Measles and Homœopathic Immunizations

by Randall Neustaedter

Here are three common questions asked by patients about our work; often they are more complex but I should like to address them as I have generalized them.
1) Is *Morbillinum* effective in preventing measles?
2) Is homœopathic prophylaxis scientifically proven? and
3) Is the allopathic vaccine safe?

Homœopathic Vaccines

In the absence of any evidence which shows long-term immunity induced by homœopathic vaccines, I cannot advise the use of specific nosodes (preparations of the disease product) as prophylaxis for the diseases. There is no basis in homœopathic theory or principle for the routine and wholesale administration of potentized substances for long-term prevention. There is no reason to suspect that these vaccines would work years after they have been administered, and they could give parents a false sense of security regarding the diseases. This could amount to a misrepresentation of homœopathic medicine. In addition, many homœopaths question the safety of routinely using a homœopathic preparation which is not indicated on the basis of symptom expression.

The possible 'disordering' effect of a high potency homœopathic medicine is a controversial subject. I am very cautious about using remedies in high potency. Others are more cavalier. Many homœopaths do administer the nosodes as 'protection' from the diseases and varying protocols have been described. Since none of these have been tested in any rigorous fashion, the 'correct' dosage schedule is purely speculative. The homœo-pathic preparations may be effective, they may be suppressive, or they may have no effect on the body. Their effects may also vary for different individuals. I do not recommend them because of these uncertainties.

There is some evidence which suggests that homœopathic vaccines do act to prevent diseases during an epidemic exposure, though these reports are incomplete. The homœopathic literature on this point has been reviewed and discussed by Michael Traub[1]. The most impressive report is that of Castro and Nogueira of Brazil who administered *Meningococcinum* 10c in a single dose during a meningitis epidemic in 1974[2]. Of the 18,640 children given the homœopathic nosode, four developed meningitis (0.02%), compared to 32 cases in the 6,340 unvaccinated children (0.5%). This was not a well controlled study. Other reports are tentative or poorly reported. Eisfelder reported an uncontrolled study of 50,000 children who were given *Lathyrus* in varying potencies during the polio epidemic of the 1950's. Only one of these children developed (non-paralytic) polio[3,4,5]. Other studies of pertussis[6] and influenza[7] suggest some clinical effect of the nosodes during epidemics as well.

It is far more reassuring to me for a child to undergo constitutional homœopathic treatment in order to prevent serious disease, but that is my own prejudice. No evidence exists to show what effect homœopathic medicines have on the development of disease complications. It does seem sensible to develop the strongest immune system possible in order to prevent untoward complications of the many diseases that confront children. Homœopathy claims to support the immune system's functioning and there is ample anecdotal proof for this in the voluminous literature of cured cases of

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allergy and recurrent infection in children. It also behoves us to encourage the avoidance of all substances that purportedly weaken the immune system. Allopathic vaccines have been so accused.

Measles

The measles vaccine has resulted in some varied statistics. Since the licensing of measles vaccine in 1963, the incidence of measles has declined to less than 2 percent of previous levels[8]. Nonetheless, reports of epidemics in fully vaccinated populations have appeared periodically and consistently since the vaccine's introduction[9,10,11]. A typical example is reported by Gustafson. During the spring of 1985 a measles outbreak occurred in two fully immunized secondary school populations (greater than 99 percent of students immunized). On serologic testing, 95 percent of students showed immunity to measles. The epidemic occurred in the remaining 5 percent, all of whom had been 'adequately' vaccinated[12]. Some authors have postulated that a waning immunity over time is responsible for these outbreaks among older children[9]. Others blame primary vaccine failure. In any case, the public health goal of eradicating measles in the United States by 1982 was not met, despite rigorous vaccine programmes. Gustafson concludes that such a goal is impossible to meet. Measles cases now consistently occur in the vaccinated. A review of measles outbreaks in the United States during 1985–1986 revealed that a median of 60 percent of cases in school age children occurred in vaccinated individuals[8]. Similarly, a review of 1,600 cases of measles in Quebec, Canada between January and May, 1989, showed that 58 percent of school-age cases had been previously vaccinated[13]. In states with comprehensive (kindergarten through 12th grade) immunization requirements, between 61 and 90 percent of measles cases occur in persons who were appropriately vaccinated[8].

The official response to measles vaccine failure and epidemics has varied. Within the first ten years after widespread immunization, the vaccine failures prompted public health authorities to repeatedly raise the recommended age for immunization. In 1969 the age for vaccine administration was raised to 12 months or older[14]. Because of continued vaccine failure, the age for administration was subsequently raised to 15 months[15].

During 1988, an epidemic in Los Angeles prompted a reconsideration of vaccine recommendations when statistics showed that 38 percent of cases were were less than 16 months old[16]. The age for vaccine administration was then lowered again to 9 months in areas with recurrent measles transmission[17]. These children would then require revaccination at 15 months. The fact that a large percentage of measles cases occurs in school-age children and adolescents has caused a reassessment of measles vaccination policy. A two-dose measles vaccine schedule is now recommended in the United States. The first dose is given at 15 months of age or later. The second dose of vaccine is intended to overcome the problems with primary vaccine failure and to reinforce waning immunity. The American Academy of Pediatrics recommends this dose at 11 or 12 years of age[18]. The Center for Disease Control recommends this second dose at entry to kindergarten or first grade, 4-6 years of age[19]. Neither of these policies has been evaluated in any studies.

Serious reactions to measles vaccine have been repeatedly reported in the medical literature. These include encephalitis[20,21], retinopathy and blindness[22], seizures, Guillain-Barre syndrome, and subacute sclerosing panencephalitis. These serious immediate reactions and the spectre of possible long-term autoimmune reactions suggested by Richard Moskowitz[23] call into question the safety of the measles campaign. A disturbing syndrome of atypical measles has occurred in children previously immunized. This consists of an illness with exaggerated rash, muscle weakness, peripheral œdema and severe abdominal pain with persistent vomiting[24]. These reactions have occurred following the immunization as well[25].

Summary

Homœopathy provides treatment for measles, which is likely to prevent encephalitis complications. The vaccine is associated with some severe side effects. Long term effects of the measles vaccine are unknown. The incidence of measles cases has shifted to older populations since the widespread use of the vaccine. And the vaccine itself has questionable effectiveness for individuals. Parents must decide whether they are willing to risk the possible side effects of the vaccine for their children. I do not advise its use.

There is no evidence that homœopathic vaccines are effective in prevention of disease years after the dose has been given, and there is doubt about the advisability of using any homœopathic preparation which is not indicated on the basis of presenting symptoms.❑

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continued on page 42