Whooping Cough

by Michael Nightingale

Whooping cough us a so-called infectious disease characterised by paroxysmal coughing which is the cause of the typical "whoop". It arises mainly as a result of a catarrhal condition of the upper respiratory tract and is usually only seen in young children. The paroxysmal coughing may cause alarm in young parents because the child appears to be choking whilst trying to get his breath between the bouts of explosive coughing. One of the main causes of the condition is wrong feeding and the chief culprits are refined starchy foods and milk: the typical toddler's diet! There is also no doubt at all that it is more prevalent where there is poor hygiene, overcrowding, lack of sanitation and under-nutrition.

The proper remedy for the disease is sound nutrition and good living conditions which ensure that a child will not contract the disease or if he does it will he a mild episode. When the illness is contracted the child should rest, take a diet of spring water and a little fruit juice for three days followed by a fuller regime of vegetables and fruit. The vegetables and fruit may be taken in the form of juice or may be conservatively cooked. They should not be eaten at the same meal and no other foods should be permitted until the child feels well. Compresses should be applied to the throat area until the coughing and respiratory discomfort have eased. Plenty of water should be taken and this should preferably be spring water rather than ordinary tap water. If this regime is adhered to there is no danger of adverse complications and complete recovery will be both rapid and without trauma.

Vaccination for whooping cough is obviously incapable of dealing with the basic problem which has been identified and should therefore be abandoned in favour of a programme of health building through proper diet, exercise, fresh air and rest. However, even allopathic doctors who may not always agree with the basic cause of whooping cough which has been described, are embroiled in a never-ending controversy regarding the desirability of whooping cough vaccination: one group saying that it is needed so that the disease can eventually be eliminated and that deaths from complications can be prevented, whilst the other group contend that the protection from the vaccine is so poor that the risk of post-vaccinal encephalopathy (which may be fatal) exceeds the advantage or pay-off from the vaccine.

What we have to understand before we can make any rational appraisal of whooping cough vaccination is that if the underlying pathology is already present, a vaccination, even if it is effective, does nothing to eradicate this state. If it succeeds in preventing whooping cough it merely leaves the child susceptible to some other condition such as

bronchitis, flu or perhaps a respiratory syncitial virus infection. If all these are avoided, the child will be unable to throw off toxins which have accumulated and will be a candidate for a much more serious degenerative condition in later life: So in fact we have it both ways. If the vaccine works it is unfortunate since we are merely swopping whooping cough for some other disease which may be more serious, and if it doesn't then there is no point in having it in the first place.

Often the protective value of whooping cough vaccine has been as low as 20%, which, considering the risks involved in the vaccination, must make it one of the worst vaccines available from both a cost effective and relative risk point of view. Dr A. B. Christie, writing in C*ommunity Health* in 1971, said that some of the figures for the incidence and mortality for whooping cough reflects low standard of health services with little if any whooping-cough immunisation, but the rise in incidence and the occurrence of cases in vaccinated children cannot be explained in this way, for whooping cough vaccine has been included in the routine triple vaccine offered to infants in Britain throughout the period under consideration. The whooping cough incidence per 100,000 in England and Wales rose from 17.8 in 1962 to 69 in 1967 and many cases occurred in vaccinated children.

More recently, in the *British Medical Journal* in 1979 Dr Ditchburn reported his findings concerning an epidemic of whooping cough in a rural practice in Shetland. Before 1974 all children were 'immunised' for pertussis but after that date immunisation was stopped. The epidemic in 1977 was, therefore, viewed with apprehension. Whereas nearly all children over 3 ¼ had been immunised, none under that age had been immunised for pertussis. The important point in Dr Ditchhurn's article is that there was no significant difference in the proportion of children developing whooping cough between those born after immunisation had been discontinued nor was there a significant difference in the incidence of whooping cough between the 'immunized' and 'non immunised'. Moreover, there was no apparent decline in vaccine induced immunity in older children against younger ones, which counters the suggestion that pertussis immunisation decreases with time. The 'discovery' that vaccinated and unvaccinated children develop diseases in similar proportions has been noted many times previously in several conditions: particularly whooping cough and diphtheria, thus illustrating that the real cause for the decrease in these diseases lies elsewhere. Before looking at this more closely, it is also worth noting that Dr Ditchburn reported that the condition was relatively mild in social classes 1-111. that no child required admission to hospital and that none suffered permanent damage. All this without the benefit of the care described at the outset of this article. In his study of'whooping cough vaccination Dr Ditchburn states that one child started convulsing on the night of his second vaccination and required antiepileptic treatment for seven years. This child developed whooping cough eight

years after the vaccination in the 1977 outbreak. It will come as no surprise that this doctor ended his article with the statement that his findings did not support the routine use of pertussis immunisation in rural Shetland.

Space does not permit the reporting of numerous articles in similar vein involving urban children as well as rural ones. Perhaps we could conclude this aspect of the matter by quoting Dr T. Pollock, who said in 1970 that it was found in a survey begun in 1967 that about 56% of fully vaccinated children under four years developed whooping cough when exposed to pertussis in the home. This is only a little less than that in unvaccinated children *(Proceedings of the Royal Society of Medicine* 1970, 63, 8, 811).

It is common knowledge that whooping cough, like measles, scarlet fever and diphtheria, is a very much less severe disease than in times past, and it is the generally accepted idea that vaccination has been mainly responsible for this. In fact nothing could he further from the truth. Scarlct fever declined dramatically in both morbidity and mortality without vaccination and for the most part prior to the advent of antibiotics. Measles declined in a similar fashion prior to the introduction of vaccination and, being a viral disease,' is not affected by antibiotics. In any case, like scarlatina, it had already declined dramatically prior to the advent of the first antibiotics. Diphtheria also declined prior to the national campaign of immunisation. Whooping cough, just as these other diseases, had also changed and mortality in particular had been reduced from an average of 512 per million in England and Wales from 1871-80 to a mere 2 per million by 1956, one year prior to the introduction of the national vaccination programme. Even by 1930, long before the introduction of vaccination or modern drug therapy, the mortality had decreased to 51 per million.

The graphs in Figs 1-3 show this very well. Fig one shows the decline of three zymotic diseases:

whooping cough, scarlet fever and smallpox. Fig 2 shows the decline in mortality from whooping cough and measles. Fig 3 shows the decline in mortality from whooping cough in children under 15 years of age with an indicator showing the introduction of vaccination. It is clear that the vaccination programme was introduced ***after*** the disease had declined: not before. Fig 4 shows a close-up of mortality decline in the period 1950-1976, i.e. just prior to and just after the introduction of widespread vaccination.

It cannot be adduced from the graph that vaccination has altered in any way whatsoever the trend in mortality from this disease. As to notifications, there is some

indication that these did fall after the introduction of whooping cough vaccination (Fig 5) but there is no evidence to support the assumption that this has had the slightest favourable influence on mortality or general health.

The decline in severity in the zymotic diseases which took place from the end of the last century was doubtless due to sanitation, better nutrition, better housing, and improved hygiene rather than to any specific medical measures. Had whooping cough vaccine been discovered in the nineteenth century it might have been useful but, certainly for the western world, it has little or no value today. Even if it was entirely safe there would be little to recommend it, but in fact it is also one of the more hazardous vaccines in current usage.

It is always difficult to obtain accurate information concerning the ill-effects of vaccination because administrators of the vaccine are always unwilling to attribute such untoward reactions to the vaccine. A survey in Dublin *(cf British Medical Journal* 27th June 1972) indicated that 2 per 1,000 children had a moderate reaction as a result of triple vaccine administration and 0.6 had a severe reaction. This means that for every million children vaccinated there will be approximately 2,000 suffering from moderately severe reactions including screaming episodes and drowsiness, whilst 60 will suffer from severe reactions. Strom in 1967 *(British Medical Journal* 1967, *4,* 320-323) reported neurological reactions in 167 cases out of 516,276 vaccinees, which gives a rate of 0.32 per 1,000. These included destructive encephalopathy, hypsarhythmia, shock, uncontrollable screaming and serous meningitis. Apart from these reactions he also reported skin and gastrointestinal complications.

To summarise, we have produced sound evidence to show that:

1. Whooping cough is a mild condition in otherwise healthy children and leaves no permanent damage. When correctly treated it serves only to enhance health.

2. Whooping cough vaccine is generally of *low* efficacy and carries considerable risk of side effects which may include permanent brain damage.

3. Lowering of whooping cough rates does nothing to alter the general mortality rate.

4. The suppression or prevention of acute conditions may lead to later degenerative conditions of a much more serious nature.

We can only conclude that whooping cough vaccination is not at present advisable for normal children in the U.K. but may be useful for children who live in overcrowded conditions and suffer poor nutrition. This is even more the case if they are likely to be treated by inadvisable methods if they contract the disease.

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