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# Increased Risk of Myocarditis: Doctor Who Promoted COVID Shots on TV Calls for Global Stop to COVID-19 Vaccines

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*Lately, Dr. Aseem Malhotra, a British cardiologist who was previously supportive of COVID-19 vaccines has been the topic of breaking news stories for demanding a global stop to the distribution of the same vaccines he once promoted.*

It was certainly a first for a doctor who had heavily promoted the vaccines to publicly demand a global stop to the mRNA injections.

In February 2021, Malhotra was asked to appear on Good Morning Britain, after a previously vaccine-hesitant film director Gurinder Chadha, Order of the British Empire (OBE)—who was also interviewed—explained that she was convinced by Malhotra to take the jab.

However, more than a year later, in August 2022, Malhotra appeared on GB News, revealing that he had sent an open letter to the then-Prime Minister Boris Johnson and President Joe Biden calling for the immediate release of the raw data from Pfizer's original COVID-19 vaccine trial.

A month later, in an article he published in the Journal of Insulin Resistance on Sept. 26, 2022, Malhotra discussed the current problems with the COVID-19 vaccinations and demanded an immediate stop to these vaccines. He also discussed how the decades-long accumulation of problems within the medical and pharmaceutical community have led to the global disaster of COVID-19 vaccinations.

What got him to change his mind?

Well, it was his own personal tragedy that changed him into a doctor calling for a global stop to the very vaccines he once promoted.

## A Personal Tragedy

As a leading cardiology consultant for many years, Malhotra was taught the benefits of vaccines, believed in them, and advocated for them.

In his first article, Malhotra wrote that vaccinations are some of the safest interventions in the world compared to most drugs, given that they are administered to prevent disease in healthy people and not to treat illness.

With this belief, Malhotra welcomed the news in the summer of 2020, when several pharmaceutical companies, including both Pfizer and Moderna, announced that they had developed a vaccine with more than "95 percent effectiveness" at preventing infection from the dominant circulating strain of SARS-CoV-2 2019.

Malhotra, as a proponent of vaccines, volunteered at a vaccine center and was one of the first to receive two doses of Pfizer's messenger ribonucleic acid (mRNA) vaccine.

He also recommended that his patients and the people around him take it.

His late father, Dr. Kailand Chand, a general practitioner, former deputy chair of the British Medical Association (BMA) and its honorary vice president, also took two doses of the Pfizer mRNA injection. Dr. Chand received the honorary Order of the British Empire (OBE) from the late Queen Elizabeth II of the UK in 2009.

Six months later, however, on July 26, 2021 Chand suffered a cardiac arrest at home after experiencing chest pain.

A subsequent inquiry revealed that a significant ambulance delay likely contributed to his death. Though his passing was a shock, what astounded Malhotra was Chand's autopsy results.

The autopsy showed that two of his father's three major coronary arteries had severe blockages, with 90 percent blockage in his left anterior descending artery and a 75 percent blockage in his right coronary artery.

This finding shocked everyone, according to Malhotra, as Chand was "an extremely fit and active 73-year-old man."

It was particularly difficult for Malhotra to accept these results as he knew Chand's medical history and lifestyle habits.

> "My father, who had been a keen sportsman all his life, was fitter than the overwhelming majority of men his age," Malhotra wrote.
>
> "Since the previous heart scans (a few years earlier, which had revealed no significant problems with perfect blood flow throughout his arteries and only mild furring), he had quit sugar, lost belly fat, reduced the dose of his blood pressure pills, started regular meditation, reversed his pre-diabetes, and even massively dropped his blood triglycerides, significantly improving his cholesterol profile," Malhotra wrote.

Even during the lockdowns, Chand walked an average of 10,000 to 15,000 steps everyday.

Malhotra could not explain the autopsy findings, it looked to him as if there was no heart attack but only a severe blockage, which was unexpected given Chand's lifestyle habits.

As a leading cardiologist, Malhotra had successfully prescribed lifestyle regimens to his patients to reduce their metabolic symptoms. He had even co-authored to a highly impactful study advising lifestyle changes to prevent coronary heart disease.

His years of study, his father's health, and previous health reports didn't match up with the autopsy findings.

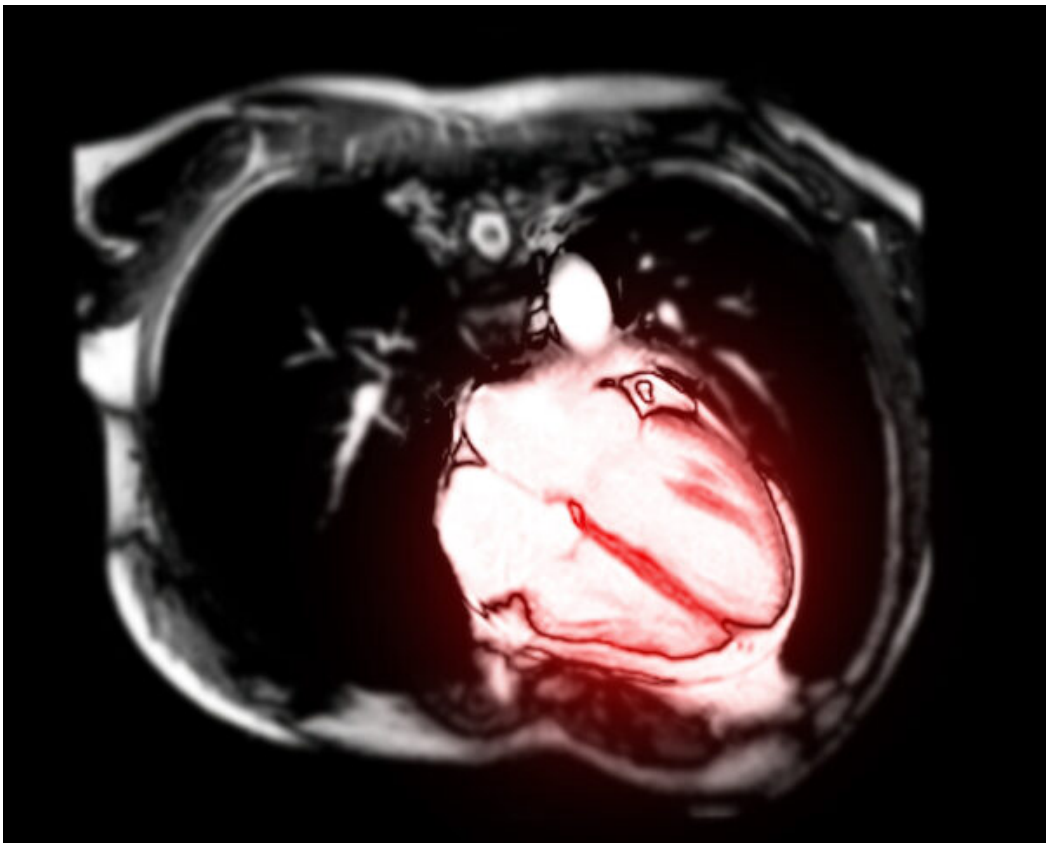
Finally, in November, Malhotra was made aware of a peer-reviewed abstract published in Circulation, a reputable journal on cardiovascular and coronary diseases.

The abstract evaluated over 500 middle-aged patients through regular follow up and predicted their risk of a heart attack by measuring and modeling the inflammatory markers present.

Before vaccination, these people had a 11 percent (pre-mRNA vaccine) risk of suffering a coronary event in the next 5 years, this number increased to 25 percent two to 10 weeks post-vaccination—a significant increase.

The study received some criticism as there was no control group; namely, patients who had not received the vaccination to compare against. But, even if the findings are just partially correct, the vaccine may then accelerate progression of coronary disease, Malhotra concluded.

The finding sowed suspicion in Malhotra's mind. He questioned if his father's death could have been related to his COVID-19 vaccinations, and began to critically evaluate the data.



Magnetic resonance imaging of the heart (Radiological imaging/Shutterstock)

## Alarming Heart Data

Malhotra recalled that one of his colleagues disclosed that he would not be taking the vaccine as he was considered to have a low risk of mortality from COVID-19 and also because of what he saw in Pfizer's pivotal mRNA trial published in The New England Journal of Medicine.

That report, with six months of Pfizer vaccine data published in September 2021, rang one of the first alarms in Malhotra's mind. In the report's Supplementary Appendix, it showed four cardiac arrests in the Pfizer vaccine recipients versus only one in the placebo group.

> "Even though the numbers are small and did not report to reach a statistical difference, it is already a potential safety signal and quite unusual from pharmacovigilance perspective. A detailed due diligence on the causal relationship of these cases should have been conducted, as if there was a biological causal factor underlying this phenomena, the small number in phase 3 clinical trials will be expanded into much larger folds in post marketing data, which is what we have observed now," said Dr. Yuhong Dong, an infectious disease expert with a pharmacovigilance background and a columnist with The Epoch Times.

Unfortunately, this signal was overlooked; jab programs continued and more alarms continued to ring.

While health authorities repeatedly maintained that myocarditis is more common after COVID-19 infection than after vaccination, real world data does not provide support for their assertions.

A JAMA study published in August 2021 of data from 40 U.S. hospitals recorded that the incidence of myocarditis skyrocketed from the spring of 2021 when vaccines were rolled out to the younger cohorts while myocarditis incidence had remained at baseline rates from 2019 to 2020, drawing a possible association between COVID-19 vaccinations and the development of myocarditis.

Further, a Nordic study published in April 2022 showed that mRNA vaccinations were associated with increased risk of myocarditis over the background rates.

The study evaluated 23.1 million residents across four Nordic countries and found myocarditis risk was the highest in young males aged 16 to 24 years after receiving the second vaccine dose.

Compared to unvaccinated subjects, young vaccinated males had an excess of four to seven myocarditis events in 28 days per 100,000 vaccinated after the second Pfizer dose, and between 9 to 28 excesses per 100,000 vaccinated after the second Moderna dose in young males aged 16-24 years.

Although the studies seemed to point towards the mRNA vaccinations, health authorities continued to repeat the agenda that myocarditis events are higher in those with COVID-19 infections than in those who were vaccinated.

Strong evidence for rebuttal came in March 2022 from a study in Israel. These findings helped Malhotra and most doctors attribute the cause of the myocarditis to the COVID-19 vaccine, not to the COVID-19 infection.

The authors evaluated more than 196,000 unvaccinated patients who experienced a COVID-19 infection and compared them to more than 590,000 people who have not been vaccinated nor infected, composing a total of more than 787,000 people in this large scale study.

Both the groups who were infected and uninfected had a myocarditis and pericarditis rate of below 0.01 percent, though the number was actually lower for the group infected by COVID-19.

Comparing this finding to the other reports (pdf) of myocarditis emerging in vaccinated children, the results are "strongly suggesting that the increases observed in earlier studies were because of the mRNA vaccines, with or without COVID-19 infections as an additional risk in the vaccinated," Malhotra wrote.

Although vaccine-induced myocarditis is not often fatal in young adults, MRI scans revealed that, of the ones admitted to hospital, approximately 80 percent have a certain degree of persistent myocardial heart damage, which predicts unfavorable outcomes for the future.

> "It is like suffering a small heart attack and sustaining some—likely permanent—heart muscle injury," wrote Malhotra.
>
> "It is uncertain how this will play out in the longer-term, including if, and to what degree, it will increase the risk of poor quality of life or potentially more serious heart rhythm disturbances in the future."

It is now reported in July 2022 in the JAMA Internal Medicine that the leading cause of death in the United States during the pandemic—from March 2020 to October 2021—was heart disease.

> "Data obtained in England suggest that there was no increase from November 2020 to March 2021, and thereafter the rise has been seen disproportionately in the young. This is a huge signal that surely needs investigating with some urgency."
>
> "Similarly, a recent paper in Nature revealed a 25 percent increase in both acute coronary syndrome and cardiac arrest calls in the 16- to 39-year-old age group which was significantly associated with administration of the first and second doses of the mRNA vaccines but had no association with COVID-19 infection."

## Misleading Clinical Data

Malhotra found that the efficacy data coming from the mRNA vaccine manufacturers themselves were obfuscated, misleading the public and most doctors.

> "In terms of efficacy, headlines around the world made very bold claims of 95 percent effectiveness, the interchangeable use of 'efficacy' and 'effectiveness' glossing over the big difference between controlled trials and real-world conditions," Malhotra wrote.

Without evaluating the data, most doctors and the general public interpreted the statement to mean "if 100 people are vaccinated then 95 percent of people would be protected from getting the infection."

This assumption was even echoed by Rochelle Walensky, director of the U.S. Centers of Disease Control and Prevention (CDC), who conceded in an interview in March 2022 that it was a news story from CNN reporting 95 percent effectiveness that made her optimistic the vaccine would stop transmission of the infection.

In reality, the original trial revealed that a person was 95 percent "less likely" to catch the autumn 2020 variant. This is a relative risk reduction, which is very different from the absolute risk reduction everyone had inferred.

> "In absolute terms, they [the vaccinations] provided 0.84 percent protection which means only one in 119 people would be protected from infection," Malhotra said on GB News.

In the context of the Pfizer trial, relative risk reduction shows how much the vaccine reduces your risk of whatever measured compared to people who are not vaccinated. However, a vaccinated person would need to know the absolute risk for the unvaccinated to calculate their overall risk.

What did the Pfizer trial measure?

Malhotra wrote that the Pfizer trials results could only show how the vaccine reduced the risk of testing COVID-19 positive while symptomatic. A positive testing result was assumed to be indicative of infection, which Malhotra argued was also misleading.

The symptomatic COVID-19 infection rate in the placebo group was 0.88 percent (162 infection out of 18,325), whereas the infection rate in Pfizer jab group was 0.04 percent (8 infection out of 18,198).

He clarified that Pfizer's trial results do not show—despite popular belief—the risk of severe infection, nor COVID-19 mortality.

What is an unvaccinated person's chance of testing positive for COVID-19 with symptoms?

It is 0.88 percent. Meaning that out of 10,000 people who are unvaccinated, 88 of them would test positive with symptoms to COVID-19.

That also means around 9,912 unvaccinated people out of the same 10,000 would not test positive—higher than 99 percent.

For a vaccinated person, reducing the 0.88 percent by 95 percent gives a 0.04 percent risk of testing positive while symptomatic, meaning 10,000 people would need to be vaccinated to reduce positive symptomatic numbers to four.

The actual difference in absolute risks of a positive test result between the vaccinated and the unvaccinated group is 0.84 percent rather than 95 percent, which is what the public assumed.

> "This absolute risk reduction figure (0.84%) is extremely important for doctors and patients to know but how many of them were told this when they received the shot? Transparent communication of risk and benefit of any intervention is a core principle of ethical evidence-based medical practice and informed consent," wrote Malhotra.

Malhotra implies that the mixing of relative and absolute risk results were deliberate to manipulate the public.

As Gerd Gigerenze, director of the Max Planck Institute, once said "It's an ethical imperative that every doctor and patient understand the difference between relative and absolute risks to protect patients against unnecessary anxiety and manipulation."(pdf)

With such minor improvements, the benefits of COVID-19 vaccination for humans are tenuous, not to mention the data on potential risks.

Pfizer's six-month period trial resulted in a higher number of deaths attributed to COVID-19 in the placebo group with two deaths as opposed to one in the vaccine group. However, the all-cause mortality over a longer time period showed that the vaccine group had 19 deaths, with 17 deaths in the placebo group.

People may argue that the mRNA vaccine protects people against death. Again the number in the Pfizer paper only showed the relative reduction but not the absolute number. Malhotra has shown us some simple math to explain the absolute protection rate of the Pfizer vaccine against death.

> "If there is a 1 in 119 chance the vaccine protects you from getting symptomatic infection from ancestral variants, then to find the protection against death, this figure (n = 119) must be multiplied by the number of infections that lead to a single death for each age group. This would give (for up to two months after the inoculation) the absolute risk reduction (for death) from the vaccine," Malhotra explains.
>
> "For example, if my risk at age 44 of dying from Delta (should I get infected with it) is 1 in 3000, then the absolute risk reduction from the vaccine protecting me from death is 1 over 3000 multiplied by 119, that is, 1 per 357 000."

These absolute "protection" rates of the Pfizer jabs are way too low to be rated as effective enough that people would need them at all.

Further, the trials for children also showed no reduction in symptomatic infections.

The study used a surrogate measure of antibody levels in the blood to define efficacy.

Here is the catch: Surrogate markers may correlate with clinical improvement, in this case increased immunity, but correlation does not mean causation, so meeting the surrogate marker is not a sign that the vaccine will work.

Even the U.S. Food and Drug Administration's own website states that "results from currently authorized SARS-COV-2 antibody tests should not be used to evaluate a person's level of immunity or protection from COVID-19 at any time, and especially after the person received a COVID-19 vaccination."

With these examples, Malhotra presented his argument that the vaccinations did very little for immune protection, if anything at all.

With the clinical efficacy so obfuscated, Malhotra argued that most of the vaccinated did not give informed consent, as neither they nor their doctor knew about the exact immunity they would receive following vaccination.

Despite all these concerns, vaccination mandates were pushed in the United States and globally while reports of vaccine-related health concerns persisted.

## Vaccines Causing More Harm Than Good?

Other adverse events occurring after COVID-19 vaccines have been widely reported.

Dr. Jessica Rose, a Canadian molecular biologist and data analyst, has found unprecedented rises in cardiac, neurological, and immunological events reported in the U.S. Vaccine Adverse Event Reporting System (VAERS).

Yellow card data from the health authority (MHRA) in the United Kingdom, showed around 1 in 120 mRNA COVID-19 recipients suffering a likely adverse event that is beyond mild. In comparison, for the measles, mumps, and rubella (MMR) vaccine, the number of reports per vaccinated was around 1 in 4,000, more than 30 times less frequent than for COVID vaccine recipients.

Malhotra explained that conventional vaccines have been based on an "inert"—meaning unreactive—part of the bacteria or virus to "educate" the immune system. The injections are also localized and short-lived.

The spike protein was chosen as the vaccine candidate for COVID-19. It is a protein segment that enables cell entry and therefore chosen as an immunogen to teach the immune system to form an immunity.

> "However, this protein is not inert, but rather it is the source of much of the pathology associated with severe COVID-19," Malhotra wrote.

Studies on the COVID-19 vaccines have also shown that the spike proteins are being produced continuously at unpredictable amounts for at least four months after vaccinations and can be found everywhere in the body after a jab in the arm muscle.

This included endothelial damage, clotting abnormalities, lung damage, and much more.

Perhaps the most conclusive study was published on Aug. 31, 2022, led by researchers in the United States, Australia, and Europe who evaluated Pfizer and Moderna's own clinical trial findings submitted to the FDA.

Contrary to the FDA's conclusions, the authors found that the risk of severe adverse effects from the mRNA vaccines is higher than the risk of hospitalization from COVID-19 infection.

> "It seems difficult to argue that the vaccine roll-out has been net beneficial in all age groups," Malhotra wrote, citing the rising adverse event reports and the clinical data

> showing little improvement.

Malhotra called for a global stop to the COVID-19 mRNA vaccinations.

> “Adverse events from vaccines remain constant, whereas the benefits reduce over time as new variants are less virulent and not targeted by an outdated product … a pause and reappraisal of vaccination policies for COVID-19 is long overdue,” concluded Malhotra.

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*Featured image: Dr. Aseem Malhotra. (Courtesy of Dr. Aseem Malhotra)*

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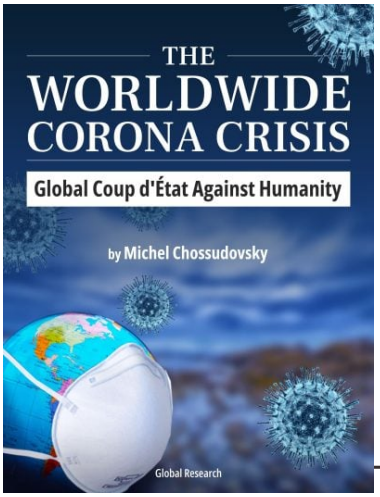


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