Dichiarazione

Già Direttore del Servizio Educazione all'Appropriatezza e Medicina basata sulle Prove di una grande Azienda Sanitaria pubblica italiana e membro CSS

Da pensionato lavoro a titolo gratuito e non ho conflitti di interessi da dichiarare.

Come Presidente della Fondazione *Allineare Sanità e Salute* dichiaro che la Fondazione si regge sul lavoro volontario e gratuito di Consiglio Direttivo, Comitato scientifico e autori delle pubblicazioni.

E che

non presenta conflitto, ma **allineamento** con gli interessi del SSN e della Salute della comunità dei cittadini. Ma verificate!

Alberto Donzelli – Presidente della www.fondazioneallinearesanitaesalute.org e Coord. Commissione Medico-scientifica indipendente Home | CMSi (cmsindipendente.it)

La CMSi chiede dal 2021 un confronto scientifico/istituzionale, finora negato, ...

In questa presentazione parlerò del fatto che:

1) gli screening tumorali, pur **aumentando le diagnosi** di tumore, **non** riducono la mortalità per tutte le cause (esempio tumore mammario)

2) l'aumento di diagnosi (e, in minor misura, di mortalità) per cancro verificatosi nel mondo tra i giovani nei 30 anni dal 1990 al 2019 si potrebbe in parte spiegare con la diffusione degli screening (oltre che con la diffusione dei maggiori fattori di rischio: fumo, alcol, dieta ricca di carni, povera di frutta…)

3) però negli ultimi 2-3 anni i dati statistici di vari Paesi documentano un forte aumento di diagnosi e di morti di tumore, in particolare nei giovani, che fa necessariamente pensare all'ingresso di qualche **nuovo** e **importante fattore di rischio**

4) ci sono varie razionali ipotesi esplicative legate alle campagne vaccinali (in particolare con i vaccini a mRNA anti COVID-19)

Int. J. Epidemiol. Advance Access published January 15, 2015

International Journal of Epidemiology, 2015, 1–14
doi: 10.1093/ije/dyu140
Original article

Screening e mortalità totale

Original article

Does screening for disease save lives in asymptomatic adults? Systematic review of meta-analyses and randomized trials

Nazmus Saquib,[1] Juliann Saquib[1] and John PA Ioannidis[1,2,3]*

[1]Stanford Prevention Research Center, Department of Medicine, Stanford University School of Medicine, Stanford, CA, USA [2]Department of Health Research and Policy, Stanford University School of Medicine, Stanford, CA, USA and [3]Department of Statistics, Stanford University School of Humanities and Sciences, Stanford, CA, USA

*Corresponding author. Stanford Prevention Research Center, Medical School Office Building, Room X306, 1265 Welch Rd, Stanford, CA 94305, USA. E-mail: jioannid@stanford.edu

- We evaluated the evidence on 39 screening tests for 19 diseases where mortality is a common outcome.
- We found 48 randomized controlled trials and 9 meta-analyses that addressed either disease-specific or all-cause mortality.
- Reductions in disease-specific mortality were uncommon and reductions in all-cause mortality were very uncommon, or even non-existent with these screening tests.

Cochrane Library

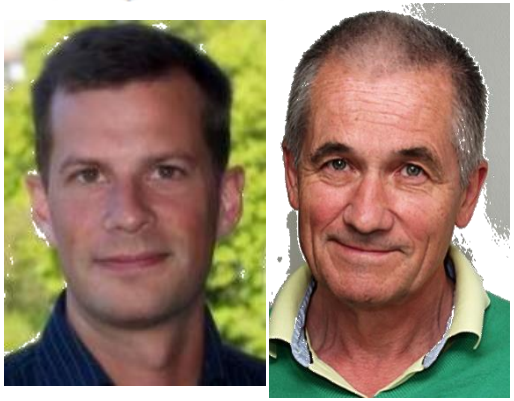
Cochrane Database of Systematic Reviews

Che cosa dicono le migliori prove disponibili?

(basate su studi randomizzati controllati, disegno *gold standard* per valutare l'efficacia di un intervento sanitario)

General health checks in adults for reducing morbidity and mortality from disease (Review)

Krogsbøll LT, Jørgensen KJ, Gøtzsche PC



Krogsbøll LT, Jørgensen KJ, Gøtzsche PC.
General health checks in adults for reducing morbidity and mortality from disease.
Cochrane Database of Systematic Reviews 2019, Issue 1. Art. No.: CD009009.

Analysis 1.6. Comparison 1 Health checks versus control, Outcome 6 Total mortality - age of trial.

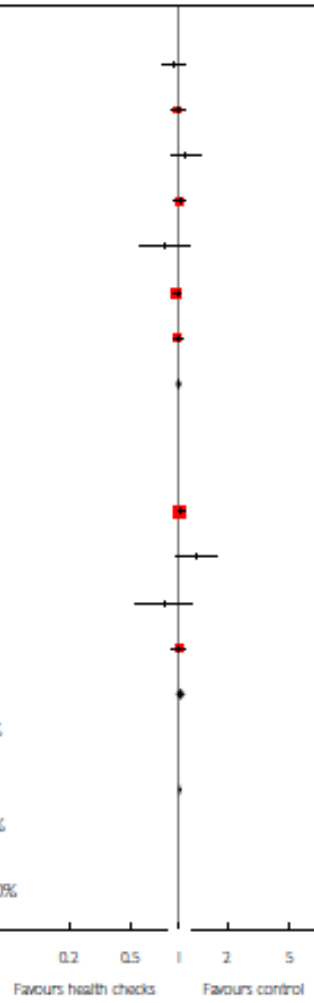
Data dei RCT
(rispetto a mortalità totale)

Review: General health checks in adults for reducing mortidity and mortality from disease

Comparison: 1 Health checks versus control

Outcome: 6 Total mortality - age of trial

Study or subgroup	log [Risk Ratio] (SE)	Weight	Risk Ratio IV,Random,95% CI
Trial started before 1980			
Göteborg 1963	-0.08338161 (0.09329714)	2.4 %	0.92 [0.77, 1.10]
Kaiser Permanente 1965	-0.02020271 (0.05459466)	7.1 %	0.98 [0.88, 1.09]
South-East London 1967	0.09531018 (0.10343498)	2.0 %	1.10 [0.90, 1.35]
Stockholm 1969	0.01980263 (0.04240699)	11.8 %	1.02 [0.94, 1.11]
Malmö 1969	-0.21072103 (0.18796486)	0.6 %	0.81 [0.56, 1.17]
Göteborg 1970	-0.02020271 (0.0312761)	21.7 %	0.98 [0.92, 1.04]
WHO 1971	-0.01005034 (0.03853068)	14.3 %	0.99 [0.92, 1.07]
Subtotal (95% CI)		**59.8 %**	**0.99 [0.95, 1.03]**
Heterogeneity: Tau² = 0.0; Chi² = 3.43, df = 6 (P = 0.75); I² =0.0%			
Test for overall effect: Z = 0.56 (P = 0.57)			
Trial started after 1980			
DanMONICA 1982	0.0295588 (0.02713786)	28.8 %	1.03 [0.98, 1.09]
OXCHECK 1989	0.2390169 (0.14994558)	0.9 %	1.27 [0.95, 1.70]
Ebeltoft 1992	-0.22314355 (0.20581798)	0.5 %	0.80 [0.53, 1.20]
Inter99 1999	0 (0.04604295)	10.0 %	1.00 [0.91, 1.09]
Subtotal (95% CI)		**40.2 %**	**1.02 [0.96, 1.09]**
Heterogeneity: Tau² = 0.00; Chi² = 3.81, df = 3 (P = 0.28); I² =21%			
Test for overall effect: Z = 0.71 (P = 0.48)			
Total (95% CI)		**100.0 %**	**1.00 [0.98, 1.03]**
Heterogeneity: Tau² = 0.0; Chi² = 8.60, df = 10 (P = 0.57); I² =0.0%			
Test for overall effect: Z = 0.23 (P = 0.82)			
Test for subgroup differences: Chi² = 0.80, df = 1 (P = 0.37), I² =0.0%			



Negli studi più recenti i risultati non migliorano affatto?!

Analysis 1.19. Comparison 1 Health checks versus control, Outcome 19 Cancer mortality - age of trial.

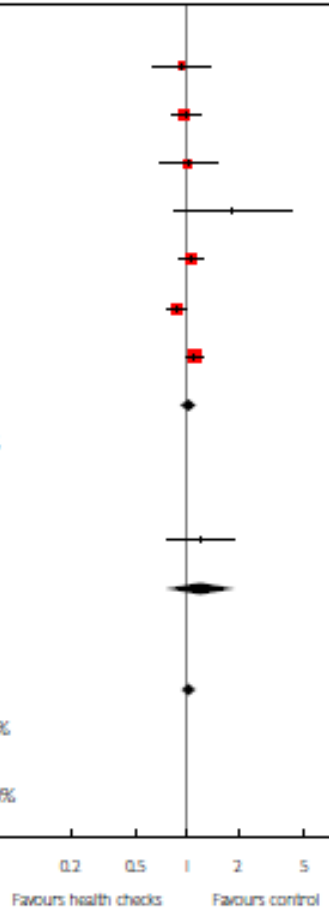
Data dei RCT
(rispetto a mortalità da cancro)

Review: General health checks in adults for reducing morbidity and mortality from disease

Comparison: 1 Health checks versus control

Outcome: 19 Cancer mortality - age of trial

Study or subgroup	log [Risk Ratio] (SE)	Weight	Risk Ratio IV,Random,95% CI
Trial started before 1980			
Göteborg 1963	-0.07257069 (0.20003035)	5.5 %	0.93 [0.63, 1.38]
Kaiser Permanente 1965	-0.02020271 (0.10343498)	15.2 %	0.98 [0.80, 1.20]
South-East London 1967	0.00995033 (0.20181826)	5.4 %	1.01 [0.68, 1.50]
Malmö 1969	0.63127178 (0.40996279)	1.4 %	1.88 [0.84, 4.20]
Stockholm 1969	0.04879016 (0.08953493)	18.2 %	1.05 [0.88, 1.25]
Göteborg 1970	-0.13926207 (0.06744554)	24.2 %	0.87 [0.76, 0.99]
WHO 1971	0.10408971 (0.06207813)	26.0 %	1.11 [0.98, 1.25]
Subtotal (95% CI)		**95.9 %**	**1.01 [0.91, 1.12]**
Heterogeneity: Tau² = 0.01; Chi² = 9.90, df = 6 (P = 0.13); I² =39%			
Test for overall effect: Z = 0.10 (P = 0.92)			
2 Trial started after 1980			
OXCHECK 1989	0.17395331 (0.23578033)	4.1 %	1.19 [0.75, 1.89]
Subtotal (95% CI)		**4.1 %**	**1.19 [0.75, 1.89]**
Heterogeneity: not applicable			
Test for overall effect: Z = 0.74 (P = 0.46)			
Total (95% CI)		**100.0 %**	**1.01 [0.92, 1.12]**
Heterogeneity: Tau² = 0.01; Chi² = 10.41, df = 7 (P = 0.17); I² =33%			
Test for overall effect: Z = 0.24 (P = 0.81)			
Test for subgroup differences: Chi² = 0.49, df = 1 (P = 0.49), I² =0.0%			



Per cancro? Va persino peggio…!

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Screening mammografico NON riduce mortalità totale

Institute for Scientific Freedom

Socrates

Socrates (c. 470–399 BC) was a Greek philosopher who is credited as the founder of Western philosophy. Socrates and his interlocutors examined a subject in the style of questions and answers. In 399 BC, he was accused of impiety and corrupting the youth. After a trial that lasted a day, he was sentenced to death. He spent his last day in prison, refusing offers to help him escape. We are indebted to Socrates. Even today, people are executed for asking questions. The Institute for Scientific Freedom works to preserve honesty and integrity in science and to help develop a better healthcare where more people will benefit; fewer will be harmed; and more will live longer in good health.

Mission statement

The Institute has three visions:

1. All science should strive to be free from financial conflicts of interest.
2. All science should be published as soon as possible, and made freely accessible.
3. All scientific data, including study protocols, should be freely accessible, allowing others to do their own analyses.

The Institute's primary area of work is healthcare.

https://www.scientificfreedom.dk/2023/05/03/screening-for-breast-cancer-with-mammography

Institute for Scientific Freedom

Screening for breast cancer with mammography

By Peter / May 3, 2023

This is the title of a Cochrane review I first published in 2001 and **lastly updated in 2013** (1). Because many more deaths have now been published (2,3), **I updated the review again on 10 January 2023**, and on 6 February, my co-author had independently assessed the new data and agreed with what I had found.

The **updated mortality data show even more clearly than before that mammography screening does not save lives, which is the official mantra used for justifying screening**. When we analysed invitations to breast screening from seven countries, we found that 19 pamphlets (95%) had suggestive headlines, such as, "Have a screening mammogram, it **may save your life**."

https://www.scientificfreedom.dk/2023/05/03/screening-for-breast-cancer-with-mammography

Two of the three studies with adequate randomisation have been updated with many more deaths. **Breast cancer mortality is an unreliable outcome that is biased in favour of screening**, **mainly because of differential misclassification of cause of death**. We therefore **need to look at total cancer mortality and total mortality** instead.

The **trials with adequate randomisation did not find an effect of screening on total cancer mortality, including breast cancer (risk ratio 1.00**, 95% confidence interval 0.96 to 1.04). **All-cause mortality was not significantly reduced either (risk ratio 1.01**, 95% CI **0.99 to 1.04**).

La differenza di mortalità total non è statisticamente significativa, ma va in direzione opposta a quanto desiderato.

Proiettata su una coorte di 100 donne con mammografia (vs 100 donne senza) sarebbe nel tempo 1 caso in più di mortalità totale con lo screening.

Su una coorte di 10 milioni di donne con mammografia (vs 10 milioni senza) sarebbero nel tempo 100 mila casi in più di mortalità totale con lo screening.

As reported earlier, **total numbers of lumpectomies and mastectomies were significantly larger in the screened groups (risk ratio 1.31**, 95% CI 1.22 to 1.42), as were **number of mastectomies (risk ratio 1.20**, 95% CI 1.08 to 1.32).

(*Zambrano, La Bussola Quotidiana*)

Il Prof. **Francesco Schittulli**, oncologo e presidente della Lilt (Lega italiana lotta ai tumori) ha rilasciato un'intervista a Telenorba, la televisione della sua città.

Nel 2022 c'è stato un aumento di ca. mammari nelle giovani sotto i 40 anni: ~11 mila casi (+15% sul 2021), su un totale di ~60 mila casi di cancro mammario nelle donne italiane nel 2022.

Il Prof. Schittulli ha detto: «Non voglio aprire il capitolo della vaccinazione, io non sono un no vax … però sarebbe anche opportuno capire…».

Il giornalista che lo intervista gli chiede quale sia la relazione tra COVID, vaccini e cancro. E Schittulli: «Registro un aumento dei tumori in fase avanzata, perché la popolazione non è stata sottoposta allo *screening*».

Ma non è una spiegazione: dal sito del **Ministero della Salute**, lo *screening* per tumore mammario è per donne tra 50 e 69 anni, con mammografia ogni 2 anni, ma «in alcune Regioni si sta sperimentando lo *screening* tra i 45 e i 74 anni». Sotto i 40 anni, però, non c'è screening: sono tumori clinicamente manifesti…

Allora anticipare gli screening? Intanto, andare alla radice:

1) Smettere di inoculare, soprattutto i giovani!

2) Puntare decisi sulla prevenzione primaria di provata efficacia

Cosa possono fare le donne per prevenire il cancro al seno?

Oltre allo **screening mammografico**, ci sono comportamenti da adottare o da evitare per ridurre il rischio di ammalarsi e morire di cancro al seno?

Pillole e miniPillole di educazione sanitaria

Allineare Sanità & Salute
Fondazione

Screening mammario dai 40 anni?

https://www.uspreventiveservicestaskforce.org/uspstf/sites/default/files/file/supporting_documents/breast-cancer-screening-draft-rec-bulletin.pdf

U.S. Preventive Services TASK FORCE

USPSTF Bulletin

Task Force Issues Draft Recommendation Statement on Screening for Breast Cancer

Science now shows all women should get screened starting at age 40; more research still needed in key areas

WASHINGTON, D.C. – May 9, 2023 – The U.S. Preventive Services Task Force (Task Force) today posted a draft recommendation statement on screening for breast cancer. The Task Force now recommends that all women get screened for breast cancer every other year starting at age 40. **This is a B grade.** More research is needed on whether or not women with dense breasts should have additional screening with breast ultrasound or MRI, and on the benefits and harms of screening in women older than 75. **These are I statements.** The use of the term women in this draft recommendation includes cisgender women and other people assigned female at birth.

Grades in this recommendation:

B: Recommended.

I: The balance of benefits and harms cannot be determined.

Learn more here

Br. J. Cancer (1987), **56**, 814–819 © The Macmillan Press Ltd., 1987

Breast cancer and atypia among young and middle-aged women: A study of 110 medicolegal autopsies (donne di 20-54 anni)

M. Nielsen[1], J.L. Thomsen[2], S. Primdahl[1], U. Dyreborg[3], & J.A. Andersen[4]

[1]*Department of Pathology, Frederiksberg Hospital, Copenhagen, DK-2000 F;* [2]*University Institute of Forensic Medicine, Copenhagen, DK-2100 Ø; and Departments of* [3]*Radiology and* [4]*Pathology, Odense University Hospital, Odense, DK-5000 C, Denmark.*

Summary In 110 consecutive, medicolegal autopsies of young and middle-aged women (range 20–54 years) the breasts were examined by an extensive histopathologic method and by correlative specimen radiography. Malignancy was found in 22 women (20%) of which only one was known to have had clinical invasive breast cancer (IBC). At autopsy 2 women had IBC (2%), the remaining *in situ* carcinoma (*in situ* BC) of microfocal type (18%), i.e. 15 (14%) intraductal carcinomas (DCIS), 4 (3%) lobular carcinoma *in situ* (LCIS) and one (1%) both DCIS and LCIS. Forty-five per cent of the women with malignancy had multicentric and 41% had bilateral lesions. Forty-five per cent of all histologically confirmed malignant lesions were identified by specimen radiography. Adenosis, benign epithelial hyperplasia, papilloma and duct ectasia were positively associated with malignancy. In addition malignancy was significantly more frequent among women aged more l abuse and with steatosis or cirrhosis of ent in young and middle-aged women.

Table I Number of women with primary malignant and atypical breast lesions among 110 medicolegal autopsy cases.

Type of lesion	*No. of women*
Invasive breast cancer (IBC)	2
Intraductal carcinoma (DCIS)	15
Lobular carcinoma *in situ* (LCIS)	4
DCIS/LCIS	1
Total number of malignant lesions	22 (20%)
Atypical ductal hyperplasia (ADH)	8 (7%)

22 tumori (20%)

Table V Age distribution of 110 women with and without malignant and atypical breast lesions

Years	*Total number of women* ($n=110$)	*Number of women with breast cancer* ($n=22$)	*Number of women with atypical lesions* ($n=8$)
20–29	23	0	1
30–39	36	3 (8%)	2
40–49	33	13 (39%)	4
50–54	18	6 (33%)[a]	1

[a]Two women had invasive breast cancer

da 40 ai 49 aa.
4 donne su 10?!

Thomas *et al. BMC Cancer* (2017) 17:808
DOI 10.1186/s12885-017-3808-1

BMC Cancer

RESEARCH ARTICLE Open Access

Prevalence of incidental breast cancer and precursor lesions in autopsy studies: a systematic review and meta-analysis

Elizabeth T. Thomas[1], Chris Del Mar[2], Paul Glasziou[2], Gordon Wright[1], Alexandra Barratt[3] and Katy J. L. Bell[2,3*]

Abstract

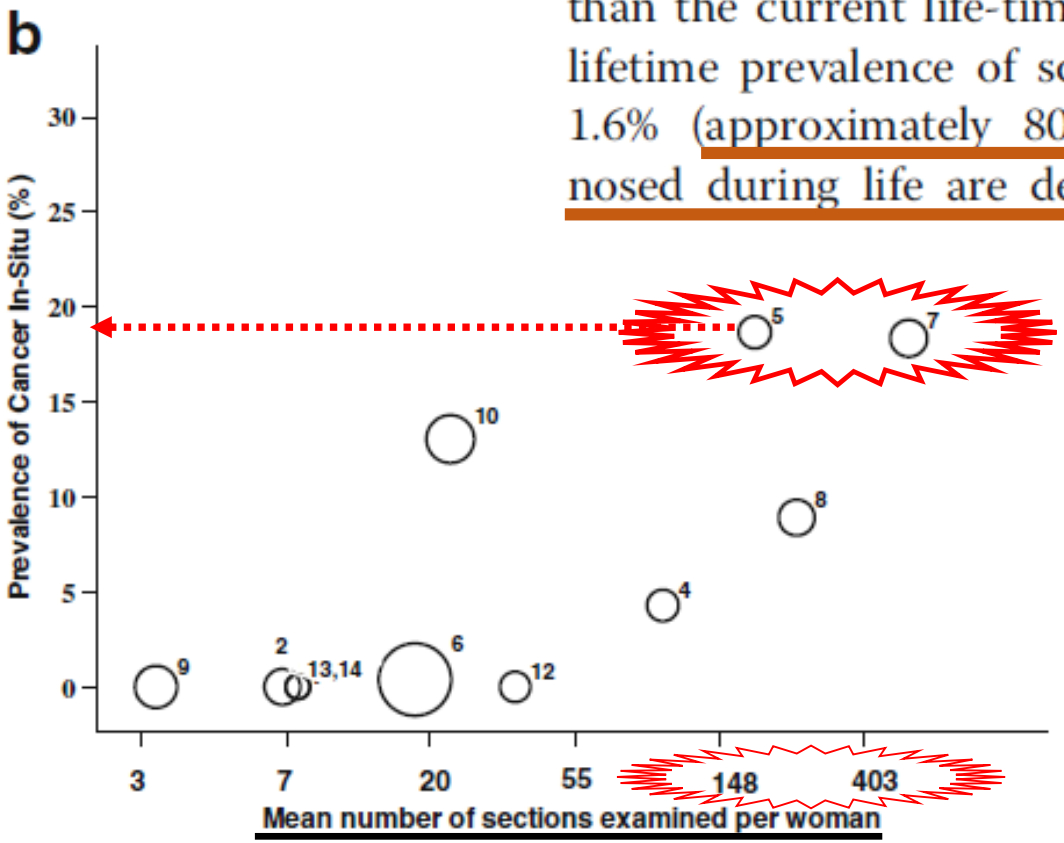
Background: Autopsy studies demonstrate the prevalence pool of incidental breast cancer in the population, but estimates are uncertain due to small numbers in any primary study. We aimed to conduct a systematic review of autopsy studies to estimate the prevalence of incidental breast cancer and precursors.

...

Results: We included 13 studies from 1948 to 2010, contributing 2363 autopsies with 99 cases of incidental cancer or precursor lesions. More thorough histological examination (≥20 histological sections) was a strong predictor of incidental in-situ *cancer* and *atypical hyperplasia* (OR = 126·8 and 21·3 respectively, $p < 0·001$), but not *invasive cancer* (OR = 1·1, $p = 0·75$). The estimated mean prevalence of incidental cancer or precursor lesion was 19·5% (0·85% *invasive cancer* + 8·9% in-situ *cancer* + 9·8% *atypical hyperplasia*).

likely to be due to overdiagnosis. The implications of this are that up to ~40% (~3%/7.4%) of screen-detected invasive cancers, or up to ~24% (~3/12.4%) of all invasive cancers, may be currently overdiagnosed. Others' estimated overdiagnosis rates fall between our approximate lower and upper bounds [11, 43, 47–50].

For in-situ breast cancer, our estimate for the prevalence pool of incidental lesions is ~9%, much higher than the current life-time prevalence of ~2·0% [40], and lifetime prevalence of screen-detected in situ cancer of 1.6% (approximately 80–85% of in-situ cancers diagnosed during life are detected by screening [51]). This



Ciò in studi fino al 2010.
Con nuove tecnologie (mammograf. digitale, tomosintesi) e biopsie + intense, **peggio**!

https://www.adnkronos.com/cronaca/cancro-diagnosi-giovani-tumore-terapia_JSc0jJjErKHCK2Y1mPZa8

Tumori, dal 2000 boom casi nei giovani. Burioni: "Dato inquietante"

13 gennaio 2024 | 15.39 Redazione Adnkronos

Il professore: "Netto aumento dell'incidenza e non sappiamo perché"

"**Un dato inquietante: negli ultimi 20 anni si è registrato un netto aumento dell'incidenza di alcuni gravi tumori tra i giovani**. E non sappiamo ancora il perché".
È il commento al servizio del 'Wall Street Journal' postato sui social da **Roberto Burioni**

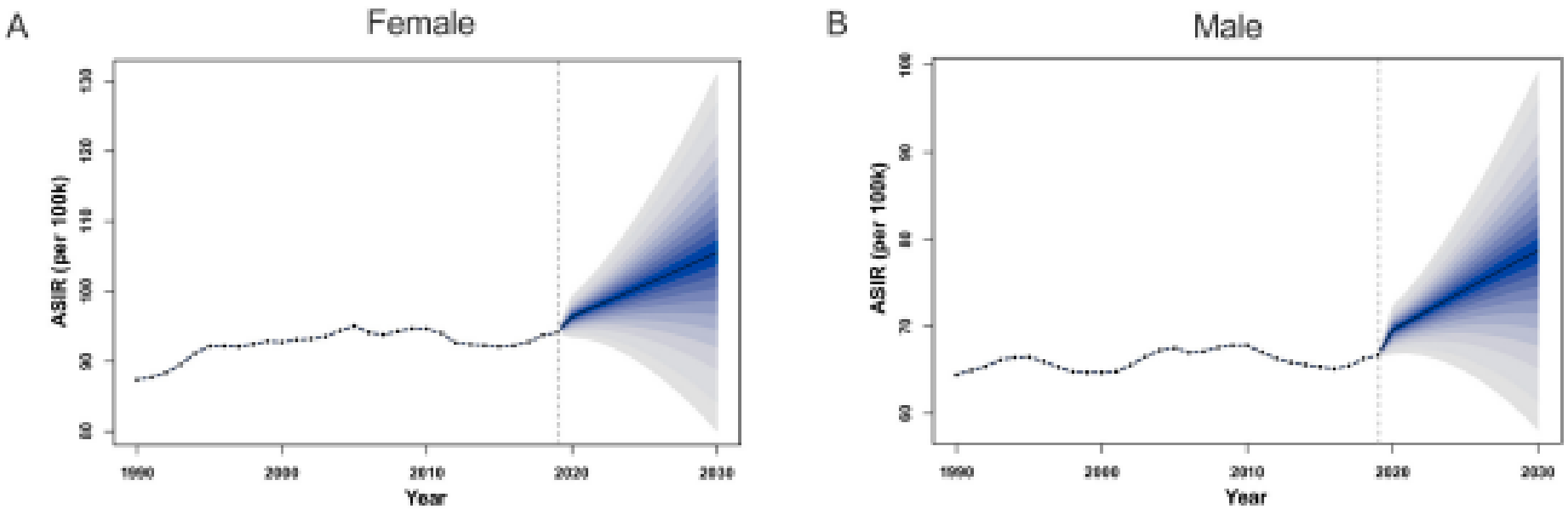
Open access Original research

BMJ Oncology

Global trends in incidence, death, burden and risk factors of early-onset cancer from 1990 to 2019

Zhao J, et al. BMJ Oncology 2023;2:e000049. doi:10.1136/bmjonc-2023-000049

Jianhui Zhao,[1] Liying Xu,[1] Jing Sun,[1] Mingyang Song,[2,3] Lijuan Wang,[4] Shuai Yuan,[5] Yingshuang Zhu,[6] Zhengwei Wan,[7] Susanna Larsson,[5,8] Konstantinos Tsilidis,[9,10] Malcolm Dunlop,[11,12] Harry Campbell,[5] Igor Rudan,[5] Peige Song ,[13] Evropi Theodoratou,[4,11] Kefeng Ding ,[6] Xue Li [1,4]



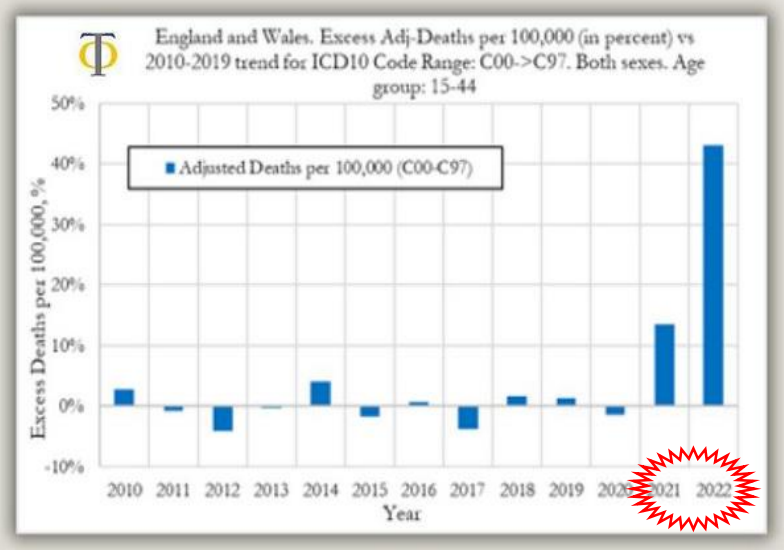
ASIR = tassi di incidenza standardizzati per età

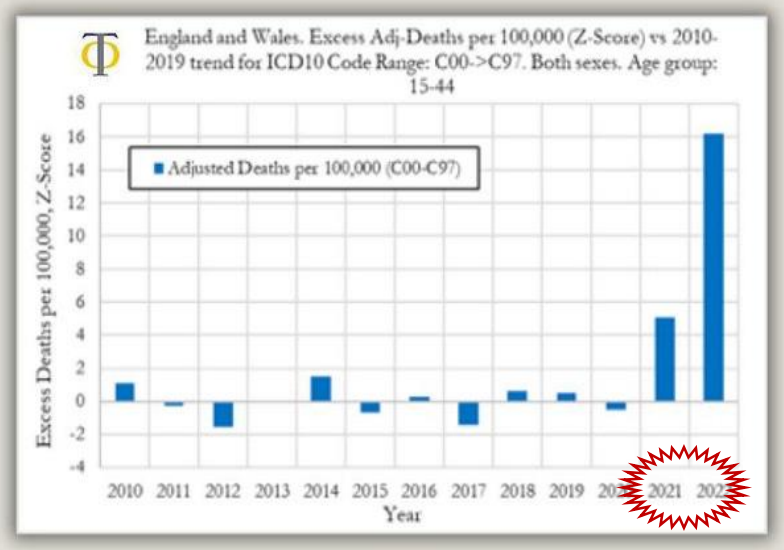
Un articolo del WSJ mostra “allarme” per un aumento del 13% delle diagnosi nel **Regno Unito** in 20 anni (dal 2000 al 2019), ma ignora che nel 2021-’22, successivi al lancio di massa dei vaccini a mRNA si vede qualcosa di ben superiore a prima, nei morti di soli 2 anni. È un’omissione grave e singolare, dato che in UK ci sono i dati fino a fine 2022!

UK - Death & Disability Trends for Malignant Neoplasms (Cancer), Ages 15-44

Data Source: UK Office of National Statistics (ONS)

Excess adjusted deaths rates from malignant neoplasms for ages 15 to 44, in England and Wales





LEFT:
Relative deviation from trend, percent.

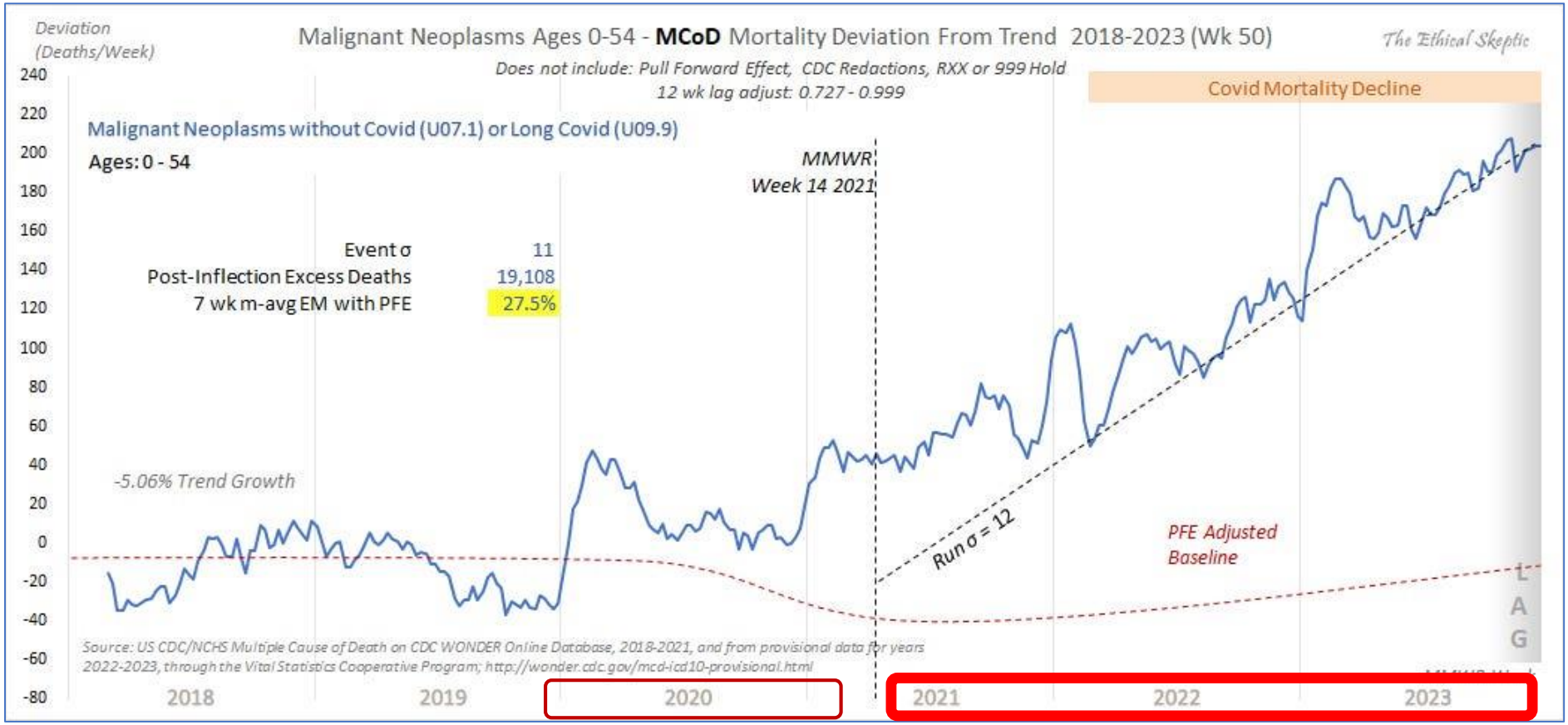
RIGHT:
Deviation from trend, Z-Score

- Our analysis shows that the excess death rates from malignant neoplasms remained un-altered in 2020, rose by 13% in 2021, and about 43% in 2022.
- The excess mortality from malignant neoplasms in 2021 & 2022 are highly statistically significant with Z-scores of 5 & 16, respectively. These are very strong signals.
- These signals are corroborated by similar findings when measuring rises in the fraction of deaths from malignant neoplasms relative to all other deaths with classified causes.

Full analysis at phinancetechnologies.com
DIRECT LINK: bit.ly/UK-Cancer15-44

Phinance Technologies

E negli **Stati Uniti d'America**?

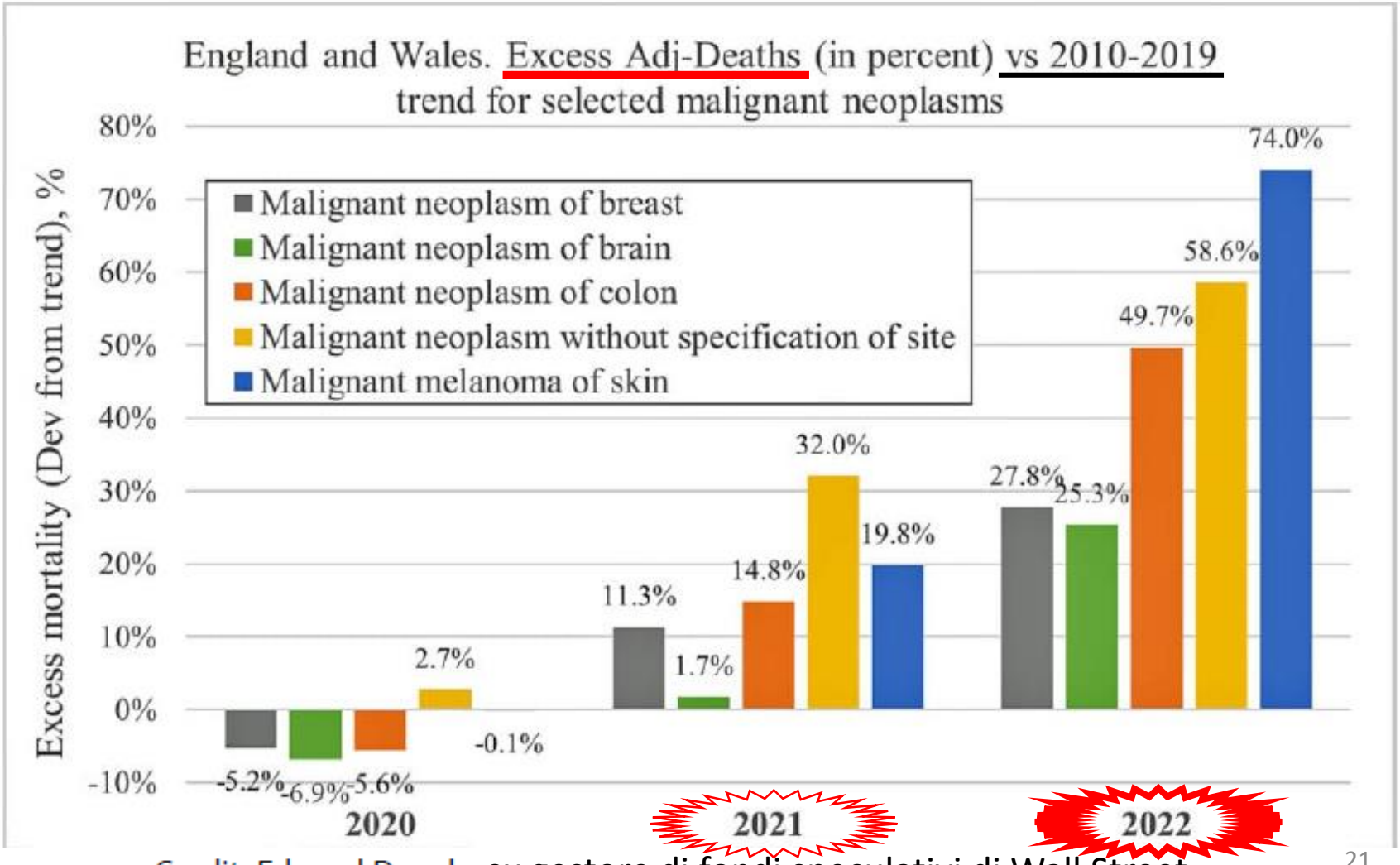


11/21/23
COVID ›

New Report: Young People Dying of Cancer at 'Explosive' Rates, UK Government Data Show (da dati ONS)

An analysis of U.K. government data shows an unprecedented increase in cancer deaths among 15- to 44-year-olds following the rollout of COVID-19 vaccines, according to a new report by data analyst Edward Dowd. The

27/11/23, 09:56 New Report: Young People Dying of Cancer at 'Explosive' Rates, UK Government Data Show • Children's Health Defense



Credit: Edward Dowd - ex gestore di fondi speculativi di Wall Street

https://newsacademy.it/scienze-e-salute/2023/12/08/svizzera-aumento-esplosivo-dei-casi-di-cancro-il-governo-nasconde-i-dati/

Arzneimittelreport der Helsana 2022 (30.11.23) Rapporto sui farmaci 2022

UNIVERSITÄT LUZERN

Jahr	Anzahl Bezüger von Krebsmedikamenten
2013	90'446
2014	104'522
2015	104'107
2016	106'774
2017	79'525
2018	82'942
2019	83'072
2020	88'188
2021	152'168
2022	153'956

I dati di Helsana, l'assicuratore leader su malattie e infortuni in Svizzera, mostrano un aumento impressionante delle persone richiedenti farmaci antitumorali. Il noto economista assicurativo Beck dell'Università di Lucerna ha lanciato l'allarme. In una pubblicazione del 30 novembre mostra un aumento del 94% dal 2017 al 2022.

Secondo Beck, i dati ufficiali dell'Ufficio federale di statistica, poi ritirati senza spiegazioni, hanno inizialmente rivelato un aumento sconcertante di malattie croniche, in particolare **attacchi di cuore, ictus e cancro**. Beck suggerisce una correlazione con le vaccinazioni antiCOVID, non con la COVID-19, perché non c'era nel 2020.

Una delle possibili spiegazioni:

BMJ Journals

Log In Basket

Journal for ImmunoTherapy of Cancer

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An immune evasion mechanism with IgG4 playing an essential role in cancer and implication for immunotherapy

Hui Wang [1], Qian Xu [1], Chanyuan Zhao [1], Ziqi Zhu [1], Xiaoqing Zhu [1], Junjie Zhou [1], Shuming Zhang [1], Tiqun Yang [1], Biying

Abstract

Background Recent impressive advances in cancer immunotherapy have been largely derived from cellular immunity. The role of humoral immunity in carcinogenesis has been less understood. Based on our previous observations we hypothesize that an immunoglobulin subtype IgG4 plays an essential role in cancer immune evasion.

Methods The distribution, abundance, actions, properties and possible mechanisms of IgG4 were investigated with human cancer samples and animal tumor models with an extensive array of techniques both in vitro and in vivo.

Results In a cohort of patients with esophageal cancer we found that IgG4-containing B lymphocytes and IgG4 concentration were significantly increased in cancer tissue and IgG4 concentrations increased in serum of patients with cancer. Both were positively related to increased cancer malignancy and poor prognoses, that is, more IgG4 appeared to associate with more aggressive cancer growth. We further found that IgG4, regardless of its antigen specificity, inhibited the classic immune reactions of antibody-dependent cell-mediated cytotoxicity, antibody-dependent cellular phagocytosis and complement-dependent cytotoxicity against cancer cells in vitro, and these effects were obtained through its Fc fragment reacting to the Fc fragments of cancer-specific IgG1 that has been bound to cancer antigens. We also found that IgG4 competed with IgG1 in reacting to Fc receptors of immune effector cells. Therefore, locally increased IgG4 in cancer microenvironment should inhibit antibody-mediated anticancer responses and help cancer to evade local immune attack and indirectly promote cancer growth. This hypothesis was verified in three different immune potent mouse models. We found that local application of IgG4 significantly accelerated growth of inoculated breast and colorectal cancers and carcinogen-induced skin papilloma. We also tested the antibody drug for cancer immunotherapy nivolumab, which was IgG4 in nature with a stabilizing S228P mutation, and found that it significantly promoted cancer growth in mice. This may provide an explanation to the newly appeared hyperprogressive disease sometimes associated with cancer immunotherapy.

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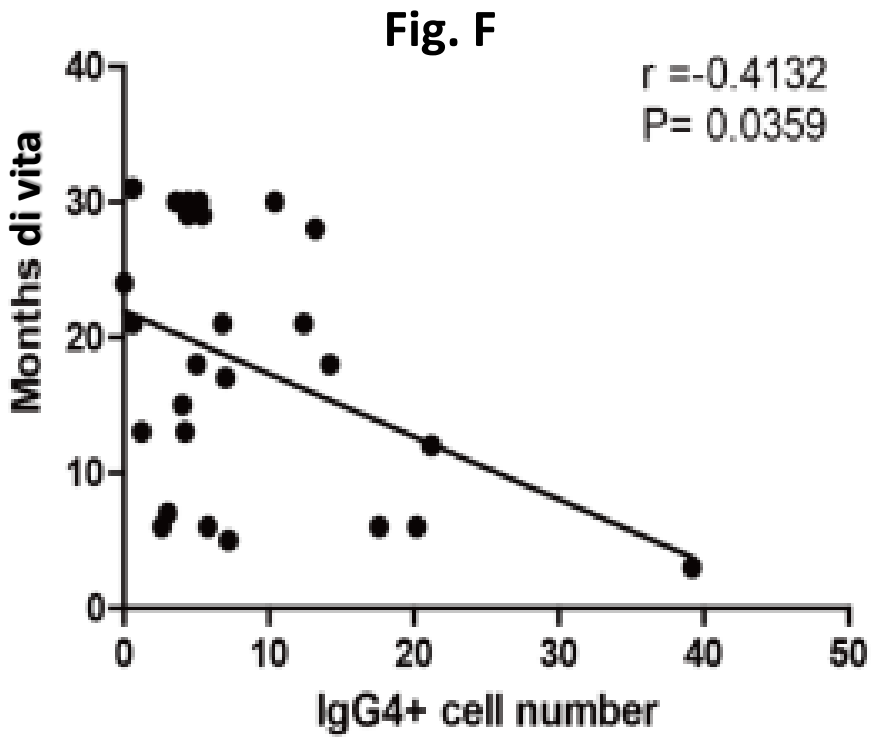
The antibody drug for cancer immunotherapy nivolumab, which was IgG4 in nature… significantly promoted cancer growth in mice… explanation to the hyperprogressive disease sometimes associated with cancer immunotherapy.

(Wang 2020) **RISULTATI. Le IgG4 erano aumentate in modo significativo nel siero di pazienti con cancro**, e questo aumento era correlato allo stadio del cancro e alla prognosi del paziente.

Prima abbiamo misurato la concentrazione di IgG1, IgG2, IgG3 e IgG4 nei sieri di 82 pazienti con cancro all'esofago.

Le IgG4 erano aumentate in modo significativo in pazienti con cancro in confronto con 70 soggetti sani.

La concentrazione di IgG4 era aumentata da ~3% all'11%.



Era anche aumentato in modo significativo il rapporto IgG4:IgG totali. La significatività statistica di entrambi raggiungeva p<0,0001. L'aumento di IgG4 era anche correlato con lo stadio del cancro (stadi avanzati → più IgG4).

Più alte concentrazioni di IgG4 nel siero si associavano a prognosi peggiore (**Fig. F**).

I linfociti con IgG4 e la concentrazione di IgG4 erano significativamente aumentati nel microambiente del cancro, e l'aumento si associava con l'infiltrazione di cellule cancerose.

Nel suo blog, Chudov conclude con un messaggio che vuol essere di speranza:

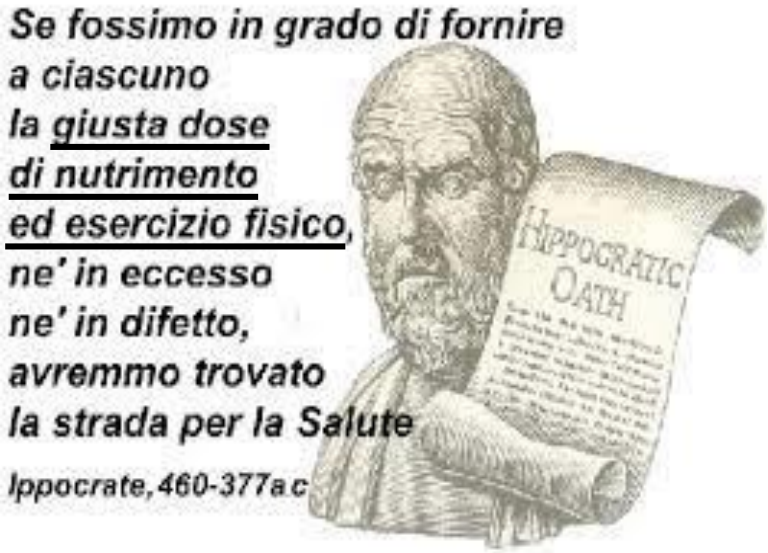
«**Ragioni per sperare che queste scoperte biologiche risparmino la maggior parte delle persone**:

- Stiamo solo iniziando a comprendere gli effetti degli anticorpi IgG4 sul cancro
- Solo ~metà dei vaccinati produce IgG4 in quantità
- Non c'è prova ad oggi che gli anticorpi IgG4 causino il cancro; le prove indicano solo che potenziano e accelerano tumori esistenti.

Ciò che le prove mostrano in modo crescente è che alcuni tumori, curabili prima delle iniezioni di mRNA, possono diventare aggressivi e difficili da trattare, condizione che gli autori dello studio del BMJ chiamano "malattia iperprogressiva".

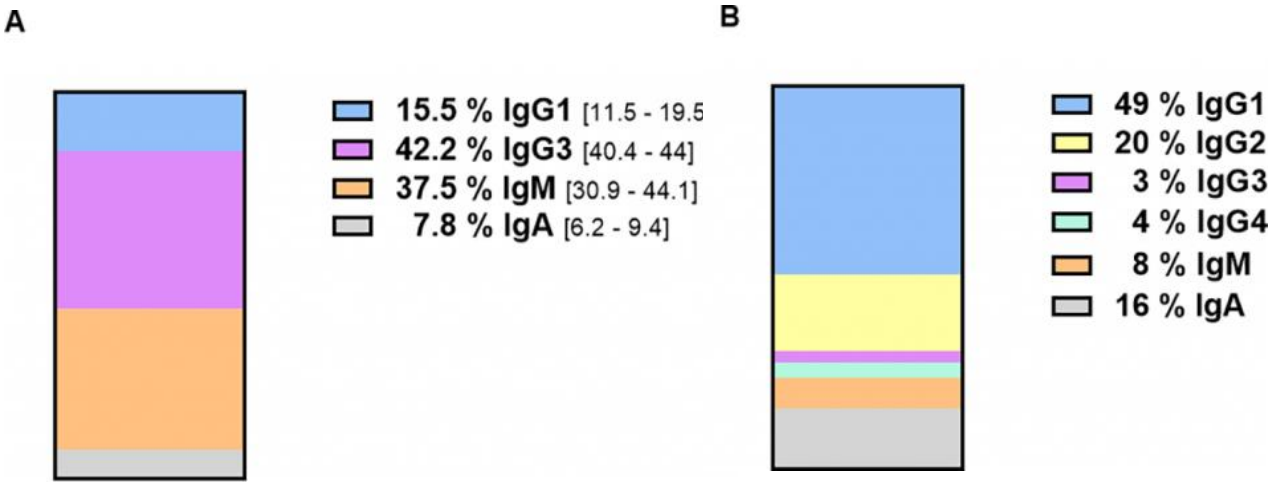
Spero e prego che il numero di persone affette da "malattia iperprogressiva" sia basso.»

Io aggiungo che spero nella «vis medicatrix naturae» (**forza risanatrice della natura**, Ippocrate), che **può consentire nel tempo anche il recupero della competenza immunitaria**, purché si punti su **scelte salutari** (a partire da quelle di base) e si smetta di ripetere inoculazioni di questi «vaccini».



Il naufragio di tutti i naufragi: miliardi di persone messe nei guai con danni alla risposta immunitaria (*Rintrah, 24 dicembre 2022*)

Dopo la vaccinazione con vaccini a mRNA, la risposta immunitaria contro la Spike si sposta via via verso le IgG4, che sono risposta fisiologica dopo un'esposizione ripetuta a sostanze che il corpo deve tollerare, come veleno delle api, polline o proteine delle arachidi.



A sinistra si vede quali anticorpi effettuano la neutralizzazione, a destra la loro % relativa nella massa anticorpale.

Nonostante costituiscano solo il 3% della massa anticorpale, le **IgG3 effettuano il 42,2% delle neutralizzazioni**. Le IgA sono impegnate nel muco e combattono lì i virus. **Le IgM** rispondono all'infezione **riducendo la carica virale**.
Le IgG3 si uniscono quindi alla lotta e contrassegnano tutti i nascondigli rimanenti di questo virus, in modo che il corpo non finisca per tollerarlo.

L'eccesso di mortalità può essere anche una conseguenza indiretta del vaccino, interferendo con la nostra risposta ottimale al virus →

% (*Rintrah, 24 dicembre 2022)* Dopo il 2° inoculo, le IgG4 iniziano a risaltare, e peggio dopo le reinfezioni. Dopo il 3° inoculo, peggio ancora. Con reinfezioni dopo 3° booster, le IgG4 si rilevano a >40%, dominando la risposta alle infezioni.

È vero che le IgG non importano solo per favorire la fagocitosi (cioè: cellule immunitarie mangiano le particelle virali), ma anche per la neutralizzazione, che non sarebbe compromessa verso altri virus. Però:

1. i virus evolvono rapidamente, per evitare gli anticorpi neutralizzanti
2. le IgG4 non contano per la neutralizzazione, merito soprattutto delle IgG3.

Ma le IgG3 vanno quasi a zero dopo il 3° inoculo, a vantaggio di un nuovo anti-corpo dominante IgG4, con risposta omogenea in miliardi di persone, che hanno ora imparato a tollerare gli stessi epitopi! Ciò peggiora la risposta al SARS-CoV-2!

Ma alcune catene di aminoacidi ora tollerati nel SARS-CoV-2 sono presenti anche in altri virus respiratori (es. in VRS, che ora gli adulti imparano a tollerare e possono diffondere a bambini a cariche maggiori, con > virulenza!).

La biodiversità delle risposte immunitarie, che mancava nei Nativi Americani, li ha resi così vulnerabili ai virus introdotti dai colonizzatori!