

TWiV 1336 Clinical Update

Host: Vincent Racaniello

Guest: Daniel Griffin

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Vincent Racaniello: *This Week in Virology*, the podcast about viruses, the kind that make you sick.

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From *MicrobeTV*, this is *TWiV, This Week in Virology*, Episode 1336, recorded on July 2, 2026. I'm Vincent Racaniello, and you're listening to the podcast all about viruses. Joining me today from New York, Daniel Griffin.

Daniel Griffin: 200 miles south, I guess, of New York, out here in the Atlantic.

VR: Oh, you're in the open ocean?

DG: I am. It was wonderful. I woke up this morning to be greeted by dolphins, a whole pod of dolphins jumping, spinnaker up.

VR: Oh, cool.

DG: That's beautiful.

VR: Is the boat sailing right now?

DG: Yes. I set everything. Autopilot is on. We're doing this double-handed. We did the race down to Bermuda. We're fully crewed. Now, just two of us are racing back. We're allowed to use the autopilot. Pretty excited about the big spinnaker up.

VR: How fast are you going? How many knots?

DG: Right now, we're doing seven knots, but I'm hoping the wind builds.

VR: Wow. First clinical update on a sailboat. This is cool. All right. No bow tie today. You have a life preserver.

DG: No, I got my PFD on, but let's jump into it because who knows what will happen. Hello, everyone. I'm going to start with a Herman Melville quotation. I was thinking of him a lot, when you just look out, and you see just nothing but oceans. It reminds me of the beginning of the book there, *Moby-Dick*, where the young lad says he wants to see the world. He's like, "Look out there. That's what you're going to see."

[laughter]

All right. "Of all the preposterous assumptions of humanity over humanity, nothing exceeds most of the criticisms made on the habits of the poor by the well-housed, well-warmed, and

well-fed."

VR: I think it's great. I think, Daniel, they should not be poor. The well-fed should take care of the poor, and they fail to do so.

DG: That is really true. We got a lot to talk about today. News, the new ACIP charter, a new charter for the panel that advises the Centers for Disease Control and Prevention on vaccine use substantially refocuses the responsibilities of the committee downplaying its role in recommending the use of new vaccines and giving it responsibility to assess alternatives for disease prevention.

Whereas previous iteration of the committee's charter stressed the importance of vaccine research, relevant experience, and the selection of its members, the new version posted to the CDC's website merely stipulates that the panel, as a whole, should represent a balanced range of scientific, clinical, and public health expertise relevant to the committee's mission. A broad umbrella under which people with little experience in vaccines or vaccination policy might conceivably fit. It is the American College of, what is it, Immunization Practices. Isn't that what that I stands for?

VR: Advisory Committee on Immunization Practices.

DG: Yes.

VR: Yes. It's about immunization. This charter is ridiculous. People need to understand this, folks. Oh, my gosh. This is what you have.

DG: Membership and designation, the committee consists of up to 19 voting members appointed by the Secretary of Health and Human Services who are special government employees, including the chair and vice chair. Members shall collectively represent a balanced range of scientific, clinical, and public health expertise relevant to the committee's mission, whatever that will now be. The committee shall include persons knowledgeable about consumer perspectives and/or social and community aspects of immunization programs.

VR: What do you think about that, Danny? Do you really need to have a consumer perspective and social and community? Is this all about whether the vaccines work and they're safe or not?

DG: That really was the narrow focus previously. It was not marketing and consumer preferences. It really was an expert panel letting us know, are these vaccines safe? Are they effective? Should it be recommended?

All right. HPV. This is nice. In *CIDRAP*, we have the headline, "HPV Vaccination Eliminated Cervical Cancer Deaths in Young UK Women in Recent Years, Study Suggests." Let's look at the article.

The article, "Cervical Cancer Mortality Trends Following HPV Vaccination in England, 2001-24: An Analysis of Population-based Mortality Data," was published in *The Lancet*. This group analyzed population-based cervical cancer mortality data from England between 2001 and 2024 among women aged 20 to 24, 25 to 29, and 30 to 34 years of age.

HPV vaccination coverage by birth cohort was obtained from official records used to

estimate for each age group and calendar year of death, the proportion of women who'd been vaccinated. Here we go. In women aged 20 to 24 years, between 20 and 24, in whom vaccination coverage was around 88% to 90% at 12 to 13 years, no deaths occurred compared with 23.1 expected deaths based on historical rates, corresponding to a mortality reduction of 100%.

In earlier birth cohorts who were offered vaccination up to age 18 with coverage around 63% to 87%, mortality reductions of 80% in women aged 20 to 24 in 2015, 2019, 69% in women aged 25 to 29 in 2024 to 2024. The relative risk reduction in vaccinated women was estimated from population data to be 100%. Really, this is amazing. Up until the end of 2024, HPV vaccination in England was associated with a reduction of about 200 cervical cancer deaths.

VR: This is amazing vaccine. It is completely safe and does not warrant the lawsuits that are brought up against it, especially by RFK Jr. and his colleagues.

DG: I think that's a lot of why we put this out here. This is a cancer vaccine.

VR: It really works well too.

DG: Getting protected - incredibly well. Screwworm, the case counts keep going up. I think I'm going to start keeping track of, but we're up to a total animal cases of 29. They're down there, clustered in the Texas, New Mexico area.

VR: On this chart here, they have fly trap detection. It's zero. Why aren't they detecting positive flies?

DG: I think we're still at a low enough level. They're just starting to come in. We're starting to see domestic cases. It'll be interesting as things go forward when we start to see these screwworm flies become so prevalent., we're picking up in our fly traps. It certainly shows you that's a late indicator, so we don't want to rely on that.

Ebola, nothing good. The article, "Size of the 2026 Ebola Outbreak and Risk of Cross-border Spillover from Bundibugyo Virus in Ituri Province, DR Congo, and its Implications for Preparedness: A recalibrated Stochastic Modelling Study," was published in *The Lancet Infectious Diseases*. They probably had you right there, right?

VR: Yes.

DG: This is another modeling study with quite a title. The modeling study aimed to establish a short-term trajectory of the outbreak and probability of cross-border spillover into countries with elevated risk of importation to guide preparedness priorities. A linked daily hazard spillover model estimated importation probability for Uganda, it's already happened, South Sudan, Rwanda, and Burundi over a 12-week horizon. The early suspected case series, which peaked at 1,077 on May 26, 2026, before being substantially revised downward by lab reclassification, is reported for context but not used for calibration, so they're doing it based on the actual numbers.

Now, lab-confirmed DR Congo cases rose from 33 on May 18, 2026 to 598 by June 8, 2026. We're going to end up here with three scenarios. Also, we're going to have a high, a low, and a central scenario, and the moderates always win. Calibrated to the confirmed case

anchor of 598 on June 8, they're giving us a central basic reproduction number of 1.71. The confirmed case trajectory is most consistent with the central scenario. Under the central scenario, the ensemble projected a median of 990 cumulative confirmed cases by Week 12. That would be June 24.

Keep that in mind. We'll see where we are. We're above it, but prediction interval and 174 deaths. The low scenario predicted 870 confirmed cases, 160 deaths, and the early suspected case count, as mentioned, was recalibrated. Cross-border spillover remained material. Uganda, 94.2% importation probability, and that's already happened. South Sudan, 69.3%, Rwanda, 8.6%, Burundi, 2%.

VR: This prediction graph, Daniel, they have the high scenario, 66,000 cases by Week 24. That's incredible.

DG: I think we're really going to end up in the center here, but yes, 66,000, that is scary.

VR: This is because we have no way, we have no vaccines or antivirals at this time. We only depend on case detection to limit this.

DG: Yes. If you look at the numbers already, so our numbers as of June 27. That's really good if you think about here. They're talking basically about this point in time, what are we going to end up? They say June 24, they're predicting 990 -174. We blew past that. We're at 1,274 in the DRC. The confirmed deaths are 360. We're worse than the central prediction.

What are we doing about it? A couple of things. U.S. CDC raises Ebola outbreak response to highest level. This move, reserved for the most severe health crises, signals growing concern over the rare strains rapid spread. In *CIDRAP*, we read that construction of U.S.-backed Ebola quarantine unit in Kenya is stopped after weeks of legal turmoil, deadly protests. The construction of a U.S.-funded Ebola quarantine building near Laikipia Air Base in Kenya has officially been stopped by Kenya's Health Cabinet Secretary Aden Duale.

The 50-bed facility was announced last month as a treatment site for Americans exposed to the deadly virus in the DRC or Uganda. Kenyans protest the construction site, saying the building would unnecessarily put the Kenyan population at risk and add excessive strain to the country's health system.

You mentioned therapeutics. ASPR Supports Global Ebola Response While Strengthening U.S. Preparedness. We hear that the Administration for Strategic Preparedness and Response, ASPR, part of the U.S. Department of Health and Human Services, is supporting international efforts to respond to the ongoing Bundibugyo Ebolavirus outbreak in the DRC through deployment of investigational medical countermeasures, advancement of vaccine and therapeutic development, and continued investments in domestic preparedness as part of this coordinated effort.

We're going to see the transfer of investigational doses of MPB134. That's a monoclonal antibody therapeutic candidate developed through a partnership with BARDA and Mapp Biopharmaceutical for compassionate use in the DRC and Uganda. They're supporting the transfer of doses to the University of Oxford for use in a randomized clinical trial evaluating the safety and potential efficacy. I think that's key because this has been used in the past, but you really need to actually know if it's helpful or not.

Measles. Maybe I'm good. I'm happy I'm out at sea because the numbers are now 2,228 measles cases in the U.S. CDC has that at 2,134, and 2,242 confirmed cases was what we had last year. I guess we're starting to have, what, over 2,000 measles cases per year in the U.S., and everyone's OK with this?

VR: Not OK with it. Neither are you.

DG: We are not OK with this. None of our listeners are OK with this.

VR: It's just crazy. We should be zero.

DG: Should be zero. Speaking of zero, what's going on with COVID, Vincent? It's gone. It vanished.

VR: I don't think it vanished, but the wastewater is pretty low.

DG: Look at that. It's low. It's staying low. Where's that summer peak? Which I actually have to say is helpful if we can get rid of the summer peak because everyone gets all confused. They're like, "I only want to get a vaccine once a year. What do I do? We keep having these double peaks. I want the vaccine to work for a solid year." If we only have one peak once a year like flu, then we're in much better shape.

VR: It's this month that we're going to see. July, it starts to go up. Actually, next clinical update, we might see some activity if it's going to go up, but it is remarkably flat.

DG: All right. Fingers crossed. Got all my fingers crossed for this. All right. I'm going to close out there. No one is safe until everyone is safe. We are in the midst of our Foundation International Medical Relief of Children fundraiser. We're doubling your donations, hoping to send a maximum donation of \$10,000 to our Uganda Bududa site to help our colleagues who are there in the midst of all this. This is a great way, if you feel like, "Oh, gosh, this is horrible. I'm reading about Ebola. What can I do to help?" This is a great way. We know that this money goes directly to help people. Go to parasiteswithoutborders.com and click on that Donate button.

VR: It's time for your questions for Daniel. You can send yours to Daniel@microbe.tv. Brianna writes, "I'm a primary care physician in the Midwest, avid listener since 2020. A few episodes ago, you spent a lot of time on the shingles vaccine and its multitude of benefits beyond simply protection from shingles. In my practice, the biggest barrier to increasing shingles vaccination is that Medicare does not cover the vaccine in the clinic. Patients have to go to a pharmacy for the vaccine to be covered. My understanding is that this is because it's covered under Medicare Part D only. This barrier, in combination with the unfortunate reputation that the vaccine has for side effects, makes this to be one of the more difficult vaccines to get completed in my patients. Do you have any insight into how this Medicare coverage barrier could be circumvented? I struggle with pessimism that this type of thing would ever gain the attention of national lawmakers."

DG: I think right now is not a great time for optimism to see our government, or HHS, or Medicare, CMS is going to do anything to help with this. I think the growing data, ask your patients. Ask them about the shingles vaccine. Ask them about the dementia vaccine. Have you had your dementia vaccine yet? Oh my gosh, this can reduce your chance of dementia and Alzheimer's and all these horrible things. Maybe have that conversation with a family

member in the room because most of us don't want to have dementia. We certainly don't want our parents and loved ones to have dementia. Maybe we can do what we can, but yes, I think it's going to be a little time before we overcome this access payment barrier.

VR: Why is it just for pharmacists, Daniel? What's the logic behind that?

DG: I don't think there's logic. I think there's just a history here.

VR: I see.

DG: This has been the case for really long times.

VR: Jacob writes, "I truly appreciate your podcast, especially the clinical update. I'm writing today not to complain, but to understand. Do scree worms have something to do with viruses? You have added them to the weekly report on flu, COVID, Ebola, etcetera. Is there a connection I'm missing, or is just a way of underlining the collapse of the CDC under Trump?"

DG: They're not viruses. They're parasites, ectoparasites. It just seems like the clinical update, we've expanded a little. I think I talked about pertussis at one point. Yes, every so often, you're going to see stuff that's not classically virology or that isn't virology, and it's not just to bash the commander-in-chief.

VR: It's the scree worm, basically. That's the parasite, right?

DG: That's the parasite, yes.

VR: Anonymous writes, "Daniel, great news. Your willingness to answer my questions about the continuing effectiveness of Pemgarda against current variants has made all the difference. After you answered my last few questions about this, I told my doctor what you said, along with a link describing you from the Parasites Without Borders website. Subsequently, he agreed to refer me to the local infusion center for Pemgarda. As a result, I had my first infusion in five months a few days ago. Thank you for having such a major impact on this listener's health and well-being."

DG: Oh, that's great. That's great.

VR: Folks, sometimes it takes a little extra effort, and you have to bring Daniel's information there, but it can work. You'll see from this -

DG: Yes, happy to help when I can.

VR: This next email, again, Charmaine writes, "I recently had my annual gynecological exam and said to the doctor, 'I want to give you my rant about the HPV vaccine.' She said, 'Go for it.' I then said, 'When they came out with this thing, only those who are over 26 were eligible. I was bummed. Oh, so people over 26 don't have sex? That's ridiculous.' To which the doctor would reply, 'Well, you're most likely already infected.' To which I would retort, 'Yes, well, it doesn't mean I'm infected with every strain.' Later, they changed the eligible age to 45. At that point, I was over 45.

I then expounded on the latest research I'd learned from you guys about its lowering the risk of an infection proceeding to cancer and even being used as a treatment once one has

cancer. Her back was somewhat to me as she was preparing the PAP test materials, but I thought I detected a slight smile creep over her face. When I was done with my rant, she said, 'Do you want it?' I asked, 'Do you have it?' To which she responded, 'Yes, we have it in stock. I think we should give it to tonsil cancer patients.' I explained that I realized that it would most likely not be covered by the insurance. I was willing to pay cash.

She said, 'It's expensive.' 'How much?' I asked, '\$350 and you need three.' It took me a beat. Then I said, 'Well, am I going to buy a new coat or am I going to protect myself against cancer? I have to keep my priorities straight. Let's do it.' They gave it to me right then and there and made appointments for the other two shots. My gynecologist rocks. She is very good and also very cool. This is in the San Francisco Bay Area." That's a great experience.

DG: Fantastic. I'm so glad that we can keep poking the bear and seeing results like this.

VR: Number two, "Daniel, on the *Puscast* you guys were talking about amoxicillin versus Augmentin and the increased risk for GI problems like diarrhea with Augmentin. When my son was a toddler, he's now 32, he had a particularly gnarly infection, probably ear, that was not going away or responding to amoxicillin. The doc gave us Augmentin and warned about diarrhea. I had an idea. Along with other foods, I fed him yogurt three times a day. Voila, no diarrhea. Similarly, when I had a recent UTI, I was prescribed nitrofurantoin. A nurse friend of mine said it may cause diarrhea. It didn't. I have Greek yogurt for breakfast, kefir for lunch, and sauerkraut as part of my dinner almost every day. It seems if you keep replacing the good bugs, you are fine.

DG: This is great. Thanks very much. Not only people, but actually even we take care of dogs, and they're taking probiotics, so sweeping the nation. Maybe we should just feed them sauerkraut and kefir.

VR: John writes, "This one crossed my window via a blurb on Instagram. There have been norovirus outbreaks along the Appalachian Trail. Chasing it down further, I found this nice BeaconBio summary." He gives a link for that. "When I hear norovirus, I think cruise ship. Hiking seems about the complete opposite of going on a cruise. Since I've never seriously thought of taking one, I hadn't paid a lot of attention to norovirus except to suppose that outbreaks on cruise ships were likely to originate with salad bars. On aboard ships, could aerosolized fomites from people vomiting from seasickness be another mechanism for transmission?"

DG: This is great. I'm thinking about on the Appalachian Trail, "Oh my gosh, what a horrible place to have norovirus." You're camping, can't take a shower. Aargh, that might cut short my Appalachian experience. Yes, vomiting is an issue. When you vomit, we've actually seen transmission because you do aerosolize it. That is winter vomiting disease. It's incredibly infectious, a small amount to get you sick.

VR: In this article, they note that the Appalachian Trail poses elevated risk because they have shared privies, communal bear boxes, shelters, and water sources that facilitate environmental and fomite contamination. There's no running water, so you can't do soap and water hand-washing, which is a really good way to stop noroviruses.

DG: I think that's a problem. They're doing the alcohol, thinking they're all good, but not -

VR: No good.

DG: -helping with norovirus.

VR: No. That's *TWiV* weekly clinical update with Dr. Daniel Griffin. Thank you, Daniel.

DG: Oh, thank you. Everyone, be safe.

VR: Good luck in your race there.

DG: [chuckles] Thank you, Vincent.

[music]

[00:23:21] [END OF AUDIO]