

EFFICACIA E SICUREZZA DEI VACCINI COVID-19 E OBBLIGO VACCINALE

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Conversione in legge del decreto-legge 26 novembre 2021, n. 172, recante misure urgenti per il **contenimento dell'epidemia da COVID-19 e per lo **svolgimento in sicurezza delle attività economiche e sociali****

L'uso che viene fatto del **Green Pass, e ora anche l'introduzione dell'**obbligo vaccinale** per categorie a contatto con il pubblico, continua a fondarsi sull'assunto che la non contagiosità sia garantita:**

- 1. dalla **vaccinazione**;**
- 2. dalla **guarigione**;**
- 3. dall'**esito negativo di un tampone**.**

arrivando in tal modo al contenimento della circolazione di SARS-CoV-2.

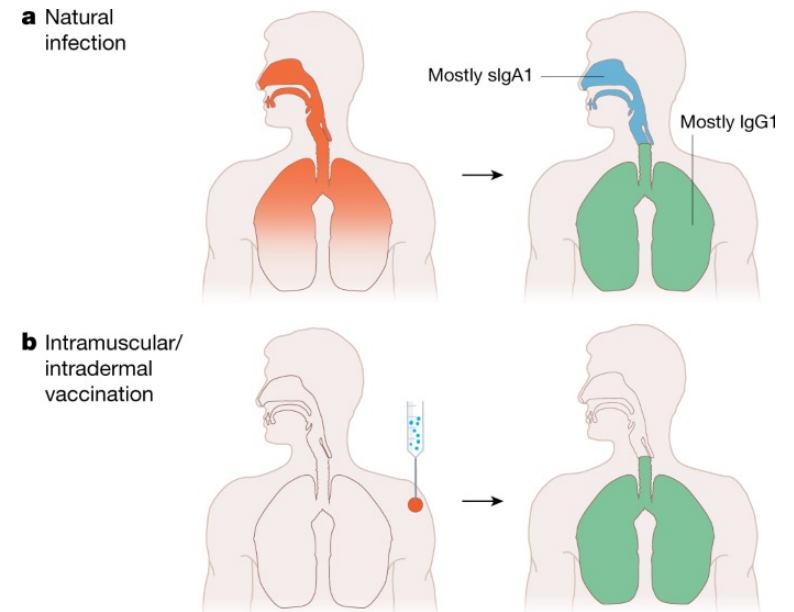
Il primo assunto è **falso, il secondo **non è documentato** e solo il terzo è **vero**.**

SARS-CoV-2 vaccines in development

Florian Krammer [Nature](#) 586, 516–527 (2020) | [Cite this article](#)473k Accesses | 586 Citations | 4869 Altmetric | [Metrics](#)

«However, it is important to note that natural infection induces both mucosal antibody responses (secretory immunoglobulin A (IgA)) and systemic antibody responses (IgG). The upper respiratory tract is thought to be mainly protected by secretory IgA, whereas the lower respiratory tract is thought to be mainly protected by IgG. Vaccines that are administered intramuscularly or intradermally induce mainly IgG, and no secretory IgA. It is therefore possible that **most vaccines currently in development induce disease-preventing or disease-attenuating immunity, but not necessarily sterilizing immunity.**»

Mucosal and systemic immune responses to natural infection with respiratory viruses and to vaccination



PROTEZIONE DA SARS-CoV-2 e COVID-19

mesi

1 2 3 4 5 6 7 8 9 10 11 12

vaccino

ricovero/decesso



COVID-19 sintomatico



trasmissione del contagio



guarigione

contagio



VACCINI COVID-19 E PROTEZIONE DAL CONTAGIO

Eyre DW, et al. **The impact of SARS-CoV-2 vaccination on Alpha & Delta variant transmission.** *medRxiv* 2021.09.28.21264260; doi: <https://doi.org/10.1101/2021.09.28.21264260>

Harris RJ, et al. **Effect of Vaccination on Household Transmission of SARS-CoV-2 in England.** *N Engl J Med.* 2021 Aug 19;385(8):759-760.

Shah ASV, et al. **Effect of Vaccination on Transmission of SARS-CoV-2.** *N Engl J Med.* 2021 Oct 28;385(18):1718-1720.

Singanayagam A, et al. **Community transmission and viral load kinetics of the SARS-CoV-2 delta (B.1.617.2) variant in vaccinated and unvaccinated individuals in the UK: a prospective, longitudinal, cohort study.** *Lancet Infect Dis.* Published: October 29, 2021 DOI: [https://doi.org/10.1016/S1473-3099\(21\)00648-4](https://doi.org/10.1016/S1473-3099(21)00648-4)

Shamier MC, et al. **Virological characteristics of SARS-CoV-2 vaccine breakthrough infections in health care workers.** *medRxiv* 2021.08.20.21262158; doi: <https://doi.org/10.1101/2021.08.20.21262158>

LETTER | VOLUME 11, 100272, DECEMBER 01, 2021



The epidemiological relevance of the COVID-19-vaccinated population is increasing

Günter Kampf  

Open Access • Published: November 19, 2021 • DOI: <https://doi.org/10.1016/j.lanepe.2021.100272>

«It appears to be grossly negligent to ignore **the vaccinated population as a possible and relevant source of transmission when deciding about public health control measures.»**

Review Article | [Published: 20 November 2012](#)

Under-Reporting of Adverse Drug Reactions

A Systematic Review

[Lorna Hazell](#)  & [Saad A.W. Shakir](#)

[Drug Safety](#) **29**, 385–396 (2006) | [Cite this article](#)

4100 Accesses | **892** Citations | **615** Altmetric | [Metrics](#)

- ✓ **Under-reporting rate: 94%** (interquartile range 82–98%);
- ✓ No difference between **general practice** and **hospital**;
- ✓ Some **general practice** show higher under-reporting rate for all ADRs compared with more serious or severe ADRs (**95%** and **80%**, respectively);
- ✓ Some **hospitals** show high under-reporting rate for more serious or severe ADRs (**95%**).

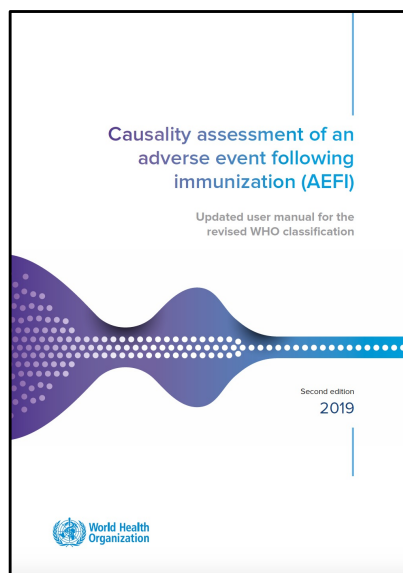


Fig. 3. Causality assessment algorithm

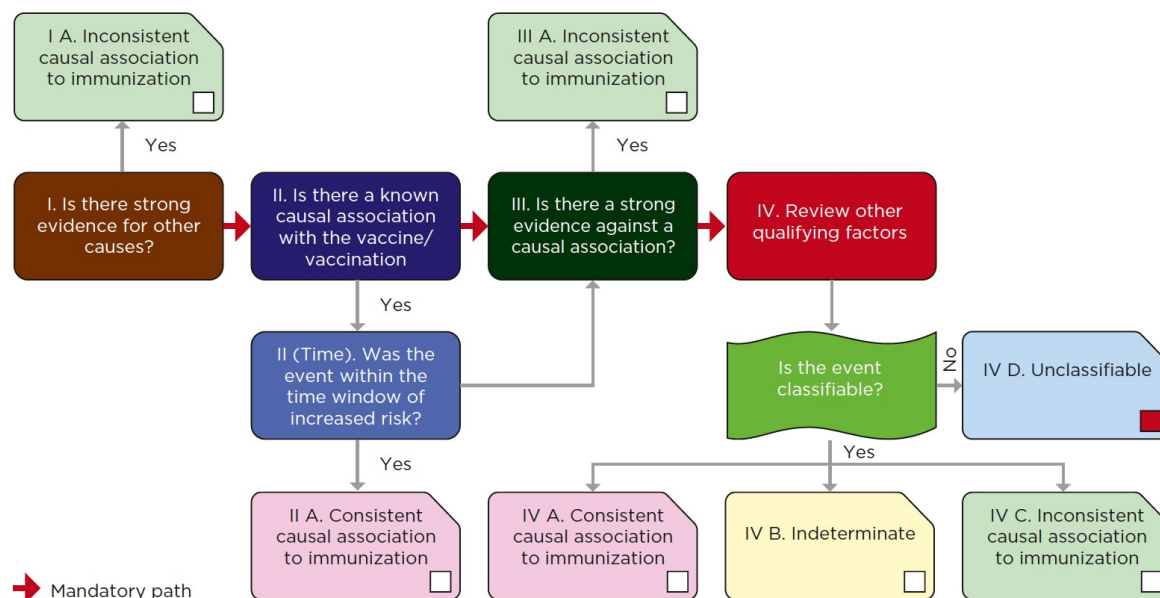
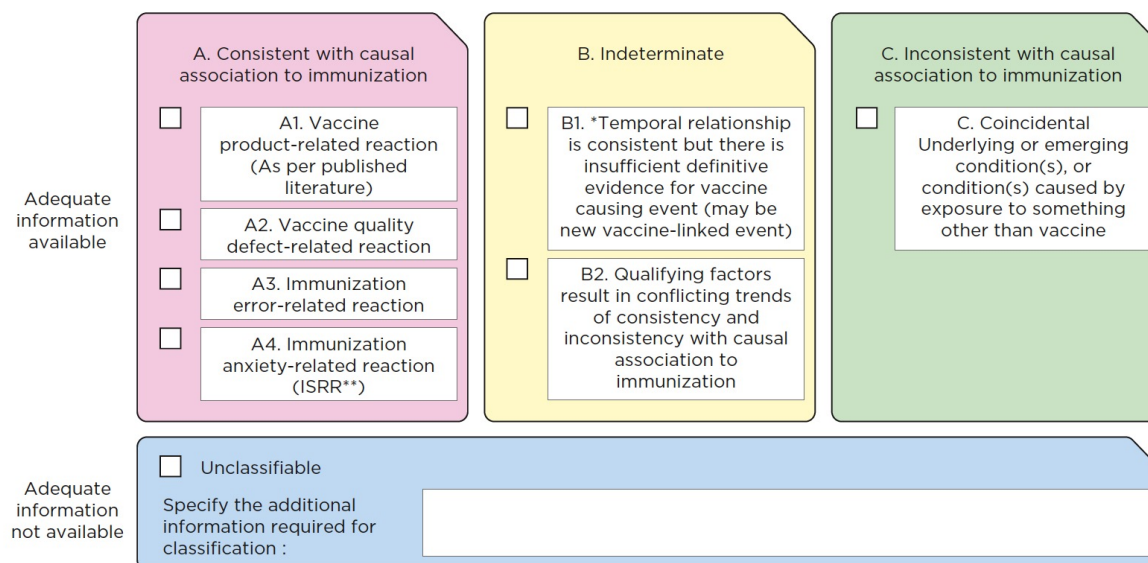


Fig. 4. Causality assessment classification



*B1 : Potential signal and maybe considered for investigation
** Immunization stress related response

ORIGINAL ARTICLE

Safety of the BNT162b2 mRNA Covid-19 Vaccine in a Nationwide Setting

Noam Barda, M.D., Noa Dagan, M.D., Yatir Ben-Shlomo, B.Sc., Eldad Kepten, Ph.D., Jacob Waxman, M.D., Reut Ohana, M.Sc., Miguel A. Hernán, M.D., Marc Lipsitch, D.Phil., Isaac Kohane, M.D., Doron Netzer, M.D., Ben Y. Reis, Ph.D., and Ran D. Balicer, M.D.

ABSTRACT

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RISK OF MYOCARDITIS

vaccination
2.7 per 100,000

SARS-CoV-2 infection
11.0 per 100,000

Neurological complications after first dose of COVID-19 vaccines and SARS-CoV-2 infection

[Martina Patone](#), [Lahiru Handunnetthi](#), [Defne Saatci](#), [Jiafeng Pan](#), [Srinivasa Vittal Katikireddi](#), [Saif Razvi](#), [David Hunt](#), [Xue W. Mei](#), [Sharon Dixon](#), [Francesco Zaccardi](#), [Kamlesh Khunti](#), [Peter Watkinson](#), [Carol A. C. Coupland](#), [James Doidge](#), [David A. Harrison](#), [Rommel Ramanan](#), [Aziz Sheikh](#), [Chris Robertson](#) & [Julia Hippisley-Cox](#) 

[Nature Medicine](#) (2021) | [Cite this article](#)

100k Accesses | 1 Citations | 1708 Altmetric | [Metrics](#)

RISK OF GBS

vaccination
0.038 per 100,000

SARS-CoV-2 infection
0.145 per 100,000

ORIGINAL ARTICLE

Myocarditis after BNT162b2 mRNA Vaccine
against Covid-19 in Israel

D. Mevorach, E. Anis, N. Cedar, M. Bromberg, E.J. Haas, E. Nadir,
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R. Dichtiar, D. Novick, Y. HersHKovitz, R. Dagan, I. Leitersdorf, R. Ben-Ami, I. Miskin,
W. Saliba, K. Muhsen, Y. Levi, M.S. Green, L. Keinan-Boker, and S. Alroy-Preis

ABSTRACT

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RISK OF MYOCARDITIS

second dose in males

16-19 y – 15.07/100,000

20-24 y – 10.86/100,000

25-29 y – 6.99/100,000

Table 3. Risk of Myocarditis within 21 Days after the First or Second Dose of Vaccine, According to Age and Sex.*

Age and Sex	First Dose			Second Dose		
	Recipients	Cases	Risk per 100,000 Persons	Recipients	Cases	Risk per 100,000 Persons
	<i>number</i>			<i>number</i>		
Male recipients						
All ages	2,668,894	17	0.64	2,507,210	96	3.83
16–19 yr	224,518	3	1.34	199,115	30	15.07
20–24 yr	261,741	5	1.91	239,396	26	10.86
25–29 yr	246,638	3	1.22	228,988	16	6.99
30–39 yr	491,126	2	0.41	461,044	17	3.69
40–49 yr	458,268	3	0.65	433,069	5	1.15
≥50 yr	986,603	1	0.10	945,598	2	0.21
Female recipients						
All ages	2,773,802	2	0.07	2,618,425	12	0.46
16–19 yr	219,460	0	0	199,706	2	1.00

CONCLUSIONI

Le evidenze presentate indicano che:

- ✓ la **vaccinazione** non ha effetti apprezzabili sulla contagiosità e sulla circolazione di SARS-CoV-2, ed è quindi un pericoloso equivoco fondarvi un qualsiasi (**super**) **Green pass** che induce malintesi sensi di sicurezza e soprattutto consente la circolazione di un enorme numero di persone potenzialmente contagiose;
- ✓ i benefici della **vaccinazione** presentano ben precisi limiti di intensità e durata e sono molto differenti per età e fattori di rischio;
- ✓ i rischi della **vaccinazione** sono solo parzialmente noti, e tuttavia – malgrado i limiti dei sistemi di rilevazione delle reazioni avverse – sono paragonabili o superiori ai benefici attesi per molte categorie.

Per queste motivazioni, i fondamenti del **Green pass** e dell'**obbligo vaccinale** come strumenti per la promozione di salute e sicurezza pubblica sono non solo inconsistenti bensì rendono questi due strumenti rischiosi per la salute e la sicurezza collettive e individuali.