The connection between mRNA COVID vaccines and cancer relapse and occurrence.

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My name is Professor Angus Dalgleish. I am an oncologist and immunologist with decades of experience in cancer immunotherapy and HIV research, including early clinical use of cancer immunotherapy in the United Kingdom long before checkpoint inhibitors were approved. I am Professor Emeritus and Foundation Chair of Oncology at the University of London, and Principal of the Institute of Cancer Vaccines and Immunotherapy.

Beginning in late 2021, I observed a series of unexpected cancer relapses and unusually aggressive disease presentations among patients whose conditions had remained stable for years.

A consistent pattern quickly became apparent: these relapses followed repeated COVID booster administration.

These were patients in long-term remission who suddenly relapsed after being advised to receive additional doses of the vaccine.

Despite the seriousness of these observations, there was little willingness to openly investigate these potential safety signals.

From my background in HIV research and immunology, including early work involving the CD4 receptor, I was particularly sensitive to signals involving T-cell function and immune dysregulation. This led me to become concerned that repeated boosting strategies might contribute to impaired immune surveillance in vulnerable individuals, a concern later supported by evidence of exhausted T-cell responses following repeated vaccination.

Over time, however, it became increasingly clear that the pattern extended far beyond relapse in vulnerable cancer patients alone.

I began observing something far more alarming: unusually aggressive cancers, advanced-stage disease in younger individuals, and clinical presentations that differed sharply from what we would normally expect in routine oncology practice. Something broader — and far more concerning — appeared to be emerging.

In my own clinical practice, I observed a marked increase in unexpected cancers among boosted patients, including breast, prostate, pancreatic, lymphoma, gall bladder, glioma, and bladder cancers.

Some of the most striking observations came from colorectal cancer surgeons, who described a shift from earlier-stage, more routinely detected disease toward patients presenting with metastatic stage IV cancers and unusual thrombotic features.

Increasingly, these patterns extended beyond clinical settings and into personal lives. I watched close friends develop aggressive late-stage cancers and rapidly deteriorate following repeated booster administration.

At that point, the issue no longer felt purely academic or theoretical. It became deeply personal.

I became increasingly concerned by unresolved questions surrounding the biologic behavior of mRNA-based platforms.

Emerging literature proposed several biologically plausible mechanisms linking these vaccines to cancer progression, including immune dysregulation, vascular injury, and effects involving oncogenic and tumor-suppressor pathways.

Additional issues involved residual DNA fragments and SV40 promoter/enhancer sequence elements identified in certain vaccine lots, findings which I believe warranted far greater regulatory scrutiny and independent investigation given their potential oncogenic implications.

Through my previous work with mRNA experts and service on the Scientific Advisory Board of CureVac, I also became increasingly uneasy about questions involving biologic stability, genomic interaction, and the adequacy of long-term safety evaluation surrounding repeated mRNA exposure. For example, unresolved questions remain regarding potential interactions with cellular genetic processes, potentially activating cancer-promoting pathways while disrupting tumor suppression.

The consistency of these clinical observations, combined with emerging mechanistic evidence, should have prompted far greater scientific scrutiny and open investigation than they received.

Instead, many clinicians and researchers became increasingly hesitant to openly question or investigate these potential safety signals at all. As a UK citizen, I found it striking that several members of the Royal Family, who were vaccinated, publicly disclosed unexpected cancer diagnoses during the same period many clinicians were reporting unusually aggressive cancers more broadly. Given what we know already, I have no doubt in my mind that the mRNA vaccine likely played a significant role in the development of these unexpected cancers. I raise this not to imply certainty regarding any individual case, but to illustrate how difficult open scientific discussion surrounding these broader patterns has become, even when the observations are highly visible.

Science does not advance through silence, suppression, or reputational protection. It advances through rigorous inquiry, transparent debate, independent replication, and the courage to follow evidence wherever it leads.

I believe there is now an urgent need for independent investigation into the potential relationship between repeated mRNA vaccination, immune dysregulation, and aggressive cancer progression, particularly in vulnerable populations.

If legitimate scientific concerns cannot be openly examined, public trust in medicine and public health institutions will continue to erode. Accountability and transparency are not threats to science. They are the foundation that makes science worthy of public trust.