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Warning: The COVID Jabs Are Administered Incorrectly

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STORY AT-A-GLANCE -

- Recent research suggests that by not aspirating the needle to make sure the injection is not going into your bloodstream, vaccine administrators may be contributing to vaccine injuries
- Mice given an mRNA COVID shot intravenously developed myopericarditis, inflammation of the heart and surrounding heart sack
- Intravenous injections of the mRNA "vaccine" induced visible degeneration and death of heart muscle cells. This damage is likely permanent, as heart cells do not regenerate. The damaged or lost cardiac tissue is simply replaced by scar tissue, which permanently inhibits muscle contraction
- Intravenous injection also caused calcium deposits on the inner (visceral) layer of the pericardium, a condition that can lead to restrictive pericarditis and diastolic heart failure
- The mice that received the COVID shot intravenously also had extensively damaged liver cells

In the featured video above, retired nurse lecturer John Campbell, Ph.D., reviews research[1] showing that intravenous injection of mRNA COVID shots can induce acute myopericarditis in mice. As it turns out, most health professionals in the U.K. and U.S. are administering the COVID shots incorrectly, thereby raising the risk of serious side effects such as heart inflammation.

COVID Shots Are Administered Incorrectly

As explained by Campbell, when you administer an intramuscular injection, the injection is supposed to go into the muscle — not a vein or blood vessel. To ensure you haven't hit a blood vessel, you need to pull the plunger out a bit before injecting the fluid in the syringe to confirm that the needle isn't in a blood vessel.

> **"By not aspirating the needle to make sure the injection is not going into the bloodstream, vaccine administrators may be contributing to vaccine injuries."**

If blood is aspirated when pulling back the plunger, you know you're in a blood vessel, which is what you don't want. In that case, you'd pull the needle out and find another spot. However, this is not being done. By not aspirating the needle to make sure the injection is not going into the bloodstream, vaccine administrators may be contributing to vaccine injuries. This "really must change," Campbell says.

Intravenous Injection Can Induce Myopericarditis

Campbell is referring to a peer-reviewed study[2] published in the journal Clinical Infectious Diseases in mid-August 2021. The researchers acknowledged that myocarditis and pericarditis are known side effects of the mRNA COVID shots, and wanted to determine whether the method of injection might have something to do with it.

To that end, they injected mRNA "vaccine" intravenously into one group of mice, and intramuscularly into another group. A third and fourth group received intravenous and intramuscular injections of normal saline (placebo).

They then compared the clinical manifestations, signs of disease in various tissues, mRNA expression in tissues, and levels of cytokines and troponin in the blood.

Cytokines are an essential part of the inflammatory process. They're also important signaling molecules.

Cytokine levels go up when inflammation is present. When cytokine release goes out of control, you end up with what's known as a cytokine storm, which can be lethal. Troponin, meanwhile, is a marker for heart damage.[3] Elevated levels are indicative of an acute or recent heart attack.

While there were side effects associated with both methods, only the mice injected intravenously went on to develop myopericarditis, i.e., inflammation of the heart and/or heart sack. As detailed by the authors:[4]

> *"Though significant weight loss and higher serum cytokine/chemokine levels were found in IM [intramuscular vaccine injection] group at 1 to 2 days post-injection (dpi), only IV [intravenous vaccine injection] group developed histopathological changes of myopericarditis as evidenced by cardiomyocyte degeneration, apoptosis and necrosis with adjacent inflammatory cell infiltration and calcific deposits on visceral pericardium, while evidence of coronary artery or other cardiac pathologies was absent.*
>
> *SARS-CoV-2 spike antigen expression by immunostaining was occasionally found in infiltrating immune cells of the heart or injection site, in cardiomyocytes and intracardiac vascular endothelial cells, but not skeletal myocytes.*
>
> *The histological changes of myopericarditis after the first IV-priming dose persisted for 2 weeks and were markedly aggravated by a second IM- or IV-booster dose.*
>
> *Cardiac tissue mRNA expression of IL-1β, IFN-β, IL-6 and TNF-α increased significantly from 1dpi to 2dpi in IV but not IM group, compatible with presence of myopericarditis in IV group. Ballooning degeneration of hepatocytes was consistently found in IV group."*

‘Grossly Visible Pathology in the Heart’

As noted by Campbell, intravenous injection of the mRNA “vaccine” induced “grossly visible pathology in the heart.” This included visible degeneration, apoptosis and necrosis (cell death) of heart muscle cells.

Naturally, if the cells of your heart are damaged, your heart will be unable to contract properly and this damage will be permanent, as heart cells do not regenerate[5] like many other tissues do.

The damaged or lost cardiac tissue is simply replaced by scar tissue, which will permanently inhibit muscle contraction. Intravenous injections of the mRNA “vaccine” also caused calcium deposits on the inner (visceral) layer of the pericardium.

When a tissue is injured, it can become calcified. So, calcification of the visceral pericardium is further evidence that heart damage is occurring. Of course, since the pericardium surrounds your heart, which needs to expand and contract for you to stay alive, calcification — hardening — of this protective sack can be devastating for your health. When this occurs, you can end up with a condition called restrictive pericarditis, which in turn can lead to diastolic heart failure.

Inflammation Found in Many Areas of the Heart

The researchers also found COVID spike antigen inside:

1. Immune cells found in the heart
2. Cardiomyocytes
3. Intracardiac vascular endothelial cells

As explained by Campbell:

> *“What this means is, because the vaccine was given intravenously, the RNA to make the spike protein went into the blood; it got into the myocardial cells ...*

> *The myocardial cells produce the spike protein, [they] express that to their cell surface.*
>
> *Of course, [the spike protein] is a foreign protein, so the body's immune cells said 'Oh, foreign protein there!' and they attacked it, and they attacked the cell, and that's what caused the inflammation, the myocytes in the myocardium.*"

Spike antigen, and therefore inflammation, was also found in the intracardiac vascular endothelial cells, meaning the cells that line the blood vessels of your heart. This damage is what gives rise to blood clots.

Campbell suspects other serious side effects, such as vaccine-induced immune thrombotic thrombocytopenia (VITT[6]) might also be related to incorrectly injecting the COVID shots straight into the bloodstream.

Damage Aggravated After Second Dose

After the first dose of mRNA "vaccine" administered intravenously, the changes associated with myocarditis persisted for two weeks. The damage was then "markedly aggravated" after the second dose, whether intravenous or intramuscular.

In other words, if the first dose was given incorrectly into the blood stream, then even if the second dose was administered correctly into the muscle, damage to the heart was still significantly increased after that second dose.

> *"And of course, this is exactly what we are seeing,"* Campbell says. *"There is more myopericarditis after the second booster dose than after the first one. That has now been exactly duplicated in this study. We need to change the policy."*

The researchers also discovered cytokines in the heart tissue of the animals injected intravenously, including interleukin (IL)-1 beta, IL-6, interferon beta and tumor necrosis factor (TNF) alpha. All of these cytokines cause inflammation, and you do not want inflammation in your heart.

It's worth noting that the mice that received intramuscular injections actually had higher cytokine levels in their blood than those in the intravenous group, so inflammation is clearly present regardless of the injection method.

Intravenous Injections Also Damaged the Liver

The mice injected intravenously also had "ballooning degeneration of hepatocytes." Hepatocytes are liver cells, and they were also extensively damaged. Aside from the heart and the liver, all other organs "appeared normal" in all groups. All of these findings caused the researchers to conclude that:

> *"Inadvertent intravenous injection of COVID-19 mRNA-vaccines may induce myopericarditis. Brief withdrawal of syringe plunger to exclude blood aspiration may be one possible way to reduce such risk."*

As noted by Campbell, "both Pfizer/BioNTech and Moderna have clearly stated that their vaccines should only be given via [the] intramuscular route, not intravenously," so why are health authorities not making sure the shots are given properly? "It's just completely unacceptable," he says.

Curiously enough, the U.K., the U.S. and the World Health Organization all actually specify that you should NOT aspirate the needle, as that will help minimize the pain associated with the injection. "It's unbelievable," Campbell says, as these guidelines actually promote preventable injuries.

Adenovirus-Based Shots and Thrombosis

According to Campbell, adenovirus-based COVID shots also need to be injected intramuscularly and not intravenously. Here, the greatest risk associated with intravenous injection appears to be thrombocytopenia (low platelet count, which results in uncontrolled bleeding).

Campbell refers to a 2007 paper[7] that looked at adenovirus-induced thrombocytopenia. They concluded that when adenoviral gene transfer vectors are injected directly into the

tail vein of mice, thrombocytopenia routinely occurs.

Guidance Needs To Be Updated Immediately

Campbell is now urging his viewers to contact their political representatives and call on them to update the COVID shot guidance. Campbell has written a number of letters himself, one ending up on the desk of Nadhim Zahawi, MP, the British minister for COVID vaccine deployment. In a written reply, Zahawi rebuffs Campbell's concerns, telling him there's nothing to worry about:

> *"From the reports of major thrombosis with concurrent thrombocytopenia, we have not been able to identify any evidence of association with errors in administration in the UK cases.*
>
> *The very rare clotting condition reported following the administration of the University of Oxford/AstraZeneca COVID-19 vaccine is thought to be due to an immunological mechanism, rather than the way in which the vaccine is given.*
>
> *Guidance published by the Public Health England (PHE) states 'There is no need to pull back the plunger (aspirate) before the plunger is depressed to release the vaccine into the muscle because there are no large blood vessels at the recommended injection sites.'"*

As noted by Campbell, of course they haven't been able to identify evidence of association between thrombocytopenia and incorrect injection, because when you do it wrong, you don't know it — unless you aspirate. "So, this is just poppycock, what Zahawi has written here," Campbell says.

He also points out that Zahawi provides no evidence that the blood clotting disorder is in fact due to an immunological mechanism and has nothing to do with the method of injection. Campbell suspects that while there may be an immunological mechanism at work, intravenous injection may also be part of the problem, or it might add to it.

Campbell also highlights the ludicrousness of there not being any significant blood vessels in the deltoid. Tissue that does not have an adequate blood supply will die and fall off in a few days. Of course there are plenty of blood vessels in your deltoid. “If you know someone in power, get them to change the policy,” Campbell says. He tried, but clearly, the political elite are not willing to listen, and will dismiss concerns by actual doctors.

Sources and References

- [1, 2] Clinical Infectious Diseases August 18, 2021; ciab707
- [3] CMAJ November 8, 2005; 173(10): 1191–1202
- [4] Clinical Infectious Diseases August 18, 2021; ciab707, Results
- [5] UCLA Health Cardiac Repair and Regeneration
- [6] StatPearls July 18, 2021
- [7] Blood 2007; 109(7): 2832-2839