From: Ian Packington
To: <coshita@oehha.ca.gov>
Date: 5/5/2009 5:51 AM
Subject: Fluoride and cancer, developmental and reproductive toxicity

Dear Ms. Coshita and CIC Members

I wish to add a last minute plea that you consider very carefully all the evidence now available - and fully documented and submitted to you by others - in order to achieve a fundamental clarity of conviction in your deliberations; namely that the fluoride ion is a fundamentally biotoxic species capable of promoting almost indefinite proliferations of aberrant biochemical activity in human cytoplasm - from before conception (acting on oocytes, e.g. as a clastogen promoting trisomies of all kinds) through embryogenesis, fetal and postnatal development, adolescence and adulthood, and then cumulatively in artificially 'ageing' of body tissues, thus making specific diseases of old age more severe, including many kinds of cancer, and increasing death rates. All this harm is, of course, dose-dependent.

I submit to you that, via evolution in a natural environment containing various sources of fluoride pollution, we and other higher species can cope effectively with occasional moderate doses of common fluorides, via efficient renal action and partial sequestration to bone, but chronic, cumulative damage from inevitable daily doses of the order of miligrams or tens of milligrams cannot be so remedied;

effective clearance is never achievable, and there is inevitable and ongoing tissue damage (detected by analysis of biochemical markers) and skeletal accumulation, which, as Dr John Yiamouyiannis first forcefully pointed out in 'Fluoride, the Aging Factor' amounts to an 'intolerable burden' on our species in particular, because of our evolved extended period of development, particularly of brain, and our relatively long lifetimes.

I wish to add two examples of epidemiological evidence from this side of the Atlantic, which strengthen the case against mass fluoridation in particular, but also against persistent environmental fluoride pollution.

1. In 70% fluoridated Eire, osteosarcoma rates have been consistently about 40% higher in adolescent males than in unfluoridated Northern Ireland over at least 30 years of records. [Fluoridation began in Eire in the 1960s].

2. Last August, at the 28th ISFR Conference in Toronto, I presented the preliminary results of my extended investigation of perinatal mortality in the West Midlands (70% fluoridated) - an Abstract of which will appear in a 2009 issue of 'Fluoride' Journal as part of the Conference Proceedings. Only "excess deaths attributed to the consequences of extreme prematurity"- Wigglesworth fetopathology category [D]- achieved statistical significance [$p < 0.01$] over the four-year period 1991-1994 for which comprehensive data had been published in the Report (1996) by the West Midlands Perinatal Audit [WMPA]entitled "Stillbirth and Neonatal Death 1991-1994"

- but this excess loss appears in every one of the 11 predominantly fluoridated Health Authority Areas [DHAs] and not at all in three remaining unfluoridated DHAs c.f. the rest of England and Wales (a 'step' result that is virtually impossible to attribute purely to chance). North Staffordshire DHA is also entirely unfluoridated, but, as the active centre of the pottery and fine china industry for over 200 years, the cumulative environmental burden of fluoride toxicity via air and soil/dust pollution makes residents of 'the Potteries' effectively exposed, even in the early 1990s, to relatively very high levels of environmental fluoride pollution, which has almost certainly adversely affected intergenerational reproductive health. North Staffordshire's perinatal mortality, with due regard to its average Jarman Score, represents the greatest excess of perinatal mortality - at least 35%, including in particular [D] losses - of all the 15 West Midlands DHAs. The most socially deprived and fully fluoridated North Birmingham DHA comes next.

In fact every category of intranatal and postnatal loss is higher in the fluoridated DHAs - which includes [C] -intranatal deaths due mainly to asphyxia or to birth trauma - and [E] deaths attributable to special conditions e.g. lethal infections, blood group incompatibilities et al (the great majority of which occur postnatally). [I ignore deaths due to lethal congenital anomalies, because of unknown proportions of therapeutic abortions carried out in the different DHAs over this period].

In conclusion, over this four-year period, net *reported* stillbirth rates (from 24 weeks on, but not including late fetal losses [LFL] which occurred in weeks 20-23 inclusive) were marginally *lower* in the fluoridated DHAs c.f. the three typical remaining unfluoridated DHAs -which is only to be expected, really, in the light of the
far greater combined excess of [CDE] loss - all deaths clearly associated with at least the initiation of a live birth process.

The only possible conclusion I can draw, having also examined the possible confounding effects of persistent toxic air pollution, which are present, but represent a relatively minor adjustment to the datasets, is that fetuses whose mothers were exposed to a fluoridated supply, and which were, for any reason, subjected to intrauterine growth and/or respiration constraints and, in accordance with overall maternal stress, who were as a result delivered significantly prematurely, were alway approximately 70% more likely to die than if they were born to mothers who had lived in unfluoridated areas. [There is no significant difference in net premature birth rates in fluoridated c.f. unfluoridated DHAs, but the average birthweights in the fluoridated DHAs are significantly lower i.e. both inevitable and elective premature deliveries in unfluoridated West Midlands and in England and Wales

as a whole were significantly more likely to result in neonatal survival than the equivalent events in any artificially fluoridated DHA - though net Jarman Score, measuring social and economic deprivation, was strongly correlated with the actual measured excesses observed in each and every fluoridated DHA].

I submit to you that such an analysis ought now to be undertaken in every U.S. state, in accordance with the local population's fluoridation status and its level of material deprivation, and that the hitherto unexposed excess of perinatal mortality clearly attributable to maternal, hence fetal fluoridation status - which exactly parallels (in advanced and relatively well -nourished communities) what Dr. Albert Schatz reported for Chile in the 1970s (resulting in the Socialist Administration of President Allende revoking all artificial fluoridation schemes then operating in Chile) - an entirely unnecessary death toll which has accumulated inexorably for every year that any community has had a fluoridated water supply. This should be taken into due consideration as clear evidence that mass fluoridation is specifically harmful to normally formed but gestationally challenged fetuses. [When they are born, they are significantly more likely to fail to thrive, and many more suffer almost immediate and fatal asphyxia because, for any number of possible reasons, they are less well-equipped on delivery for independent respiration (and e.g. resistance to infection et al) and hence for survival].

I trust that this recent evidence will be duly noted in your deliberations. It would be most appropriate that
the country whose Administration first introduced the practice of mass fluoridation - for reasons carefully documented recently by Christopher Bryson in 'The
Fluoride Deception' - were now to lead us out of the blind alley of quite unnecessary and often lethal toxic sequelae which fluoridation practice inevitably inflicts upon its unfortunate recipients, irrespective of race, creed or political affiliations.

Yours sincerely

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Vice-Chair: National Pure Water Association [NPWA]
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