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Review Article

Potential Implications of COVID-19 Vaccination for Blood Donation: A Retrospective Case Series and Literature Review - Part I of II

James A Thorp, MD[1], Claire Rogers, MSPAS PA-C[2], R Clinton Ohlers, PhD[3], M Nathaniel Mead, PhD[4], Nicolas Hulscher, MPH[5], Kirstin Cosgrove, CCRA[6], Sierra Hamm, RN[7], David Speicher, PhD[8], Steven Hatfill, MD M Med[9]

[1]Independent Researcher, Chief of Maternal and Prenatal Health at The Wellness Company. Ob/Gyn and Maternal-Fetal Medicine Subspecialist as an Independent Contractor. Gulf Breeze, FL. Advanced Biological Research Group ABRG.org, United States.
[2]COVID-19 Clinical Care, Independent Researcher. McCullough Foundation, United States.
[3]Independent Researcher, Executive Director of Safe Blood Foundation, United States.
[4]Independent Researcher, McCullough Foundation, United States.
[5]Independent Researcher. Senior Fellow, McCullough Foundation, The Wellness Company, United States.
[6]Independent Researcher, Advanced Biological Research Group ABRG.org, IPAK-EDU IRB, McCullough Foundation, United States.
[7]Independent Researcher, Clinical Care, United States.
[8]Chief Scientific Officer, Cyrus Scientific, United States.
[9]Independent Researcher, Advanced Biological Research Group ABRG.org, United States.

*Correspondence: Claire Rogers; *jclaireprice@gmail.com*

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Abstract

Introduction: Blood transfusion safety relies on rigorous donor screening, pathogen testing, regulatory oversight, and quality-control procedures. Since the introduction of modified mRNA COVID-19 vaccines in 2021, concerns have emerged regarding shedding, persistence and biodistribution of vaccine-associated components, including spike protein, vaccine-associated synthetic mRNA, lipid nanoparticles, and plasmid DNA and others. The purpose of this two-part series is to explore case-series data along with reviewing the available peer-reviewed evidence on whether blood from COVID-19-vaccinated donors is associated with any measurable harm to recipients. ***Methods:*** Part I is a retrospective descriptive case series that is a hypothesis-generating, safety-surveillance study. Nine cases are presented who believed they experienced serious medical events following blood transfusion. Cases were identified through patient and family outreach, public testimony, advocacy organizations, interviews, and media reports. Data sources included medical records, caregiver diaries, interviews, and publicly available reports. In Part II we explore case relevance to the CDC FDA Vaccine Adverse Event Reporting System (VAERS). ***Results:*** The nine cases presented include reports of thromboembolic disease, progressive clotting disorders, myocarditis, pericardial disease, multi-organ system failure, disseminated intravascular coagulation, and death after transfusion exposure. ***Conclusions:*** This study suggests that blood donated by COVID-19-vaccinated individuals may contain biologically active vaccine-derived constituents that could cause adverse clinical outcomes. The case reports and cited studies identify questions that warrant further investigation. All the pathogenic components of the COVID-19 vaccine or byproducts from it, have been found in several studies to be circulating in the blood of vaccinated donors. Healthcare providers must honor the ethical principles of patient autonomy and non-maleficence and support patients' requests for autologous and directed designated donor blood. Screening blood donations for the presence of spike protein, amyloid, fibrin-microclot complexes, vaccine-derived mRNA, and plasmid DNA using quantitative assays and PCR-based methods should be considered for further evaluation by relevant public health and regulatory authorities, including the CDC and FDA.

Keywords: ***Blood transfusion, Covid vaccines, Post transfusion complications, Spike protein, Parkinsons disease, Prion disease, Creutzfeldt-Jakob disease, fibrin-microclot complexes, Large fibrinous white clots, Amyloid aggregates, Pregnant women.***

Introduction

Directed blood donations arose as a patient alternative to blood from the general supply, particularly, as a response to the acknowledged failure of health authorities and the blood banking industry to protect the public during the early AIDS outbreak of the early 1980s. Directed donations thereby ensured the first pillar of medicine, patient autonomy, giving patients the ability to avoid life-threatening risk where public authorities had greatly underestimated that risk. Similar concerns surrounding the safety of the COVID-19 vaccines and the safety of the blood supply have resulted in renewed interest in directed donations among the public. At the same time, operating on faith in the COVID-19 vaccines' safety and efficacy, many health institutions globally have denied patients this right, undermining this central pillar of medical ethics.

In the "Baby W case", the High Court of New Zealand denied the parents' request to use donor-designated blood from donors who had not received COVID-19 vaccines for their infant's surgery [1]. On state record in Idaho [2], Texas [3], and Wyoming [4] patients likewise have been denied directed blood donations, and, the authors are aware this also happened in Washington, Minnesota, Ohio, Hawaii and other states. In many instances, patients were required to travel to other states to receive treatment. These policies are in breach of the *Principles of Biomedical Ethics* [5], *The American Medical Association* [6], and *The World Medical Association* [7], all affirming patients' right to choose or refuse their own medical care.

It is important to recognize that individuals who challenged prevailing views in the past, whether HIV contamination of the blood supply, hepatitis C transmission through blood products, the effectiveness of masks during the pandemic, or the safety of COVID-19 vaccines were often met with skepticism, criticism, dismissal, certification removal, license revocation, or even job loss. In each of the aforementioned examples, initial dissenting views were subsequently validated and contributed to changes in public understanding and, in some cases, improved blood safety and public policy revisions.

Blood transfusions are relatively uncommon in the general U.S. population with approximately 4–5 million Americans receiving blood transfusion(s) per year, representing an annual prevalence of about 1–1.5% of the population [8]. Although rigorous safety standards have been implemented, several major blood-safety scandals occurred internationally between the 1970s and 1990s, including well-documented incidents in France, Canada, Japan, the United Kingdom, Ireland, Germany, and other countries involving HIV- and hepatitis C- contaminated blood products [9]. More than 12,000 Americans were infected with HIV through blood transfusions, and roughly 8,000-10,000 individuals with hemophilia acquired HIV through contaminated clotting-factor concentrates during the early years of the AIDS epidemic. About 300,000 Americans were infected with hepatitis C virus through contaminated blood transfusions and blood products before effective screening measures were introduced in 1992.

In 1995 the Department of Health and Human Services (HHS) commissioned a review of the institutional handling of the HIV blood transfusion crisis in the early 1980's. Entitled *HIV and the Blood Supply: An Analysis of Crisis Decision-making,* the review discovered three areas of failure on the part of decision makers that are repeating themselves again today: 1) underestimation of risk and failure to mitigate risk; 2) over reliance on the blood industry in shaping policy; and, 3) over-emphasis on scientific certainty of risk to the blood supply rather before acting rather than on realistic probability of risk [10]. These historical tragedies underscore the profound impact of blood donor safety failures and serve as a sobering reminder of the need for unwavering vigilance, transparency, and continuous improvement in transfusion medicine to prevent harm. These three warnings from the HHS commission from 1995 are currently being ignored.

As the 1995 HHS authors noted, "Many officials of the blood banks, the plasma fractionation industry, and the FDA accepted with little question estimates that the risk of AIDS was low ('one in a million transfusions'), and they accepted advice that control strategies … would be ineffective, too costly, or too risky" [11].

In 1981, a post-partum woman was transfused with HIV-contaminated blood, and she subsequently transmitted it to her husband and to a later-born son, who died from AIDS-related illness [12]. In another high-profile case, tennis legend Arthur Ashe contracted HIV from a contaminated blood transfusion he received during heart bypass surgery in 1983. At the time of his surgery, routine screening of the US blood supply for the HIV virus had not yet been established, as testing did not begin until 1985. Ashe did not learn that he was HIV-positive until 1988 when he was hospitalized for emergency brain surgery.

With the introduction and widespread distribution of novel mRNA-based COVID-19 vaccines during the 2021 pandemic response, reports emerged of a phenomenon commonly referred to as "shedding." Women around the world began sharing accounts on social media describing significant changes in their menstrual cycles following close contact with individuals who had received COVID-19 vaccines [13,14]. Many of these reports described similar patterns and symptoms, leading to increased public discussion and concern. However, large social media platforms and accounts sharing these discussions often faced censorship, content restrictions, or removal from online platforms [15].

The shedding phenomenon is not a new concept. Roctavian [16], developed by BioMarin Pharmaceutical is an adeno-associated virus serotype 5 vector gene therapy approved for adults with severe hemophilia A. During clinical development, investigators detected vector DNA in semen after administration, which is referred to as vector shedding or biodistribution/shedding of vector DNA. As a result, the prescribing information includes reproductive precautions: For 6 months after administration, men must not donate semen, and men and their female partners must prevent or postpone pregnancy. Zolgensma is also an adeno-associated virus (serotype 9)-based gene therapy used for spinal muscular atrophy. The FDA-approved prescribing information acknowledges shedding, primarily through stool after treatment. For this reason, caregivers are instructed to practice good hand hygiene and careful diaper disposal for at least 1 month after infusion [17].

Section 8.3.5.1 of Pfizer's clinical trial protocol, *Exposure During Pregnancy*, included provisions for reporting pregnancies involving individuals who had experienced "environmental exposures" to the study intervention (COVID-19 vaccine). Pfizer describes an exposure to the study intervention in a vaccinated individual occurring by inhalation or skin contact by an unvaccinated individual [18]. Male participants were warned by Pfizer to remain abstinent from intercourse or use a condom when having sex with a woman of childbearing potential and to not donate sperm for 28 days after the last dose. It is widely hypothesized that the shedding process occurs, but the actual substance being shed remains a subject of debate, whether through the lipid nanoparticles (LNP), spike protein, COVID-19 vaccine mRNA via exosomes, or other byproducts of the COVID-19 vaccines. Dr. Pierre Kory [19]. and others [20] have published extensively on shedding after COVID-19 mRNA vaccinations, and they suggest it is either the

precursor to the spike protein or the spike protein itself that is being shed.

Interestingly, a large meta-analysis of 100 studies report that COVID-19 scent is detectable by dogs [21] One study demonstrated the capability of scent dogs to detect the COVID-19 vaccinated subjects [22]. These findings suggest that COVID-19 infection and mRNA vaccination may produce distinct, detectable olfactory signatures, which raises intriguing questions about the physiological differences induced by the inoculations, as well as the implications for broader monitoring potential.

New organizations have emerged whose sole focus is to provide blood products from donors who have not received mRNA COVID-19 vaccines [23,24]. It is estimated that approximately 80% of Americans have received at least one COVID-19 vaccine indicating a scarcity of unvaccinated donors. Currently, the FDA and American Red Cross do not screen blood for vaccine-derived mRNA, spike protein, plasmid DNA, amyloid, fibrin-microclot complexes, or other potential contaminants.

A preprint publication from Japan [25] and an article featured in the Expose [26] cite the following six potential mechanisms: 1) spike protein contamination; 2) amyloid aggregates and microthrombi; 3) alterations in normal immune function or immune suppression due to immune imprinting or shift to IgG4 class; 4) lipid nanoparticles and pseudo-uridine mRNA; 5) aggregated red blood cells or platelets; and, 6) memory B cells producing IgG4.

In marked contrast with these reports, the American Red Cross, the American Association of Blood Banks, federal health agencies, and other major blood authorities claim that blood from COVID-19-vaccinated donors poses no known additional risk and is universally safe [27,28]. The purpose of this two-part series is to analyze international case series data and review the available peer-reviewed evidence on whether blood from COVID-19-vaccinated donors is associated with any measurable harm to recipients, while distinguishing established findings from theoretical risks and areas warranting further research.

Methods

This study is a retrospective descriptive case series intended to generate hypotheses through safety surveillance. This study was submitted to the IRB and found to meet the criteria for exemption from IRB oversight. Nine non-COVID-19-vaccinated individuals from the United States, the Netherlands, and Scotland experienced serious adverse medical events following receipt of blood transfusion(s). The purpose of this investigation was to document and summarize cases in which patients, family members, or caregivers expressed concern that exposure to mRNA vaccine components and/or byproducts via transfused blood or blood products may have contributed to subsequent morbidity or mortality.

Cases were identified through direct patient or family outreach to the investigators, public testimony, social media reports, interviews, advocacy organizations, and review of available documentation. Cases were eligible for inclusion if all the following criteria were met:

1. The patient received one or more blood transfusions or blood-derived products.
2. The patient, surviving family member, caregiver, or treating clinician reported that the patient had never received a COVID-19 vaccine.
3. A serious medical event, clinical deterioration, or death reportedly occurred after transfusion.
4. The patient, family member, caregiver, or treating clinician expressed concern regarding a possible relationship between transfusion exposure and the subsequent clinical event.

Information was obtained from one or more of the following sources: contemporaneous caregiver/family diaries; interviews with patients, family members, or caregivers when available; public testimony; social media statements and publicly accessible postings; and media reports and published case narratives.

Given the small sample size, heterogeneous clinical presentations, and descriptive nature of the investigation, no formal statistical analyses were performed. Data were analyzed qualitatively and presented as individual case reports. Temporal associations between transfusion exposure and subsequent clinical events were documented. The authors did not confirm laboratory results, imaging results, medical records, or autopsy reports.

Results

Case Reports

Case 1: The patient was a male infant born on January 3, 2022, with tracheoesophageal fistula (TEF) and was subsequently diagnosed with double-outlet right ventricle (DORV) [29]. He received treatment at a tertiary pediatric medical center. On January 24, 2022, during surgical repair of the TEF, the infant received a blood transfusion from the general blood supply. According to the parents, directed donor blood had been arranged for a planned future cardiac procedure but was not used during the TEF surgery.

The parents stated that within 12 hours of the transfusion, the infant's peripherally inserted central catheter (PICC) in the lower extremity became occluded, and a thrombotic complication was identified at the catheter site. According to the parents, the hospital staff advised them this was a common occurrence and could be readily treated. The parents further stated that, despite anticoagulant therapy, the thrombus progressed rapidly over the subsequent 18 to 20 days, extending from the lower extremity into the femoral vein, inferior vena cava, right atrium of the heart and into the superior vena cava.

The parents publicly described the clinical course as follows: [30]

> "This is my son before and after he got a blood transfusion of poisoned blood. We begged the hospital to let us get pure blood. They refused and gave the blood to him without our consent. He developed a blood clot instantly that stretched from his knee to his heart. He made it two weeks before he died."

According to the parents, the thrombotic material was unusually extensive and resistant to anticoagulant therapy. They attributed these findings to the blood transfusion.

The case has been discussed by multiple media outlets and commentators. In addition to coverage by *The Gateway Pundit*, reports also appeared in *National File* [31], and the parents participated in a 42-minute interview on Children's Health Defense (CHD.TV) [32], discussing the clinical course and their concerns. Dr. Samir Missak also expressed the opinion that transfusion with blood from donors vaccinated against COVID-19 was lethal to the infant [33].

According to the parents, the hospital subsequently refused to provide copies of the infant's medical records and advised them that no records of the hospitalization existed. The family contends

that these actions were undertaken intentionally to delay resolution of the matter and to prejudice their ability to file a timely wrongful death action within the applicable statute of limitations.

The primary source materials include parental statements, publicly available media interviews, published news reports, and other available documentation describing the case.

Case 2: The patient is a 58-year-old non-COVID-19-vaccinated female residing in California who was hospitalized in December 2023 for shortness of breath and anemia. According to available information, her anemia was attributed, at least in part, to chronic but stable kidney disease. She remained hospitalized for approximately 26 days, from December 2023 through early January 2024. Early in the hospitalization, the patient reportedly received six to eight units of blood. According to her husband, she subsequently developed severe pericardial effusion with extensive clot formation within the pericardial sac. Her condition was reportedly considered life-threatening and required invasive pericardial drainage. According to her husband, one physician informed them that the blood transfusion could have caused these complications. The husband further reported that both he and the patient were uncertain whether she would survive this period of acute clinical deterioration. The reported clinical findings included pericarditis, pericardial effusion, thrombotic material within the pericardial sac, the need for pericardial drainage, and a prolonged hospitalization of approximately 26 days. According to the patient's husband her only reported exposure to blood products occurred through transfusions administered during the hospitalization. He reported a temporal association between the transfusions and the subsequent onset of severe pericardial disease. Her husband also stated that he retained samples of fluid and material removed from the pericardial space during treatment.

The primary source materials for this report include interviews and public statements made by the patient's husband, including at least two social media posts [34,35]

Case 3: A 68-year-old non-COVID-19-vaccinated Caucasian male from North Dakota was hospitalized on October 20, 2022, for severe blood loss resulting from gastrointestinal bleeding caused by a duodenal ulcer. During his hospitalization, he developed severe anemia from acute blood loss and required multiple blood transfusions. According to the available medical records and information provided by his family, he received approximately 13 units of blood products. The patient remained hospitalized from October 20 through November 2, 2022. On November 7, 2022, he was transferred to another hospital, where he remained under treatment until his death on December 4, 2022.

According to the patient's widow, he had a non-specified preexisting predisposition to thrombosis prior to his hospitalization. She further reported that, during his treatment, a physician commented that the volume of transfused blood was so substantial that it had effectively replaced a significant portion of the patient's circulating blood volume and, for that reason, the physician was not concerned about his underlying tendency toward clot formation.

Following his hospitalization and transfusion therapy, the patient developed multiple documented thrombotic complications, including acute deep vein thrombosis involving both lower extremities, a large pulmonary embolism, and a right ventricular intracardiac thrombus. The pulmonary embolism progressed to the extent that it required surgical thrombectomy.

During his terminal hospitalization, the patient also developed cardiogenic shock, sepsis with acute organ dysfunction, acute kidney injury, myocardial infarction, hepatic injury ("shock liver"), and ultimately multisystem organ failure. According to the patient's widow, the severe thrombotic complications developed after the blood transfusions. She further reported that the extent of the clotting was substantially greater than anything she had previously observed in the patient. The patient died on December 4, 2022 [36].

Case 4: A non-COVID-19-vaccinated 63-year-old female residing in the Netherlands was diagnosed with esophageal cancer. In December 2022, she underwent radiation therapy, which reportedly resulted in hemoptysis and anemia. According to her spouse, she was stable and receiving treatment in Germany by oncology, and her tumor burden had substantially decreased in response to therapy. The patient requested blood from non-COVID-19-vaccinated donors and was denied by her healthcare providers. In January 2023, the patient received approximately four units of packed red blood cells from the general supply for treatment of anemia. According to available reports, approximately 5 days after the transfusion, she developed acute thromboembolic complications, including pulmonary embolism and lower-extremity thrombosis. She subsequently died later that month. The immediate reported cause of death was pulmonary embolism. According to statements attributed to the treating nurse, the onset of the pulmonary embolism was considered temporally associated with the blood transfusion. A physician involved in the patient's care reportedly noted that pulmonary embolism is not a commonly recognized transfusion reaction and stated that a transfusion-related adverse event could not be excluded [37,38].

Case 5: A 65-year-old non-COVID-19-vaccinated Caucasian male from Scotland underwent hip replacement surgery on November 21, 2023, during which he received a blood transfusion. Following the procedure, he reportedly developed a range of multisystem symptoms involving neurologic, cardiovascular, musculoskeletal, hepatic, and genitourinary systems. According to a recorded personal statement, the patient experienced facial paralysis consistent with Bell's palsy, cardiac symptoms, nonspecific liver-related symptoms, bladder dysfunction, neck pain, and peripheral neuropathy of the feet described as paresthesia ("pins and needles"). He also reported an exacerbation of pre-existing arthritis, including joint pain and swelling [39].

The patient described his condition as severe and progressively worsening following the surgical procedure and transfusion. Although this patient never directly received a COVID-19 vaccination, he stated that he considered himself "unofficially vaccinated," attributing his post-operative symptoms to presumed exposure to blood products from donors who may have received COVID-19 vaccination. He further reported that his symptoms were like those he associated with post-vaccination adverse event profiles. The patient also reported a family history of health events he believed were temporally associated with COVID-19 vaccination, including a sister who experienced recurrent hospitalizations following vaccination, and a brother who reportedly died of renal failure after vaccination, with no known prior history of kidney disease.

Case 6: This case was sourced *verbatim* from Dr. Pierre Korry's Substack, *The Forgotten Side of Medicine*, December 21, 2022 [40]. Note that the patient's actual words were not edited.

> "Neither of us have been "vaccinated" but my husband was given multiple transfusions against my will (his labs were borderline, so they could have held off) after the staff left him to pass out and dead-fall from a

> bedside commode, causing his first pneumothorax and nearly causing his death on that floor. He had been rapidly titrating off Vapotherm and was on his way home after 5 weeks' quarantine. [Vapotherm is a high-flow respiratory support system that delivers warmed, humidified oxygen and air through a nasal cannula. It is used to help patients who are experiencing respiratory distress while allowing them to breathe spontaneously without requiring immediate intubation.] It was directly following the transfusions he became profoundly ill and spent the remainder of his time in ICU after transferring to a larger, city hospital (total 5 months' hospitalization).
>
> I witnessed the surgeons dragging material from his multiple chest tubes (he had up to 4 at one time and had to have them replaced more times than I can recall due to clotting completely and him crashing again) that resembled fully formed 2' long + whitish beach worms. They looked very much like what was shown in that video. They tried to tell me it was blood, purulent matter and other cell material, which is impossible an olympic gerbil jump-rope team could have competed using these for a good, long time they were dragged out using forceps in single, long strands."

Case 7: The patient is a non-COVID-19-vaccinated kidney transplant recipient who, according to his spouse, in November 2023, was found to have significantly low hemoglobin levels necessitating his transplant physicians to order a blood transfusion. He reportedly received a total of 3 units of blood. According to available medical history, the patient's transplanted kidney, which had been normally functioning for approximately 20 years, failed in the summer of 2024. He subsequently initiated dialysis and continued treatment for the following year until late August 2025. On August 25, 2025, he underwent a second kidney transplant from a living donor. In November 2025, the patient presented to the emergency department with right leg pain and was diagnosed with a deep vein thrombosis, for which anticoagulation therapy was initiated. On March 14, 2026, the patient sustained a minor trauma to his right shin while moving heavy tables and chairs at church. According to his spouse, he later noted swelling, bruising, and significant bleeding. She reported that blood was absorbed through his clothing and that a towel used to clean the area appeared to contain a clot-like material, which was photographed. The spouse further described visible fibrin-like material within the specimen, which she associated with "white blood clots of the vaccinated."

According to the spouse, the patient attempted to separate the blood clot and was able to do so. She reported that white material within the clot appeared to stretch when pulled apart. She further stated her belief that these findings had been present for only a few months, beginning after the patient discontinued dialysis, and that the clots had not yet developed into larger or more structurally firm formations. The spouse reported that photographs of the material were taken and that the specimen was subsequently retained in a small glass container. She indicated that the images were annotated with an arrow identifying areas where she observed white, hardened, and nodular material within the clot.

The spouse expressed her hypothesis that the patient's dialysis treatments may have delayed the onset of thrombotic symptoms by filtering thrombogenic substances present in the blood. She stated that, after the patient's kidney transplant and discontinuation of dialysis, she believed an accumulation of those substances resulted in the subsequent development of blood clotting. In support of this opinion, she cited comments made by Gary Brecka during an interview on the Shawn Ryan Show.

Case 8: A 30-year-old non-COVID-19-vaccinated Caucasian female Gravida 5, Para 4014 from Pennsylvania labored spontaneously at term, delivering a 9-pound baby boy at home with a nurse midwife in attendance. Her pregnancy, labor, and delivery were uneventful. She had 3 prior term vaginal deliveries, all home births, and one early miscarriage. Her blood type is Rh negative, and in total she received 5 doses of RhoGAM after all her pregnancies. About 30 minutes after delivery she began experiencing heavy bright red vaginal bleeding, despite a well-contracted post-partum uterus. There was no evidence of uterine atony. Six attempts to gain IV access failed. The midwife administered intramuscular oxytocin. An ambulance was called and by 90 minutes post-delivery she was in the hospital. The source of the hemorrhage was a cervical laceration, and this was repaired in the operating room. She received 8 units of blood and plasma. Afterward she developed disseminated intravascular coagulation (DIC) and required a 32-day hospitalization. She experienced deep vein thrombosis (DVT) in her right leg 6 weeks post-partum. There is no family history of blood clots, DVT, or thromboembolism in her parents and her 9 siblings. A hematological consult in 2024 obtained a thrombophilia work up which was completely negative except for a slightly lowered protein S functional activity, although the protein S antigen was in the normal range. A follow up hematology consult in 2026 noted similar findings, a normal protein S antigen level (88% with normal reference range 60-140%), and a slightly low protein S functional activity (48% with a normal reference range 54-129%). These findings are consistent with an acquired protein S deficiency.

Case 9: A 52-year-old non-COVID-19-vaccinated Caucasian male from Mississippi underwent extensive medical evaluation and treatment between January and June 2022, including multiple hospitalizations, blood transfusions, oncologic treatment, infectious disease evaluation, and ultimately open-heart surgery. He sustained a leg injury from a falling tree branch in September 2021. By November 2021, he developed progressive lower-extremity pain that significantly impaired ambulation. Initial evaluations identified impaired circulation, pulmonary emboli, a clot at the site of leg injury, and enlarged lymph nodes. On January 3, 2022, he presented to the emergency department with chest pain and gastrointestinal bleeding. On January 8, he returned with weakness, pallor, confusion, severe pain, anemia, and a collapsed lung. He also tested positive for SARS-CoV-2 by PCR. During this hospitalization, a bleeding esophageal lesion was identified, and he received his first blood transfusion. Following quarantine requirements related to COVID-19, he was evaluated by oncology and diagnosed with advanced esophageal cancer, later estimated to be stage IV. Treatment subsequently included blood transfusions, iron infusions, chemotherapy, and immunotherapy.

Between January 10 and March 21, 2022, the patient received a total of 26 units of packed red blood cells from multiple facilities and suppliers. According to his wife's treatment diary, transfusions occurred repeatedly throughout February and March, including two units of blood on each of the following dates: February 18, February 22, February 28, March 8, March 11, and March 18. Additional transfusions occurred before and after these dates, totaling 26 units by March 21. According to the patient's wife, episodes of clinical deterioration appeared to follow blood transfusions. Blood clotting was so pronounced and pervasive that

multiple blood-draws attempts at different locations were required because the clots prevented it.

In her contemporaneous treatment diary, she documented observations of increased lower-extremity pain and swelling, worsening edema, progression of cutaneous lesions, increased clotting during blood draws, pulmonary symptoms, fatigue, and general decline occurring after transfusion events. She reported that these temporal associations led her to suspect that transfusions were contributing to her husband's worsening condition and prompted inquiries regarding the source of donor blood. These observations represent caregiver-reported temporal associations and were recorded throughout the treatment course.

Throughout treatment, additional documented findings included: extensive thrombotic complications; pulmonary emboli; splenic infarctions; lower-extremity edema and pain; recurrent chest pain and dyspnea; tachycardia; pleural and pericardial effusions; progressive vascular abnormalities; thrombocytopenia; hemolytic anemia; cardiomegaly noted on imaging; and cutaneous lesions involving the feet and lower extremities. During several hospital encounters, difficult blood drawings due to clotting were noted by the patient's wife. Dermatologic evaluation on March 23 led to biopsy of lower-extremity lesions. On March 30, pathology demonstrated thrombotic vasculopathy.

The patient and treating physicians also pursued evaluation for infectious etiologies. Cultures and additional testing were performed because of concern for possible bacterial infection and endocarditis. By April 2022, vascular imaging reportedly demonstrated absent flow in the left femoral vein and evidence of recanalization in the right leg. In May 2022, the patient developed worsening dyspnea and chest symptoms. Echocardiography performed between May 16 and May 19 identified vegetations on the cardiac valves and heart failure consistent Libman Sachs endocarditis that has been described in COVID-19 vaccination [41] Chemotherapy was subsequently discontinued.

Hospitalization from May 29 through June 2022 revealed: severe hemolytic anemia (hemoglobin 6.3 g/dL); significant damage to the mitral and aortic valves; and heart failure secondary to endocarditis. The patient underwent double-valve replacement surgery on June 6, 2022. Although initially recovering postoperatively, he subsequently developed cardiogenic shock, persistent hypotension requiring vasopressors, respiratory failure requiring mechanical ventilation, and progressive renal failure. After consultation with the care team and family, life-sustaining measures were withdrawn. The patient died on June 12, 2022. The primary source materials include complete medical records, a contemporaneous treatment diary maintained by the patient's wife, and a recorded podcast interview discussing the case [42,43].

Discussion

This study demonstrates the possibility that donated blood by COVID-19-vaccinated individuals may contain biologically active vaccine-derived constituents causing adverse clinical outcomes. The clinical cases described and the cited references warrant further investigations into potential COVID-19 vaccine-derived contaminants in donor blood. Since 2021, researchers have reported a wide range of serious adverse events following modified mRNA (modRNA) COVID-19 vaccination, including thromboembolic disorders, myocarditis, neurodegenerative diseases, and autoimmune conditions. The complications following blood transfusions in our 9 non-COVID-19-vacinated patients were similar to well-known complications following COVID-19 vaccines including venous thromboembolism [44] in all 9 cases, multi-organ system failure [45-48] in 4 cases, carditis [49-52] in 2 cases, and disseminated intravascular coagulation (DIC)[53-60] after a normal term vaginal delivery.

The central concern raised by this paper is that blood donors are currently not screened for numerous constituents that circulate in the blood after COVID-19 vaccination, including spike protein, vaccine-derived mRNA, plasmid DNA fragments, lipid nanoparticles, amyloid fibrin-microclot complexes, and other vaccine-associated byproducts. If these materials can persist in circulation for months or years after injection, then transfusion medicine faces a previously unexamined exposure pathway. The assumption that blood products derived from vaccinated donors are biologically equivalent to pre-2021 blood products has not been rigorously tested and should not be presumed without direct investigation.

What Circulates in the Blood of COVID-19 Vaccine Recipients?

Several studies report the presence of circulating spike protein following COVID-19 vaccination [61-67]. Other reports raise the hypothesis that vaccine-associated products may contribute to a range of clinical manifestations by shedding, including menstrual irregularities and abnormal bleeding [13,14], headache, fatigue, nosebleeds, bruising, fertility-related concerns, and adverse pregnancy outcomes. Although causality remains unproven, these findings suggest the need for additional research into potential exposure pathways and biological effects [68,19]. According to a Yale study, researchers found that some participants with post-vaccination syndrome had detectable circulating SARS-CoV-2 spike protein more than 700 days after their last vaccination, including some individuals without evidence of prior COVID-19 infection [69]. Even more concerningly, Hulscher and colleagues demonstrated spike protein, vaccine mRNA, plasmid DNA, and the SV40 enhancer circulating in the blood for 1,222 days [64]. This finding about SV40 is particularly alarming as it is known to be associated with serious cancer concerns, previously prompting regulators to create policies to keep it out of vaccines [70,71].

Halma and colleagues [72] raised concerns over secondary exposure to COVID-19 vaccines (lipid nanoparticles, modified mRNA, adenoviral DNA, and/or spike protein) via blood transfusion, breastfeeding, and organ donation. According to Halma, pharmacovigilance signals included case reports and VAERS data showing adverse events linked to transfusions and breastfeeding from vaccinated donors. They expressed concerns over not only primary exposure to injection by-products, but also of secondary exposure through bodily fluids. They cited several lines of evidence, including mechanistic understanding, pharmacovigilance, case reports of blood manifestations in product recipients, and case reports of autopsies from COVID-19-injected donors suggest that it may be a plausible concern.

In a two-part series published in 2023, Parry and colleagues described the pathogenic nature of spike protein describing it as “spikeopathy” [65,66]. Importantly, spike protein is not the only vaccine-derived constituent that may be relevant in this context. Other components potentially present in the circulation of vaccinated individuals include vaccine mRNA, fragmented mRNA species, lipid nanoparticles, fibrin-microclot complexes, and prion-like amyloid aggregates. Investigators have proposed that SARS-CoV-2 spike protein (whether from infection, vaccination, or both) may contribute to amyloid formation, fibrin-microclot complexes, protein misfolding, or prion-like phenomena [73,74]. Thorp and colleagues propose that an “energy steal” at the cellular level, resulting from the diversion of energy away from normal cellular functions toward spike protein production, also contributes to

protein misfolding as well as amyloid and prion production [75]. More recently, Thierry and colleagues documented that 100% of the COVID-19 vaccinated participants had prion-like amyloid fibrin-microclot complexes in a recent peer-reviewed study [76,77].

Since 2021, embalmers have reported large, calamari-like intravascular fibrous casts encountered during routine preparation of the deceased and a multiyear international survey documents such self- reported observations across five countries from 2022–2025 [78]. Embalmers emphasized that they rarely witnessed these findings before the COVID-19 vaccination rollout [79]. Several independent authors have highlighted these findings in living patients after COVID-19 vaccination [80,81,82,83]. These white fibrous specimens were recently analyzed using Raman micro spectroscopy and the Kjeldahl method [84]. Expert Raman analysis distinguishes a native like, predominantly α helical configuration in one specimen from a more β sheet enriched, aggregation advanced state in the other. The combined spectroscopic and compositional data indicate that calamari-like intravascular fibrous casts represent atypical protein aggregates exhibiting heterogeneity consistent with stage dependent β sheet enrichment, distinct from conventional postmortem thrombi. These findings further underscore the concern for amyloid-like β-sheet aggregation and prion-like substances circulating in the blood after COVID-19 vaccination.

Perhaps the most concerning observation is that many of the pathological features described in these transfusion recipients, including thromboembolic disease, myocarditis, pericardial inflammation, progressive clotting disorders, dramatic and extensive amyloid-like fibrin formations, and multisystem deterioration, closely resemble adverse events repeatedly reported following direct COVID-19 vaccination. While such similarities do not establish causation, they raise the possibility that transfusion recipients may be exposed to the same biologically active constituents that have been detected in vaccinated individuals. As Ueda et al note, cases of encephalitis caused by blood from dengue vaccine recipients have been reported as recently as 2023, indicating that the current system for managing and tracking blood products is not adequate [85]. Given the enormous scale of global blood utilization, even a low-frequency risk could have substantial public health implications and warrants urgent investigation.

Two retrospective cohort studies by Roubinian et al., published in *Transfusion*, evaluated whether donor SARS-CoV-2 infection or mRNA COVID-19 vaccination was associated with adverse outcomes in blood recipients [86,87]. The first study examined clinical outcomes in hospitalized non-COVID patients receiving plasma or platelet transfusions before and after 2020. The authors concluded that transfusions during periods of widespread donor SARS-CoV-2 infection and vaccination were not associated with increased adverse outcomes. The second study likewise found no association between adverse outcomes and products from previously infected, or vaccinated donors and concluded that donor COVID-19 infection and vaccination need not be considered in blood allocation.

As Ueda et al.,[25] pointed out, the 2024 Roubinian study had major methodological flaws:

> "Roubinian et al. reported that transfusions of plasma and platelet blood components collected before and after COVID-19 vaccination were not associated with increased adverse outcomes in transfusion recipients who did not develop COVID-19. However, they evaluated only plasma and platelet preparations, not red blood cell or whole blood preparations. The long-term effects remain unclear, as the study only followed up recipients to the point of 30-day readmission rates."

Standard hemovigilance systems under-detect rare or delayed signals. There are novel risks, including those related COVID-19-vaccine byproducts such as vaccine-derived spike protein, which may persist for year 3.5 years or longer [64]. The study was severely under-powered for more rare side effects. Overall, the Roubinian studies cannot rule out all possible long-term serious adverse events.

Exposure misclassification has been an ongoing problem with evaluating COVID-19 vaccine outcomes. If CDC vaccination definitions (≥14 days after injection) were applied, donors who donated within 14 days of vaccination could have been classified as unvaccinated, introducing a major bias association toward the null. These limitations are inherent to observational donor-linked studies and support complementary designs with more granular or verified exposure data when evaluating infrequent or delayed outcomes.

A 2026 single-center retrospective study by Jacobs et al.,[88] describes 15 patients (including 9 pediatric patients) who refused standard blood inventory and requested directed donations from non-COVID-19-vaccinated donors. The authors opine that these rare requests (48 directed units among >144,000 processed) were associated with treatment delays, clinical escalation or deterioration in some cases, resource inefficiencies, and oversight gaps. While the authors characterize such requests as a departure from evidence-based medicine, we assert it is a deviation from standard of care to not adequately screen blood donors. Moreover, honoring a patients request for donor-designated blood is a mandatory ethical requisite based on published ethical principles including patient autonomy and non-malfeasance.

Our study has several limitations. The authors purposely did not review medical records to verify claims made. Vaccination status of donated blood cannot be proven. This study has the same limitations inherent to any case series; it cannot prove causation. Blood transfusions are interventions administered for significant underlying medical illnesses. The associated morbidities could potentially contribute to the complications after a blood transfusion.

Conclusions

This hypothesis-generating safety-surveillance study suggests the possibility that blood donated by COVID-19-vaccinated individuals may contain biologically active vaccine-derived constituents that could cause adverse clinical outcomes. The case reports and cited studies identify questions that warrant further investigation. All the pathogenic components of the COVID-19 vaccine or byproducts from it, have been found in several studies to be circulating in the blood of vaccinated donors. The public should be alerted to this possibility of injuries caused by blood transfusions. Healthcare providers must honor the ethical principles of patient autonomy and non-maleficence and support patients' requests for autologous blood donation and/or designated donor blood. Ueda and colleagues' common sense and scientifically sound recommendations for not only protecting the Japanese blood supply, but the global blood supply must be implemented. Further studies are necessary. Screening blood donations for the presence of spike protein, amyloid, fibrin-microclot complexes, vaccine-derived mRNA, and plasmid DNA using quantitative assays and PCR-based methods should be considered for further evaluation by relevant public health and regulatory authorities, including the CDC and FDA.

Declarations

Ethics approval and consent to participate

Not applicable

Data Availability

All data available on corresponding author upon responsible request

Conflicts of Interest/Competing Interest

Clinton Ohlers, PhD is the Vice President of SafeBlood, Inc

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