

Swine flu

How proportionate is the pandemic response?

Dr Robert Verkerk raises questions about the new flu outbreak and how to respond to it

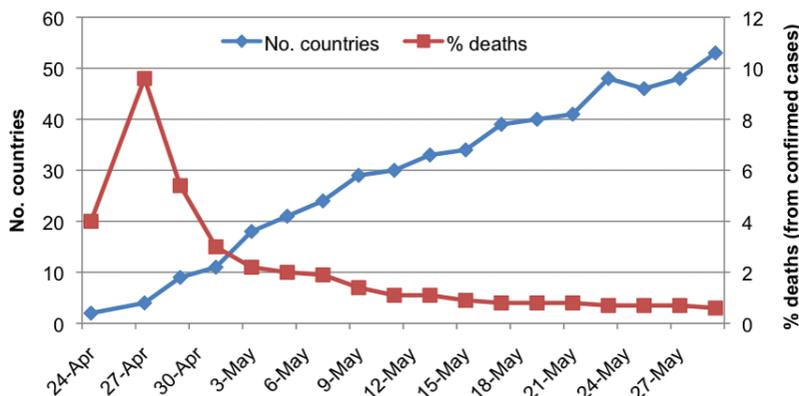


Figure 1. The relationship between the number of countries in which confirmed cases of new influenza A(H1N1) cases have occurred and the percentage of related deaths (data derived from the WHO updates: www.who.int/csr/disease/swineflu/updates/en/index.html).

No one doubts the suffering that some have experienced due to the current outbreak of new influenza A(H1N1), formerly referred to as ‘swine flu’. But in the context of many other human diseases, the media reaction to the disease, as well as the international coordination of responses by governments, the pharmaceutical industry and vaccine manufacturers seems somewhat disproportionate.

To put it in context, in sub-Saharan Africa at least a million people die a year from malaria – the mortality figures average out at around 3,100 people *each day*. Worldwide, ordinary seasonal influenza causes 3 to 5 million cases of severe illness each year and kills between 250,000 and 500,000 people annually.

Since the new strain of H1N1 was found to be spreading rapidly in Mexico in April, causing sometimes severe symptoms or even death in persons primarily under 60 years of age, the World Health Organization (WHO), as of 29 May, has been able to confirm 15,510 cases – but just 99 deaths (0.6%). In the case of the vast majority of confirmed infections of ‘new influenza’, the symptoms have been mild and present no threat to life at all.

When you look at the pattern of deaths compared to the spread of the virus, it’s clear that the virus is spread-

ing, yet causing a declining death rate, which appears to have settled, at least for the time being, at a around half a percent of those infected (Fig 1). This is a common pattern in epidemics. The greatest virulence often occurs in the early stages – then it tends to peter out. While the majority of infected persons have so far suffered only mild ‘flu symptoms, one shouldn’t become complacent. A mutation or reassortment of the virus may yet cause significant death and distress. However, there is no evidence yet of any such change to the virus.

We should not forget that this virus’ close relative, the avian-derived H1N1 virus that causes mostly non-lethal, seasonal influenza, originally caused between 25–50 million deaths during the ‘Spanish flu’ of 1918–20. In the 90 years since its first outbreak, its virulence has never returned to the levels found in the early waves of infection in humans. Will it be any different for the new subtype?

Disturbing trend

What’s perhaps most disturbing is the reliance placed on pharmaceuticals and vaccines by the WHO, governments and the ‘healthcare system’ generally. The primary way of ‘dealing’ with the infection is the dispensing of antiviral drugs, in particular Tamiflu (Roche) and Relenza (GSK).

Sales of Tamiflu in the first quarter of 2009 skyrocketed to \$347m worldwide, while those for Relenza were \$324m. Most of the sales were generated through government stockpile orders, as the WHO’s Pandemic Phase 5 alert triggers international pandemic preparedness.

The WHO’s pandemic rating scale has absolutely no bearing on the virulence of the virus and is characterised simply ‘by human-to-human spread of the virus into at least two countries in one WHO region’. One can’t help feeling this is very convenient for the drug companies, given that the last pandemic scare was three years ago, when governments then upped their stockpiles to prepare for another pandemic that never unleashed itself fully.

Vaccine producers, which collaborate closely with the WHO, have also been triggered into producing a vaccine for the new strain of influenza, which is expected to be ready this autumn, to be added to the seasonal influenza vaccine. One can only imagine just how much pressure will be brought to bear on the general public around the world to receive this new cocktail vaccine later this year.

Unfortunately, there’s been far too little talk about non-drug measures such as social distancing and hygiene as means to reduce infection, while nothing has been said officially about measures to enhance the effectiveness of the best viral control system known to humankind: the human immune system. Enlightened governments should be talking about combining social distancing, ‘open-air treatment’ and specific nutritional and botanical approaches that are known to facilitate a better modulated, immune response. For the time being, these are things we must investigate ourselves because we are unlikely to hear about them from our governments.

From a scientific standpoint, the over-reliance on drugs and vaccines is deeply questionable. Of particular concern is the lack of efficacy and side-effects of antiviral drugs in dealing with serious influenza and the variable efficacy and safety of vaccines, especially when a pandemic strain might be quite unstable.

Given the current threat, are you prepared to be injected with a new vaccine, or be treated with Tamiflu or Relenza? Do you believe that those who opt for such approaches are given enough information on which to make an informed choice? I, for one, do not. ❖

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