Hospitals & Asylums

Purple Pitcher Plant (*Sarracenia purpurea)* Monkeypox Cure Trial HA-22-7-22

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Monkeypox was first discovered in 1958 when two outbreaks of a pox-like disease occurred in colonies of monkeys kept for research. The first human case of monkeypox was recorded in 1970. Since then, monkeypox has been reported in people in several other central and western African countries. Prior to the 2022 outbreak, nearly all monkeypox cases in people outside of Africa were linked to international travel to countries where the disease commonly occurs, or through imported animals. In 2022 scientists at the Centers for Disease Control and Prevention (CDC) are tracking multiple cases of monkeypox that have been reported in several countries that don't normally report monkeypox. It's not clear how the people were exposed to monkeypox, but early data suggest that gay, bisexual, and other men who have sex with men make up a high number of cases. However, anyone who has been in close contact with someone who has monkeypox is at risk. Since 1 January and as of 22 June 2022, 3413 laboratory confirmed cases and one death have been reported to WHO from 50 countries/territories in five WHO Regions. A large part of the population is vulnerable to monkeypox virus, as smallpox vaccination, which is expected to provide some protection against monkeypox has been discontinued since the 1980s. Only a relatively small number of military, frontline health professionals and laboratory workers have been vaccinated against smallpox in recent years. There has been concern in the literature about a resurgence of smallpox due to bioterrorism. The most hated, overcompensated, censor, unethical biomedical researcher and AIDS marketer, Anthony Fauci, Director of the National Institute of Allergies and Infectious Diseases, who is much more difficult to impeach than it is to cure coronavirus, or get a call for impeachment from politicians who don't, seems typical of the incompetent corruption of global public health that caused the COVID-19 pandemic (Kennedy '21).

The International Health Regulations (2005) Emergency Committee met on 23 June 2022 regarding the multi-country monkeypox outbreak to advise the WHO Director-General on whether it constituted a Public Health Emergency of International Concern (PHEIC). This meeting and whole monkeypox pandemic seems to have been in response to the charges of megamurder related to the incomptentence of the WHO to respond to either flu or coronavirus pandemics, and specifically against WHO Director-General Tedros Adhanom Ghebreyesus and UN Secretary-General Antonio Guterres, both of whom were re-elected without opposition despite the millions of people who have died from the easily cured COVID-19 pandemic, because they "immunized vaccine corporations" rather than informing the public of the miraculous and readily available natural remedies, before their Pinocchio nose, in the Convention on Pandemic Treatment (mentholyptus cough drops cure both coronavirus colds and the wet cough of influenza) attached to the Hydrocortisone, Eucalyptus, Lavender, Peppermint or Salt Helps Water Cure Coronavirus Colds Act HA-2-2-22.

Many people have asked me if I was doctor of osteopathy (DO). I have stopped the routine denial that the medical textbook is the foundation of medical knowledge, when it is actually deferential to the differential diagnosis of random diseases in strangers, people who want to hear Stonebreaker (Chanca piedra) cures urinary gallstones overnight, milk thistle cures amanita mushroom poisoning and now purple pitcher plant *Sarracenia purpurea* may cure monkeypox, no matter what ails them. It is really relieving to get to the end of the medical specialty research with the discovery of safe, cost-effective, curative natural remedies, solutions that are proven to actually work and are readily available over-the-counter, at reasonable prices, thereby avoiding the entire genocide of membership in the medical and pharmaceutical professions and industries. Today the story is that, in the late 1800's, the Micmac

Indians of Nova Scotia proclaimed the existence of a botanical-based remedy for smallpox. During this time, Herbert Miles, the Assistant Surgeon to the Royal Artillery, reported that during an outbreak of smallpox "an old squaw going amongst them, and treating the cases with (a botanical) infusion…was so successful as to cure every case". This botanical infusion was later described as being derived from the carnivorous plant, *Sarracenia purpurea* (Arndt '12). By the end of XIXth century several surgeons and practitioners related to the US army, as well as the prestigious botanist Charles F. Millspaugh (1892), described the use of poultices and infusions from the Indigenous medical flora based on the purple pitcher plant *Sarracenia purpurea* (family *Sarraceniaceae*) to be effective for treating smallpox, in a likely case of medical appropriation of the Indigenous therapeutic knowledge (Lawrence-Mackey, 2019). The authors showed that the plant extract was not only active against smallpox, but also against other poxviruses, papovirus SV-40 and various herpes viruses, including papillomavirus and Epstein-Barr virus-associated carcinomas, usually by inhibiting the virus replication at the level of early transcription (Moore and Langland, 2018). For VACV, a single treatment with was fairly effective at preventing viral replication, but partial replication soon recovered, likely due to a breakdown or utilization of the active component(s) within the extract. However, treating the cells with fresh *S. purpurea* every six hours completely abolished the replication of VACV. This correlates well with how patients were treated in the past where the treatment regime involved taking 4–6 doses of the extract per day. Data supports that extracts of *S. purpurea* effectively inhibit the replication of VACV, MPXV and VARV i*n vitro* (Arndt '12). A bottle of SBL Homeopathy *Sarracenia Purpurea* (30 ML) (Select Potency) liquid dilution by Exportmall (1000 CH) costs $6.36 at Amazon.

Tecovirimat (also known as TPOXX or ST-246) is FDA-approved for the treatment of human smallpox disease caused by *Variola virus* in adults and children. However, its use for other orthopoxvirus infections, including monkeypox, is not approved by the FDA. Therefore, CDC holds a non-research expanded access Investigational New Drug (EA-IND) protocol that allows for the use of tecovirimat for primary or early empiric treatment of non-variola orthopoxvirus infections, including monkeypox, in adults and children of all ages. In animal studies, tecovirimat has been shown to decrease the chance of dying from infections with orthopoxviruses when given early in the disease course. In people, efficacy has been limited to drug levels in blood and a few case studies. A case series of individuals infected with *Monkeypox vir*us, which included one patient treated with tecovirimat, suggests that tecovirimat may shorten the duration of illness and viral shedding. Three patients were treated with brincidofovir (200 mg once a week orally), all of whom developed elevated liver enzymes resulting in cessation of therapy. One patient was treated with tecovirimat (600 mg twice daily for 2 weeks orally), experienced no adverse effects, and had a shorter duration of viral shedding and illness (10 days hospitalisation) compared with the other six patients. One patient experienced a mild relapse 6 weeks after hospital discharge (Adler et al '22).

For many centuries, smallpox devastated mankind. In the 18th century in Europe, 400,000 people died annually of smallpox, and one third of the survivors went blind. The case-fatality rate in infants was even higher, approaching 80% in London and 98% in Berlin during the late 1800s. It was common knowledge that survivors of smallpox became immune to the disease. The most successful way of combating smallpox before the discovery of vaccination was inoculation. The terms *inoculation* and *variolation* were often used interchangeably. Variolation, was likely practiced in Africa, India, and China long before the 18th century, when it was introduced to Europe. The inoculator usually used a lancet wet with fresh matter taken from a ripe pustule of some person who suffered from smallpox. The material was then subcutaneously introduced on the arms or legs of the nonimmune person. The fatality rate for the naturally contracted smallpox disease was 14%, whereas a mortality rate of only 2% was exhibited among variolated individuals. When a smallpox epidemic threatened his army in the winter of 1776, General Washington ordered that all troops be inoculated (variolated). Edward Jenner

was born on May 17, 1749, in Berkeley, Gloucestershire, the son of the Rev. Stephen Jenner, vicar of Berkeley. Edward was orphaned at age 5 and went to live with his older brother. At age 13 David Jenner was apprenticed to a country surgeon and apothecary in Sodbury, near Bristol. The record shows that it was there that Jenner heard a dairymaid say, "I shall never have smallpox for I have had cowpox. I shall never have an ugly pockmarked face." It was a common belief that dairymaids were in some way protected from smallpox. In May 1796, Edward Jenner found a young dairymaid, Sarah Nelms, who had fresh cowpox lesions on her hands and arms. On May 14, 1796, using matter from Nelms' lesions, he inoculated an 8-year-old boy, James Phipps. Subsequently, the boy developed mild fever and discomfort in the axillae. Nine days after the procedure he felt cold and had lost his appetite, but on the next day he was much better. In July 1796, Jenner inoculated the boy again, this time with matter from a fresh smallpox lesion. No disease developed, and Jenner concluded that protection was complete. Jenner sent vaccine to his medical acquaintances and to anyone else who requested it. After introducing cowpox inoculation in their own districts, many recipients passed the vaccine on to others (Riedel '05).

In the 1950s a number of control measures were implemented, and smallpox was eradicated in many areas in Europe and North America. In 1967, a global campaign was begun under the guardianship of the World Health Organization and finally succeeded in the eradication of smallpox in 1977. On May 8, 1980, the World Health Assembly announced that the world was free of smallpox and recommended that all countries cease vaccination: "The world and all its people have won freedom from smallpox, which was the most devastating disease sweeping in epidemic form through many countries since earliest times, leaving death, blindness and disfigurement in its wake". Smallpox vaccination provides full immunity for 3 to 5 years and decreasing immunity thereafter. If a person is vaccinated again later, immunity lasts even longer. Historically, the vaccine has been effective in preventing smallpox infection in 95% of those vaccinated. In addition, the vaccine was proven to prevent or substantially lessen infection when given within a few days of exposure. The smallpox vaccine is not given with a hypodermic needle. It is not a shot as most people have experienced. The vaccine is given using a bifurcated (two-pronged) needle that is dipped into the vaccine solution. When removed, the needle retains a droplet of the vaccine. The needle is used to prick the skin 15 times in a few seconds. The pricking is not deep, but it will cause a sore spot and one or two droplets of blood to form. The vaccine usually is given in the upper arm and leaves a life-long scar. In the past, about 1,000 people for every 1 million people vaccinated for the first time experienced reactions that, while not life-threatening, were serious. These reactions included a toxic or allergic reaction at the site of the vaccination (erythema multiforme), spread of the vaccinia virus to other parts of the body and to other individuals (inadvertent inoculation), and spread of the vaccinia virus to other parts of the body through the blood (generalized vaccinia). These types of reactions may require medical attention. In the past, between 14 and 52 people out of every 1 million people vaccinated for the first time experienced potentially life-threatening reactions to the vaccine. Based on past experience, it is estimated that 1 or 2 people in 1 million who receive the vaccine may die as a result.

ACAM200 and JYNNEOSTM (also known as Imvamune or Imvanex) are the two currently licensed vaccines in the United States to prevent smallpox. ACAM2000 is administered as a live *Vaccinia* virus preparation that is inoculated into the skin by pricking the skin surface. Following a successful inoculation, a lesion will develop at the site of the vaccination (i.e., a "take"). The virus growing at the site of this inoculation lesion can be spread to other parts of the body or even to other people. Individuals who receive vaccination with ACAM2000 must take precautions to prevent the spread of the vaccine virus and are considered vaccinated within 28 days. JYNNEOS is administered as an attenuated live virus that is non-replicating. It is administered as two subcutaneous injections four weeks apart. There is no visible "take" and as a result, no risk for spread to other parts of the body or

other people. People who receive JYNNEOS are not considered vaccinated until 2 weeks after they receive the second dose of the vaccine. Past data from Africa suggests that the smallpox vaccine is at least 85% effective in preventing monkeypox. Monkeypox is a serious disease. It causes fever, headache, muscle aches, backache, swollen lymph nodes, a general feeling of discomfort, exhaustion, and severe rash. Studies of monkeypox in Central Africa—where people live in remote areas and are medically underserved—showed that the disease killed up to 11% of people infected. In contrast, most people who get the smallpox or monkeypox vaccine have only minor reactions, like mild fever, tiredness, swollen glands, and redness and itching at the place where the vaccine is given. However, these vaccines do have more serious risks, too. In certain groups of people, such as people with serious immune system problems, complications from ACAM2000 can be severe. If you have concerns about whether you should receive ACAM2000, talk to your healthcare provider. This vaccine has the potential for more side effects and adverse events than the newer vaccine, JYNNEOS, that is a regular injected vaccine.

In conclusion, ideal treatment of the 2022 monkeypox pandemic would be with Purple Pitcher Plant (*Sarracenia purpurea)*. Clinical trials are needed to verify, uphold and inform the public of the 100 percent cure rates exhibited in 19th century smallpox studies and 21st century *in vitro* studies. The population is no longer vaccinated against smallpox. Tecovirimat antiviral and ACAM2000 and JYNNEOS smallpox vaccines are only thought to reduce the risk of death when administered quickly, within about four days of exposure. After the dismal failure of the COVID vaccine, there is little motivation for the entire population, or even the entire male homosexual population, to get vaccinated against a novel monkeypox pandemic. People would be better treated with the public knowledge that the FDA, CDC and WHO support clinical trials of Purple Pitcher Plant (*Sarracenia purpurea*) to cure monkeypox, smallpox, other poxviruses, papovirus SV-40 and various herpes viruses, including papillomavirus and Epstein-Barr virus-associated carcinomas.

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