it was easily treated by short courses of antibiotics, which sometimes it isn't. Then it was only the Ixodes dammini tick, which we now know is not even a separate valid tick species. If you look through-

out the history, almost every time a major dogmatic statement has been made about what we 'know' about this disease, it was subsequently proven wrong or underwent major modifications."

The Steere camp experts have indeed been wrong along. Why should we believe anything they now say about the profitable Lyme Epidemic they created under the pretext of biowarfare-related vaccine research? Why should doctors be hamstrung by the treatment guidelines Steere's clones have created to perpetuate the epidemic under the pretext of treating it?²⁰⁴

Was the CDC's Steere camp "less receptive to what patients were describing" because they were being rewarded with perpetual research grants to develop predetermined policies consistent with disease-perpetuation for vaccine development and marketing?

Given the source of Lyme disease, and the people behind the denial of treatment, it is my opinion that we are in the midst of another phase of the CDC Tuskegee Experiment and twin epidemics of disinformation and disease.

For victims of the disease and concerned members of the public, knowledge of the situation must be our own Phase I. But knowledge without action is fruitless. It is up to us to wage Phase II: alerting members of Congress and other officials and demanding action.

And we cannot stop

until implementation of Phase III: Making sure our demands are heard and acted on by turning the Lyme Epidemic into the Lyme Solution. This entails protection for doctors who know how to treat Lyme and informing other doctors and the public at large about the nature of the epidemic and who is behind its perpetuation. To this end,

President Obama must extend the mission of his Presidential Commission, formed in the wake of recent revelations on the expanding scope of the Tuskegee Experiment,²⁰⁵ to specifically investigate the CDC's role in Lyme disease treatment-denial.

Lyme disease is not my problem, it is not the Lyme community's problem. It is not an American problem. It is now an international problem. And it is up to you, to all of you, to solve it.

Let the haunting words of Joseph Mengele, conductor of Nazi medical experiments, ring from the past into the present: "The more we do to you, the less you seem to believe we are doing it."

ABOUT THE AUTHOR:

Jerry Leonard is a Lyme disease patient and author. He has written three books on unethical medical experiments conducted by the government -- including experiments involving the systematic injection of tumor cells and monkey cancer virus in humans so that model forms of cancer could be induced and maintained

in human subjects for vaccine research. For an overview of Jerry's work, see:

America's Secret Weapons: http://winstonsmith.net/americas_secret_weapons.htm

Contact Jerry at jerryleonard999@yahoo.com.

Additional Resources:

The source of Lyme disease has been traced to a biological warfare experiment gone out of control through books, films, and television documentaries.

Books:

- ❖ Lab 257, by Michael Carroll
- ❖ <http://search.barnesandnoble.com/books/product.aspx?userid=i98a5vf98j&isbn=0060011416&itm=3>

Articles:

- ❖ Elena Cook, "Lyme Is A Biowarfare Issue"

<http://www.elenacook.org/bwsept06.html>

- ❖ Marjorie Tietjen, "Discreet Methods of Biological Warfare"

<http://www.publichealthalert.org/Articles/marjorietietjen/Discreet%20Methods%20of%20Biological%20Warfare.html>

- ❖ Marjorie Tietjen, "Lyme Disease - A Biological

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Weapon?"

<http://www.rense.com/general63/lyme.htm>

❖ Mark Sanborne, "The Mystery of Plum Island: Nazis, Ticks and Weapons of Mass Infection"

<http://www.ww4report.com/node/%201898>

❖ Tina J. Garcia, "Biowarfare Lab Directors Are Experts on Lyme Disease, A Level II Debilitating Biological Agent"

<http://www.rumormillnews.com/cgi-bin/archive.cgi?noframes;read=189403>

Videos/Documentaries:

❖ ***Under the Eightball***, documentary by Tim Grey (film links Lyme disease epidemic to biowarfare research)

<http://www.youtube.com/watch?v=4UOhME0K4hw>

❖ ***Under Our Skin*** (film that documents the non-treatment of Lyme disease victims)

<http://www.underourskin.com/>

❖ Plum Island episode, Jesse Ventura's "Conspiracy Theory" discusses Lyme disease and biowarfare
http://www.youtube.com/watch?v=aC1gV_6aSIA

Appendix A

Lyme-Biowarfare Connections

"...we are dealing here with a formidable 'smart stealth' type of bacteria that is hard to eradicate-one that does extreme damage to psyche and soma if not treated aggressively over the long term when missed in the first days following inoculation by the vector..."

--Dr. Virginia Sherr

Researchers have demonstrated the extensive ties between the CDC's biodefense unit and the perpetuation of the Lyme Epidemic.

Here is a summary of the connections between the Lyme Epidemic and biowarfare:

❖ The causative agent of Lyme disease (*Borrelia burgdorferi*) was identified by and named after a biowarfare researcher named Willy Burgdorfer, who worked at a biowarfare lab (Rocky Mountain Labs) developing and publishing methods for infecting *Ixodid* ticks with *Borrelia* agents-a decade or so before an epidemic caused by *Borrelia* agents spread by *Ixodid* ticks broke out just outside a top-level biowarfare lab that did outdoor tick research.

❖ Lyme disease itself is named after Lyme, Connecticut-the town a few miles from a top-level biowarfare lab (Plum Island Animal Disease Research Center) that not only did outdoor tick experiments but

also has a history of pathogen leaks.

❖ Plum Island still conducts tick research with African Swine Fever Virus, which, according to papers published by Lyme/biowarfare experts such as Alan Barbour, has "sequence similarities" to segments of DNA in the telomeres of the *Borrelia* organism which causes Lyme disease.

❖ Plum Island propagates this genetically engineered virus in ticks for vaccine studies. This virus, according to numerous reports, has also reportedly been used by the U.S. in real-world biological warfare attacks.

❖ Lyme disease has properties ideal for a disabling biowarfare agent: rapid dissemination within the body but causing delayed symptoms, relapsing antibiotic resistant infection, protective cyst formation (similar to anthrax), capability for inducing both mental and physical incapacitation

❖ Just as the Lyme spirochete epidemic was getting started, we learned in 1977 of a massive government research effort known as MKULTRA that was "concerned with the research and development of chemical, biological and radiological materials" to do exactly what Lyme does: "severely" incapacitate human victims.

❖ To accomplish this goal, the government engaged in "extensive testing

and experimentation" on unwitting human subjects "at all social levels, high and low, native Americans and foreign."

❖ The vector for Lyme disease (*Ixodid* ticks) was "discovered" by a biowarfare defense expert (Allen Steere) from the CDC's Epidemic Intelligence Service (EIS).

❖ The Lyme bacterium was first propagated in cell cultures by another CDC EIS biowarfare expert (Alan Barbour), in a biowarfare lab. This researcher had previously studied anthrax for the military, and went on to create mutant strains of *Borrelia burgdorferi*. He now directs a biowarfare lab at the University of California, Irvine Campus.

❖ The Lyme Epidemic is being perpetuated by researchers affiliated with the CDC's biowarfare defense unit (EIS), including Steere (EIS) and Eugene Shapiro (EIS) by forcing doctors to treat (or not treat) patients according to treatment guidelines that are so draconian and riddled with self-serving recommendations that the organization that put them out was investigated and reprimanded by the Attorney General of Connecticut.

❖ Gary Wormser is the lead author on the fraudulent treatment guidelines published by the IDSA, which prevent patients from getting effective treatments. In his spare time, he lectures as an expert on biowarfare

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agents and treatments: How Germs Become Weapons: Recognizing Agents -- Treating Patients.)

❖ The research study Wormser used to justify his position that Lyme disease is readily cured with short courses of antibiotics was a fraudulent study authored by Mark Klempner, a CDC EIS agent who also now directs a biowarfare lab, at Boston University. (This celebrated study to allegedly investigate long-term antibiotic treatment of Lyme patients was halted before long-term antibiotics could even be administered.)

❖ The first vaccine against the disease was developed and licensed by a defense contractor (Yale Corporation) that worked closely with Plum Island biowarfare lab on biowarfare and vaccine agents. The lead investigator for the vaccine field trials (Steere) was a Yale and EIS alumnus who has done everything in his power to deny effective antibiotic treatments to Lyme victims, so that the immune response to the disease could be mapped out in untreated controls.

❖ Lyme disease was recently named as a biowarfare agent by the U.S. government.

Thus, it is not a question whether Lyme is a biowarfare agent. The question is, when was it first investigated as one?

Related questions include:

What are the odds that a *Borrelia* disease agent spread by *Ixodid* ticks and the policies of the CDC's biowarfare unit, which has been identified by the government as a potential biowarfare agent, would be named after a biowarfare researcher who published methods for infecting *Ixodid* ticks with *Borrelia* agents?

What are the odds a *Borrelia* disease that broke out just outside a biowarfare lab that conducted tick research is not a biowarfare agent?

And what are the odds that treatment denial for this disease agent, which is controlled by various agents of the biowarfare wing of an agency that conducted experiments limiting treatment for a similar disease agent (both the Lyme *Borrelia* and syphilis are classified as spirochetes), is not part of a similar experiment conducted on a grander scale, under the auspices of biowarfare research?

"The number of Steere camp Lyme researchers with a background in the Epidemic Intelligence Service (EIS) and/or biowarfare research is too numerous to be pure coincidence. Two scientists who have played a central role in the Lyme story, Barbour and Klempner, have been placed in charge of new biowar super-labs set up in the aftermath of 9-11, where they are aided by some of their Steerite colleagues. Others, while not in charge

of super-labs, are nevertheless in receipt of substantial grants for biowarfare research."

--Elena Cook, "Lyme Is A Biowarfare Issue"

Appendix B

The research history of Willy Burgdorfer, name-sake of Lyme disease:

In the 1950s, Willy Burgdorfer, who isolated the tick-vectored Lyme disease spirochete and for whom the causative *Borrelia* is named, worked on artificially forcing *Borrelia* disease agents (like relapsing fever *Borrelias*) to infect new tick vectors. (Burgdorfer then used these artificially infected ticks in attempts to infect lab animals.)

He also published papers describing the "occult infections" due to these relapsing fever spirochete disease agents. In parallel with these studies, he developed production-like methods for transferring diseases to *Ixodid* ticks, the same species that spreads the occult *Borrelia* infection initially called Lyme disease, which Burgdorfer later compared to the relapsing fever *Borrelias* he had studied.

The lab he conducted this research in and which later isolated the Lyme spirochete is now a "biosafety level 4" biowarfare research facility, just like the biowarfare lab at the epicenter of the Lyme Epidemic (Plum Island Animal Disease Center), which conducted outdoor tick research and is suspected of being the source of the Lyme

Epidemic.

Given the manner in which Lyme disease broke out and the deadly manner in which it has been intentionally mismanaged ever since, hard questions must be asked:

❖ When Burgdorfer was developing techniques to artificially expand the host-range of *Borrelias* to new tick species, and then to lab animals, was he in fact conducting biological warfare research at the Rocky Mountain Laboratory?

❖ Did this research feed in to the tick research that was conducted at Plum Island Animal Disease Center, the outdoor biowar test facility for such insect vectors? And was Plum Island, the outdoor test facility for Fort Detrick, the center of the U.S. biological warfare effort?

❖ Was the causative agent of Lyme disease later "discovered" by a military epidemiologist as part of a suspected public relations/containment effort to control information about the burgeoning epidemic and its ties to the military?

❖ Did this effort surrounding the so-called "natural" outbreak of a zoonotic agent lead to an experimental vaccine effort (orchestrated by CDC/EIS biowarfare agents) similar to that which happened in Egypt, when human vaccine experiments were conducted after the "natural" outbreak of Rift Valley fever virus, an out-

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break that occurred in the same time-frame as the Lyme disease outbreak?

In the time period leading up to the Lyme Epidemic, Burgdorfer worked for the military in a capacity consistent with this hypothesis: He was a member of the Armed Forces Epidemiology Board investigating insect vectored diseases. The disastrous non-response to the Lyme Epidemic has been orchestrated by military epidemiologists using their influence in the government, medical infrastructure and media.

Appendix C

Open Letter Written to the World Warning of CDC and IDSA Complicity in Deliberately Mistreating Lyme Victims

By Tina Garcia

Founder of Lyme Education Awareness Program
(L.E.A.P. Arizona)
www.leaparizona.com

Tina Garcia is a Lyme victim and patient advocate who has caught her state epidemiologist red-handed publishing research establishing Western blacklegged ticks in Arizona tentatively identified as Lyme disease and then subsequently denying that information to her in writing. Tina has also documented the fraud behind the CDC's and IDSA's treatment guidelines.

I am a chronic Lyme disease patient and advocate who has struggled with *Borrelia burgdorferi* (Bb) infection for twelve years, since 1998. The bacteria ravaged my body for six years before I was finally diagnosed and began antibiotic treatment at the end of 2004. At one point I could barely walk and could not effectively communicate due to encephalopathy, neurological and musculoskeletal involvement. I became disabled from the disease and lost my job and my home.

To this day, it has been a devastating journey, and this debilitating chronic infection caused by the bite of a tick in Arizona has profoundly altered my life. I could not find one doctor on my insurance plan who would provide treatment. Therefore, my insurance denied coverage, and my family had to pay for it. We were never able to afford the intravenous antibiotics that were recommended by my Lyme-treating physicians. The delayed diagnosis and denial of treatment extended my suffering, caused disability and has prevented a full recovery thus far. My case is not unique; thousands have reported the same lack of medical care.

I am not shy to state publicly that the main reason for the denial of diagnosis and treatment and terrible suffering that I have experienced was caused directly by the

Infectious Diseases Society of America's Clinical Practice Guidelines for Lyme Disease and the Centers for Disease Control and Prevention's (CDC) dissemination of those Guidelines on its website.

Another reason for the medical neglect of Lyme patients is the failure of the National Institutes of Health (NIH) to conduct meaningful treatment studies. To date, the efforts of the NIH have been unconscionably weak in this area. Studies should have been conducted a long time ago to determine the efficacy of long-term combinations of antibiotics (months to years, as is provided for tuberculosis and leprosy infections), in search of an effective treatment protocol to alleviate the widespread suffering and loss of productivity experienced by those who have developed chronic Lyme infection, due to lack of timely diagnosis and treatment.

Of particular significance, the NIH study performed by IDSA guideline author, Mark Klempner, M.D., was a study that was analyzed statistically by statistical scientist Alison Delong and found to be flawed.

It would be considered inhumane to bring up the issue of antibiotic resistance when referring to patients receiving long-term treatment for tuberculosis or leprosy, both of which are bacterial infections. Leprosy and Lyme

disease share the ability to damage the nervous system.

Why then, do the CDC and IDSA find it acceptable to publish articles and guidelines that encourage the denial of long-term antibiotic therapy to Borreliosis patients, based upon the premise that such treatment causes antibiotic resistance? Do the CDC and IDSA endorse the practice of sacrificing Lyme disease patients, who are afflicted with neurological damage from embedded infection and resulting persistent inflammation, on the altar of antibiotic resistance, in an effort to save antibiotic use for others?

Professor Garth Nicolson, a microbiologist who has studied Bb, stated that the antibiotic resistance argument is "particularly lame." He explained that another reason for antibiotic resistance is the INADEQUATE antibiotic treatment of virulent pathogens, such as *Borrelia burgdorferi*, the bacterium that causes Lyme disease. If you have ever received a prescription for antibiotics from the pharmacy, you may recall that the sticker on the side of the bottle recommends that all the medication be used according to the instructions - that all of it should be taken by the patient. This recommendation is made because UNDERTREATMENT of bacterial infections causes antibiotic resistance.

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Therefore, each time a physician adheres to IDSA treatment guidelines for Lyme disease, they are contributing to the antibiotic resistance of *Borrelia burgdorferi*. Each time a Lyme disease patient is UNDERTREATED, Bb undergoes antigenic variation. In other words, it changes to evade the immune system and antibiotics. This is another way that the pathogen persists in the tissues (not only the blood) of those who are infected.

In addition, there is no definitive test that proves that Bb is eradicated with the recommended treatment set forth by the CDC and IDSA. Numerous tissue samples would need to be collected and tested to determine this, as Bb does not predominantly reside in the blood, at times rendering antibody tests inconclusive. In order to eradicate Bb from the brain, antibiotics must be administered which cross the blood-brain barrier to get into the cerebrospinal fluid, and not all antibiotics are able to do this.

The good news for me is that I have made significant progress through the use of intermittent antibiotic therapy (oral and intramuscular injections) for the past six years. That's a lot of antibiotic, but the antibiotics have allowed me to regain function. I am grateful for the progress I have made, and my hope is to get to a point where I can go back

to work as a functioning and productive member of society. However, I am now suffering from small vessel disease in my brain and multiple sclerosis-type symptoms which incapacitate me periodically.

I was selected by Connecticut Attorney General Richard Blumenthal and the Infectious Diseases Society of America (IDSA) Lyme Disease Review Panel to testify on behalf of the worldwide Lyme disease patient community at a legal hearing held in Washington, D.C. on July 30, 2009.

The hearing was the result of an antitrust investigation of the IDSA and its Lyme Disease Practice Guideline authors, which was conducted by then Connecticut Attorney General (now Senator Blumenthal).

It was a privilege to speak on behalf of thousands of people suffering from chronic Lyme infection. However, the outcome of the hearing and the extensive review of submitted medical research, that clearly showed the existence of persistent Lyme infection despite antibiotic treatment, was a rubber stamping of the current IDSA Guidelines, with no immediate changes recommended by the Review Panel. This decision has served the insurance industry by guaranteeing the continuation of diagnosis and treat-

ment denials, as insurance companies base their denials on the IDSA Practice Guidelines for Lyme disease.

Although the information I am submitting is contrary to what has been reported in numerous articles in the mass media, it is the truth about the medical neglect that Lyme disease patients are experiencing. Lyme disease patients have struggled for more than thirty-five years, due to a complicated web of issues involving inadequate testing methods, ineffective treatment recommendations published by the IDSA and the failure of the NIH and the CDC to perform new and utilize existing patient-centered research.

By definition, screening tests should have at least 95% sensitivity. The ELISA screening test that is recommended by the CDC lacks such sensitivity and falls short in its specificity, thereby missing detection of a significant number of cases. Such a scenario would be unacceptable for HIV, syphilis, hepatitis, tuberculosis, heart disease, diabetes and cancer; it is, therefore, unacceptable for Lyme infection, also.

During the Lymerix vaccine clinical trials, chief investigator Dr. Allen Steere did not use the ELISA because of its lack of sensitivity and specificity.

"ELISA's are commercially available but lack

sufficient sensitivity and specificity for use in efficacy trials...The CDC criteria, however, were developed as a surveillance tool, which frequently necessitates a compromise between sensitivity and specificity to reach the optimal surveillance objective....The CDC criteria were therefore deemed to be inadequate for the purpose of conducting a pivotal efficacy trial."

It is, therefore, obviously inappropriate for the ELISA to be used as a screening test in the clinical setting, for if and only if the ELISA is positive are patients "allowed" to progress to the next level of testing -- the Western blot:

"This study confirmed in the reference and research laboratory setting the previously documented problems with accuracy and precision of serodiagnostic tests by using WCS antigens of *B. burgdorferi* (4-11). The study confirmed that a serious disparity existed between the test results obtained by CDC and those obtained by academic reference centers with the best testing performances. These results guided corrective action and led to the adoption by CDC and ASTPHLD of a two-test approach to serodiagnosis (23), which forms the basis for the future national standardization of Lyme disease serologic testing methods."

How many hoops

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must patients jump through to receive diagnosis and treatment? In the case of Lyme disease, half of the patients cannot make it through the first hoop (the ELISA), and therefore, never get the chance to be tested by way of the second (Western blot).

This testing recommendation leaves approximately half of all patients with no diagnosis or treatment -- that is certainly medical neglect. Due to its fallibility, the CDC's serodiagnostic testing recommendation for use of the ELISA as a screening test for Lyme disease should be reassessed by an unbiased committee not associated with the CDC or individuals involved in creating the Dearborn recommendation (which would include authors of the IDSA Practice Guidelines that were investigated by the Connecticut Attorney General).

Published research has demonstrated that *Borrelia burgdorferi* uses antigenic variation to evade the host's immune system, thereby ensuring its survival and causing persistent infection. Bb has the ability to morph into various forms. It is commonly recognized as a corkscrew-shaped spirochete; however, it can change into a cyst form, a cell-wall-deficient form, a granular form and a bleb form and protects itself with a biofilm that sequesters it from attack by the immune system and

antibiotics.

Published research indicates that "the interplay between the host and invading spirochetes results in a cascade of signaling events that *B. burgdorferi* can use to facilitate persistent infection."

Uncertainty about the existence of chronic Lyme infection is a direct result of misleading information and opinions that have been circulated by the IDSA Guideline authors who were investigated by the Connecticut Attorney General, along with other spokespersons for the CDC. This is a small group of researchers who have, for many years, continually received a large portion of the federal research funds allocated for Lyme disease. Their unfounded statements that chronic Lyme infection does not exist directly contradict the research they have already published in which they did, indeed, demonstrate persistent infection. In fact, there is no uncertainty about chronic infection among patients and the physicians who actually treat patients with chronic Lyme disease.

If patients do not receive diagnosis in the early stage, the disease will develop into a chronic, relapsing/remitting illness that becomes even harder to diagnose and treat. Attempting to clear an embedded infection (one that has persisted for several years), with an early-

stage, short-term treatment protocol as has been recommended by the IDSA, is ludicrous. *Borrelia burgdorferi* colonizes all the organs and tissues of the body, and due to its antigenic variation, its biofilm and its ability to morph into evasive forms, repeated courses of various antibiotics are needed to fight the embedded infection.

In the hurried world of practicing clinicians, it is easy for the line between acute and chronic treatment recommendations to appear nebulous, and those who espouse the CDC/IDSA party line are quite adept at smudging the line that should separate acute from chronic treatment. In fact, the Lyme Medical Cartel has continually used the media to accomplish their despicable dissemination of false medical information. However, if one reads the published literature and makes the crucial distinction between the research on acute and the research on chronic Lyme infection, one will see that there actually is no controversy at all. The controversy has been fabricated by the Lyme Medical Cartel.

Patients are in desperate need for government healthcare agencies, such as the CDC, to utilize research that has already demonstrated persistent infection. You will hear so-called "Lyme experts" make statements that chronic

Lyme disease does not exist. You will also hear them reference terms they coined - Post Lyme Syndrome (PLS) and Medically Unexplained Symptoms (MUS). There is no proof of the existence of either PLS or MUS in relation to infection from *Borrelia burgdorferi*; these are merely opinions passed off as consensus.

Once again, much of the research on persistent infection has been published by the individuals who are now calling persistent infection "Post Lyme Syndrome" and "Medically Unexplained Symptoms." They are, therefore, contradicting their own research. Their contradictions, published in the IDSA Practice Guidelines, have resulted in the wasteful use of federal research funds, caused insurance denials of treatment and the medical neglect of suffering patients.

In my opinion, the NIH and CDC have continually wasted precious funding allocated by Congress, which should instead be utilized for patient-centered research, not pet projects of individuals investigated for their financial conflicts of interest related to Lyme vaccines, patents for diagnostic tests and consulting arrangements with insurance companies.

The General Accounting Office (GAO) previously investigated the matter of research funds for Lyme disease and determined that the CDC did, in

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fact, spend appropriated funds on Lyme disease research. This determination, although accurate, did not expose the research monopoly that exists between the CDC and the "most powerful IDSA panelists" who authored the IDSA Practice Guidelines for Lyme disease. Yes, they funded Lyme research, but the majority of the funds have been granted to members of the Lyme Medical Cartel, who in my opinion, take their marching orders from the CDC.

Connecticut Attorney General Blumenthal revealed the following in his May 1, 2008, Press Release:

"The IDSA guidelines have sweeping and significant impacts on Lyme disease medical care. They are commonly applied by insurance companies in restricting coverage for long-term antibiotic treatment or other medical care and also strongly influence physician treatment decisions.

"Insurance companies have denied coverage for long-term antibiotic treatment relying on these guidelines as justification. The guidelines are also widely cited for conclusions that chronic Lyme disease is nonexistent.

"This agreement vindicates my investigation -- finding undisclosed financial interests and forcing a reassessment of IDSA guidelines. My office uncovered undisclosed

financial interests held by several of the most powerful IDSA panelists. The IDSA's guideline panel improperly ignored or minimized consideration of alternative medical opinion and evidence regarding chronic Lyme disease, potentially raising serious questions about whether the recommendations reflected all relevant science.

"The IDSA's 2006 Lyme disease guideline panel undercut its credibility by allowing individuals with financial interests -- in drug companies, Lyme disease diagnostic tests, patents and consulting arrangements with insurance companies -- to exclude divergent medical evidence and opinion.

In today's health-care system, clinical practice guidelines have tremendous influence on the marketing of medical services and products, insurance reimbursements and treatment decisions. As a result, medical societies that publish such guidelines have a legal and moral duty to use exacting safeguards and scientific standards."

Cancer patients are given the choice of chemotherapy with dangerous drugs that not only destroy cancer cells, but cause extensive damage to the rest of the body, as well. Despite the risks associated with cancer chemotherapy, cancer patients are given additional treatment when they

relapse, and physicians specializing in cancer therapy are not discouraged from doing so.

Lyme disease patients do not relish using antibiotics for prolonged periods, just as cancer patients do not enjoy undergoing chemotherapy. However, at the present time, antibiotic therapy is the only treatment that provides relief and improvement in symptoms, and the choice of accepting the risks of intravenous infusion of antibiotics should rest with the patient and their treating physician, not the IDSA, which the majority of Lyme patients view as a pseudo-paternalistic medical dictatorship.

Veteran Lyme patients are quite knowledgeable of the disease they are infected with and most can talk circles around medical doctors who have no experience treating the disease. It is simple reasoning to come to the conclusion that the majority of IDSA member physicians fall into this category, as they deny the existence of the disease.

Therefore, if ID physicians deny the existence of Lyme disease and refuse to treat patients, they don't have any experience with the disease, correct? So, how can they refer to themselves as Lyme experts? Such a physician would actually be considered a charlatan. The IDSA mantra that chronic Lyme disease does not exist is the

blindfold that allows these sheepish IDSA member physicians to fall off the cliff into an abyss of ignorance and arrogance.

Research has demonstrated the remitting and relapsing nature of Lyme disease infection. It is, therefore, inhumane to deny Lyme patients access to long-term antibiotic therapy that is legally prescribed by licensed physicians. If Lyme disease patients are willing to accept the risks of such treatment in lieu of a chronic, debilitating, infectious disease, insurance companies should provide coverage for such treatment and not shirk their responsibility based upon the IDSA Practice Guidelines - guidelines that were written by those who, at the same time that they publish guidelines for use by the insurance industry, they also serve as insurance consultants and expert witnesses in medical board prosecutions against physicians who actually have experience treating the disease.

Lyme disease patients expect insurance companies to cover long-term antibiotic therapy, if such therapy is recommended by their treating physicians. In the clinical setting, Lyme disease patients and treating physicians have consistently reported evidence of in utero transmission and suspect sexual transmission, as well. Due to the fact that

SPECIAL REPORT

Borrelia burgdorferi has been found to live in frozen blood for up to eight months, transmission via our nation's blood supply should also be studied and given serious consideration.

Studies on such modes of transmission have not been adequately pursued. I have strongly urged that such research be funded and performed immediately, as our failure to address these important issues of transmission of Lyme disease, a spirochetal disease that is similar to syphilis, may be jeopardizing public health and perpetuating the pandemic.

The Lyme patient community has requested assistance from the CDC and the IDSA for many years, but patients have been either ignored or publicly ridiculed. Thus the need for me to write this lengthy essay as a public service.

The Lyme patient community no longer relies upon the CDC or the IDSA to be the guardians of our health, as the research and programs that are funded and performed by them and the clinical practice guidelines that are published and disseminated by them are not "patient-centered." Nor is the research that demonstrates the existence of persistent infection utilized by the CDC and IDSA for the benefit of patients.

Instead, the research is contradicted, or simply ignored, in favor of

personal agenda-promoting opinions and manufactured disease parameters. As revealed formerly in the CT Attorney General's Press Release, these financial conflicts of interest were exposed during the antitrust investigation of the IDSA and its 2006 Lyme Disease Practice Guideline authors. Unfortunately, the Attorney General was not able to extend his investigation into the bowels of the monopoly -- the CDC and its Division of Vector-Borne Infectious Diseases, and possibly, the United States Public Health Service, which if you recall, led the Tuskegee Study of Syphilis from 1932 to 1972.

Despite extensive funding for Lyme disease research, the healthcare needs of Lyme disease patients have been neglected for too long. Precious funds are wasted by those who place their own interests in developing a Lyme vaccine and marketable test kits above the health needs of patients. Clinical practice guidelines are being written and published to serve the personal agendas of the authors and those who have a stake in the guidelines, barring the most important stakeholders - the patients.

The irresponsible behavior of the IDSA prior to, during and following the investigation and review process of the IDSA Practice Guidelines for Lyme disease, in the form of fraudulent public statements that

chronic Lyme infection does not exist and their continued dissemination of other false information, has caused the majority of their infectious disease member physicians to deny diagnosis and treatment to chronic Lyme disease patients.

The CDC plays a leading role on the world stage of health. The CDC provides a link to the IDSA Practice Guidelines for Lyme disease on its website, and this action has resulted in diagnosis and treatment denial to chronic Lyme disease patients in the U.S. and in other endemic countries around the globe.

At the recent October Institute of Medicine forum on the state of the science of Lyme disease, the patient community suggested that funding be given to other researchers not involved in the Lyme Medical Cartel research monopoly. This monopoly is the one that Willy Burgdorfer, Ph.D., discoverer of the Lyme disease bacterium, referred to when he made the following statement in the film "Under Our Skin":

"The controversy in Lyme disease research is a shameful affair. And I say that because the whole thing is politically tainted. Money goes to people who have, for the past 30 years, produced the same thing-nothing. Serology has to be started from scratch with people who don't know beforehand the results of

their research."

Allowing the current IDSA treatment guidelines, and their tacit endorsement by the CDC, to stand as a factual reference is irresponsible medicine that continues the damaging medical neglect of thousands of patients who have been diagnosed with Lyme disease in North, Central and South America, Europe, Asia and Australia. This is an infectious disease pandemic that is disabling people worldwide. Many patients who have been diagnosed with multiple sclerosis, ALS, Parkinson's, Alzheimer's, rheumatoid arthritis, fibromyalgia, chronic fatigue and lupus have subsequently been diagnosed with and treated for *Borrelia burgdorferi* infection. The reason these diagnoses are made initially is because chronic Lyme infection can manifest as all of these conditions. Published medical research has also shown that *Borrelia burgdorferi* can cause certain types of cancer.

If you read the Tuskegee Timeline on the CDC website, you may be surprised at the similarities between the Tuskegee Study of Syphilis that was inhumanely carried out by the United States Public Health Service / condoned by the CDC and the denial of diagnosis and treatment for those infected with *Borrelia* (a cousin to syphilis).

SPECIAL REPORT

The journalist who broke the story of the Tuskegee Study in the 1970s helped bring closure to that inhumane medical "study" that resulted in a public apology from President Clinton and a financial settlement with the victims and their families.

It is time for additional investigations (Congressional and otherwise) to be conducted to publicly establish the facts surrounding one of the most widespread medical crimes in the history of mankind, with the intention to hold the perpetrators accountable for their despicable betrayal of public trust.

Sincerely,
Tina J. Garcia
Founder, LEAP Arizona