Szczepienia ochronne

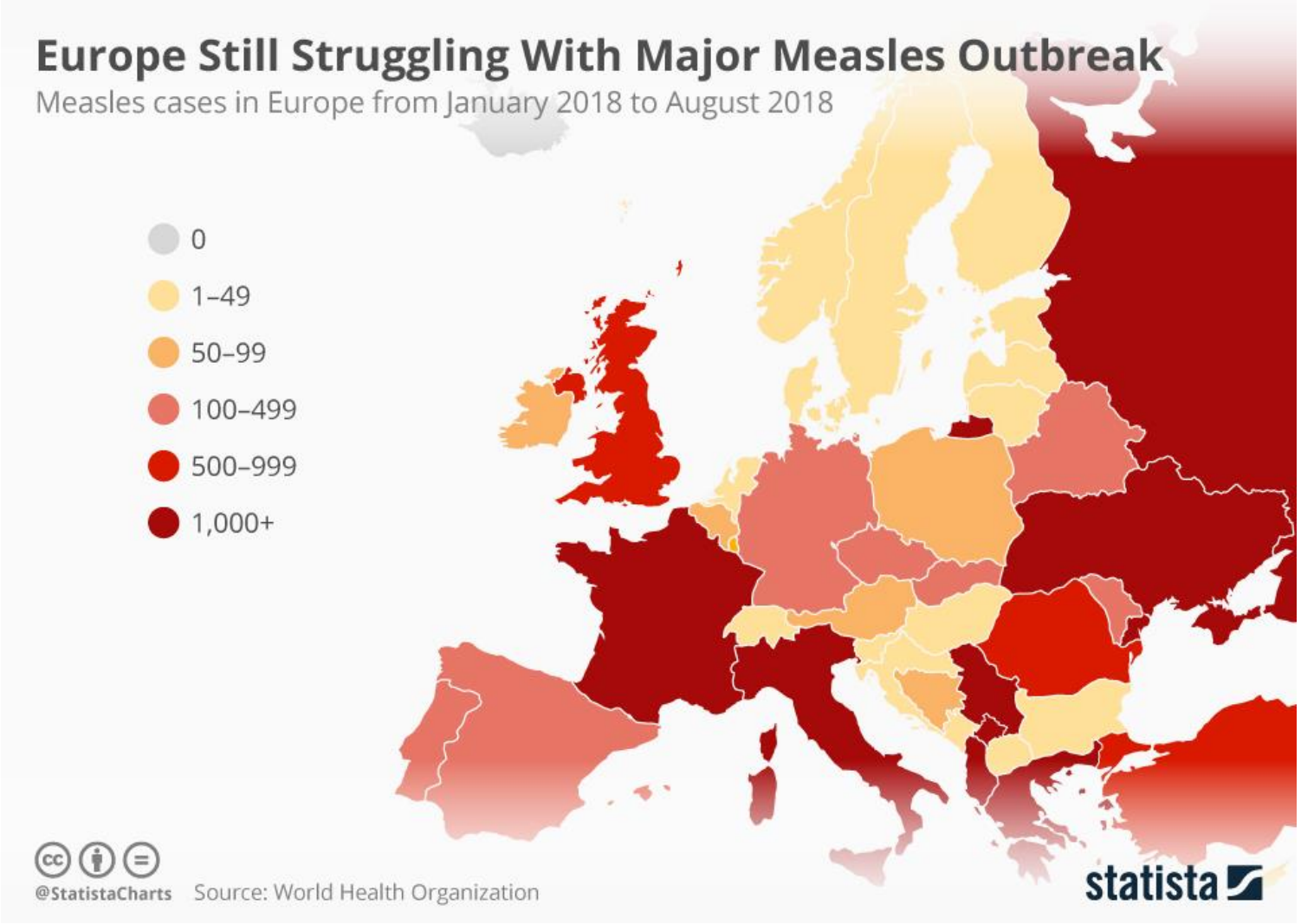
Klinika Pediatrii

W 1796 roku w angielskim hrabstwie Gloucestershire……

WHO ogłasza całkowitą eradykację ospy prawdziwej w 1980 roku

Obiecujące początki, ale…

Efekty?


Europe Still Struggling With Major Measles Outbreak
Measles cases in Europe from January 2018 to August 2018
0
1–49
50–99
100–499
500–999
1,000+
@StatistaCharts
Source: World Health Organization
statista

Profilaktyka chorób

- Uodpornienie bierne – anty-RSV, anty-WZW B
- Uodpornienie czynne – szczepienie

Szczepienia..

- Inaktywowane
- Atenuowane

Inaktywowane czyli „zabite”

- **Wirusowe:** IPV (polio); KZM; grypa; wścieklizna; WZW A; WZW B
- **Bakteryjne:**

- DTP, DTPa

Atenuowane, czyli „żywe”

- **Wirusowe:** MMR, VZV, Rotawirusy
- **Bakteryjne:** BCG, doustna szczepionka przeciwko cholerze

Szczepienia..

- Monowalentne
- Poliwalentne
- Skojarzone

Szczepienia..

- Monowalentne:

WZW A, B, Tężec

- Poliwalentne

IPV, grypa

- Skojarzone – uodparniają przeciwko wielu chorobom, np. DTP

https://www.mp.pl/pacjent/choroby-zakazne/szczepienia/158371,klasyfikacja-i-sklad-szczepionek

- **Stałym przeciwwskazaniem do wykonywania szczepień ochronnych jest tylko:**

wystąpienie ciężkiej ogólnoustrojowej reakcji na poprzednią dawkę szczepionki (lub na jakikolwiek jej składnik)

- **Stałym <u>przeciwwskazaniem do</u> wykonywania <u>szczepień żywych</u> dodatkowo:**

głębokie zaburzenia odporności

(wrodzone lub nabyte)

FAŁSZYWE przeciwwskazania:

- Kontakt z osobą w ciąży/karmiącą piersią
- Karmienie piersią
- Niedożywienie
- Wcześniactwo
- Drgawki gorączkowe proste w wywiadzie
- Rekonwalescencja po chorobie

NIE opóźniać szczepienia, gdy:

- łagodna choroba dróg oddechowych

LUB

- inna OSTRA choroba o LEKKIM przebiegu z gorączką / bez gorączki.

- **Szczepionki „nieżywe”:** można podać jednocześnie albo w dowolnym odstępie czasu po podaniu innej szczepionki.
- **Szczepionki „żywe”:** tego samego dnia lub po upływie 4.tyg.

NOP

- Medyczny objaw czasowo związany ze szczepieniem który może być spowodowany wieloma przyczynami (WHO)
- Zaburzenie stanu zdrowia, które wystąpiło w okresie **4 tygodni** po podaniu szczepionki (szczepienia.pzh.gov.pl)

NOP

- Rozpoznanie – na podstawie badania lekarskiego
- Każde zaburzenie stanu zdrowia, które może mieć związek ze szczepieniem podlega zgłoszeniu przez lekarza
- Lista NOP w rozporządzeniu MZ

ROZPORZĄDZENIE MINISTRA ZDROWIA z dnia 21 grudnia 2010 r. w sprawie niepożądanych odczynów poszczepiennych oraz kryteriów ich rozpoznawania

„Nowości”

- „Żywa” szczepionka (atenuowana, donosowa, 4-walentna) przeciwko grypie
- od 24 miesięcy do <18 lat
- Wirusy wielokrotnie pasażowane, aby rozmnażały się tylko w temp. ok. 25°C

http://szczepienia.pzh.gov.pl/nowa-szczepionka-przeciw-grypie-sezonowej/

Szczepienie przeciw gruźlicy

- **rozważyć możliwość obserwacji dziecka przez dobę**

I. SZCZEPIENIA OBOWIĄZKOWE

A. SZCZEPIENIA OBOWIĄZKOWE DZIECI I MŁODZIEŻY WEDŁUG WIEKU – KALENDARZ SZCZEPIEŃ

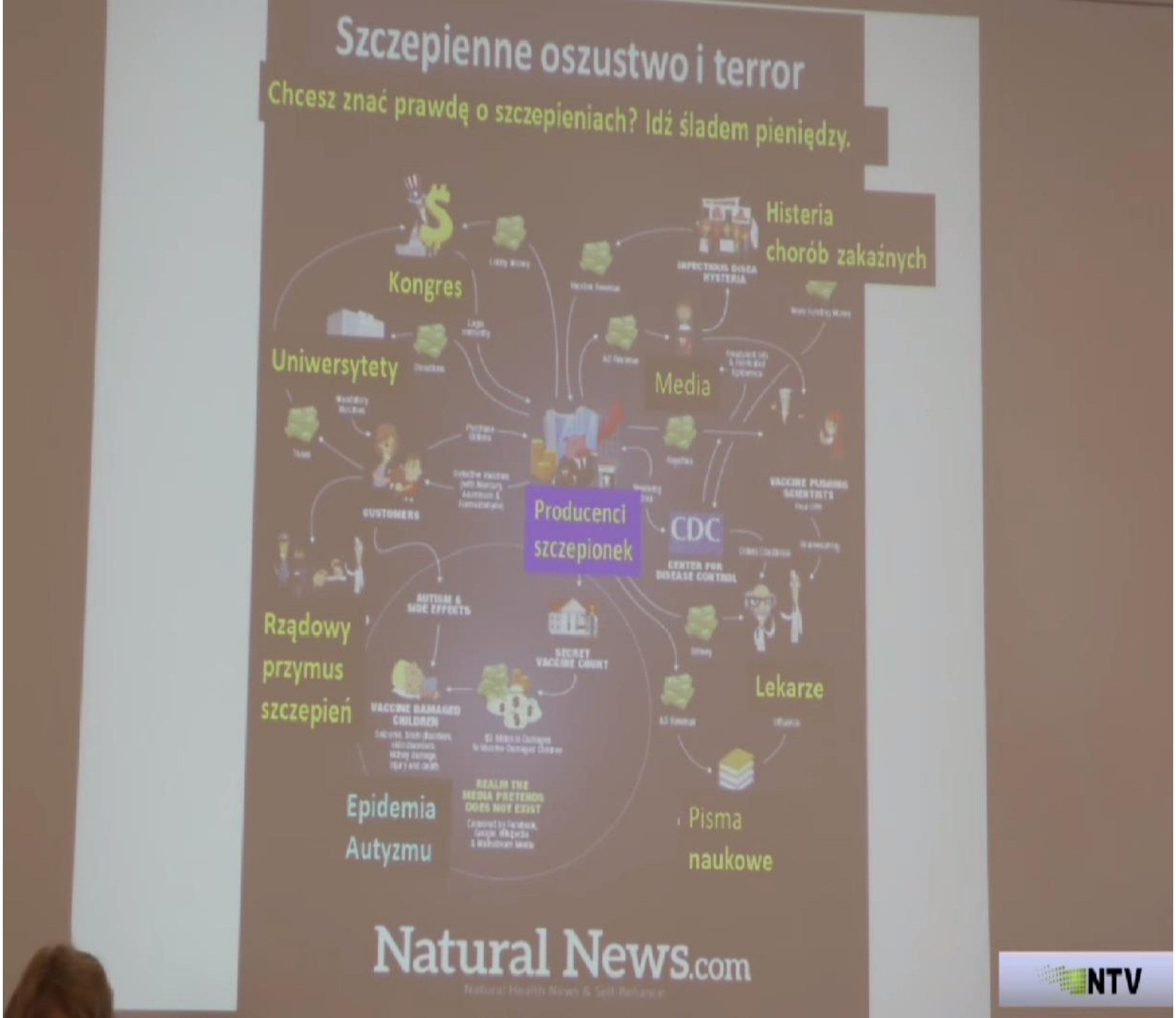
Wiek		Szczepienie przeciw	Uwagi
W 1 roku życia	W ciągu 24 godzin po urodzeniu	GRUŹLICY – śródskórnie szczepionką BCG WIRUSOWEMU ZAPALENIU WĄTROBY typu B (WZW typu B) – (pierwsza dawka szczepienia podstawowego) – domięśniowo lub podskórnie (według wskazań producenta szczepionki)	Szczepienie noworodków przeciw GRUŹLICY powinno być przeprowadzone przed wypisaniem dziecka z oddziału noworodkowego. Patrz część III PSO „Informacje uzupełniające – zasady szczepień przeciw wybranym chorobom zakaźnym": – szczepienia przeciw WZW typu B, – szczepienia przeciw GRUŹLICY, – szczepienia dzieci urodzonych przedwcześnie.

PSO 2020

MMR dawka przypominająca

- Przesunięto podanie drugiej dawki (przypominającej) szczepionki przeciwko odrze, śwince i różyczce z 10. na 6. rok życia
- W praktyce:

  Podać w 6rż. LUB w 10rż.


Szczepienne oszustwo i terror
Chcesz znać prawdę o szczepieniach? Idź śladem pieniędzy.
Kongres
Histeria chorób zakaźnych
Uniwersytety
Media
Producenci szczepionek
CDC
Rządowy przymus szczepień
Lekarze
Epidemia Autyzmu
Pisma naukowe
Natural News.com

KONTROLA UMYSŁU
poprzez przymusowe szczepienia
i technologię 5G
EWA PAWELA

Szczepienia a autyzm

Ileal-lymphoid-nodular hyperplasia, non-specific colitis, and pervasive developmental disorder in children

A J Wakefield, S H Murch, A Anthony, J Linnell, D M Casson, M Malik, M Berelowitz, A P Dhillon, M A Thomson, P Harvey, A Valentine, S E Davies, J A Walker-Smith

Summary

Background We investigated a consecutive series of children with chronic enterocolitis and regressive developmental disorder.

Methods 12 children (mean age 6 years [range 3–10], 11 boys) were referred to a paediatric gastroenterology unit with a history of normal development followed by loss of acquired skills, including language, together with diarrhoea and abdominal pain. Children underwent gastroenterological, neurological, and developmental assessment and review of developmental records. Ileocolonoscopy and biopsy sampling, magnetic-resonance imaging (MRI), electroencephalography (EEG), and lumbar puncture were done under sedation. Barium follow-through radiography was done where possible. Biochemical, haematological, and immunological profiles were examined.

Findings Onset of behavioural symptoms was associ[illegible] by the parents, with measles, mumps, and rub[illegible] vaccination in eight of the 12 children, with meas[illegible] infection in one child, and otitis media in [illegible]. All 12 children had intestinal abnormalities [illegible] from lymphoid nodular hyperplasia to [illegible] ulceration. Histology showed patchy chronic infla[illegible] in 11 children and reactive ileo[illegible] hyperplasia in seven, but no granulomas. Be[illegible] disorders included autism (nine), disintegrati[illegible] (one), [illegible] possible postviral or vaccinal encephalitis [illegible]. There were no focal neurological abnormalities and [illegible] and EEG tests were normal. Abno[illegible] laboratory results [illegible] significantly raised urinary [illegible] acid compared with age-matched contro[illegible] (p[illegible]03), low haemoglobin in four children, [illegible] low [illegible] IgA in [illegible] children.

Inter[illegible]ation [illegible] associated gastrointestinal di[illegible] and [illegible] regression in a group of prev[illegible], which was generally associated in time [illegible] possible environmental triggers.

Lancet 199[illegible]**351**: 637–41

See Commentary page

Introduction

We saw several children who, after a [illegible] of apparent normality, lost acquired skills, inclu[illegible] communication. They all had gastrointestinal [illegible]mptoms, [illegible]luding abdominal pain, diarrhoea, and [illegible]ting and, i[illegible] some cases, food intolerance. We [illegible]cribe [illegible] clinical f[illegible]ings, and gastrointestinal featu[illegible] of these ch[illegible]n.

Patients and meth[illegible]s

12 children, con[illegible]tive[illegible]ed to [illegible] department of paediatric gastr[illegible]erology [illegible] a hi[illegible]y of a pervasive developmenti[illegible]der with lost [illegible]ed skills and intestinal symptoms [illegible] abdomina[illegible], bloating and food intolerance), were inv[illegible]ated. All children were admitted to the ward f[illegible]eek, accomp[illegible]d by their parents.

[illegible]ical investigations

[illegible] took histor[illegible] including details of immunisations and [illegible]sure to infec[illegible] diseases, and assessed the children. In 11 ca[illegible] the histor[illegible] obtained by the senior clinician (JW-S). Neur[illegible] psychiatric assessments were done by [illegible]sultant staff (PH, MB) with HMS-4 criteria.[1] Developmental [illegible] included a review of prospective developmental records from parents, health visitors, and general practitioners. Four children did not undergo psychiatric assessment in hospital; all had been assessed professionally elsewhere, so these assessments were used as the basis for their behavioural diagnosis.

After bowel preparation, ileocolonoscopy was performed by SHM or MAT under sedation with midazolam and pethidine. Paired frozen and formalin-fixed mucosal biopsy samples were taken from the terminal ileum, ascending, transverse, descending, and sigmoid colons, and from the rectum. The procedure was recorded by video or still images, and were compared with images of the previous seven consecutive paediatric colonoscopies (four normal colonoscopies and three on children with ulcerative colitis), in which the physician reported normal appearances in the terminal ileum. Barium follow-through radiography was possible in some cases.

Also under sedation, cerebral magnetic-resonance imaging (MRI), electroencephalography (EEG) including visual, brain stem auditory, and sensory evoked potentials (where compliance made these possible), and lumbar puncture were done.

Laboratory investigations

Thyroid function, serum long-chain fatty acids, and cerebrospinal-fluid lactate were measured to exclude known causes of childhood neurodegenerative disease. Urinary methylmalonic acid was measured in random urine samples from

RETRACTED

Szczepienia a autyzm

OBJECTIVE: To evaluate whether the MMR vaccine increases the risk for autism in children, subgroups of children, or time periods after vaccination.

DESIGN: Nationwide cohort study.

SETTING: Denmark.

PARTICIPANTS: 657 461 children born in Denmark from 1999 through 31 December 2010, with follow-up from 1 year of age and through 31 August 2013.

MEASUREMENTS: Danish population registries were used to link information on MMR vaccination, autism diagnoses, other childhood vaccines, sibling history of autism, and autism risk factors to children in the cohort. Survival analysis of the time to autism diagnosis with Cox proportional hazards regression was used to estimate hazard ratios of autism according to MMR vaccination status, with adjustment for age, birth year, sex, other childhood vaccines, sibling history of autism, and autism risk factors (based on a disease risk score).

RESULTS: During 5 025 754 person-years of follow-up, 6517 children were diagnosed with autism (incidence rate, 129.7 per 100 000 person-years). Comparing MMR-vaccinated with MMR-unvaccinated children yielded a fully adjusted autism hazard ratio of 0.93 (95% CI, 0.85 to 1.02). Similarly, no increased risk for autism after MMR vaccination was consistently observed in subgroups of children defined according to sibling history of autism, autism risk factors (based on a disease risk score) or other childhood vaccinations, or during specified time periods after vaccination.

LIMITATION: No individual medical charts were reviewed.

CONCLUSION: The study strongly supports that MMR vaccination does not increase the risk for autism, does not trigger autism in susceptible children, and is not associated with clustering of autism cases after vaccination. It adds to previous studies through significant additional statistical power and by addressing hypotheses of susceptible subgroups and clustering of cases.

Ann Intern Med. 2019 Apr 16;170(8):513-520. doi: 10.7326/M18-2101. Epub 2019 Mar 5

10 Reasons Not To Vaccinate

36.9K 235 41 295

10 Reasons Not To Vaccinate

36.9K 235 41 295

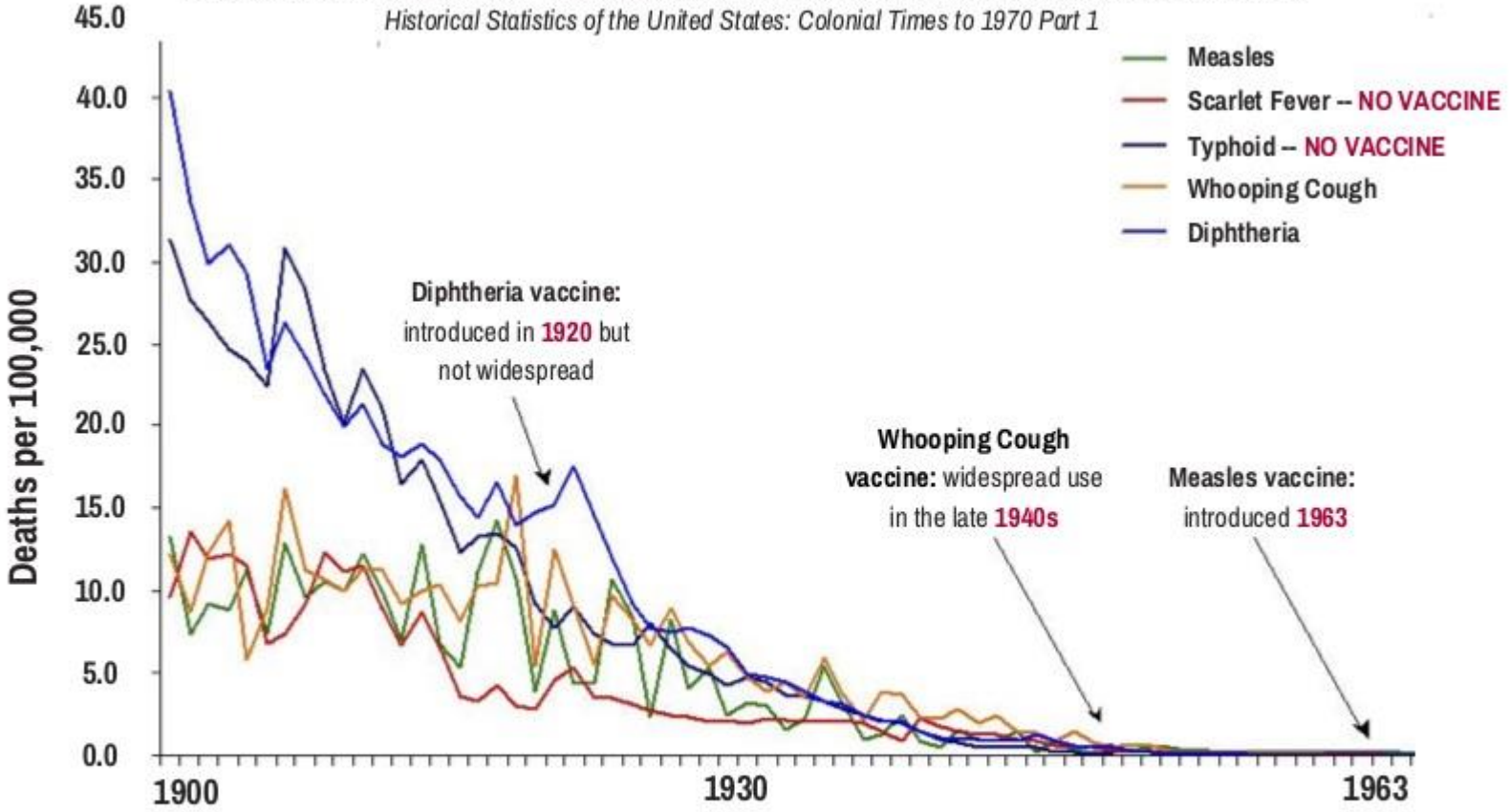
2. **Vaccines do NOT work.** They may create a temporary increase in antibodies for a particular disease, but this does not equate to immunity to disease. Vaccines, with all of their toxins and their unnatural way of introducing disease directly into one's blood stream, decrease cellular immunity, which is more critical for one's immune system. Neurologist Russell Blaylock has lectured and written extensively on this subject.

When there are outbreaks of disease, unvaccinated children are often blamed. Whenever the outbreaks are examined more closely, the data show that the majority of those suffering have been vaccinated for the disease.

Disease charts show that diseases were mostly eliminated prior to the creation of vaccinations. What is truly responsible for most communicable disease elimination is clean water and improved sanitation. See the following graphs: Disease Graphs Showing Decline of Childhood Illnesses Prior to Vaccines.

United States: Disease Mortality Rates

References: Vital Statistics of the United States 1937, 1938, 1943, 1944, 1949, 1960, 1967, 1976, 1987, 1992;
Historical Statistics of the United States: Colonial Times to 1970 Part 1



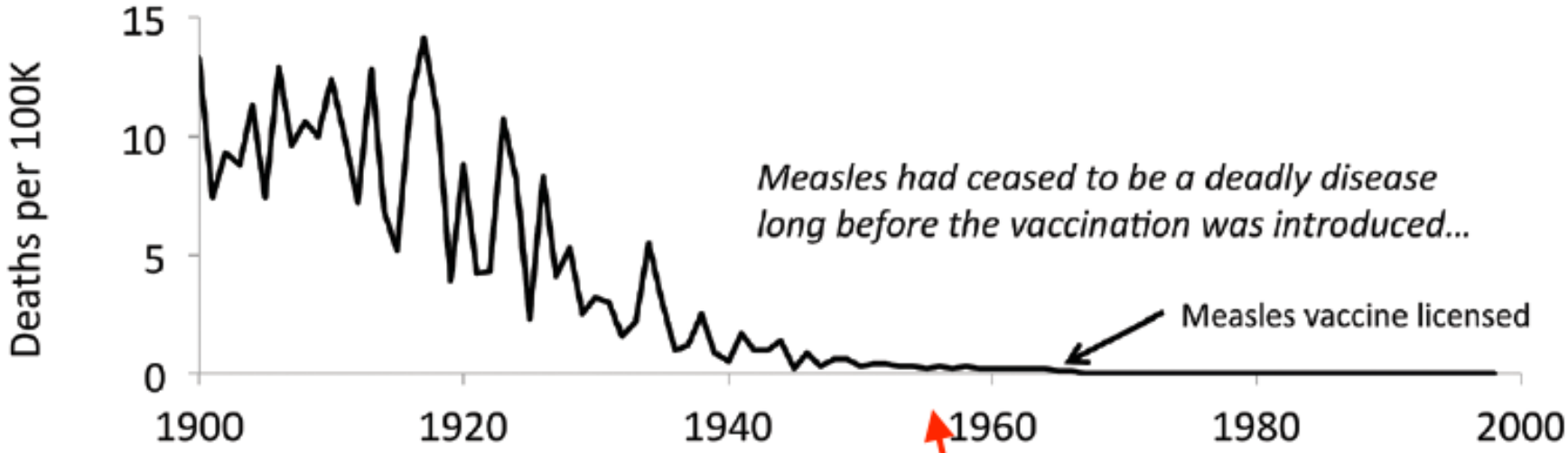
*Despite common belief, infectious disease deaths **DECREASED 85-90%* BEFORE VACCINES** were introduced in the US. Diseases **WITHOUT VACCINES** -- including Scarlet Fever, Tuberculosis, Cholera and Typhoid -- followed the **SAME** trend.*

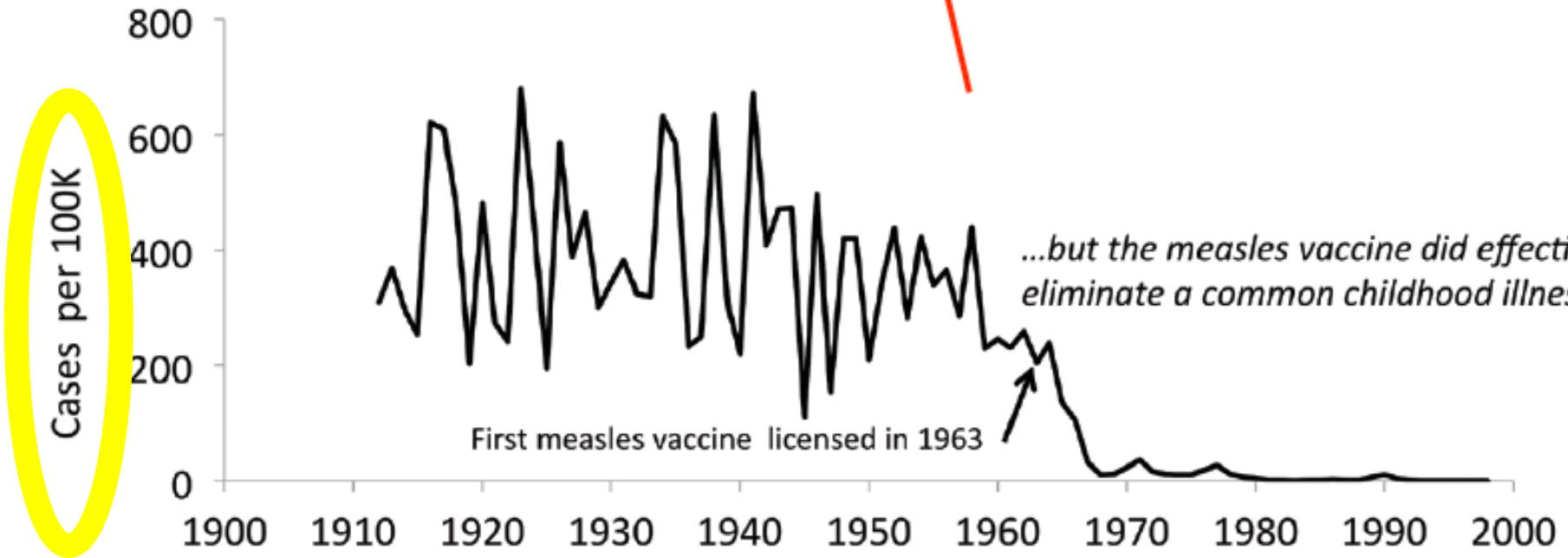
Trends in the Health of Americans During the 20th Century. Pediatrics

www.LearnTheRisk.org/diseases

Ale…

MEASLES INCIDENCE AND MORTALITY IN THE 20TH CENTURY





vaxopedia.org

Ale?

Vactruth
Your Child Your Choice

8. **The only way to create true life-long immunity to a disease is through natural exposure to the disease in which the body creates true antibodies and immunity on many levels.**

Rash first appears
on face and neck...
...Spreading quickly
to cover entire body

10 Reasons Not To Vaccinate

36.9K 235 41 295

9. **Vaccines kill infants, children and adults.** Strong evidence links vaccines to sudden infant death syndrome (SIDS). [2] More than one hundred previously healthy young women have died as a result of the HPV vaccine. [2] The flu vaccine has been documented as awarding the most

CDC:

Vaccines have not been shown to cause sudden infant death syndrome (SIDS).

Babies receive multiple vaccines when they are between 2 to 4 months old. This age range is also the peak age for sudden infant death syndrome (SIDS). The timing of the 2 month and 4 month shots and SIDS has led some people to question whether they might be related. However, studies have found that vaccines do not cause and are not linked to SIDS.

Multiple research studies and safety reviews have looked at possible links between vaccines and SIDS. The evidence accumulated over many years do not show any links between childhood immunization and SIDS.

Placing healthy babies on their backs to sleep reduces the risk of SIDS.

SIDS is the sudden, unexpected death of a baby younger than 1 year of age that doesn't have a known cause even after a complete investigation. These deaths often happen during sleep or in the baby's sleep area.

In 1992, the American Academy of Pediatrics recommended that healthy babies be placed on their backs to sleep. That recommendation, along with the National Institute of Child Health and Human Development's 1994 "Back-to-Sleep" campaign (now known as the Safe to Sleep® campaign), encouraged caregivers to place infants on their backs to sleep, and coincided with a dramatic reduction in the SIDS rate in the United States. See the latest recommendations on a safe infant sleep environment from the American Academy of Pediatrics.

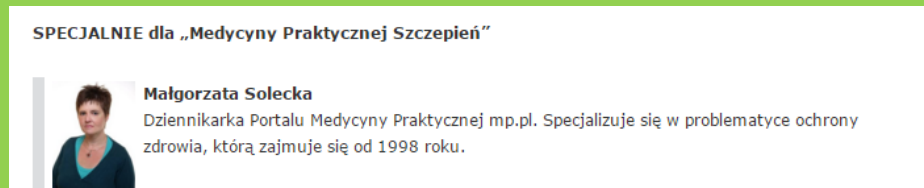
Also, research has found the rate of SIDS declined dramatically following the 1994 "Back-to-Sleep" campaign, and then stabilized in the 2000s at a time when the number of infant immunizations was increasing. The findings provide strong evidence that immunization is not linked to SIDS. See the published article on SIDS rates .

Learn more about SIDS

Learn more about CDC resources, publications, and activities to address SIDS.

”Ministerstwo Zdrowia sprawdzało, jaki odsetek lekarzy i pielęgniarek szczepi się przeciwko grypie.

…szczepieniu w sumie poddało się 10% personelu medycznego…



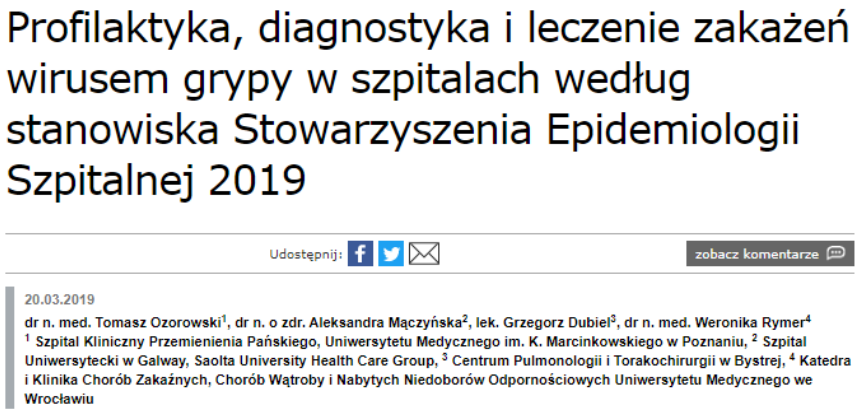
LEKARZE NIE SZCZEPIĄ SIEBIE I SWOICH RODZIN

Gdyby szczepionki były tak bezpieczne i skuteczne, jak próbuje nas przekonać medycyna, lekarze byliby pierwszymi zaszczepionymi osobami. Są oni bowiem każdego dnia

narażeni na kontakt z chorymi pacjentami: w klinice, gabinecie czy podczas wizyt u pacjentów. Należą do grupy osób z „wysokim ryzykiem". Jednakże, jak się okazuje, wielu lekarzy odmawia szczepienia siebie i swoich rodzin.

Grypa w szpitalu

- Lekarze 2-krotnie, pielęgniarki 5-krotnie zwiększone ryzyko zakażenia
- **Skuteczność szczepienia w grupie pracowników medycznych (70,5-90.5%)**



Profilaktyka, diagnostyka i leczenie zakażeń wirusem grypy w szpitalach według stanowiska Stowarzyszenia Epidemiologii Szpitalnej 2019

Udostępnij: zobacz komentarze

20.03.2019

dr n. med. Tomasz Ozorowski[1], dr n. o zdr. Aleksandra Mączyńska[2], lek. Grzegorz Dubiel[3], dr n. med. Weronika Rymer[4]
[1] Szpital Kliniczny Przemienienia Pańskiego, Uniwersytetu Medycznego im. K. Marcinkowskiego w Poznaniu, [2] Szpital Uniwersytecki w Galway, Saolta University Health Care Group, [3] Centrum Pulmonologii i Torakochirurgii w Bystrej, [4] Katedra i Klinika Chorób Zakaźnych, Chorób Wątroby i Nabytych Niedoborów Odpornościowych Uniwersytetu Medycznego we Wrocławiu

Sezon 2020/2021

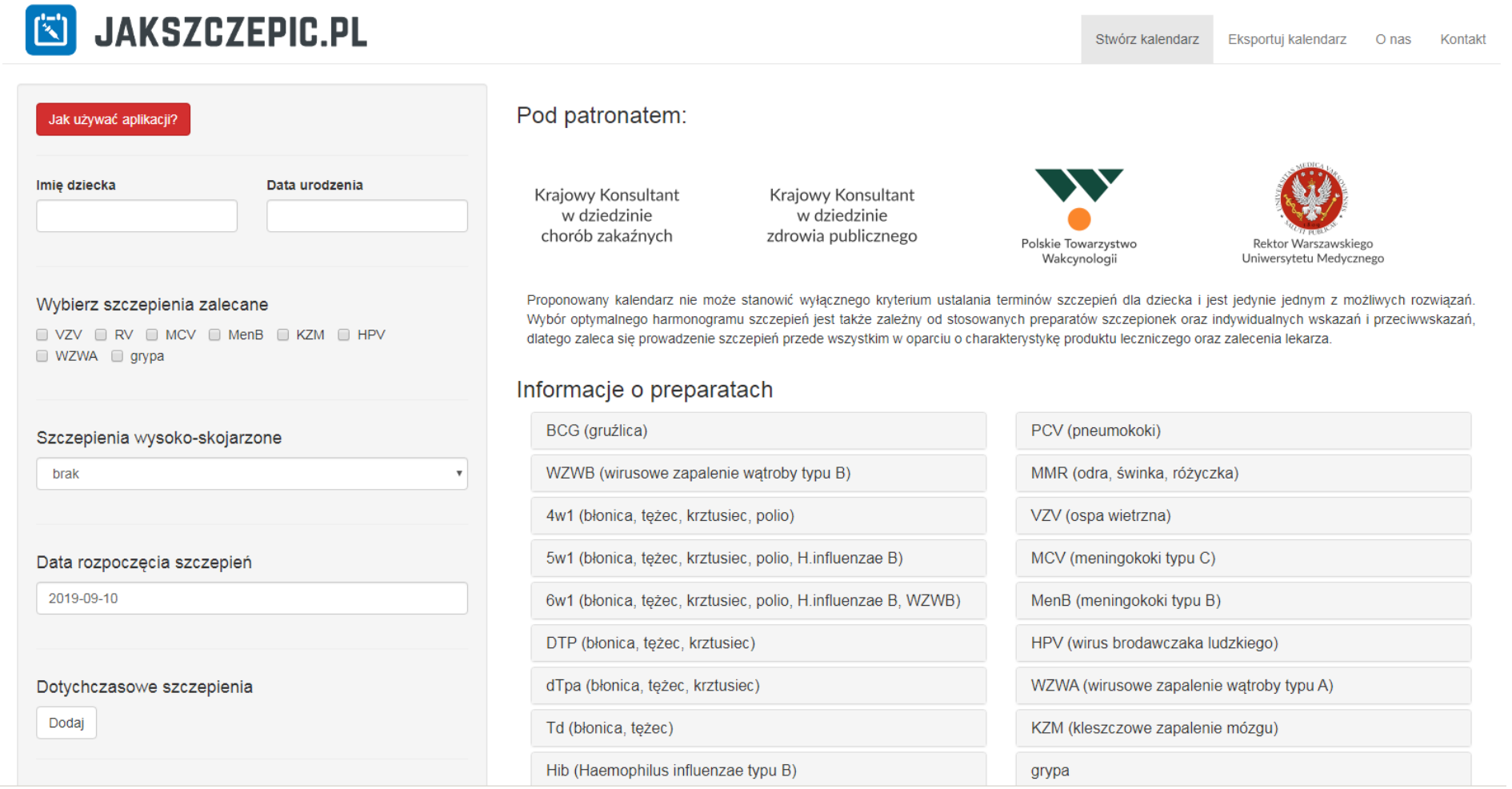
Czy zaszczepiłeś/aś się przeciwko grypie bądź planujesz szczepienie?

TAK

Nie?

Dlaczego?

Układanie Indywidualnego Kalendarza Szczepień



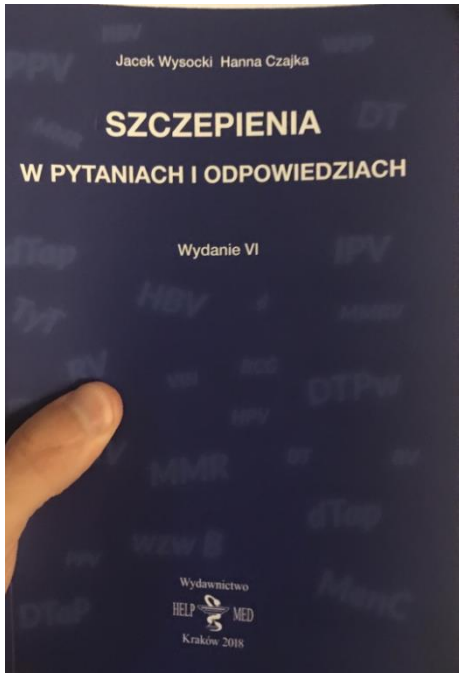
Dodatkowo..

„Pediatria przez przypadki”
Warszawa 8-9.12.2017

Mama nie chce szczepić dziecka…

Hanna Czajka

Wojewódzki Specjalistyczny Szpital Dziecięcy
im. św. Ludwika w Krakowie
Wydział Medyczny Uniwersytetu Rzeszowskiego



Odra – Profilaktyka poekspozycyjna

Szczepienie MMR preferowane u osób >12. miesiąca życia

- Rozważyć nawet od 6. mż. Wg CHPL od ukończenia 9. mż.
- Należy przeprowadzić **w ciągu 72 godzin od kontaktu**
- Szczepienie poekspozycyjne **1 dawką szczepionki**

Student medycyny – grupa ryzyka?

- **Obowiązkowe**:
  WZW B
- **Zalecane**:

- Grypa
- Krztusiec (dTpa)
- MMR
- Ospa wietrzna
- Meningokoki

https://www.mp.pl/szczepienia/specjalne/182860,szczepienie-personelu-medycznego-realia-w-polskiej-ochronie-zdrowia (artykuł z dn 02.07.2018)

Chcesz wiedzieć więcej?

- Przejrzyj kalendarz szczepień **(PSO 2020)**
- Poznaj szczepionki: żywe/nieżywe **(mp.pl)**
- Poczytaj o kwalifikacji do szczepienia **(projekt)**
- Zapoznaj się z profilaktyką poekspozycyjną (wirusy i bakterie) **(mp.pl)**
- Profilaktyka poekspozycyjna chorób zakaźnych. Cz. 1: odra

  29.08.2018

  lek. Anna Kozłowska-Jalowska, dr n. med. Andrzej Załęski, dr hab. n. med. Ernest Kuchar
  Klinika Pediatrii z Oddziałem Obserwacyjnym Warszawskiego Uniwersytetu Medycznego

COVID19 a szczepienia
Doniesienia WHO

Immunogens used to develop viral vaccines

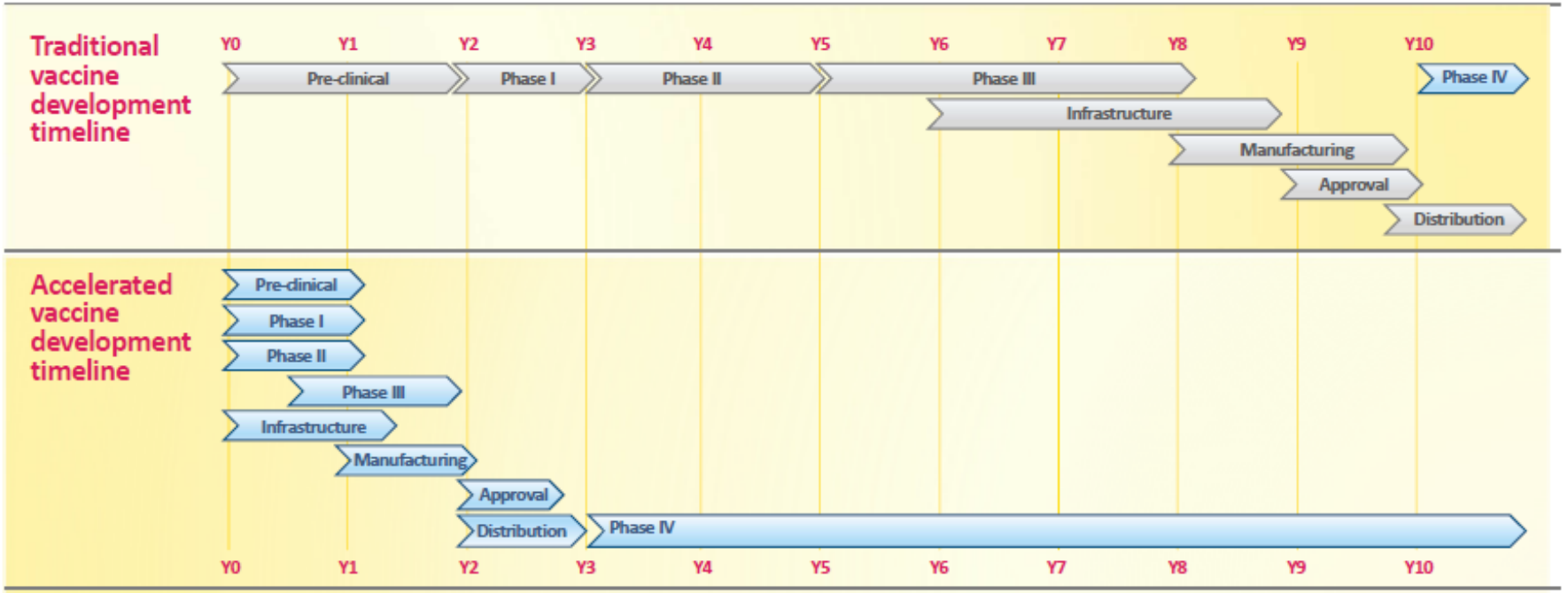
- Vaccines are being developed with different technologies — some well-known and others completely new for human vaccines, such as peptide and nucleic acid technologies

IMMUNOGEN	HOW IT WORKS	ADVANTAGE	DISADVANTAGE	EXAMPLE of vaccines
Attenuated live virus	Live virus but doesn't cause disease	Induces same response as natural infection	Not recommended for pregnant women and immunocompromised persons	Measles, rubella, mumps, yellow fever, smallpox (vaccinia)
Whole inactivated virus	Inactivated dead virus	Induces strong antibody response	Requires large quantities of virus	Influenza, rabies hepatitis A
Protein subunit	A protein derived from a pathogen	May have fewer side effects than whole virus (redness, swelling at injection site)	May be poorly immunogenic; complex process	Influenza
Recombinant	Host cell is used to express an antigen	No need to produce the whole virus	May be poorly immunogenic; High cost	Hepatitis B
Peptides	Synthetic produced fragment of an antigen	Rapid development	Poorly immunogenic; High cost	*COVID-19 vaccines in development*
Replicating or non-replicating viral vector	Viral pathogen expressed on a safe virus that doesn't cause disease	Rapid development	Prior exposure to vector virus (eg. adenovirus) may reduce immunogenicity	Ebola
Nucleic acid	DNA or RNA coding for a viral protein	Strong cellular immunity; rapid development	Relatively low antibody response	*COVID-19 vaccines in development*

Why there are so many COVID-19 vaccines in development

- There are many different COVID-19 vaccines in development because it is not yet known which ones will be effective and safe
- Based on experience, **roughly 7% of vaccines in preclinical studies** succeed. Candidates that reach **clinical trials have about a 20% chance of succeeding.**
- Different vaccine types may be needed for different population groups
- For example, some vaccines may work in older persons and some may not, as the immune system weakens with older age

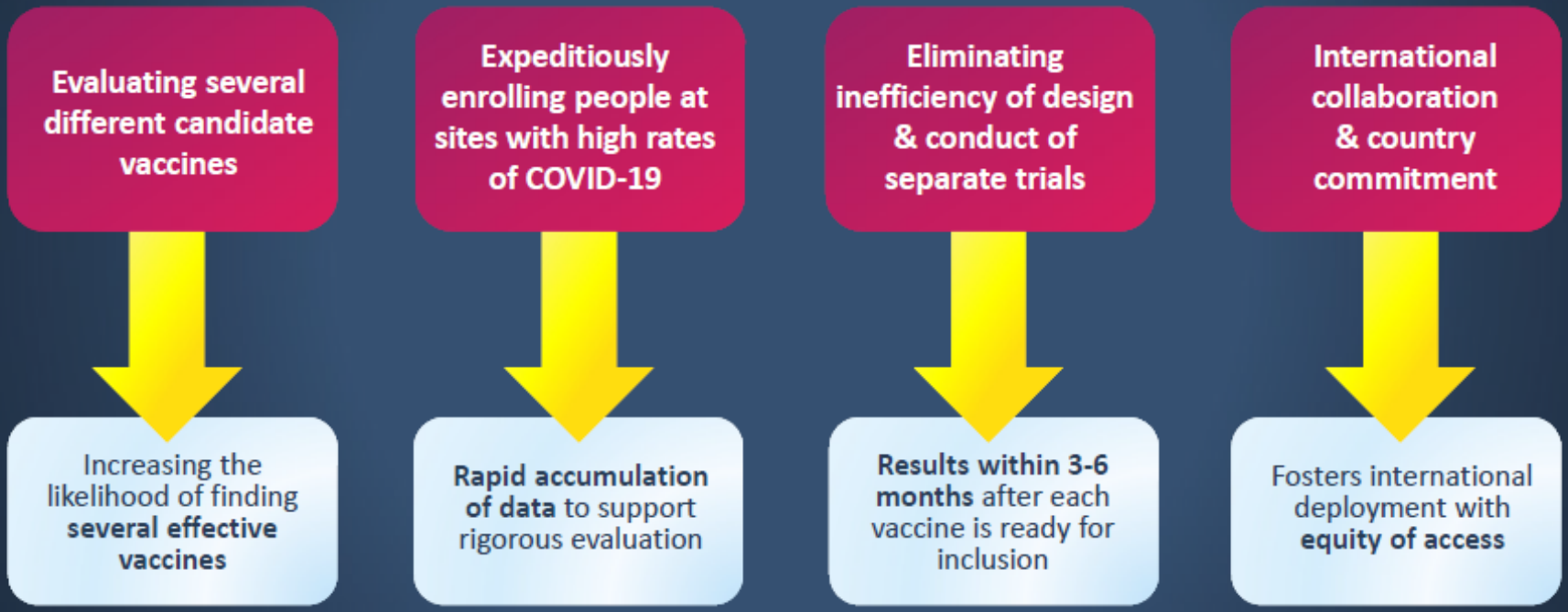
COVID-19 vaccine accelerated development



- Normal vaccine development performs each step in sequence
- To accelerate COVID-19 vaccine development, **steps are done in parallel**
- All usual safety and efficacy monitoring mechanisms remain in place; such as adverse event surveillance, safety data monitoring & long-term follow-up
- **Phase IV post-marketing surveillance** for side effects is critical and essential

WHO Solidarity vaccine trial

Achieving rapid progress towards global objectives



https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)31821-3/fulltext

Dziękuję za uwagę