

## AntiCOVID-19 Vaccines for Children

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### ABSTRACT

Emergency use authorization of the COVID-19 vaccine to prevent coronavirus disease 2019 is reported from the Medical Letter on Drugs and Therapeutics as well as from the contradictions presented by the drug producers to FDA and CDC for the messenger RNA vaccines to be approved or authorized. According to the knowledge of the first SARS and of the MERS, the children were not exposed to the civet and to the camels as the adults. The children are infected by the virus without suffering a serious illness, but they are an important source of infection. There is no COVID-19 emergency among children: there is no increase in mortality. The risks of hospitalization for COVID-19 in children are very low and often concern children with other pathologies. The children's detection of the congenital defect of the MTHFR mutation makes them hypersensitive to the vaccine for thrombotic manifestations. One myocarditis every 10.000 inoculations for young people means risking much more for the vaccine than for the virus.

**Keywords:** Children, COVID-19, Vaccine, Omicron strains, Influenza virus

### INTRODUCTION

In the leaflet of the mRNA vaccine for COVID-19 we can read that pregnant women are advised against its administration, as well as avoiding pregnancy up to two months after its inoculation (1,2). Side effects such as fever, headache, joint pain et al are also reported; allergic reactions, new infections i.e. flu, or worsening of symptoms; autoimmune diseases (3,4).

For children and adolescents, the risk of contagion is zero. Absurd to argue that children should receive the vaccine, to prevent infecting vaccinated grandparents!

If grandparents and the frail people are vaccinated why vaccinate the children whom we have seen do not die with Covid? How is it possible that it is written in the leaflet of current vaccines that there is a risk of autoimmune diseases and we don't really take it into account? You risk Kawasaki syndrome, it involves heart inflammation, but there is also the danger of autism.

Even the WHO has declared it unnecessary to vaccinate children when millions of frail people around the world need it, but there are not enough doses. However, you look at it, the situation could be decisive. The scientific community remains highly divided.

Hopefully this will not happen, since we are talking about children, but if after the inoculations of the anti-Covid vaccine there were serious adverse reactions or even deaths, the justifications used for the mass vaccination of adults this time could not hold up, given the absence of deaths

of children during Covid, as well as the substantial statistical irrelevance of mortality in that age group.

The Italian Drug Agency (AIFA) has reported an update on the risk of myocarditis and pericarditis with mRNA vaccines (03-12-2021) which follows the same update by the European Medicines Agency (EMA) (29/11 2/12-2021).

One myocarditis per 10,000 inoculations for young people means much more risk from serum than from the virus.

Since children infected with SARS-CoV-2 are usually asymptomatic or with mild symptoms, there is no emergency for them. On the other hand, the increase in infections did not cause an increase in mortality (5). On the other hand, the risk of hospitalization for COVID-19 in children is also very low (6).

Pediatric multisystem inflammation syndromes (MIS.C) is rare/very rare as long COVID symptoms are mild.

Since vaccine-induced protection is very low over time, herd immunity is not achieved and on the other hand the number of children in vaccine trials has been insufficient (7); finally, it is not ethical to vaccinate children to indirectly protect others.

In conclusion, the risks of pediatric vaccination outweigh the benefits and adverse events could increase with boosters, planned at least every year.

## **METHODS**

The main question is where it comes from the new coronavirus? Observing the new sequences, resultable comparable to what we already know, so it seems that it is a recomcombination of previously known coronaviruses.

As of January 20, 2020, 14 genomic sequences of 2019-nCoV have been communicated by 6 of several laboratories that report to the National Center for Genbank of Biotechnology Information and GISAID (Global Initiative on Sharing All flu data).

The molecular mechanisms that underlie it of its functionality and the pathogenesis of new virus have been studied by researchers of the Chinese Academy of Medical Sciences and from the Union Medical College of Beijing, using 3 genomes of the COVID-19, which have been sequenced from samples collected on 2019-12-30 and on 2020-01-01 by the National Institute Viral Disease Control and Prevention (which is part of the CDC Chinese) and are available via GISAID.

These genomic sequences have been paragonated to bat SARS-type coronavirus, to coronavirus of human SARS and to coronavirus of human MERS. Only 5 nucleotides were found different out of a total of 29800 nucleotides of the 3 genomes of COVID-19; 14 “open reading”, ie fragments, were also identified, capable to code for 27 proteins, including 4 structural proteins and 8 accessory proteins. Previous research indicates that the accessory proteins may mediate the response of the host cell towards the virus, which can affect pathogenicity and may be part

of virus particle. Structural proteins are well retained among all coronaviruses, while those accessories are generally unique to each specific group of coronaviruses. The sequences of the amino acids show the connections of these new viruses to the bat SARS-like coronaviruses and a less distance from the coronavirus of SARS. Even more distant is the relationship of COVID-19 from the MERS coronavirus (8, 9).

## RESULTS

According to the experience of the first SARS and of MERS, children were not exposed to civet and camels; in a similar way it is thought it could happen with SARS from COVID-19. Indeed, children are infected from the virus without suffering serious illness, but they represent an important source of infection (10, 11).

The virus is found in their rectal swabs. Growing up, with age many specific cells of the immune system are no longer active and therefore the body loses its ability to respond so effectively. In fact, it has been tried experimentally that young mice respond to lung tissue damage from viral infection by prostaglandins, while adult mice succumb.

The juvenile immune system and its efficiencies Helper T cells respond to COVID SARS 2. Helper cell CD4 lymphocytes stimulate B cells to produce antibodies against the virus and control the infection. In this case Th2 lymphocytes are able to control the re-inflammation caused by the viral infection, preventing an exuberant and delayed reaction as occurs in adults. The different hormone structure and the same proglansins favor the female subject towards the coronavirus responsible for the pandemic.

Another important discourse concerns the ACE2 receptor, i.e., angiotensin-converting enzyme 2. Both the first SARS and the current one has the same cellular entry route through this receptor for coronaviruses. The receptor is particularly abundant on the cells of lower pulmonary tracts, the situation of which explains the high incidence of bronchitis and related pneumonia to the severe infection of COVID-19. The same receptor is abundantly represented on the mouth and on the tongue, facilitating the viral entry of the oral host organism. Despite its reduction with adulthood, the ACE2 enzyme is an important regulator of the immune response: in particular inflammation protects mice against damage acute lung disease triggered by sepsis. In the 2014 it was demonstrated that the enzyme ACE2 pro-holds against lethal avian influenza.

Some of the best-performing patients had high protein levels in their sera.

By blocking the gene for ACE2, a severe lung damage in mice infected with H5N1, while treating mice with ACE2 human decreased lung damage.

A fall in ACE2 activity in the older subject is partly responsible for the diminished ability to reduce the inflammatory response with old age. The reduction of ACE2 receptors in older adults it enables them to not being able to cope with COVID-19.

We are not all the same and it cannot be imposed indiscriminate and everywhere use of the mask. Only the infected must wear masks and must have accourteousness with distances when they attend people at risk. But the mask cannot be imposed on children. At least up to 12 years

old. The hygiene rules must be observed carefully by all, with common sense. On the other hand, the use of masks under six is completely prohibited (WHO), since one could induce a functional "autism", because there are three areas of the cerebral cortex in evolution on the basis of associations and emotions that a child understands at that age.

A study published (12) shows that fragments of RNA can persist, even in the cavity nasal, for weeks, after the infection is already been eradicated (therefore no virions persist such within the body). This, together to cross-reactivity phenomena (positivity towards coronaviruses similar to Sars-Cov-2, linked to use of high concentrations of the primer of PCR trigger, is the basis of false positives PCR, which, therefore, do not represent the reference method for mass tracking. An that the method for establishing the current yellow zones, orange and red by calculating the assumptions "get infected" is wrong; they are imposing borders on us absolutely useless lies and closures from the point from a health point of view.

The detection of asymptomatic positive cases in the post-lockdown Wuhan has been very low (0.303/10,000) and there was no evidence than the cases identified as positive asymptomatic they were infectious (13).

These observations allowed the decision of the authorities to adjust the strategies of prevention and control in the post-period lockdown. Further studies are required to fully evaluate the amount and the actual cost of citywide infection screening SARS-CoV-2 on health, behavior, the economy and social relations of the population.

A hypothesis that can explain the disparity between the Africa and the other continents concerns the total age of the population. In general, the population of Africa is younger than in the regions most affected by COVID-19. Some researchers have shown that other human coronaviruses that cause common colds can lead to an immune response that could provide protection against COVID-19.

The same crowded neighborhoods that would have brought to the rapid spread of other coronaviruses

they may have protected the population from SARS-CoV-2.

A certain level of preexisting immunity protection may explain why the epidemic did not occur, as it did in other parts of the world. According to the professor Shabir Madhi "protection could be much more intense in highly populated areas, in African contexts. He could explain why the most people on the continent suffer from asymptomatic or mild infections " (14) for crossing immunity in the family environment of the betacoronaviruses transmitted by zoonoses.

## **DISCUSSION**

Once it's reactivated, the immune system produces only and exclusively the necessary antibodies (15), with precision and efficacy surprising the deficiency. Most viruses anymore common and less aggressive are made out in this way, usually within a few days. New viruses are addressed with a similar approach (16).

The only difference is that the immune system has no memory of them because it has never met them earlier, so it takes longer to produce the necessary antibodies (17).

Meanwhile, the innate part of the immune system continues with its reaction to broad beam for much longer than necessary. The acquired side has finished and won the real battle, the innate part does not realize it and continue to fight as if nothing happened. And for this reason sometimes the nose that drops fluid, sore throat and cough may last for weeks, even after a quite modest viral infection. Therefore, empower your own immune system would not be a very good idea.

Over-the-counter products cannot boost the acquired part of the immune system. In the treatment of viruses that cause symptoms such as cold, the most important thing is to suppress, don't boost, the clumsy and crude answer of the innate part of our immune system. And for this reason, that you take medicines for reduce fever and antihistamines. Even if a little natural tending were possible, the concept to its basis is wrong. In extreme cases, one overreaction to an infection can even led to changes in our vascular system, leading to sepsis of opportunistic infections (18).

### CONCLUSION

A messenger RNA vaccine can alter cellular DNA by transcribing viral sequences integrated into the genome by a reverse transcriptase” of the cells or a reverse transcriptase of an HIV and these DNA sequences can be integrated into the cellular genome (19). This “transcriptase” was already well known with another coronavirus.

The SARS-CoV-2 spike impairs the repair and inhibition of DNA damage such as recently tried by recombination virus vaccine in vitro (Hui J and Ya-Fang M).

New individuals are very unlikely to be born since the parents are unable to produce viable offspring due to the DNA damage in sperm and egg cells.

There is no Covid emergency among children. There is no increase in mortality from Covid among the children. The risks of hospitalization for Covid in children are very small: 1 in over 46,000 diagnoses of COVID-19, and often concern children with other pathologies. AIFA reported to an update on myocarditis risk e pericarditis with mRNA vaccines (03-12-2021) which follows the same update by of the EMA (29/11 2/12-2021). A myocarditis every 10000 inoculations for young means risk much more for the serum than with the virus (20).

For the two mutations of MTHFR the risk is increased with the high value of circulating homocysteine for thrombotic manifestations. In this situation the child is hypersensitive to the vaccine content (20).

The past Fall and Winter seasons we were dealing with epidemic flu, SARS-CoV-2 Omicron strains and hRSV without much trouble according to the majority of pediatric doctors (21).

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