

THE MAN-MADE PEANUT ALLERGY EPIDEMIC

A revealing history of a medical mystery

By Heather Fraser

It is seldom recognized, commented historian René Dubos, that each society and every civilization creates its own diseases.¹ Is the peanut allergy epidemic man-made? And if so, how has it been created in millions of children in just 20 years and who or what are its architects?

The features of the epidemic continue to puzzle doctors. In the US alone, 5.6 million people – 2% of the population – are allergic to peanuts and nuts almost all having experienced onset as toddlers.

This epidemic tipped into critical mass around 1998 when the first flood of allergic children entered kindergarten sending a shock through education systems. Prevalence of the allergy increases with parental income, education and accessible health care. It does not increase with consumption. In developing countries where peanut consumption is high, the allergy is virtually unknown. In the west, children who have never eaten a peanut experience reactions on initial exposure to the food.

Immunologists claim that this allergy is an immune system abnormality. This view is contrary to that of Dr. Charles Richet, who identified and named the condition anaphylaxis in 1901. Richet proved that anaphylaxis is an inevitable side effect of vaccination. It is a universal reaction of animals to *any protein* injected into the bloodstream – the first injection sensitizes, the second injection or subsequent consumption of the protein unleashes the life threatening reaction.

Since Richet's Nobel Prize winning research, doctors have known "how to" create anaphylaxis using a needle. Without the invention of the convenient hypodermic needle in 1853, anaphylaxis would not have gained common currency much less become epidemic. The needle allowed doctors to deliver substances directly into the blood, by-passing the modifying effects of the digestive system. And with the introduction of compulsory vaccination for diphtheria in 1895, anaphylaxis arrived en masse. Thousands of children were made ill or died from what doctors labeled "serum sickness". By 1906, the sickness was understood to be a systemic allergic reaction. Extreme sickness was characterized by anaphylaxis, swelling, shock, asphyxia and death.

Serum sickness was the first man-made *mass* allergic phenomenon.

The historical link between vaccination and mass allergy is rarely mentioned by doctors. Health officials have several rational arguments for not discussing the subject. One is that US Vaccine Injury Compensation Program guidelines make it impossible to prove a causal link between vaccination and a later "onset" of anaphylaxis – that is, when the toddler first eats peanut butter. The guidelines only recognize anaphylaxis that occurs shortly after injection.

The second argument was summarized by Richet himself who wrote that anaphylaxis "perhaps a sorry matter for the individual, is necessary to the species There is something more important than the salvation of the person and that is integral preservation of the race..²

¹ René Dubos, *The Dreams of Reason: Science and Utopias* (New York, 1961) p. 71.

² Charles Richet, "Acceptance Lecture", Nobel Prize for Medicine, 1913.

And that “something” was protecting the whole of society from disease by vaccination – a goal that justifies the unavoidable casualties. A third rationalization is economic. Vaccine consumers absorb the cost of damage. Therefore, it makes financial sense to ignore the problem – which can’t be proven anyway. And if litigation brought by angry parents becomes unwieldy, government will intercede with legislation to protect them as it did in 2001 and again in 2008 in the wake of a leaked report that the mercury-based vaccine preservative Thimerosal, was contributing to the massive rise in childhood autism.^{3 4}

The framework for disease management with the needle began as business-minded makers of pharmaceuticals well over 100 years ago met the demands of government and doctors faced with massive immigrant influx during the first industrial revolution. Competition between pharmaceutical companies fed a media soon reliant upon lucrative and unregulated medical ads. In the early 20th century, a meld of compulsory vaccination for military and civilian populations and persuasive ads quickly transformed patients into medical consumers.

Consumers more afraid of disease than the side effects of treatment embraced the tradition of vaccination. For vaccine makers, however, unwanted side effects were balanced with the cost of production. They no longer used horse blood or mouse brain – the former was implicated in serum sickness and the latter was known to create encephalitis. However, an irreplaceable ingredient was vegetable oil. While cost effective and potent, oils could also be dangerous -- they easily over stimulated the immune system.

Lulled perhaps by medical advance, officials were surprised by the second mass allergic phenomenon that began in the 1930s. This was the first outbreak of food anaphylaxis in history and it was caused by just one food: cottonseed oil.

Refined cottonseed oil was a primary excipient in the injected “wonder drug” antibiotics and in vaccines. Well documented issues had weakened the US seed crusher industry which with dropping standards was producing contaminated oils. Protein laden cottonseed oil was found to have been distributed to pharmaceutical and food manufacturers.

The outbreak might have been investigated more thoroughly if it hadn’t ended so soon. Prevalence of the allergy peaked in the late 1940s, gradually declined and then fell from the medical journals, history and memory. This decline may be attributed to a change in vaccine ingredients. After WWII, oil from cottonseed was replaced.

This replacement oil was inexpensive, tariff protected, US grown and controlled tightly by a more reliable industry infrastructure; it came from peanuts. Manufacturers improved their refining processes to remove as much of the protein as possible (although not all according to a 2008 FDA report) thus preventing now well understood allergic implications.

With trace peanut protein in some vaccines, the allergy built a profile very quietly in the 1950s but grew more noticeable through the late 1960s and early 70s. The first peanut allergy study in 1974 by S.A. Bock in the US identified its growing prevalence.

Vaccine innovations in this period included genetic modifications of proteins, manipulation of molecular weights to target specific antigens and the inclusion of an “adjuvant”. An adjuvant provokes the immune system to create antibodies while requiring less antigen (virus/bacteria). Adjuvant 65, dubbed the immunologists “dirty secret” increased antibody production 13 fold although no one knew exactly why or how. This useful, cost effective “black box” ingredient combined refined peanut oil with aluminum. It was added to childhood vaccines in the 1960s.

³ Defense of vaccine damage is explicit in the transcript of famed 2000 Simpsonwood conference in which 48 government bodies and vaccine makers discuss a report linking mercury in vaccines to autism. This transcript was reviewed by R.F. Kennedy Jr., “Deadly Immunity,” *Rolling Stone Magazine* (June 20, 2005).

⁴ Anon, “The Man Behind the Vaccine Mystery”, *CBS Evening News*, Washington, Dec. 12, 2002. www.cbsnews.com In a post 9-11 world, Senate Majority Leader Bill Frist stated, vaccine makers must be free from lawsuits so that they can protect Americans from bio-terrorist attacks.

Two further changes to childhood vaccines were the introduction of the influenza Hib B in 1988 that was eventually rolled into an unprecedented 5 vaccines in one needle, the PENTA. Neither parents nor family doctors questioned these changes authorized by a WHO expert committee and recommended to governments in western countries. In the documented rush to pull this formula together, it seemed to escape notice that the molecular weights of proteins in the Hib B were almost identical to those in peanut.

Peanut allergy tipped quietly into epidemic between 1987 and 1994. ER records in westernized countries revealed the tip of the iceberg in the early 1990s – 90% of all admissions for allergy were for peanut.

The allergy hit critical mass around 1998. The tipping point came when the first massive wave of food allergic children entered the public school systems at ages 4 and 5. Pre-school and kindergarten teachers and principals were taken by surprise⁵ at the sudden appearance of not one but several food allergic kids in each school, hundreds in each school board, thousands across the US, the UK, Canada and other western countries.

Allergy researchers frantic for an answer to this deadly phenomenon questioned the role skin creams with poorly refined peanut oil, levels of peanut consumption, methods of peanut preparation. They examined long-shot risk factors such as birth month, blood type, gender and race. None pointed to vaccination, a common childhood event with a proven history of creating mass anaphylaxis. It is not without irony that in virtually every medical article on the allergy mice are made anaphylactic to peanut by injection.

If vaccination is the functional mechanism by which millions of children have been sensitized to peanut why isn't every child allergic? One researcher pointed out in 2004 that "Adjuvant 65 offers the advantage over mineral oil used in [other adjuvants] that it can be metabolized". "Metabolized" means that the body can break down and eliminate the waste vaccine. This ability to detoxify varies between individuals and is today an enormous challenge for western children increasingly weakened by digestive imbalance.

And even if one does not accept the *Injection Hypothesis*, the balance between fear of disease and risk of side effects has clearly shifted. Educated parents for whom official rationalizations now ring hollow are beginning to refuse vaccination.

In the wake of the Thimerosal debacle in 2000 and the ongoing celebrity endorsed media campaign (generationrescue.org) which insists that vaccination causes autism, vaccine makers have been quietly phasing out the use of mercury in vaccines used in the west. Stocked batches of these vaccines have been shipped to China and other Asian and African countries where they have been administered to children, populations of new medical consumers.

In China, where peanut consumption is high, the allergy was virtually unknown in 2001.⁶ Recent studies in 2008 and 2009 indicate that peanut allergy is on the rise in Chinese and Singaporean children.⁷

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⁵ Wendy Harris, "Abnormal Response to Normal Things," Professionally Speaking Magazine, Ontario College of Teachers, Sept. 2000.

⁶ K. Beyer K, et al. "Effects of cooking methods on peanut allergenicity," *J Allergy Clin Immunol.* 2001 Jun;107(6):1077-81.

⁷ Europrevall.org and Chiang Wen Chin, "Food Allergy in Singapore," SingHealth.com (2009)