Iatrogenic Contributing Factors to Disease

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Opinion Article

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INTRODUCTION

Iatrogenic-induced diseases (IID) are a leading cause of sickness and death. For example, "Adverse effects of medical treatment (AEMT) pose a significant global health concern, yet prior studies have mostly focused on specific adverse events or single countries, leaving the long-term global epidemiological patterns insufficiently characterized."…..."data from the Global Burden of Disease (GBD) study 2021" were used, and "AEMT were defined based on GBD criteria, and incidence, prevalence, deaths, and disability-adjusted life years (DALYs) data were extracted."…..."Globally, there were 12,481,276 new cases of AEMT, with 122,330 deaths, resulting in 4,846,981 DALYs loss in 2021." A 2024 study showed "An estimated 795000 Americans become permanently disabled or die annually across care settings because dangerous diseases are misdiagnosed".

The goal of the present Op-ed is to identify 1) the full spectrum of Iatrogenic-induced contributing factors (CFs) to diseases, 2) the specific diseases to which they contribute, and 3) the biological mechanisms that link these specific CFs to the specific diseases identified. This AI-based study used myriad AI software packages and an iterative relevance feedback approach to develop a query that could retrieve the necessary data, and it provided that query to two AI software packages (ChatGPT and Claude) for final response. The final query is in Appendix 1, and the Claude and ChatGPT final responses are contained in Appendices 2 and 3, respectively. While the bulk of the narrative of this Op-ed is based on the ChatGPT response, the Claude response is excellent as well, and is worth reading for anyone interested in the details of this topic.

The remainder of this Op-ed consists of an Executive Summary section, a Background section, a Results and Discussion section, a Summary and Conclusions section, a Final Thoughts sub-section at the end of the Summary and Conclusions section, and Appendices A, B, C, D.

PART I. EXECUTIVE SUMMARY

This investigation maps disease-producing exposures arising from healthcare to clinical outcomes and their biological mechanisms. It spans pharmaceuticals, infections, procedures, devices, imaging and radiation, blood products and transplantation, vaccines, critical care, diagnostic and system processes, product quality, and reproductive and developmental exposures. The core evidence inventory comprises 262 individually numbered contributing-factor (CF) entries in twelve categories; each may encompass several distinct exposure-outcome relationships.

The most informative findings are mechanistic convergence (different exposures reaching common disease pathways), mechanistic divergence (one exposure generating multiple disorders), and susceptibility-dependent risk. Major shared mechanisms include mitochondrial and oxidative injury, immunologic reactions, microbiome disruption, endothelial and coagulation dysfunction, mechanical or ischemic injury, DNA damage, endocrine disruption, fibrosis, and neuroadaptation. The Op-ed includes the full CF catalogue, disease-centered analysis, an indexed relationship matrix, interaction examples, biomarker framework, and evidence and research priorities.

Evidence is differentiated at two levels: strength of exposure-outcome causation and strength of the proposed mechanistic explanation. An established clinical adverse outcome does not imply that every proposed molecular pathway is established. Quantitative burden estimates depend on populations, dose, follow-up and ascertainment. Reported associations are not automatically causal.

PART II. BACKGROUND AND METHODS

2.1 Scope and definitions

An iatrogenic contributing factor is a healthcare-related intervention, exposure, device, environmental condition, or care-process event that increases the likelihood, severity, or duration of a pathological outcome. Direct, indirect, interaction-mediated, process-mediated, psychosocial, and developmental effects are distinguished. Disease, syndrome, symptom, laboratory abnormality, and death are distinct outcome types. Omissions of indicated care are treated separately from direct biological exposure effects.

2.2 Study design and evidence boundaries

This is a structured, narrative, mechanism-oriented evidence synthesis rather than a prospectively registered systematic review or de novo quantitative meta-analysis. The catalogue and mechanistic descriptions derive from an extensive supplied biomedical synthesis and are reorganized here into a standalone research report. Additional conceptual frameworks and candidate mechanisms are explicitly treated as analytic hypotheses where primary-source verification is unavailable. Bibliographic references supplied in the source material provide starting points; they are not a complete claim-by-claim reference audit.

The inclusion framework encompasses medication adverse reactions and errors, invasive and noninvasive procedures, medical devices, infection and antimicrobial selection, radiologic exposure, blood products, transplantation, immunization, hospitalization and intensive care, diagnostic and psychological cascades, system failures, environmental and product exposures, and reproductive or developmental effects. ***Exclusion of an event from this inventory must not be interpreted as evidence that it cannot occur***.

2.3 Analytical framework

Each CF is evaluated along the chain: specific exposure → molecular initiating event → cell/tissue perturbation → organ dysfunction → defined clinical phenotype. Each relationship should additionally be characterized by dose, route, duration, latency, susceptibility, interaction partners, biomarker evidence, incidence, reversibility, and prevention. The appendix uses compact narrative mapping where the available source does not support fully atomized relationship-level fields.

2.4 Evidence appraisal

Dimension	Assessment principle
Causal relationship	Established / probable / possible or hypothesized / conflicting / evidence against; judged from epidemiology, clinical intervention and alternative explanations.
Mechanistic pathway	Directly demonstrated in humans / supported by translational evidence / experimental or proposed / unknown.
Quantitative risk	Record numerator, denominator, comparator, observation period and uncertainty; do not infer rates from passive reports.

Temporal relationship	Plausible induction period, exposure sequence, dechallenge, rechallenge where ethical, and competing causes.
Generalizability	Population, comorbidity, sex, age, genetics, dose and clinical setting.

2.5 Interpretation of source grades

The original catalogue denotes E (established), P (probable), H (hypothesized/associational), and C (contested or not supported). These legacy codes are retained inside catalogue entries for traceability of evidence characterization. Because entries frequently contain multiple outcomes, a single grade is not to be read as a separate causal and mechanistic validation of every listed claim. The analytical tables identify this limitation rather than creating unsupported precision.

PART III. RESULTS AND DISCUSSION

3.1 Taxonomy of healthcare-related contributing factors

3.2 Master taxonomy of iatrogenic contributing factors

This report organizes the spectrum into twelve categories, plus three cross-cutting dimensions.

1. Pharmacologic agents (expanded): anti-infectives; analgesics, anti-inflammatories, and corticosteroids; cardiovascular, renal, and metabolic agents; neuropsychiatric agents; oncologic agents; immunomodulators and biologics; hormonal and bone-active agents; dependence and withdrawal; interactions and prescribing cascades.

2. Healthcare-associated infections and antimicrobial resistance (expanded).
3. Surgical, anesthetic, and other procedural harm (expanded).
4. Implanted devices and materials (new as a stand-alone category).
5. Therapeutic and diagnostic radiation and imaging agents (new as a stand-alone category).
6. Blood products, transplantation, and biologic transfer (expanded).
7. Vaccines (expanded to cover the full vaccine schedule and newer products).
8. Hospitalization-related and critical-care harm (expanded).
9. Diagnostic cascades, overdiagnosis, and psychological iatrogenesis (new).
10. Systems, error, and human-factors CFs (new).
11. Product-quality failures, contamination, and healthcare-environment exposures (new).
12. Developmental and reproductive iatrogenesis (new).

Cross-cutting dimensions: host genetic and physiologic susceptibility (Section 3.16); iatrogenic dependence and withdrawal (entries A88 to A89 and Section 3.15); and iatrogenic cancer (Section 3.15).

3.3 Category A: Pharmacologic agents (adverse drug reactions and toxicity)

Pharmacologic exposure is the most frequent route of iatrogenic harm. Reactions arise through predictable extension of pharmacology (Type A), idiosyncratic or immune-mediated mechanisms (Type B), cumulative or delayed effects (Types C and D), withdrawal (Type E), and interactions. The sub-sections below group agents by therapeutic class.

A-I. Anti-infective agents

A1. Beta-lactams (penicillins, cephalosporins).

-Diseases: anaphylaxis, urticaria, drug-induced hemolytic anemia, serum-sickness-like reaction, acute interstitial nephritis, cholestatic hepatitis (amoxicillin-clavulanate), rare DRESS and SJS/TEN, seizures at high dose in renal failure.

-Mechanism: the opened beta-lactam ring covalently haptenates lysine residues on carrier proteins; IgE directed at these haptens cross-links on mast cells and basophils (Type I), antibody-coated red cells are cleared (Type II), and drug-specific T cells drive delayed reactions (Type IV, with HLA-DRB1*15:01 linked to amoxicillin-clavulanate liver injury); at high concentrations beta-lactams antagonize GABA-A receptors. Grade: E.

A2. Sulfonamide antibiotics (trimethoprim-sulfamethoxazole).

-Diseases: SJS/TEN, DRESS, hyperkalemia, cytopenias, hemolysis in G6PD deficiency, crystalluria, interstitial nephritis.

-Mechanism: sulfamethoxazole hydroxylamine and nitroso metabolites haptenate proteins and activate T cells; trimethoprim blocks the epithelial sodium channel (ENaC) in the distal nephron, reducing potassium secretion (amiloride-like) and tubular creatinine secretion; folate-pathway antagonism suppresses marrow. Grade: E.

A3. Fluoroquinolones.

-Diseases: tendinopathy and Achilles rupture (higher risk with age over 60, corticosteroids, renal transplant), aortic aneurysm and dissection, peripheral neuropathy, CNS toxicity, dysglycemia, QT prolongation, C. difficile infection.

-Mechanism: induction of matrix metalloproteinases and impaired collagen synthesis in tenocytes and aortic fibroblasts, chelation of divalent cations (Mg, Mn) required for collagen cross-linking enzymes, oxidative stress; GABA-A antagonism in the CNS; hERG potassium-channel block; pancreatic beta-cell K-ATP effects for

dysglycemia. Grade: E for tendon injury and QT; P for aortic disease and neuropathy.

A4. Aminoglycosides (gentamicin, tobramycin, amikacin).

-Diseases: acute tubular necrosis, irreversible cochlear and vestibular ototoxicity, neuromuscular blockade.

-Mechanism: megalin-mediated uptake into proximal tubular cells and lysosomal accumulation (phospholipidosis), reactive oxygen species and mitochondrial injury; uptake into cochlear hair cells through mechanotransduction channels, with ROS-driven apoptosis; the mitochondrial 12S rRNA m.1555A>G variant confers hypersusceptibility by promoting aminoglycoside binding to the mitoribosome. Grade: E.

A5. Vancomycin.

-Diseases: acute kidney injury (ATN and interstitial nephritis; risk rises with high troughs or AUC, duration, critical illness, and combination with piperacillin-tazobactam), infusion reaction ("red man" syndrome), neutropenia.

-Mechanism: vancomycin-uromodulin cast formation obstructs distal tubules; intracellular accumulation in proximal tubule cells drives oxidative stress and autophagic disruption (as in the draft); the infusion reaction is non-IgE mast-cell degranulation through MRGPRX2; the piperacillin-tazobactam interaction may reflect true tubular injury or inhibited creatinine secretion (debated). Grade: E for AKI and infusion reaction.

A6. Macrolides (erythromycin, clarithromycin, azithromycin).

-Diseases: QT prolongation, torsades de pointes and sudden cardiac death (modest absolute risk), drug-interaction toxicity (statin rhabdomyolysis, colchicine toxicity, hypotension with calcium-

channel blockers, DOAC accumulation), infantile hypertrophic pyloric stenosis after early-infancy exposure (association).

-Mechanism: block of the hERG (IKr) potassium channel; mechanism-based inhibition of CYP3A4 by erythromycin and clarithromycin; motilin-receptor agonism proposed for pyloric stenosis. Grade: E for QT and interactions; P for pyloric stenosis.

A7. Clindamycin and other broad-spectrum antibiotics (fluoroquinolones, third-generation cephalosporins, carbapenems).

-Diseases: antibiotic-associated diarrhea, C. difficile colitis, pseudomembranous colitis, toxic megacolon, recurrent disease, vulvovaginal candidiasis, selection of resistant organisms (see B6).

-Mechanism: loss of colonization resistance (depletion of anaerobes such as Bacteroides and Clostridia that convert primary to secondary bile acids and compete for nutrients) allows C. difficile germination and overgrowth; toxins TcdA and TcdB glucosylate Rho GTPases, collapsing the actin cytoskeleton, disrupting tight junctions, and triggering inflammation. Grade: E.

A8. Nitrofurantoin.

-Diseases: acute hypersensitivity pneumonitis, chronic interstitial pulmonary fibrosis with long-term use, autoimmune-like hepatitis, peripheral neuropathy (especially with renal impairment), hemolysis in G6PD deficiency.

-Mechanism: nitroreductase-mediated redox cycling generates superoxide and hydrogen peroxide in lung and nerve; immune-mediated pneumonitis and hepatitis. Grade: E.

A9. Linezolid.

-Diseases: thrombocytopenia and anemia (generally beyond two weeks), lactic acidosis, optic and peripheral neuropathy, serotonin syndrome with serotonergic drugs.

-Mechanism: inhibition of mitochondrial ribosomes (structurally similar to bacterial ribosomes) impairs oxidative phosphorylation; reversible, nonselective monoamine oxidase inhibition. Grade: E.

A10. Chloramphenicol.

-Diseases: dose-related marrow suppression, idiosyncratic aplastic anemia (about 1 per 20,000 to 40,000 courses), gray baby syndrome in neonates.

-Mechanism: inhibition of mitochondrial protein synthesis; reduced glucuronidation (immature UGT enzymes) in neonates leads to accumulation, mitochondrial electron-transport inhibition, and cardiovascular collapse; aplastic anemia is idiosyncratic and may involve nitroso metabolites. Grade: E.

A11. Antituberculous agents (isoniazid, rifampin, pyrazinamide).

-Diseases: drug-induced liver injury (DILI) up to hepatic failure, isoniazid peripheral neuropathy.

-Mechanism: isoniazid is metabolized by NAT2 and CYP2E1 to hydrazine and acetylhydrazine reactive intermediates (slow acetylators have higher hydrazine exposure); rifampin induces CYP enzymes and inhibits bile-salt export; isoniazid depletes pyridoxine. Grade: E.

A12. Amphotericin B (conventional) and polymyxins (colistin).

-Diseases: nephrotoxicity (distal tubular injury, hypokalemia, hypomagnesemia, renal tubular acidosis), colistin neurotoxicity.

-Mechanism: amphotericin forms pores in cholesterol-containing host membranes and causes afferent-arteriolar vasoconstriction through tubuloglomerular feedback; polycationic colistin disrupts tubular-cell membranes and induces mitochondrial oxidative stress. Grade: E.

A13. Abacavir.

-Diseases: abacavir hypersensitivity syndrome (fever, rash, gastrointestinal and respiratory symptoms; multi-organ), confined almost entirely to carriers of HLA-B57:01. This is distinct from SJS/TEN and should not be classified under it (correction to draft CF 1).

-Mechanism: abacavir binds non-covalently in the HLA-B57:01 peptide-binding groove, changing the repertoire of self-peptides presented and activating CD8-positive T cells against the host (altered-peptide-repertoire model). Prospective HLA screening nearly eliminated immunologically confirmed hypersensitivity in screened populations. Grade: E.

A14. Nucleoside reverse-transcriptase inhibitors and tenofovir disoproxil.

-Diseases: lactic acidosis, hepatic steatosis, lipoatrophy, neuropathy, myopathy (older NRTIs: stavudine, didanosine, zidovudine); proximal tubulopathy (Fanconi syndrome), chronic kidney disease, and bone loss (tenofovir disoproxil; lower with tenofovir alafenamide).

-Mechanism: inhibition of mitochondrial DNA polymerase gamma depletes mtDNA and impairs oxidative phosphorylation; OAT1-mediated uptake concentrates tenofovir in proximal tubule mitochondria. Grade: E.

A15. Early-life and repeated antibiotic exposure.

-Diseases: associations with childhood asthma, atopy, obesity, inflammatory bowel disease, and recurrent C. difficile.

-Mechanism: dysbiosis during immune and metabolic programming windows, loss of short-chain-fatty-acid-producing taxa, and altered

regulatory T-cell induction; strongly confounded by indication and family factors. Grade: H to P.

A-II. Analgesic, anti-inflammatory, and corticosteroid agents

A16. Acetaminophen (paracetamol).

-Diseases: acute liver failure from overdose or repeated supratherapeutic dosing (a leading cause of acute liver failure in the US and UK), with greater susceptibility in fasting, malnutrition, and chronic alcohol use.

-Mechanism: CYP2E1 (with CYP1A2 and 3A4) generates N-acetyl-p-benzoquinone imine (NAPQI); once glutathione is depleted, NAPQI covalently binds mitochondrial proteins, causing oxidative stress, JNK activation, mitochondrial permeability transition, and centrilobular necrosis; N-acetylcysteine replenishes glutathione. Grade: E.

A17. NSAIDs: gastrointestinal effects (ibuprofen, naproxen, diclofenac, aspirin).

-Diseases: peptic ulcer, upper gastrointestinal bleeding and perforation, small-bowel enteropathy.

-Mechanism: COX-1 inhibition reduces gastroprotective prostaglandins (mucus, bicarbonate, mucosal blood flow); direct topical acid-trapping injury; impaired platelet function worsens bleeding; synergy with H. pylori, corticosteroids, and anticoagulants. Grade: E.

A18. NSAIDs: renal and fluid-balance effects.

-Diseases: hemodynamic acute kidney injury (especially in volume depletion, heart failure, cirrhosis, CKD, and in the "triple whammy" with ACE inhibitors/ARBs and diuretics), acute interstitial nephritis, minimal-change nephrotic syndrome, hyperkalemia, sodium retention, hypertension, heart-failure exacerbation.

-Mechanism: loss of prostaglandin-mediated afferent arteriolar vasodilation lowers glomerular pressure; hyporeninemic hypoaldosteronism; immune-mediated interstitial nephritis. Grade: E.

A19. NSAIDs and selective COX-2 inhibitors: cardiovascular events.

-Diseases: myocardial infarction, stroke, heart failure, hypertension (rofecoxib was withdrawn in 2004 after the APPROVe trial; diclofenac carries high risk, naproxen relatively lower).

-Mechanism: suppression of endothelial COX-2-derived prostacyclin (vasodilator, antiplatelet) without equal suppression of platelet COX-1-derived thromboxane tips the thrombotic balance; renal sodium retention and blood-pressure elevation. Grade: E.

A20. Aspirin and other salicylates.

-Diseases: Reye syndrome in children with influenza or varicella, GI bleeding, salicylism (tinnitus, anion-gap metabolic acidosis), aspirin-exacerbated respiratory disease.

-Mechanism: Reye syndrome involves mitochondrial dysfunction (impaired beta-oxidation and uncoupling) causing microvesicular steatosis, hyperammonemia, and encephalopathy; COX-1 inhibition shunts arachidonate toward leukotrienes in aspirin-exacerbated respiratory disease. Grade: E for bleeding and salicylism; P for Reye syndrome.

A21. Systemic corticosteroids (prolonged or high-dose; also excessive inhaled, topical, or intra-articular use).

-Diseases: iatrogenic Cushing syndrome, HPA-axis suppression with adrenal crisis on withdrawal, osteoporosis and fractures, avascular necrosis, hyperglycemia and diabetes, opportunistic infections including Pneumocystis, myopathy, psychosis and mood disorders,

posterior subcapsular cataract, glaucoma, hypertension, skin atrophy, growth suppression in children.

-Mechanism: glucocorticoid-receptor signaling suppresses ACTH and causes adrenal atrophy; increases hepatic gluconeogenesis and insulin resistance; reduces osteoblast differentiation and promotes osteoblast and osteocyte apoptosis while increasing RANKL and prolonging osteoclast survival; reduces intestinal calcium absorption and raises renal excretion; upregulates muscle atrogenes (atrogin-1, MuRF1) and reduces mTOR signaling; induces lymphocyte apoptosis and represses NF-kappaB-driven immunity; femoral-head necrosis involves osteocyte apoptosis and microvascular compromise. Grade: E.

A22. Opioid analgesics: respiratory depression.

-Diseases: respiratory depression, hypoxic brain injury, death, particularly with benzodiazepines, gabapentinoids, renal failure (morphine-6-glucuronide accumulation), obstructive sleep apnea, or rapid dose escalation.

-Mechanism: mu-opioid receptor activation opens GIRK potassium channels and reduces cAMP in brainstem respiratory-rhythm generators (pre-Botzinger complex, Kolliker-Fuse), reducing respiratory drive and chemoreflex sensitivity to hypercapnia. Grade: E.

A23. Opioid analgesics: gastrointestinal and endocrine effects.

-Diseases: opioid-induced constipation, ileus, nausea, sphincter of Oddi spasm, opioid-induced androgen deficiency (hypogonadotropic hypogonadism), opioid-induced hyperalgesia.

-Mechanism: mu receptors on enteric neurons inhibit acetylcholine and VIP release, reducing propulsion and increasing sphincter tone and fluid absorption; hypothalamic suppression of GnRH; central

sensitization (NMDA and glial mechanisms) in hyperalgesia. Grade: E for constipation; P for hypogonadism and hyperalgesia.

A-III. Cardiovascular, hematologic, renal, and metabolic agents

A24. Warfarin.

-Diseases: major hemorrhage (GI, intracranial), hematoma, warfarin-induced skin necrosis, purple-toe syndrome, calciphylaxis association; teratogenic embryopathy (L5).

-Mechanism: inhibition of vitamin K epoxide reductase (VKORC1) reduces gamma-carboxylation of factors II, VII, IX, X and proteins C and S; early protein C depletion (short half-life) explains transient hypercoagulability and skin necrosis; risk is amplified by CYP2C9*2/*3 and VKORC1 promoter variants and by interactions (e.g., trimethoprim-sulfamethoxazole, azoles, amiodarone). Grade: E.

A25. Heparins (unfractionated and low-molecular-weight).

-Diseases: heparin-induced thrombocytopenia (HIT) with arterial and venous thrombosis, bleeding, hyperkalemia, osteoporosis with prolonged use.

-Mechanism: heparin binds platelet factor 4 (PF4), exposing neoepitopes; IgG anti-PF4/heparin antibodies form immune complexes that activate platelets and monocytes via Fc-gamma-RIIa, generating thrombin and consuming platelets; thrombocytopenia typically appears 5 to 10 days after first exposure (earlier with prior exposure); hyperkalemia results from aldosterone suppression. Grade: E.

A26. Direct oral anticoagulants (apixaban, rivaroxaban, edoxaban, dabigatran).

-Diseases: major bleeding (particularly gastrointestinal), accumulation and bleeding in acute kidney injury, interaction-related bleeding.

-Mechanism: direct, reversible inhibition of factor Xa or thrombin impairs fibrin generation; P-glycoprotein and CYP3A4 interactions and renal clearance determine exposure. Grade: E.

A27. Antiplatelet agents (aspirin, P2Y12 inhibitors).

-Diseases: bleeding, thrombotic thrombocytopenic purpura (rare, ticlopidine and clopidogrel), bleeding risk amplification in dual therapy.

-Mechanism: irreversible inhibition of platelet COX-1 or P2Y12 receptors; rare ADAMTS13-inhibitory autoantibodies cause TTP. Grade: E.

A28. Thrombolytics (alteplase, tenecteplase).

-Diseases: symptomatic intracranial hemorrhage (about 2% to 7% in stroke trials), systemic bleeding, orolingual angioedema.

-Mechanism: plasminogen activation causes fibrinolysis and systemic fibrinogenolysis; blood-brain-barrier disruption (matrix metalloproteinase-9) and reperfusion injury in infarcted tissue; bradykinin-mediated angioedema, more frequent with concurrent ACE inhibitors. Grade: E.

A29. ACE inhibitors and angiotensin-receptor blockers.

-Diseases: hyperkalemia, acute kidney injury (volume depletion, bilateral renal-artery stenosis), cough, angioedema (ACE inhibitors; higher in Black patients), fetopathy (L4).

-Mechanism: reduced angiotensin II lowers efferent arteriolar tone and aldosterone; ACE (kininase II) inhibition permits accumulation of bradykinin and substance P, increasing vascular permeability and cough-reflex sensitivity. Grade: E.

A30. Loop diuretics (furosemide, bumetanide).

-Diseases: hypokalemia, hypomagnesemia, volume depletion and AKI, metabolic alkalosis, hyperuricemia, falls, dose-related ototoxicity.

-Mechanism: inhibition of the Na-K-2Cl cotransporter in the thick ascending limb raises distal sodium delivery, driving potassium and hydrogen secretion; NKCC1 inhibition in the stria vascularis alters endolymph. Grade: E.

A31. Thiazide and thiazide-like diuretics.

-Diseases: hyponatremia (often in elderly women), hypokalemia, hypercalcemia, hyperuricemia and gout, glucose intolerance; association of hydrochlorothiazide with non-melanoma skin cancer.

-Mechanism: inhibition of the sodium-chloride cotransporter impairs urinary dilution and increases distal potassium loss; hydrochlorothiazide is a UV-absorbing photosensitizer. Grade: E for electrolyte disorders; H to P for skin cancer.

A32. Mineralocorticoid-receptor antagonists and other hyperkalemia-promoting drugs (spironolactone, eplerenone, amiloride, trimethoprim, heparin, calcineurin inhibitors).

-Diseases: hyperkalemia with arrhythmia, gynecomastia (spironolactone).

-Mechanism: reduced aldosterone signaling or ENaC blockade reduces potassium secretion; spironolactone antagonizes androgen receptors. Grade: E.

A33. Digoxin.

-Diseases: life-threatening arrhythmias (bidirectional ventricular tachycardia, atrioventricular block), anorexia and nausea, visual disturbances.

-Mechanism: Na+/K+-ATPase inhibition raises intracellular sodium and, via the Na+/Ca2+ exchanger, intracellular calcium, causing delayed afterdepolarizations; hypokalemia increases drug binding to the pump; accumulation in renal impairment and with interacting drugs. Grade: E.

A34. Amiodarone.

-Diseases: pulmonary toxicity (interstitial pneumonitis, organizing pneumonia, fibrosis), hypothyroidism and thyrotoxicosis, hepatotoxicity, corneal microdeposits and optic neuropathy, photosensitivity and blue-gray skin, bradycardia, peripheral neuropathy.

-Mechanism: lipophilic cationic drug accumulates in lysosomes, inhibiting phospholipases and causing phospholipidosis (foamy macrophages), with mitochondrial dysfunction, ROS, and fibroblast activation (the Hippo/YAP link in the draft is a proposed mechanism); thyroid effects reflect iodine load (about 37% iodine by weight: Wolff-Chaikoff failure to escape, iodine-induced thyrotoxicosis, and destructive thyroiditis). Grade: E (YAP

-Mechanism: H).

A35. Class I antiarrhythmics (flecainide, encainide) and class III agents (sotalol, dofetilide).

-Diseases: proarrhythmia and increased mortality after myocardial infarction (CAST trial); torsades de pointes.

-Mechanism: use-dependent sodium-channel block slows conduction and promotes re-entry in scarred myocardium; potassium-channel (hERG) block prolongs repolarization. Grade: E.

A36. QT-prolonging drugs across classes (antipsychotics, citalopram, methadone, ondansetron, macrolides, fluoroquinolones, azoles, hydroxychloroquine, arsenic trioxide, some kinase inhibitors).

-Diseases: torsades de pointes, sudden cardiac death.

-Mechanism: block of IKr (hERG) prolongs repolarization and permits early afterdepolarizations; risk is multiplied by hypokalemia, hypomagnesemia, bradycardia, female sex, structural heart disease, congenital long-QT variants, and stacking of several QT-active drugs. Grade: E.

A37. Statins.

-Diseases: myopathy (about 1 per 10,000 patient-years), rhabdomyolysis (about 1 to 3 per 100,000 patient-years), immune-mediated necrotizing myopathy (anti-HMGCR antibodies), small increase in new-onset diabetes, enzyme elevations. Muscle pain in randomized blinded trials is largely not attributable to the drug (nocebo effect), which should temper the draft's description of severe toxicity as typical.

-Mechanism: HMG-CoA reductase inhibition reduces isoprenoids and coenzyme Q10, impairing mitochondrial function and promoting myocyte apoptosis; SLCO1B1*5 raises systemic exposure; CYP3A4 inhibitors raise levels; statin-exposed autoantigen upregulation in necrotizing myopathy; reduced beta-cell and insulin-signaling function proposed for diabetes. Grade: E for rhabdomyolysis and necrotizing myopathy; P for diabetes.

A38. Beta-blockers.

-Diseases: bradycardia, atrioventricular block, bronchospasm (non-selective agents), masking of hypoglycemia, fatigue, rebound angina and arrhythmia on abrupt withdrawal (see A89).

-Mechanism: beta-1 and beta-2 blockade; receptor up-regulation during chronic blockade causes rebound hypersensitivity. Grade: E.

A39. Insulin and insulin secretagogues (sulfonylureas, meglitinides).

-Diseases: severe hypoglycemia (seizures, coma, arrhythmia, falls, injury; repeated episodes associated with dementia), weight gain.

-Mechanism: excess insulin suppresses hepatic glucose output and increases peripheral glucose uptake, depriving the brain of its obligate substrate; sulfonylureas close pancreatic beta-cell K-ATP channels independent of glucose; long-acting agents (glyburide) accumulate in CKD; recurrent hypoglycemia blunts counter-regulatory responses (hypoglycemia-associated autonomic failure). Insulin ranks among the most frequent causes of emergency visits for ADEs. Grade: E.

A40. Metformin.

-Diseases: lactic acidosis (rare, in renal or hepatic failure and hypoperfusion), vitamin B12 deficiency, gastrointestinal intolerance.

-Mechanism: mitochondrial complex I inhibition increases lactate production; calcium-dependent ileal B12-intrinsic-factor absorption is impaired. Grade: E for GI effects and B12 deficiency; P for lactic acidosis.

A41. Thiazolidinediones (pioglitazone, rosiglitazone).

-Diseases: fluid retention and heart failure, fractures (particularly in women), weight gain; a myocardial-infarction signal with rosiglitazone (contested); small bladder-cancer association with pioglitazone.

-Mechanism: PPAR-gamma activation increases distal-nephron sodium reabsorption (ENaC); shifts marrow mesenchymal differentiation toward adipocytes and away from osteoblasts. Grade: E for heart failure and fractures; H for bladder cancer.

A42. SGLT2 inhibitors.

-Diseases: euglycemic diabetic ketoacidosis, genital mycotic infections, urinary tract infection, rare Fournier gangrene, volume

depletion and AKI, amputation signal with canagliflozin.

-Mechanism: glycosuria supports yeast growth and osmotic diuresis; lower insulin with higher glucagon promotes ketogenesis during illness, fasting, or surgery. Grade: E for ketoacidosis and mycotic infection; P for others.

A43. GLP-1 receptor agonists and dual agonists.

-Diseases: gastrointestinal intolerance, cholelithiasis and cholecystitis, delayed gastric emptying with retained gastric contents at anesthesia, pancreatitis (association), non-arteritic anterior ischemic optic neuropathy (recognized by regulators in 2025 as a very rare effect of semaglutide; verify current labeling).

-Mechanism: slowed gastric transit and reduced gallbladder emptying (accentuated by rapid weight loss); the pathway for optic neuropathy is unknown. Grade: E for GI effects and gallbladder disease; H to P for pancreatitis and optic neuropathy.

A44. Proton-pump inhibitors.

-Diseases: C. difficile and other enteric infections, pneumonia (association), hypomagnesemia, vitamin B12 and iron deficiency, fractures (association), acute interstitial nephritis and CKD (association), rebound acid hypersecretion on withdrawal.

-Mechanism: loss of the gastric acid barrier shifts upper-GI microbiota; reduced intestinal TRPM6/7-mediated magnesium absorption; impaired acid-dependent B12 and iron liberation; hypergastrinemia with enterochromaffin-like cell hyperplasia causes rebound; immune-mediated interstitial nephritis. Grade: E for hypomagnesemia and interstitial nephritis; P for infection; H for fractures and CKD.

A45. Thyroid-hormone over-replacement (levothyroxine, liothyronine, including misuse for weight loss).

-Diseases: iatrogenic thyrotoxicosis, atrial fibrillation, accelerated bone loss, anxiety.

-Mechanism: excess thyroid hormone increases beta-adrenergic sensitivity, metabolic rate, and osteoclast activity. Grade: E.

A-IV. Neuropsychiatric agents

A46. Typical (first-generation) antipsychotics (haloperidol, chlorpromazine).

-Diseases: acute dystonia, parkinsonism, akathisia, tardive dyskinesia, neuroleptic malignant syndrome, hyperprolactinemia with hypogonadism and bone loss, QT prolongation.

-Mechanism: striatal D2 blockade (extrapyramidal effects emerge at high occupancy); chronic blockade induces D2 receptor up-regulation and supersensitivity, with oxidative stress and GABAergic dysfunction proposed for tardive dyskinesia; hypothalamic and striatal D2 blockade with muscle rigidity in neuroleptic malignant syndrome; tuberoinfundibular D2 blockade removes tonic inhibition of prolactin. Grade: E.

A47. Atypical (second-generation) antipsychotics (olanzapine, clozapine, quetiapine, risperidone).

-Diseases: weight gain, metabolic syndrome, type 2 diabetes, dyslipidemia; clozapine-specific agranulocytosis, early myocarditis, seizures, severe constipation and ileus, sialorrhea.

-Mechanism: antagonism of 5-HT2C and histamine H1 (and M3) receptors drives hyperphagia and adiposity, with direct impairment of insulin secretion and sensitivity; clozapine metabolites (nitrenium ion) are cytotoxic to neutrophils and immune hypersensitivity underlies myocarditis; muscarinic blockade reduces gut motility. Grade: E.

A48. Lithium.

-Diseases: nephrogenic diabetes insipidus, chronic tubulointerstitial nephropathy and CKD, hypothyroidism, hyperparathyroidism with hypercalcemia, tremor, acute neurotoxicity.

-Mechanism: lithium enters collecting-duct principal cells via ENaC and inhibits glycogen synthase kinase-3, reducing aquaporin-2 expression and apical insertion; chronic tubular injury and fibrosis; inhibition of thyroid-hormone release; altered parathyroid calcium set-point. Grade: E.

A49. SSRIs and SNRIs.

-Diseases: serotonin syndrome (usually with combinations such as linezolid or MAO inhibitors, tramadol, triptans, or other serotonergic agents), hyponatremia (SIADH), bleeding (especially with NSAIDs or anticoagulants), dose-dependent QT prolongation (citalopram), discontinuation syndrome, sexual dysfunction (a persistent post-treatment form is reported and incompletely characterized), falls and fractures in older adults, treatment-emergent suicidality in young people.

-Mechanism: SERT inhibition increases synaptic serotonin; excess 5-HT2A (and 5-HT1A) stimulation produces neuromuscular hyperactivity, hyperthermia, and autonomic instability; serotonin promotes ADH release; platelets rely on SERT to take up serotonin, so inhibition impairs aggregation; abrupt cessation unmasks receptor adaptation. Grade: E (persistent sexual dysfunction: H).

A50. Benzodiazepines and Z-drugs (zolpidem).

-Diseases: sedation, falls and hip fracture, motor-vehicle crashes, cognitive impairment, delirium in hospitalized older adults, respiratory depression (especially with opioids), paradoxical disinhibition, physical dependence with withdrawal seizures; observational association with dementia (H).

-Mechanism: positive allosteric modulation of GABA-A receptors (alpha-1 sedation, alpha-2/3 anxiolysis); chronic exposure alters receptor subunit composition and reduces receptor density, so abrupt withdrawal leaves unopposed glutamatergic excitation. Grade: E.

A51. Anticholinergic burden (diphenhydramine and other first-generation antihistamines, oxybutynin, tricyclic antidepressants, paroxetine, antispasmodics).

-Diseases: delirium, cognitive impairment, urinary retention, constipation and ileus, tachycardia, acute angle-closure glaucoma, heat stroke; observational association between cumulative exposure and dementia; tricyclic overdose causes QRS widening, arrhythmia, and seizures.

-Mechanism: central M1 blockade impairs cholinergic arousal and attention networks; peripheral antimuscarinic effects; tricyclics block cardiac sodium channels. Grade: E for delirium and peripheral effects; H to P for dementia.

A52. Valproate.

-Diseases: hepatotoxicity (including fatal microvesicular steatosis, especially in young children and POLG-variant patients), hyperammonemic encephalopathy, pancreatitis, thrombocytopenia, tremor, weight gain, polycystic-ovary-like syndrome; teratogenicity (L2).

-Mechanism: valproyl-CoA and 4-ene-valproate metabolites inhibit fatty-acid beta-oxidation and sequester CoA and carnitine; inhibition of carbamoyl-phosphate synthetase impairs ureagenesis; mitochondrial DNA polymerase gamma variants (Alpers-Huttenlocher syndrome) are a contraindication. Grade: E.

A53. Enzyme-inducing and sodium-channel anticonvulsants (carbamazepine, phenytoin, phenobarbital, lamotrigine).

-Diseases: SJS/TEN and DRESS (carbamazepine with HLA-B15:02 in Southeast and South Asian populations and HLA-A31:01 in Europeans and Japanese; phenytoin with CYP2C93 and HLA-B15:02; lamotrigine with rapid titration or valproate co-therapy), osteomalacia and bone loss, hyponatremia (carbamazepine), gingival hyperplasia (phenytoin), cerebellar toxicity, teratogenicity.

-Mechanism: carbamazepine binds directly and non-covalently to HLA-B*15:02 and the T-cell receptor (pharmacological-interaction concept), activating cytotoxic CD8-positive T cells and releasing granulysin, FasL, perforin and granzyme B; enzyme induction accelerates vitamin D catabolism. Grade: E.

A54. CNS stimulants and sympathomimetics (amphetamines, methylphenidate, pseudoephedrine).

-Diseases: tachycardia, hypertension, arrhythmia, myocardial infarction, psychosis and mania, growth suppression in children, dependence, reversible cerebral vasoconstriction syndrome (pseudoephedrine, reported).

-Mechanism: increased synaptic dopamine and norepinephrine and direct adrenergic agonism. Grade: E for cardiovascular and psychiatric effects; P for others.

A55. Gabapentinoids and proconvulsant or serotonergic analgesics (gabapentin, pregabalin, tramadol, bupropion).

-Diseases: sedation, falls, respiratory depression when combined with opioids, peripheral edema, misuse (gabapentinoids); seizures, serotonin syndrome, hypoglycemia, and hyponatremia (tramadol); dose-dependent seizures (bupropion).

-Mechanism: binding to the alpha-2-delta subunit of voltage-gated calcium channels reduces excitatory neurotransmission; tramadol combines mu-opioid, serotonin and norepinephrine reuptake effects

and depends on CYP2D6 for its active metabolite. Grade: E for sedation and seizures; P for respiratory depression.

A56. Metoclopramide and other dopamine-blocking antiemetics (prochlorperazine, promethazine, droperidol).

-Diseases: acute dystonia, akathisia, tardive dyskinesia (boxed warning for use beyond 12 weeks), QT prolongation (droperidol).

-Mechanism: striatal D2 receptor blockade with chronic receptor supersensitivity; hERG block. Grade: E.

A-V. Cytotoxic, targeted, and cellular oncologic therapies

A57. Anthracyclines (doxorubicin, daunorubicin, epirubicin).

-Diseases: dose-dependent cardiomyopathy and heart failure (risk rises with cumulative dose, young or old age, prior chest radiation, hypertension, and trastuzumab), arrhythmia, therapy-related myeloid neoplasms.

-Mechanism: poisoning of topoisomerase II-beta in cardiomyocytes causes DNA double-strand breaks and mitochondrial dysfunction; anthracycline-iron complexes generate free radicals that overwhelm limited cardiac antioxidant defenses; dexrazoxane (iron chelation and Top2B depletion) is protective. Grade: E.

A58. Trastuzumab and other HER2-directed therapy.

-Diseases: cardiomyopathy with reduced ejection fraction (often reversible).

-Mechanism: HER2/ErbB2 signaling (neuregulin-ErbB4/ErbB2) supports cardiomyocyte survival and stress adaptation; blockade removes this protective pathway, with synergy after anthracycline injury. Grade: E.

A59. Platinum agents (cisplatin, carboplatin, oxaliplatin).

-Diseases: acute tubular necrosis and magnesium wasting, permanent ototoxicity (especially in children), peripheral neuropathy, severe emesis, myelosuppression (carboplatin).

-Mechanism: uptake through OCT2 and copper transporter CTR1 concentrates cisplatin in proximal tubular and cochlear cells; DNA cross-linking, reactive oxygen species, and TNF-alpha-driven inflammation cause apoptosis; accumulation in dorsal root ganglia (no blood-nerve barrier) causes neuropathy. Grade: E.

A60. Neurotoxic cytostatics (taxanes, vinca alkaloids, oxaliplatin, bortezomib).

-Diseases: chemotherapy-induced peripheral neuropathy (sensory, painful, sometimes permanent), autonomic neuropathy (vincristine).

-Mechanism: disruption of microtubule dynamics (taxanes stabilize; vincas depolymerize) impairs axonal transport; axonal mitochondrial damage and oxidative stress; dorsal-root-ganglion accumulation; oxaliplatin's acute cold-induced neuropathy reflects altered voltage-gated sodium-channel kinetics. Grade: E.

A61. Bleomycin.

-Diseases: pneumonitis and pulmonary fibrosis (risk rises with cumulative dose, age, renal impairment, prior radiation, and supplemental oxygen), Raynaud phenomenon, skin hyperpigmentation.

-Mechanism: iron-bleomycin complexes generate reactive oxygen species that cause DNA strand breaks; lung and skin express little bleomycin hydrolase; alveolar epithelial injury and TGF-beta-driven fibroblast activation lead to fibrosis. Grade: E.

A62. Methotrexate.

-Diseases: myelosuppression, mucositis, hepatic fibrosis with long-term low-dose use, hypersensitivity pneumonitis, high-dose renal

injury, leukoencephalopathy (intrathecal or high-dose), fatal toxicity from daily instead of weekly dosing errors; teratogenicity (L6).

-Mechanism: tight-binding inhibition of dihydrofolate reductase depletes tetrahydrofolate and thus purine and thymidylate synthesis in rapidly dividing cells; methotrexate and 7-hydroxymethotrexate precipitate in acidic urine; interacting drugs (NSAIDs, PPIs, trimethoprim-sulfamethoxazole) reduce clearance; leucovorin rescue bypasses the block. Grade: E.

A63. Alkylating agents (cyclophosphamide, ifosfamide, melphalan, busulfan, chlorambucil, temozolomide).

-Diseases: myelosuppression, hemorrhagic cystitis and later bladder cancer (cyclophosphamide, ifosfamide), ifosfamide Fanconi syndrome and encephalopathy, therapy-related myelodysplastic syndrome and acute myeloid leukemia (latency about 5 to 7 years, often with chromosome 5 or 7 loss), gonadotoxicity (L10), veno-occlusive disease (busulfan), pulmonary fibrosis (busulfan, carmustine).

-Mechanism: DNA alkylation and cross-linking trigger DNA-damage response, apoptosis, and mutagenesis; the metabolite acrolein injures urothelium (mesna binds it); chloroacetaldehyde injures proximal tubule and brain. Grade: E.

A64. Topoisomerase-II inhibitors (etoposide, mitoxantrone, anthracyclines).

-Diseases: therapy-related acute myeloid leukemia with 11q23/KMT2A rearrangements (short latency, 1 to 3 years); mitoxantrone cardiotoxicity.

-Mechanism: stabilized topoisomerase-II-DNA cleavage complexes yield double-strand breaks that are misrepaired at the KMT2A breakpoint region, generating oncogenic fusion genes. Grade: E.

A65. Fluoropyrimidines (5-fluorouracil, capecitabine).

-Diseases: severe or fatal mucositis, diarrhea, neutropenia and neurotoxicity in DPD deficiency; coronary vasospasm; hand-foot syndrome; hyperammonemic encephalopathy.

-Mechanism: dihydropyrimidine dehydrogenase (DPYD) normally catabolizes most of a dose; variants (e.g., c.1905+1G>A, c.1679T>G, c.2846A>T, HapB3) prolong exposure to thymidylate-synthase inhibition and RNA misincorporation; vasospasm likely reflects endothelial dysfunction; uridine triacetate is an antidote. Grade: E.

A66. VEGF-pathway inhibitors (bevacizumab, ramucirumab, sunitinib, sorafenib, axitinib).

-Diseases: hypertension, proteinuria and thrombotic microangiopathy, arterial thromboembolism, hemorrhage, gastrointestinal perforation, impaired wound healing, posterior reversible encephalopathy syndrome.

-Mechanism: loss of VEGF-driven nitric-oxide and prostacyclin production causes vasoconstriction and microvascular rarefaction; loss of podocyte-derived VEGF produces glomerular endotheliosis; impaired endothelial and epithelial repair. Grade: E.

A67. Kinase inhibitors (ponatinib, nilotinib, ibrutinib, dasatinib, EGFR inhibitors).

-Diseases: arterial occlusive events (ponatinib, nilotinib), QT prolongation and hyperglycemia (nilotinib), atrial fibrillation and bleeding (ibrutinib), pleural effusion and pulmonary hypertension (dasatinib), rash and interstitial lung disease (EGFR inhibitors).

-Mechanism: off-target inhibition of vascular, cardiac, and platelet kinases (e.g., BTK/TEC and CSK/PI3K-Akt pathways in atrial myocytes and platelets); hERG block; EGFR inhibition in skin and

lung epithelium. Grade: E for the best-characterized events; P for mechanisms.

A68. Immune checkpoint inhibitors (anti-PD-1, anti-PD-L1, anti-CTLA-4, anti-LAG-3).

-Diseases: immune-related colitis, hepatitis, pneumonitis, thyroiditis, hypophysitis, adrenalitis, fulminant type 1 diabetes, myocarditis (often fatal), myositis and myasthenia overlap, nephritis, dermatitis, neurologic events.

-Mechanism: blockade of inhibitory checkpoints removes peripheral tolerance, allowing autoreactive T cells, cytokines, and autoantibodies to attack normal tissue, in part through shared antigens between tumor and healthy muscle, heart, or gut; pre-existing autoimmunity and gut microbiome influence risk; CTLA-4 blockade favors colitis and hypophysitis, PD-1 blockade favors pneumonitis and thyroid disease. Grade: E.

A69. CAR-T cells and T-cell-engaging bispecific antibodies.

-Diseases: cytokine release syndrome, immune-effector-cell-associated neurotoxicity (ICANS), hemophagocytic-like syndromes, prolonged cytopenias, B-cell aplasia with hypogammaglobulinemia and infections, secondary T-cell malignancies (boxed warning added by the FDA in 2024).

-Mechanism: massive T-cell activation induces macrophage release of IL-6, IL-1, and IFN-gamma, causing endothelial activation and capillary leak; endothelial activation and blood-brain-barrier disruption underlie ICANS; on-target B-cell depletion; insertional or clonal mechanisms are hypothesized for T-cell malignancy. Grade: E for acute toxicities; P for secondary malignancy.

A70. Androgen-deprivation therapy (GnRH analogs, abiraterone, enzalutamide).

-Diseases: bone loss and fractures, metabolic syndrome and diabetes, cardiovascular events, sarcopenia, cognitive effects; abiraterone-related hypertension and hypokalemia; enzalutamide-related seizures and falls.

-Mechanism: hypogonadism with loss of aromatized estradiol increases osteoclast activity and fat mass while lowering muscle mass and insulin sensitivity; CYP17 inhibition causes mineralocorticoid excess. Grade: E.

A71. Tamoxifen and aromatase inhibitors.

-Diseases: tamoxifen: endometrial hyperplasia and cancer, uterine sarcoma, venous thromboembolism, stroke, cataract; aromatase inhibitors: bone loss and fractures, arthralgia, hypercholesterolemia.

-Mechanism: tamoxifen is a partial estrogen-receptor agonist in endometrium and liver (increasing procoagulant factors and lowering antithrombin); aromatase inhibitors produce profound estrogen deprivation with RANKL-driven bone resorption. Grade: E.

A72. Immunomodulatory imide drugs (thalidomide, lenalidomide, pomalidomide).

-Diseases: teratogenicity (L1), venous thromboembolism, peripheral neuropathy, second primary malignancies (lenalidomide), cytopenias.

-Mechanism: cereblon (CRBN) E3-ligase modulation degrades IKZF1/3 (anti-myeloma effect) and SALL4 and p63 (limb and organ malformation); mechanisms for thrombosis and neuropathy are incompletely defined. Grade: E.

A73. Proteasome inhibitors (bortezomib, carfilzomib).

-Diseases: peripheral neuropathy (bortezomib); heart failure, hypertension, thrombotic microangiopathy (carfilzomib).

-Mechanism: proteasome inhibition triggers the unfolded-protein response and NF-kappaB dysregulation in neurons, cardiomyocytes, and endothelium. Grade: E for neuropathy; P for cardiovascular effects.

A74. Anti-CD20 antibodies (rituximab, obinutuzumab, ocrelizumab).

-Diseases: hepatitis B reactivation (including fulminant), progressive multifocal leukoencephalopathy, hypogammaglobulinemia, late-onset neutropenia, infusion reactions.

-Mechanism: B-cell depletion impairs humoral immunity and B-cell-dependent control of viral latency; infusion reactions reflect complement and Fc-receptor-mediated cytokine release. Grade: E.

A-VI. Immunomodulators and biologics

A75. Calcineurin inhibitors (tacrolimus, cyclosporine).

-Diseases: acute and chronic nephrotoxicity, hypertension, hyperkalemia, hypomagnesemia, neurotoxicity (tremor, PRES), post-transplant diabetes, skin cancer, lymphoproliferative disease.

-Mechanism: inhibition of calcineurin-NFAT signaling reduces IL-2 and T-cell activation; off-target increases in endothelin-1 and thromboxane with reduced nitric oxide cause afferent vasoconstriction and ischemia; TGF-beta-mediated arteriolar hyalinosis and striped interstitial fibrosis; NFAT inhibition in beta cells reduces insulin gene expression. Grade: E.

A76. TNF inhibitors (infliximab, adalimumab, etanercept, certolizumab, golimumab).

-Diseases: serious bacterial and opportunistic infections, reactivation of tuberculosis and hepatitis B, demyelinating disease, drug-induced lupus, paradoxical psoriasis, hepatosplenic T-cell lymphoma (with

thiopurines), worsening heart failure, infusion reactions with anti-drug antibodies.

-Mechanism: TNF is required for granuloma maintenance, so blockade permits latent mycobacterial reactivation; blockade increases plasmacytoid-dendritic-cell interferon-alpha, driving paradoxical psoriasis; immunogenicity of antibody biologics. Grade: E.

A77. Janus-kinase inhibitors (tofacitinib, baricitinib, upadacitinib).

-Diseases: major adverse cardiovascular events, venous thromboembolism, serious infection including herpes zoster, malignancy (boxed warnings after the ORAL Surveillance trial), cytopenias, lipid elevation, gastrointestinal perforation.

-Mechanism: broad blockade of cytokine signaling (type I interferon, IL-6, common-gamma-chain cytokines) impairs antiviral defense; mechanisms of thrombosis and cardiovascular risk are not fully defined. Grade: E for infection; P for cardiovascular and malignancy risks.

A78. Natalizumab and other targeted immune-trafficking drugs (sphingosine-1-phosphate modulators).

-Diseases: progressive multifocal leukoencephalopathy (JC virus), cryptococcal infection, macular edema, bradycardia.

-Mechanism: alpha-4-integrin blockade reduces CNS immune surveillance (risk rises with anti-JCV antibody index, duration beyond two years, and prior immunosuppression); S1P-receptor modulation sequesters lymphocytes and affects cardiac conduction. Grade: E.

A79. Thiopurines (azathioprine, 6-mercaptopurine).

-Diseases: myelosuppression (TPMT or NUDT15 deficiency), pancreatitis, hepatotoxicity, lymphoma (including hepatosplenic T-

cell lymphoma in young men with IBD), non-melanoma skin cancer.

-Mechanism: incorporation of 6-thioguanine nucleotides into DNA causes mismatch-repair-dependent cytotoxicity, with excessive accumulation in TPMT or NUDT15 variants; 6-methylmercaptopurine causes hepatotoxicity; 6-thioguanine sensitizes skin to UVA. Grade: E.

A80. mTOR inhibitors (sirolimus, everolimus).

-Diseases: impaired wound healing and lymphocele, hyperlipidemia, proteinuria, non-infectious pneumonitis, oral ulceration, new-onset diabetes, cytopenias.

-Mechanism: mTORC1 inhibition reduces cell proliferation, angiogenesis, and epithelial repair; reduced lipoprotein lipase activity; podocyte mTOR disruption. Grade: E.

A81. Drug-induced autoimmune syndromes (hydralazine, procainamide, minocycline, propylthiouracil, DPP-4 inhibitors, TNF inhibitors).

-Diseases: drug-induced lupus, ANCA-associated vasculitis, autoimmune hepatitis, bullous pemphigoid.

-Mechanism: DNA hypomethylation in CD4-positive T cells increases autoreactivity (procainamide, hydralazine); drug-altered myeloperoxidase and neutrophil extracellular trap formation (propylthiouracil); reactive metabolites forming neo-antigens; mechanism for DPP-4 inhibitor-associated pemphigoid is unknown. Grade: E for lupus and ANCA vasculitis; P for pemphigoid.

A82. Lymphocyte-depleting therapies and secondary autoimmunity (alemtuzumab, anti-thymocyte globulin, cladribine).

-Diseases: autoimmune thyroid disease, immune thrombocytopenia, anti-GBM disease.

-Mechanism: lymphopenia drives homeostatic proliferation of autoreactive clones, reduced regulatory T-cell function, and BAFF-driven B-cell hyperactivity during reconstitution. Grade: E.

A-VII. Hormonal and bone-active agents

A83. Menopausal hormone therapy.

-Diseases: breast cancer (combined estrogen-progestin, modest absolute excess in the Women's Health Initiative), venous thromboembolism, stroke, gallbladder disease, endometrial cancer (unopposed estrogen), coronary events in older or late-initiating users.

-Mechanism: oral estrogens increase hepatic synthesis of procoagulant factors and reduce antithrombin and protein S (transdermal estradiol has lower thrombotic risk); estrogen and progestin stimulate mammary epithelial proliferation through ER-alpha and progesterone receptor signaling; unopposed estrogen drives endometrial proliferation. Grade: E.

A84. Combined hormonal contraceptives.

-Diseases: venous thromboembolism (higher with desogestrel, drospirenone, or cyproterone than with levonorgestrel, and with factor V Leiden), arterial thrombosis and stroke (particularly with smoking and migraine with aura), hypertension, hepatic adenoma, small increases in breast and cervical cancer risk.

-Mechanism: ethinylestradiol increases coagulation factors and angiotensinogen and induces acquired activated-protein-C resistance; progestin type modifies the effect. Grade: E.

A85. Testosterone and anabolic-androgenic steroids.

-Diseases: erythrocytosis and thrombosis, suppression of the hypothalamic-pituitary-gonadal axis (azoospermia, infertility), hepatotoxicity (cholestasis, peliosis, adenoma with 17-alpha-

alkylated agents), cardiomyopathy and dyslipidemia, gynecomastia; in a large trial of therapeutic testosterone, no excess of major cardiovascular events but more atrial fibrillation, acute kidney injury, and pulmonary embolism.

-Mechanism: suppression of hepcidin and stimulation of erythropoiesis; negative feedback on LH and FSH; aromatization to estrogen; direct hepatocellular and myocardial effects. Grade: E for axis suppression and erythrocytosis; P for others.

A86. Bisphosphonates (alendronate, zoledronate).

-Diseases: osteonecrosis of the jaw (about 1 per 10,000 to 100,000 patient-years at osteoporosis doses; far higher at oncology doses), atypical femoral fractures, esophagitis and ulceration (oral), acute-phase reaction (IV), hypocalcemia, renal toxicity (IV), uveitis.

-Mechanism: nitrogen-containing bisphosphonates inhibit farnesyl pyrophosphate synthase, reducing protein prenylation and inducing osteoclast apoptosis; profound remodeling suppression allows microdamage accumulation, with anti-angiogenic and infection-promoting effects after dental trauma; topical mucosal injury; gamma-delta T-cell cytokine release. Grade: E.

A87. Denosumab.

-Diseases: osteonecrosis of the jaw, atypical femoral fractures, severe hypocalcemia (especially in CKD), multiple vertebral fractures after discontinuation, skin infections.

-Mechanism: RANKL neutralization profoundly but reversibly inhibits osteoclasts; on cessation, rebound osteoclastogenesis causes rapid bone loss. Grade: E.

A-VIII. Dependence and withdrawal (cross-cutting dimension)

A88. Prescription opioids: opioid use disorder, persistent use, and overdose.

-Diseases: opioid use disorder, persistent long-term use after short prescriptions (the probability of continued use at one year rises with each additional day supplied, most steeply in the first week), overdose, tolerance and hyperalgesia, neonatal opioid withdrawal syndrome.

-Mechanism: chronic mu-opioid receptor activation causes mesolimbic dopamine reward sensitization (disinhibition of ventral tegmental dopamine neurons) and neuroadaptation (cAMP superactivation, receptor desensitization, NMDA-dependent plasticity) with recruitment of stress systems (CRF, dynorphin), producing the allostatic state of dependence; risk rises with dose, duration, co-prescribed sedatives, and psychiatric comorbidity. Grade: E.

A89. Abrupt-cessation (Type E) syndromes: corticosteroids, beta-blockers, clonidine, intrathecal baclofen, antiepileptics, PPIs, and the benzodiazepine and antidepressant syndromes in A49 and A50.

-Diseases: adrenal crisis; rebound angina, myocardial infarction, and tachyarrhythmia; hypertensive crisis; baclofen withdrawal with hyperthermia and rhabdomyolysis; status epilepticus; rebound acid hypersecretion.

-Mechanism: homeostatic adaptation to chronic drug effect (adrenal atrophy; beta-receptor up-regulation; alpha-2 receptor down-regulation with catecholamine surge; GABA-B down-regulation; enterochromaffin-like cell hyperplasia) is unmasked when the drug is stopped. Grade: E.

A-IX. Interactions, prescribing cascades, and pharmacokinetic amplifiers

A90. Polypharmacy and prescribing cascades.

-Diseases: falls and fractures, delirium, ADE-related hospitalization, and cascade-driven disease (e.g., calcium-channel-blocker edema

treated with a loop diuretic; metoclopramide parkinsonism treated with levodopa; NSAID-induced hypertension treated with an antihypertensive; cholinesterase-inhibitor incontinence treated with an anticholinergic).

-Mechanism: cumulative pharmacodynamic burdens (anticholinergic, sedative, hypotensive, QT-prolonging), age-related reductions in renal clearance and hepatic metabolism, increased receptor sensitivity, and misattribution of an adverse effect to a new disease; risk rises steeply beyond about five concurrent drugs. This entry generalizes the draft's CF 50. Grade: E for harm; P for individual causal fractions.

A91. Pharmacokinetic and transporter interactions.

-Diseases: toxicity from inhibition (clarithromycin with simvastatin causing rhabdomyolysis; clarithromycin with calcium-channel blockers causing hypotension and AKI; warfarin with trimethoprim-sulfamethoxazole, azoles, or amiodarone causing bleeding; azoles with vincristine causing neuropathy; ritonavir or cobicistat with inhaled or injected corticosteroids causing Cushing syndrome and adrenal suppression) and loss of efficacy from induction (St John's wort, rifampin lowering DOAC or transplant-drug levels causing thrombosis or rejection).

-Mechanism: inhibition or induction of CYP3A4, 2C9, 2D6, 2C19, P-glycoprotein, OATP, and UGT enzymes alters drug exposure; prodrug activation (clopidogrel, tamoxifen, codeine) can fail or intensify. Grade: E.

A92. Renal and hepatic dosing failure with narrow-therapeutic-index drugs (aminoglycosides, vancomycin, digoxin, lithium, methotrexate, enoxaparin, DOACs, gabapentinoids, morphine, metformin).

-Diseases: drug-specific accumulation toxicity.

-Mechanism: reduced clearance in CKD, AKI, hepatic impairment, and hypoalbuminemia, with omission of dose adjustment or creatinine-based misestimation of GFR in sarcopenia and critical illness. Grade: E.

A-X. Other agents with important distinct mechanisms

A93. Allopurinol and other urate-lowering agents.

-Diseases: severe cutaneous adverse reactions and DRESS (HLA-B58:01 in Han Chinese, Thai, Korean, and African-American patients; risk amplified by renal impairment and high starting doses); febuxostat cardiovascular-death signal in one large trial; rasburicase hemolysis and methemoglobinemia in G6PD deficiency.

-Mechanism: oxypurinol interacts with HLA-B58:01 and T-cell receptors (pharmacological-interaction concept) to activate cytotoxic T cells with granulysin release; oxypurinol accumulates in renal impairment. Grade: E.

A94. Hydroxychloroquine and chloroquine.

-Diseases: retinopathy (cumulative dose and duration dependent), cardiomyopathy, QT prolongation, hypoglycemia.

-Mechanism: lysosomotropic accumulation and melanin binding in retinal pigment epithelium; phospholipidosis-like cardiac and muscle injury. Grade: E.

A95. Systemic retinoids (isotretinoin, acitretin) and tetracycline co-exposure.

-Diseases: teratogenicity (L3), hypertriglyceridemia, hepatotoxicity, pseudotumor cerebri (greater with tetracyclines), mucocutaneous dryness; reported mood effects remain contested.

-Mechanism: retinoic-acid-receptor activation alters lipid metabolism and cerebrospinal-fluid dynamics. Grade: E for

metabolic and mucocutaneous effects; C for depression causation.

A96. Oxidant drugs and methemoglobinemia (dapsone, benzocaine, nitrates, primaquine, rasburicase).

-Diseases: methemoglobinemia, hemolytic anemia (especially in G6PD deficiency).

-Mechanism: oxidation of hemoglobin iron (Fe2+ to Fe3+) overwhelms NADH-cytochrome b5 reductase, and in G6PD deficiency the lack of NADPH-dependent glutathione regeneration permits oxidative red-cell destruction. Grade: E.

3.4 Category B: Healthcare-associated infections and antimicrobial resistance

Healthcare-associated infections arise when invasive devices and procedures bypass mucocutaneous barriers, when broad-spectrum antimicrobials disrupt protective microbiota, when immunosuppression and critical illness impair host defenses, and when contaminated environments, water systems, equipment, or hands transmit organisms between patients. ***A central unifying mechanism for device-related infection is biofilm formation: within minutes of insertion, host proteins (fibronectin, fibrinogen) coat the synthetic surface; organisms such as Staphylococcus epidermidis, S. aureus, Pseudomonas aeruginosa, and Candida adhere, switch gene-expression programs, and secrete an extracellular polymeric matrix that shields them from phagocytes, limits antibiotic diffusion, and induces metabolic dormancy, so that cure often requires device removal***. The CDC prevalence surveys cited in Section 2.3 show that device-associated infections account for only about a quarter of HAIs; pneumonia and C. difficile are now the most common.

B1. Indwelling urinary catheters.

-Diseases: catheter-associated urinary tract infection (CAUTI), pyelonephritis, urosepsis, catheter encrustation and struvite stones

(urease-producing Proteus), urethral injury.

-Mechanism: the catheter bypasses the urethral sphincter; organisms ascend along intraluminal or extraluminal biofilm; mucosal abrasion facilitates invasion; urease-producing organisms alkalinize urine and precipitate crystalline biofilm. Grade: E.

B2. Central venous catheters and other intravascular devices.

-Diseases: central line-associated bloodstream infection (CLABSI), septic thrombophlebitis, endocarditis, metastatic infection, peripheral-line S. aureus bacteremia.

-Mechanism: extraluminal migration of skin flora along the insertion tract (short-term lines) or intraluminal contamination of hubs (long-term lines), followed by biofilm and fibrin-sheath colonization that seeds the bloodstream episodically. Grade: E.

B3. Endotracheal intubation and hospital-acquired pneumonia.

-Diseases: ventilator-associated pneumonia, non-ventilator hospital-acquired pneumonia, respiratory failure.

-Mechanism: the tube bypasses the glottis and impairs mucociliary clearance; subglottic secretions pool above the cuff and are micro-aspirated; biofilm forms on the tube; sedation, supine positioning, dysphagia, and acid suppression increase aspiration and colonization. Grade: E.

B4. Surgical incision and operation.

-Diseases: superficial, deep, and organ-space surgical site infection, sepsis, implant infection.

-Mechanism: barrier transection allows inoculation of skin flora or environmental organisms; hypothermia, hypoxia, hyperglycemia, and hypoperfusion impair neutrophil oxidative killing; foreign

material (sutures, implants) lowers the inoculum required for infection by orders of magnitude. Grade: E.

B5. Healthcare-environment Clostridioides difficile transmission.

-Diseases: C. difficile infection, toxic megacolon, recurrent disease, sepsis.

-Mechanism: alcohol-resistant spores persist on surfaces and hands and are transmitted between patients; in an antibiotic-disrupted gut, primary bile acids trigger spore germination; toxins A and B glucosylate Rho GTPases; hypervirulent ribotypes (e.g., 027) add binary toxin and toxin hyperproduction. Grade: E.

B6. Multidrug-resistant organisms (MRSA, VRE, ESBL-producing and carbapenem-resistant Enterobacterales, carbapenem-resistant Acinetobacter).

-Diseases: bloodstream, pulmonary, urinary, and wound infections with higher mortality and treatment failure.

-Mechanism: antibiotic selective pressure enriches resistant clones and drives horizontal transfer of resistance plasmids and transposons (mecA, vanA, carbapenemases); gut domination after antibiotics increases translocation; colonization pressure on wards and biofilm tolerance perpetuate transmission. Grade: E.

B7. Candida and invasive fungal infection (including Candida auris).

-Diseases: candidemia, intra-abdominal candidiasis, endophthalmitis, fungal endocarditis, device-related infection.

-Mechanism: loss of competing bacterial flora removes colonization resistance; mucosal injury, central lines, parenteral nutrition, and abdominal surgery permit translocation; C. auris colonizes skin, persists on surfaces, and is frequently multidrug-resistant. Grade: E.

B8. Hospital construction and air-handling failures (invasive mold infection).

-Diseases: invasive aspergillosis and mucormycosis in hematologic malignancy, stem-cell and organ transplant recipients.

-Mechanism: inhalation of aerosolized conidia during construction or with inadequate filtration; neutropenia and corticosteroids impair macrophage and NADPH-oxidase-dependent neutrophil killing. Grade: E.

B9. Building water systems (Legionella and other waterborne organisms).

-Diseases: Legionnaires disease, Pseudomonas, Serratia, and non-tuberculous mycobacterial infection.

-Mechanism: amoeba-hosted and biofilm-protected organisms in warm stagnant water are aerosolized; Legionella replicates within alveolar macrophages using the Dot/Icm type IV secretion system. Grade: E.

B10. Cardiac heater-cooler devices (Mycobacterium chimaera).

-Diseases: prosthetic-valve endocarditis, vascular-graft infection, and disseminated non-tuberculous mycobacterial disease, often 1 to 5 years after surgery.

-Mechanism: contaminated water tanks aerosolize organisms into the operating field during cardiopulmonary bypass; slow-growing biofilm-forming mycobacteria seed implanted prosthetic material. Grade: E.

B11. Contaminated reprocessed endoscopes (especially duodenoscopes).

-Diseases: carbapenem-resistant Enterobacterales bloodstream infection and cholangitis, other cross-infection.

-Mechanism: complex distal-tip design and biofilm with residual bioburden defeat high-level disinfection. Grade: E.

B12. Unsafe injection and infusion practices.

-Diseases: hepatitis B, hepatitis C, and HIV outbreaks (syringe reuse, multi-dose-vial contamination, shared insulin pens, endoscopy and pain-management clinics).

-Mechanism: direct parenteral inoculation of bloodborne virus. Grade: E.

B13. Dialysis-related infection.

-Diseases: catheter-related bacteremia, access-site infection, peritoneal-dialysis peritonitis, hepatitis B transmission.

-Mechanism: biofilm on dialysis catheters, repeated access, and uremia-related immune dysfunction; peritoneal contamination at connection. Grade: E.

B14. Hospital-acquired viral infection (norovirus, influenza, RSV, SARS-CoV-2).

-Diseases: nosocomial outbreaks with severe disease in elderly, immunocompromised, and neonatal patients.

-Mechanism: person-to-person, fomite, and aerosol transmission in congregate care among vulnerable hosts. Grade: E.

B15. Neonatal intensive-care infection and necrotizing enterocolitis.

-Diseases: late-onset neonatal sepsis (coagulase-negative staphylococci, S. aureus, Candida), necrotizing enterocolitis.

-Mechanism: immature innate immunity and barrier function, central lines, parenteral nutrition, and prolonged empiric antibiotics (which reduce protective Bifidobacterium and promote TLR4-driven intestinal inflammation). Grade: E for sepsis; P for the

contribution of antibiotics and acid suppression to necrotizing enterocolitis.

B16. Post-procedural endophthalmitis (cataract surgery, intravitreal injection).

-Diseases: endophthalmitis with vision loss.

-Mechanism: inoculation of conjunctival flora into the immune-privileged vitreous; bacterial toxins and uncontrolled inflammation destroy the retina. Grade: E.

3.5 Category C: Surgical, anesthetic, and other procedural harm

Procedural harm arises from mechanical, thermal, ischemic, hemodynamic, infectious, and pharmacologic insults. The AHRQ PSIs that screen for these events (including PSIs 04, 06, 09, 10, 12, and 15) are cited in Section 2.3.

C1. Operative organ, vascular, and nerve injury (including accidental puncture or laceration, PSI 15).

-Diseases: bile-duct injury and stricture, ureteral injury, bowel perforation with peritonitis, hemorrhage, sepsis.

-Mechanism: mechanical transection or thermal injury of tissue; spillage of enteric contents activates a macrophage and neutrophil response, third-spacing, and septic shock; electrosurgical thermal spread causes delayed ischemic necrosis; anatomic misidentification. Grade: E.

C2. Postoperative hemorrhage and hematoma (PSI 09).

-Diseases: hemorrhagic shock, reoperation, wound complications.

-Mechanism: surgical bleeding amplified by anticoagulants, dilutional and consumptive coagulopathy, hypothermia, and acidosis. Grade: E.

C3. Perioperative venous thromboembolism (PSI 12).

-Diseases: deep vein thrombosis and pulmonary embolism.

-Mechanism: Virchow's triad is completed by endothelial injury and tissue-factor release, an acute-phase hypercoagulable state (elevated fibrinogen and PAI-1 with fibrinolysis shutdown, driven by IL-6 and TNF-alpha), and venous stasis from immobilization; risk is highest after orthopedic and cancer surgery. Grade: E.

C4. Postoperative acute kidney injury (PSI 10).

-Diseases: acute kidney injury, dialysis dependence, progression to CKD.

-Mechanism: intraoperative hypotension and hypoperfusion, ischemia-reperfusion injury, inflammation, nephrotoxin co-exposure, bypass-related hemolysis with free hemoglobin and iron, and venous congestion. Grade: E.

C5. Perioperative myocardial injury, infarction, and stroke.

-Diseases: myocardial injury after noncardiac surgery, myocardial infarction, atrial fibrillation, perioperative stroke.

-Mechanism: supply-demand mismatch (hypotension, tachycardia, anemia), catecholamine surge, and a prothrombotic, inflammatory milieu that destabilizes plaque; cardioembolism from new atrial fibrillation; embolization or hypoperfusion in cardiac and carotid surgery. Grade: E.

C6. Postoperative delirium and cognitive dysfunction.

-Diseases: delirium, persistent cognitive decline in vulnerable patients.

-Mechanism: surgical trauma releases cytokines (IL-1-beta, IL-6) and DAMPs (HMGB1) that increase blood-brain-barrier

permeability and prime microglia; cholinergic deficiency, sleep and circadian disruption, anticholinergic, benzodiazepine, and opioid exposure, and hypoperfusion add to this; underlying neurodegeneration increases vulnerability. Grade: E for delirium; P for long-term decline.

C7. Malignant hyperthermia (volatile anesthetics, succinylcholine).

-Diseases: hypermetabolic crisis, hyperthermia, rhabdomyolysis, hyperkalemia, death.

-Mechanism: pathogenic RYR1 (or CACNA1S) variants cause uncontrolled sarcoplasmic-reticulum calcium release when triggered; dantrolene blocks the ryanodine receptor. Grade: E.

C8. Propofol infusion syndrome.

-Diseases: lactic acidosis, rhabdomyolysis, cardiac failure, hyperkalemia, renal failure (high-dose, prolonged infusion, especially in children and critical illness).

-Mechanism: impaired mitochondrial fatty-acid oxidation and respiratory-chain function. Grade: E.

C9. Succinylcholine.

-Diseases: hyperkalemic cardiac arrest in denervation injury, burns, prolonged immobilization, or muscular dystrophy; prolonged paralysis in butyrylcholinesterase (BCHE) variants.

-Mechanism: depolarization of up-regulated extrajunctional acetylcholine receptors releases potassium; impaired plasma hydrolysis prolongs block. Grade: E.

C10. Halogenated anesthetics (halothane, rarely newer agents).

-Diseases: immune-mediated fulminant hepatitis.

-Mechanism: oxidative metabolism generates trifluoroacetyl-protein adducts that act as neoantigens. Grade: E.

C11. Anesthetic exposure in the developing brain.

-Diseases: possible neurodevelopmental effects after early repeated or prolonged exposure.

-Mechanism: preclinical studies show NMDA and GABA-mediated neuroapoptosis in immature brain; a large randomized trial of a single brief exposure in infancy found no effect on IQ at age 5, and evidence for prolonged or repeated exposure remains uncertain. Grade: H to C.

C12. Local-anesthetic systemic toxicity.

-Diseases: seizures, cardiovascular collapse.

-Mechanism: sodium-channel block in CNS then myocardium; bupivacaine also inhibits mitochondrial carnitine-acylcarnitine translocase, reducing ATP; intravenous lipid emulsion is a rescue therapy. Grade: E.

C13. Neuraxial anesthesia and analgesia.

-Diseases: post-dural-puncture headache, epidural hematoma (especially with anticoagulants), epidural abscess, nerve injury, high spinal block.

-Mechanism: CSF leak causes intracranial hypotension and traction on pain-sensitive structures; bleeding or infection in a closed space compresses the cord; direct needle or toxic injury. Grade: E.

C14. Perioperative peripheral nerve injury (positioning, tourniquet, retractors, regional blocks).

-Diseases: neuropraxia and axonal injury, brachial plexopathy, ulnar and peroneal neuropathy.

-Mechanism: compression or stretch produces ischemia, demyelination, and axonal degeneration. Grade: E.

C15. Needle and catheter injury (thoracentesis, central-line placement; PSI 06).

-Diseases: iatrogenic pneumothorax, hemothorax, arterial puncture, cardiac tamponade, air embolism.

-Mechanism: pleural or vascular puncture introduces air or blood into the negative-pressure pleural space or compartments; loss of lung-chest-wall cohesion causes atelectasis; positive-pressure ventilation converts a small pneumothorax to tension. Grade: E.

C16. Persistent postsurgical pain.

-Diseases: chronic neuropathic and mixed pain after hernia repair, thoracotomy, mastectomy, amputation, and other operations.

-Mechanism: surgical nerve injury induces peripheral and central sensitization (glial activation, NMDA-dependent plasticity). Grade: E.

C17. Peritoneal adhesions.

-Diseases: adhesive small-bowel obstruction, chronic pelvic pain, secondary infertility.

-Mechanism: peritoneal trauma causes fibrin deposition and suppressed fibrinolysis (reduced tissue plasminogen activator, increased PAI-1), allowing fibroblast and capillary ingrowth into fibrous bands. Grade: E.

C18. Splenectomy.

-Diseases: overwhelming post-splenectomy infection (encapsulated organisms, Capnocytophaga), thrombosis, pulmonary hypertension.

-Mechanism: loss of marginal-zone B cells and IgM-memory, blood filtration, and opsonization. Grade: E.

C19. Thyroid, parathyroid, and neck surgery.

-Diseases: hypoparathyroidism with hypocalcemia, recurrent laryngeal nerve injury, airway-compromising hematoma.

-Mechanism: parathyroid devascularization or removal; nerve stretch or transection. Grade: E.

C20. Bariatric surgery.

-Diseases: iron, B12, folate, thiamine (Wernicke encephalopathy), and copper (myeloneuropathy) deficiency; calcium and vitamin D deficiency with osteoporosis; dumping syndrome; marginal ulcer; internal hernia; gallstones; post-bypass hyperinsulinemic hypoglycemia; alcohol use disorder.

-Mechanism: reduced acid and intrinsic factor, duodenal bypass (iron, calcium), rapid transit, altered alcohol first-pass metabolism, and incretin hypersecretion. Grade: E.

C21. Surgical menopause (bilateral oophorectomy before natural menopause) and hysterectomy.

-Diseases: bone loss, cardiovascular disease, cognitive decline (association), sexual dysfunction.

-Mechanism: abrupt loss of ovarian estrogen and androgen; hysterectomy with ovarian conservation may lead to earlier ovarian failure. Grade: E for bone loss; P to H for cardiovascular and cognitive outcomes.

C22. Endoscopic procedures (colonoscopy, ERCP, endoscopic resection).

-Diseases: perforation, delayed post-polypectomy bleeding, post-polypectomy coagulation syndrome, post-ERCP pancreatitis (about 2% to 10%), sedation-related cardiopulmonary events.

-Mechanism: mechanical, barotraumatic, and thermal injury; in ERCP, papillary edema, pancreatic-duct hydrostatic or contrast injury, and premature trypsinogen activation. Grade: E.

C23. Cardiac surgery and cardiopulmonary bypass.

-Diseases: systemic inflammatory response and vasoplegia, acute kidney injury, stroke and cognitive decline, atrial fibrillation, bleeding.

-Mechanism: contact activation of complement, kallikrein, and cytokines at the blood-circuit interface, ischemia-reperfusion injury, hemolysis, and microemboli from aortic manipulation. Grade: E.

C24. Cardiac catheterization and percutaneous coronary intervention.

-Diseases: access-site hematoma, pseudoaneurysm, retroperitoneal bleeding, stroke, coronary dissection or perforation, contrast nephropathy (E5), radiation skin injury (E3).

-Mechanism: arterial puncture combined with anticoagulation; mechanical plaque and vessel injury. Grade: E.

C25. Transcatheter aortic-valve implantation.

-Diseases: conduction block requiring pacemaker, stroke, leaflet thrombosis, paravalvular leak.

-Mechanism: compression of the conduction system adjacent to the membranous septum; embolization of calcific debris; thrombus formation on the prosthesis. Grade: E.

C26. Cesarean and instrumental delivery.

-Diseases: maternal hemorrhage, infection, thromboembolism, placenta accreta spectrum in later pregnancies, pelvic-floor disorders and obstetric anal sphincter injury after instrumental delivery or episiotomy; offspring associations with asthma, allergy, and obesity after cesarean delivery.

-Mechanism: uterine scar defects permit abnormally deep trophoblast invasion; mechanical sphincter disruption; the offspring associations are attributed to altered microbial seeding and absent labor-related hormone and stress signals but are confounded by indication. Grade: E for maternal outcomes; H for offspring associations.

C27. Induction and augmentation of labor with oxytocin.

-Diseases: uterine tachysystole with fetal hypoxia, uterine rupture (prior scar), postpartum hemorrhage from atony, water intoxication.

-Mechanism: excessive contractions reduce uteroplacental perfusion; oxytocin-receptor desensitization contributes to atony; oxytocin has antidiuretic activity. Grade: E to P.

C28. Spinal surgery.

-Diseases: adjacent-segment degeneration, failed-back-surgery syndrome, epidural fibrosis, dural tear, post-operative infection and epidural hematoma.

-Mechanism: altered biomechanics transfers load to neighboring levels; scar and fibrosis around nerve roots. Grade: E to P.

C29. Prolonged intubation and tracheostomy.

-Diseases: subglottic and tracheal stenosis, tracheo-innominate fistula, vocal-cord injury.

-Mechanism: cuff pressure above mucosal capillary perfusion pressure (about 25 to 30 mmHg) causes mucosal ischemia,

ulceration, granulation, and scar contracture. Grade: E.

C30. Thermal injury in the operating and imaging environment.

-Diseases: burns (electrosurgical alternate-site and MRI-related), airway and surgical fires.

-Mechanism: high current density through small contact areas or capacitive coupling; ignition in oxygen-enriched atmospheres. Grade: E.

C31. Epidural steroid injection.

-Diseases: spinal-cord and brainstem infarction (rare), epidural abscess, adrenal suppression, bone loss, fungal meningitis from contaminated product (K1).

-Mechanism: inadvertent intra-arterial injection of particulate steroid into radicular or vertebral arteries causes embolic infarction; systemic absorption causes HPA-axis suppression. Grade: E.

3.6 Category D: Implanted devices and materials

The draft treated devices mainly as portals for infection. Implants also cause disease through the foreign-body response (macrophage and giant-cell activation, fibrous encapsulation), wear and corrosion debris, hemodynamic and mechanical failure, and material hypersensitivity. Infection of implants (biofilm) is covered here and in Category B.

D1. Metal-on-metal hip bearings and corroding modular tapers.

-Diseases: adverse local tissue reactions (pseudotumor, soft-tissue necrosis), osteolysis, and systemic cobalt toxicity (cardiomyopathy, neuropathy, hypothyroidism, visual and hearing changes).

-Mechanism: metal particles and ions activate macrophages (including the NLRP3 inflammasome) and drive a lymphocyte-

dominated Type IV hypersensitivity; cobalt ions impair mitochondrial function and activate hypoxia-inducible-factor signaling. Grade: E.

D2. Polyethylene and other wear debris in joint arthroplasty.

-Diseases: periprosthetic osteolysis and aseptic loosening.

-Mechanism: macrophage phagocytosis of submicron particles releases TNF-alpha, IL-1, and RANKL, activating osteoclasts ("particle disease"). Grade: E.

D3. Periprosthetic joint and orthopedic-hardware infection.

-Diseases: acute and chronic implant infection requiring revision.

-Mechanism: "race for the surface" between bacteria and host tissue integration; biofilm on implant surfaces and compromised local immunity in the peri-implant tissue. Grade: E.

D4. Surgical mesh (hernia repair, pelvic-organ-prolapse repair, stress-incontinence slings).

-Diseases: chronic pain, mesh exposure or erosion, infection, dyspareunia, organ injury, recurrence; the FDA ordered transvaginal mesh for prolapse off the US market in 2019.

-Mechanism: chronic foreign-body reaction, mesh contraction and stiffness mismatch with surrounding tissue, nerve entrapment, and biofilm. Grade: E.

D5. Breast implants.

-Diseases: capsular contracture, breast-implant-associated anaplastic large-cell lymphoma (BIA-ALCL, mostly with textured implants), rupture; "breast implant illness" (systemic symptoms, causation unproven).

-Mechanism: subclinical biofilm infection drives myofibroblast-mediated fibrotic capsule formation (TGF-beta); textured surfaces with chronic bacterial and inflammatory stimulation promote clonal T-cell expansion, with JAK/STAT3 pathway mutations in lymphoma. Grade: E for contracture and BIA-ALCL; H for systemic illness.

D6. Cardiac implantable electronic devices (pacemakers, ICDs).

-Diseases: pocket and lead infection with endocarditis, venous lead thrombosis and occlusion, tricuspid regurgitation, inappropriate shocks, pacing-induced cardiomyopathy.

-Mechanism: biofilm on generator and leads; lead-endothelium interaction; dyssynchronous right-ventricular pacing causes maladaptive remodeling. Grade: E.

D7. Prosthetic heart valves.

-Diseases: thromboembolism, prosthetic-valve endocarditis, hemolysis, structural valve degeneration, bleeding from required anticoagulation.

-Mechanism: blood-surface interaction and shear stress activate platelets and coagulation (mechanical valves) and damage red cells; progressive calcification of bioprosthetic tissue. Grade: E.

D8. Coronary and peripheral stents.

-Diseases: stent thrombosis, in-stent restenosis, neoatherosclerosis.

-Mechanism: delayed endothelialization and hypersensitivity to polymer or drug (late thrombosis); vascular injury triggers smooth-muscle proliferation and neointimal hyperplasia. Grade: E.

D9. Inferior vena cava filters.

-Diseases: filter fracture, migration, caval perforation, caval thrombosis, recurrent deep vein thrombosis.

-Mechanism: foreign-body thrombogenicity and mechanical fatigue. Grade: E.

D10. CSF shunts and external ventricular drains.

-Diseases: shunt obstruction, ventriculitis and meningitis, over-drainage with subdural hematoma.

-Mechanism: biofilm; choroid-plexus and protein occlusion; siphon effect. Grade: E.

D11. Intrauterine devices and hysteroscopic sterilization implants.

-Diseases: uterine perforation, early pelvic inflammatory disease, expulsion, pain; nickel hypersensitivity and device fragmentation with the hysteroscopic implant, which left the US market in 2018.

-Mechanism: mechanical injury; introduction of vaginal flora at insertion; nickel-driven hypersensitivity and chronic inflammation. Grade: E.

D12. Hemodialysis access (grafts and arteriovenous fistulas).

-Diseases: stenosis, thrombosis, steal syndrome, infection, central venous stenosis.

-Mechanism: turbulent shear stress at anastomoses drives smooth-muscle migration and neointimal hyperplasia. Grade: E.

3.7 Category E: Therapeutic and diagnostic radiation and imaging agents

The draft combined radiation and contrast under procedural harm. They are separated here because their mechanisms (stochastic DNA damage, deterministic tissue injury, and renal or deposition toxicity) and their long-term disease outcomes differ.

E1. Therapeutic ionizing radiation.

-Diseases: acute dermatitis, mucositis, esophagitis, and pneumonitis; late fibrosis (lung, skin, soft tissue), radiation heart disease (coronary disease, valvular disease, pericarditis, cardiomyopathy; risk of major coronary events rose by about 7% per gray of mean heart dose in a large breast-cancer cohort), xerostomia, osteoradionecrosis, myelopathy and brain necrosis, cognitive decline, hypothyroidism, lymphedema, bowel stricture and proctitis, carotid vasculopathy, infertility, and second cancers (sarcoma, leukemia, breast, lung; latency 5 to more than 30 years).

-Mechanism: radiation causes direct and ROS-mediated DNA double-strand breaks, with apoptosis and mitotic catastrophe of dividing cells and endothelium; chronic inflammation, microvascular injury and ischemia, stem-cell depletion, and sustained TGF-beta/CTGF signaling activate fibroblasts and deposit collagen; surviving cells with misrepaired DNA initiate carcinogenesis. Grade: E.

E2. Diagnostic CT and other ionizing imaging.

-Diseases: small increases in lifetime cancer risk, particularly after childhood exposure (a large UK cohort estimated that cumulative head doses of roughly 50 to 60 mGy in children were associated with about threefold higher relative risks of leukemia and brain tumors, corresponding to about one excess case of each per 10,000 head scans in the following decade; reverse causation and confounding by indication remain debated).

-Mechanism: low-dose DNA damage with stochastic mutagenesis; population risk estimates rely on linear no-threshold extrapolation from higher-dose data. Grade: P for risk existence; H for magnitude at low doses.

E3. Fluoroscopically guided interventions.

-Diseases: radiation skin injury (erythema through necrosis at peak skin doses beyond a few gray), cataract, epilation.

-Mechanism: deterministic cell killing with microvascular injury when threshold doses are exceeded. Grade: E.

E4. Radiopharmaceuticals and radioiodine therapy.

-Diseases: salivary-gland dysfunction and sialadenitis, xerostomia, myelosuppression, gonadal effects, small increases in second-cancer risk.

-Mechanism: local beta or alpha energy deposition; sodium-iodide-symporter uptake in salivary tissue. Historical agents (Thorotrast, radium) caused liver angiosarcoma, leukemia, and osteosarcoma. Grade: E.

E5. Iodinated contrast media.

-Diseases: contrast-associated acute kidney injury (risk concentrated in patients with eGFR below about 30 mL/min/1.73 m2 and in intra-arterial first-pass exposure; the risk with modern low- and iso-osmolar agents given intravenously is lower than historically believed, and the draft's emphasis on highly osmolar agents is outdated), immediate hypersensitivity, delayed rash, thyroid dysfunction, extravasation injury.

-Mechanism: medullary vasoconstriction and hypoxia (adenosine, endothelin), direct tubular toxicity with ROS and increased viscosity; IgE-dependent and non-IgE (MRGPRX2) mast-cell activation; T-cell-mediated delayed reactions; iodine load causes Wolff-Chaikoff failure or iodine-induced thyrotoxicosis. Grade: E for acute reactions and thyroid effects; P for AKI magnitude.

E6. Gadolinium-based contrast agents.

-Diseases: nephrogenic systemic fibrosis (severe CKD or AKI exposed to older linear agents), tissue retention in brain and bone

(clinical significance unclear; "gadolinium deposition disease" is unproven).

-Mechanism: dissociation (transmetallation) releases free Gd3+ that deposits in tissue; circulating fibrocytes and macrophages activate and drive TGF-beta-mediated fibrosis of skin and organs. Grade: E for nephrogenic systemic fibrosis; H for retention-related illness.

E7. Magnetic-resonance hazards.

-Diseases: projectile injury, thermal burns, device and lead heating or malfunction, acoustic injury.

-Mechanism: static-field forces, radiofrequency heating, and gradient-induced currents. Grade: E.

3.8 Category F: Blood products, transplantation, and biologic transfer

F1. Allogeneic transfusion: transfusion-related acute lung injury (TRALI).

-Diseases: non-cardiogenic pulmonary edema within six hours of transfusion.

-Mechanism: a "two-hit" process: recipient inflammation primes pulmonary neutrophils, and donor anti-HLA or anti-neutrophil antibodies or bioactive lipids then activate them, releasing proteases and neutrophil extracellular traps that damage the alveolar capillary barrier; plasma from male donors reduces risk. Grade: E.

F2. Allogeneic transfusion: transfusion-associated circulatory overload (TACO).

-Diseases: hydrostatic pulmonary edema.

-Mechanism: rapid volume expansion exceeds cardiovascular reserve (older age, heart failure, renal failure), elevating pulmonary

capillary hydrostatic pressure. Grade: E.

F3. Acute hemolytic transfusion reaction (ABO incompatibility).

-Diseases: intravascular hemolysis, DIC, acute kidney injury, shock, death.

-Mechanism: preformed IgM anti-A or anti-B activates complement (C3a, C5a), triggers cytokine release and tissue-factor-driven coagulation, and free hemoglobin scavenges nitric oxide and injures renal tubules. Grade: E.

F4. Allergic, febrile, and anaphylactic transfusion reactions.

-Diseases: urticaria, fever, anaphylaxis (including in IgA-deficient recipients with anti-IgA antibodies).

-Mechanism: recipient IgE against donor plasma proteins; cytokines accumulating in stored cellular products. Grade: E.

F5. Transfusion-associated graft-versus-host disease.

-Diseases: fatal marrow aplasia, rash, hepatitis, and diarrhea.

-Mechanism: viable donor T cells (especially when donor and recipient share HLA haplotypes) engraft in an immunocompromised or HLA-haplotype-sharing recipient and attack host tissue; irradiation of cellular products prevents it. Grade: E.

F6. Chronic transfusion: iron overload and alloimmunization.

-Diseases: hemosiderosis with cardiomyopathy, cirrhosis, endocrinopathy; red-cell alloimmunization with delayed hemolytic reactions and hemolytic disease of the fetus.

-Mechanism: the body lacks a regulated iron-excretion pathway, so labile plasma iron generates radicals through Fenton chemistry; minor-antigen mismatches (Kell, Rh, Duffy) elicit anamnestic antibody responses. Grade: E.

F7. Transfusion-transmitted infection.

-Diseases: hepatitis B, hepatitis C, HIV (now exceedingly rare with nucleic-acid testing), bacterial sepsis from contaminated platelets, babesiosis, West Nile virus, Chagas disease, malaria; variant CJD (a small number of probable transfusion transmissions in the UK).

-Mechanism: direct inoculation during donor window periods or contamination. Grade: E.

F8. Massive transfusion.

-Diseases: citrate toxicity (hypocalcemia, hypomagnesemia), hyperkalemia, hypothermia, dilutional coagulopathy, acidosis.

-Mechanism: citrate chelation of divalent cations; potassium leak from stored red cells; cold, citrated, factor-poor products. Grade: E.

F9. Transfusion-related immunomodulation.

-Diseases: postoperative infection and cancer-recurrence associations.

-Mechanism: donor leukocytes and soluble mediators (sCD40L, sFasL), regulatory-T-cell induction, and microchimerism are proposed; confounded by the indication for transfusion. Grade: H to C.

F10. Plasma-derived and recombinant protein products (IVIG, anti-D, clotting concentrates).

-Diseases: thrombosis, hemolysis, aseptic meningitis, acute kidney injury (sucrose-stabilized products), anaphylaxis; historical hepatitis C and HIV transmission through contaminated concentrates.

-Mechanism: increased viscosity and procoagulant contaminants (e.g., activated factor XI), passive isohemagglutinins, osmotic nephrosis, IgA-directed antibodies, viral contamination. Grade: E.

F11. Hemostatic agents (tranexamic acid, recombinant factor VIIa, prothrombin complex concentrate).

-Diseases: seizures (high-dose tranexamic acid in cardiac surgery), arterial and venous thrombosis.

-Mechanism: tranexamic acid antagonizes glycine and GABA-A receptors; systemic procoagulant effects. Grade: E.

F12. Donor-derived disease transmission in solid-organ transplantation.

-Diseases: donor-derived infection (viral, bacterial, fungal, parasitic) and donor-derived malignancy.

-Mechanism: transplanted tissue transmits latent or occult pathogens and cells into a recipient on immunosuppression. Grade: E.

F13. Post-transplant lymphoproliferative disorder and opportunistic disease.

-Diseases: EBV-driven B-cell lymphoproliferation, cytomegalovirus disease, other opportunistic infections.

-Mechanism: suppression of T-cell surveillance permits EBV-transformed B-cell proliferation (see A75). Grade: E.

F14. Hematopoietic cell transplantation.

-Diseases: mucositis, sinusoidal obstruction syndrome (veno-occlusive disease), acute and chronic graft-versus-host disease, infection, graft failure, late cataract, endocrinopathy, and secondary malignancy.

-Mechanism: conditioning regimens injure endothelium and epithelium; alloreactive donor T cells attack host tissue amplified by

tissue-damage-driven cytokines; prolonged immune deficiency. Grade: E.

F15. Iatrogenic prion transmission.

-Diseases: Creutzfeldt-Jakob disease after cadaveric human growth hormone and human dura mater grafts (each with more than 200 recognized cases worldwide), neurosurgical instruments, corneal transplants, and variant CJD via transfusion.

-Mechanism: misfolded PrPSc seeds templated conversion of host PrPC and propagates along neural pathways over incubation periods of years to decades; prions resist standard sterilization. Grade: E.

3.9 Category G: Vaccines

Vaccines are among the most extensively monitored medical products, and the evidence base permits unusually clear separation of established adverse events from claims that were tested and not supported. Serious adverse events are rare relative to doses administered, and for most vaccines the absolute risk of a serious vaccine-attributable event is far below the risk of the disease prevented (for example, measles carries encephalitis risk on the order of 1 per 1,000 cases and a case-fatality ratio of roughly 1 to 3 per 1,000 in high-income settings, many times the risk of any serious MMR-attributable event). Entries below separate causation from mechanism in the grade, because for several vaccine events (e.g., myocarditis, narcolepsy, Guillain-Barre syndrome) the epidemiologic association is established but the mechanism is hypothesized. Incidence figures are approximate and vary by age, sex, product, dose number, and surveillance system; passive-reporting data (VAERS) were used only to generate signals, not to estimate causation.

G-I. COVID-19 vaccines

G1. mRNA COVID-19 vaccines (BNT162b2, mRNA-1273): myocarditis and pericarditis.

-Diseases: myocarditis and pericarditis, concentrated in adolescent and young adult males within about a week of the second dose. Early CDC estimates were about 12.6 cases per million second doses across ages 12 to 39 and roughly 50 to 70 per million second doses in males aged 12 to 24, with higher rates in some Nordic and Asian datasets (particularly for mRNA-1273) and lower rates with longer dosing intervals and lower doses; most cases were mild with rapid recovery, although cardiac MRI abnormalities persisted in a proportion and long-term significance is still being studied. SARS-CoV-2 infection itself causes myocarditis at higher rates than vaccination in several large cohorts.

-Mechanism: unresolved. Proposed contributors are (a) innate immune activation by the lipid nanoparticle and mRNA with elevated cytokines (IL-1-beta, IL-1 receptor antagonist, IL-15, interferon-gamma) and activated CD8-positive T and NK cells; (b) detection of free circulating spike antigen in affected adolescents; (c) molecular mimicry between spike epitopes and cardiac alpha-myosin heavy chain or troponin (hypothesized; autoantibodies were not consistently found); (d) spike-protein signaling through TLR4 on cardiomyocytes (supported mainly by in vitro work); and (e) sex-hormone modulation of Th1 inflammatory responses (testosterone) to explain male predominance. The draft presented (c) and (d) as established; they are not. Grade: E (causation); H (mechanism).

[**RNK Comments**: I do not agree that the adverse health effects from the Covid-19 vaccines (especially the mRNA-based vaccines) are rare and relatively harmless. My studies, and those of many others, have shown that the adverse health effects from these vaccines are grossly under-reported. One of my Op-eds on adverse health effects of the Covid-19 vaccine identified over 12,000 Pubmed articles showing these harms. This Op-ed was published over 2.5 years ago, and these types of articles are increasing as more

of the malfeasance that characterized the pandemic is exposed. Most of the mainline AI software packages came to this conclusion of rare adverse effects from the Covid-19 vaccines, but they all draw from the same flawed databases.

For a broader view of the recent pandemic and of the role vaccines played in that pandemic, see the Final Thoughts sub-section of the Summary and Conclusions of a recent Op-ed. The pandemic was not the "finest hour" of most of the so-called healthcare community. Many of the members of that community, along with their accomplices in the media (political and biomedical) and Academia, still support and encourage use of the Covid-19, flu, and RSV mRNA-based vaccines, despite the evidence of massive harm from the Covid-19 mRNA-based vaccines. That leads to questions of how widespread across myriad medical "treatments" this careless disregard for evidence of harm occurs in practice.]

G2. Anaphylaxis to vaccines (mRNA vaccines and others).

-Diseases: immediate hypersensitivity and anaphylaxis; about 5 per million doses with mRNA COVID-19 vaccines in US surveillance, compared with about 1 per million for other vaccines.

-Mechanism: IgE to excipients (gelatin, yeast proteins, trace egg protein, latex stoppers) or complement-activation-related pseudoallergy to PEGylated lipid nanoparticles (PEG-2000 and polysorbate cross-reactivity), possibly involving anti-PEG antibodies and MRGPRX2-mediated mast-cell activation. Grade: E.

G3. mRNA COVID-19 vaccines: other recognized or signal events.

-Diseases: vasovagal syncope (especially in adolescents), axillary lymphadenopathy, shoulder injury related to vaccine administration (G26), transient menstrual-cycle changes (small, short-lived), Bell's palsy (inconsistent signal), immune thrombocytopenia (not consistently supported), herpes zoster reactivation (weak signal).

-Mechanism: vasovagal reflex to injection; innate-immune-driven germinal-center activation in draining nodes; other mechanisms undefined. Grade: E for syncope, lymphadenopathy; P to H for others.

G4. Adenoviral-vector COVID-19 vaccines (ChAdOx1-S, Ad26.COV2.S): vaccine-induced immune thrombotic thrombocytopenia (VITT, also called thrombosis with thrombocytopenia syndrome).

-Diseases: cerebral venous sinus thrombosis, splanchnic and other thromboses with thrombocytopenia and DIC, typically 4 to 42 days after vaccination; about 4 per million doses overall in the US with Ad26.COV2.S and higher in women aged 30 to 49; European and UK estimates for ChAdOx1-S were on the order of 1 per 50,000 to 1 per 100,000 in younger adults; early mortality was high.

-Mechanism: high-titer IgG against platelet factor 4 develops without prior heparin exposure; these antibodies bind PF4 and activate platelets, neutrophils, and monocytes through Fc-gamma-RIIa, producing thrombosis, consumptive thrombocytopenia, and NETosis, as in autoimmune HIT. The trigger for anti-PF4 formation is incompletely defined (proposed: electrostatic binding of PF4 to the adenoviral capsid or free DNA with an inflammatory co-signal; clonally restricted antibodies using IGLV3-21*02 light chains have been described). Treatment uses IVIG and non-heparin anticoagulants. Grade: E (causation); P (mechanism).

G5. Adenoviral-vector COVID-19 vaccines: Guillain-Barre syndrome.

-Diseases: Guillain-Barre syndrome with Ad26.COV2.S (a few to about ten excess cases per million doses in US surveillance; a label warning was added).

-Mechanism: not established; post-vaccination autoimmunity against peripheral nerve gangliosides or myelin is hypothesized.

Grade: E (association); H (mechanism).

G-II. Measles-, mumps-, and rubella-containing vaccines

G6. MMR and MMRV: febrile seizures.

-Diseases: febrile seizures about 5 to 12 days after the first dose at 12 to 23 months (roughly 1 per 3,000 to 4,000 MMR doses; about 1 additional seizure per 2,300 to 2,600 doses when MMRV is used instead of MMR plus separate varicella vaccine). Febrile seizures after vaccination have not been associated with an increased risk of later epilepsy or neurodevelopmental sequelae.

-Mechanism: replication of live-attenuated virus stimulates innate sensors (TLRs) and release of IL-1-beta, IL-6, and TNF-alpha, which act on the hypothalamus to induce fever; fever lowers the seizure threshold in susceptible toddlers. Grade: E.

G7. MMR: immune thrombocytopenia (ITP).

-Diseases: transient ITP, about 1 per 30,000 to 40,000 doses, usually self-limited; the risk after natural measles or rubella infection is higher.

-Mechanism: immune-mediated platelet destruction (antiplatelet antibodies or immune complexes triggered by viral antigen exposure). Grade: E (causation); P (mechanism).

G8. MMR: anaphylaxis and other hypersensitivity.

-Diseases: anaphylaxis (about 1 per million doses), urticaria.

-Mechanism: IgE to gelatin or neomycin excipients; egg allergy is not a contraindication. Grade: E.

G9. Rubella-containing vaccines: joint symptoms.

-Diseases: transient arthralgia and arthritis, most often in post-pubertal women.

-Mechanism: replication of attenuated rubella virus in synovial tissue with immune-complex formation; persistent chronic arthritis has not been established. Grade: E (acute); C (chronic).

G10. Measles-containing vaccine in severe immunodeficiency.

-Diseases: measles inclusion-body encephalitis, giant-cell pneumonitis, disseminated vaccine-strain infection.

-Mechanism: absent T-cell control of the attenuated virus (contraindicated in severe cellular immunodeficiency; screening prevents it). Grade: E.

G11. Mumps component: strain-specific aseptic meningitis, parotitis, orchitis.

-Diseases: aseptic meningitis with Urabe and Leningrad-Zagreb strains (not with the Jeryl Lynn strain used in the US); rare parotitis.

-Mechanism: strain-dependent neurovirulence of live mumps virus. Grade: E (strain-specific).

G12. MMR and autism or inflammatory bowel disease (claimed association). The hypothesis arose from a 1998 case series that was retracted in 2010 after findings of ethical violations and data manipulation. A Danish national cohort of about 657,000 children found no increased autism risk after MMR vaccination, including among siblings of children with autism and other subgroups, consistent with meta-analyses of multiple studies, and no persistence of measles virus in the gut of affected children has been demonstrated.

-Mechanism: no supported mechanism. Grade: C.

G13. Thimerosal (ethylmercury) in vaccines and neurodevelopmental disorders (claimed association).

-Diseases: local delayed hypersensitivity (contact allergy) is documented. National cohorts and a population-level natural experiment (removal from most US childhood vaccines in 1999 to 2001 without a decline in autism diagnoses) do not support neurodevelopmental harm; ethylmercury is cleared faster than methylmercury. Grade: E (local hypersensitivity); C (neurodevelopmental outcomes).

G-III. Live-attenuated vaccines (other)

G14. Rotavirus vaccines: intussusception.

-Diseases: intussusception, about 1 per 10,000 infants with the first rotavirus vaccine (RotaShield, withdrawn in 1999) and about 1 to 6 excess cases per 100,000 infants with current vaccines (clustered 3 to 7 days after the first dose); vaccine-strain persistent diarrhea in severe combined immunodeficiency (contraindicated).

-Mechanism: replication of attenuated rotavirus in the gut with lymphoid (Peyer's patch) hyperplasia that acts as a lead point for intussusception; absent T-cell clearance in SCID. Grade: E.

G15. Oral poliovirus vaccine: vaccine-associated paralytic poliomyelitis and circulating vaccine-derived poliovirus.

-Diseases: paralytic poliomyelitis (about 1 case per 2.4 million doses distributed; much higher in immunodeficiency) and outbreaks of circulating vaccine-derived poliovirus in under-immunized populations.

-Mechanism: reversion of Sabin strains through mutations in the 5' untranslated region and capsid, and recombination with other enteroviruses, restores neurovirulence and transmissibility; the US moved to inactivated polio vaccine only in 2000. Grade: E.

G16. BCG vaccine.

-Diseases: injection-site abscess, regional lymphadenitis, osteitis, and disseminated BCG disease in primary immunodeficiency (severe combined immunodeficiency, chronic granulomatous disease, defects of the IL-12/interferon-gamma axis).

-Mechanism: failure of macrophage-IFN-gamma-dependent control of live Mycobacterium bovis BCG. Grade: E.

G17. Yellow fever vaccine (17D strain).

-Diseases: yellow-fever-vaccine-associated viscerotropic disease (on the order of 0.3 to 0.4 per 100,000 doses overall and several-fold higher at age 60 and older), neurotropic disease, anaphylaxis.

-Mechanism: uncontrolled vaccine-virus replication associated with impaired innate (type I interferon) responses, immunosenescence, and thymic disease; rare host genetic variants have been described. Grade: E.

G18. Smallpox (vaccinia) vaccines.

-Diseases: myopericarditis, eczema vaccinatum, progressive and generalized vaccinia, postvaccinal encephalitis, accidental inoculation.

-Mechanism: replication of live vaccinia with immune-mediated cardiac inflammation; uncontrolled spread in immunodeficiency or compromised skin barrier (atopic dermatitis). Grade: E.

G-IV. Inactivated, subunit, adjuvanted, and conjugate vaccines

G19. Inactivated and adjuvanted influenza vaccines: Guillain-Barre syndrome.

-Diseases: Guillain-Barre syndrome, about 1 to 2 excess cases per million doses in some seasons (none in others; about 10 per million with the 1976 swine-flu vaccine); natural influenza infection raises Guillain-Barre risk more than vaccination does.

-Mechanism: not established. Molecular mimicry between microbial and nerve-ganglioside epitopes is proven for Campylobacter jejuni lipo-oligosaccharide (anti-GM1 antibodies) but is only hypothesized for influenza vaccine antigens (the draft stated it as fact). Grade: E (association, small); H (mechanism).

G20. Pandemrix (AS03-adjuvanted H1N1pdm09 vaccine): narcolepsy type 1.

-Diseases: narcolepsy with cataplexy, on the order of 1 in 20,000 vaccinated children and adolescents in the most affected countries (Finland, Sweden), strongly dependent on HLA-DQB1*06:02.

-Mechanism: hypothesized autoimmune loss of hypocretin (orexin) neurons through cross-reactive T- and B-cell responses (proposed mimicry between influenza nucleoprotein and hypocretin receptor 2), amplified by the AS03 adjuvant and by wild H1N1 infection (also linked to narcolepsy in China). Grade: E (association); H (mechanism).

G21. Influenza vaccine: other reactions.

-Diseases: anaphylaxis (rare; trace ovalbumin; egg allergy is not a contraindication), oculorespiratory syndrome, febrile seizures in young children (increased with co-administration of certain vaccines).

-Mechanism: IgE to excipients; innate-driven fever. Grade: E.

G22. Zoster vaccines.

-Diseases: recombinant adjuvanted zoster vaccine (AS01B): marked reactogenicity (grade 3 systemic events in roughly 10% of recipients) and a small excess of Guillain-Barre syndrome (about 3 per million doses in Medicare analyses of adults aged 65 and older); live zoster vaccine (discontinued in the US in 2020): vaccine-strain

VZV rash, meningitis, and pneumonitis in immunocompromised recipients.

-Mechanism: AS01B (MPL plus QS-21) produces strong innate activation and cytokine release; the Guillain-Barre mechanism is unknown; live vaccine strain replicates in impaired hosts. Grade: E (reactogenicity, live-vaccine disease); P (Guillain-Barre).

G23. RSV vaccines (older adults and pregnancy).

-Diseases: Guillain-Barre syndrome after Arexvy and Abrysvo (about 7 and 9 excess cases per million doses, respectively, in a Medicare analysis of adults aged 65 and older, leading to a label warning in January 2025; the FDA concluded that evidence was insufficient to establish causation and that benefits continue to outweigh risks); numerically more preterm births with maternal Abrysvo in trials, leading to restriction of use to 32 to 36 weeks of gestation.

-Mechanism: unknown for both. Grade: P (Guillain-Barre association); H (preterm birth and mechanisms).

G24. HPV vaccines.

-Diseases: syncope (post-injection), rare anaphylaxis (about 1 to 2 per million doses). Large cohort studies and WHO, EMA, and CDC reviews found no causal association with POTS, complex regional pain syndrome, Guillain-Barre syndrome, multiple sclerosis, other autoimmune disease, or premature ovarian insufficiency.

-Mechanism: vasovagal reflex; IgE to excipients. Grade: E (syncope, anaphylaxis); C (POTS, CRPS, autoimmune and ovarian outcomes).

G25. Tetanus-, diphtheria-, and pertussis-containing vaccines.

-Diseases: Arthus-type local reactions with frequent boosters, brachial neuritis (rare, about 1 per 100,000 doses or fewer; favored as causal by the Institute of Medicine), febrile seizures, hypotonic-

hyporesponsive episodes and persistent crying (whole-cell pertussis). The claim that whole-cell pertussis causes permanent encephalopathy was not supported by case-control and cohort studies.

-Mechanism: Type III immune-complex reactions in the presence of high pre-existing antitoxin; fever and innate-immune activation. Grade: E (local and febrile reactions, brachial neuritis); C (permanent encephalopathy).

G26. Shoulder injury related to vaccine administration (SIRVA; any intramuscular vaccine).

-Diseases: bursitis, tendinopathy, adhesive capsulitis with persistent shoulder pain and reduced motion.

-Mechanism: injection into the subacromial or subdeltoid bursa (too high or too deep) causes needle trauma and bursal deposition of antigen and adjuvant with local inflammation. Grade: E.

G27. Aluminum adjuvants and other inactivated or conjugate vaccines (hepatitis A and B, pneumococcal, meningococcal, Hib, typhoid, rabies, others).

-Diseases: injection-site nodules and granulomas (persistent itching nodules in a few recipients), contact aluminum allergy, macrophagic myofasciitis (a histologic finding without an established clinical syndrome), fever (especially meningococcal B vaccines), rare anaphylaxis (hepatitis B about 1 per million doses). Large registry studies have not found associations between aluminum in childhood vaccines and autoimmune, allergic, or neurodevelopmental disorders; hepatitis B vaccine and multiple sclerosis have been repeatedly evaluated without support; "ASIA syndrome" remains a hypothesis.

-Mechanism: aluminum salts form an antigen depot and activate innate pathways (NLRP3 inflammasome and DAMP release) that

enhance immunogenicity and cause local inflammation. Grade: E (local reactions); H to C (systemic disease).

G-V. Vaccine-associated enhanced disease and other special topics

G28. Vaccine-associated enhanced disease (Dengvaxia, formalin-inactivated RSV and measles vaccines).

-Diseases: severe dengue in dengue-seronegative recipients of CYD-TDV (use restricted to seropositive persons); fatal enhanced RSV disease in infants after the 1960s formalin-inactivated vaccine; atypical measles after formalin-inactivated measles vaccine.

-Mechanism: sub-neutralizing antibodies promote antibody-dependent enhancement of infection through Fc-gamma receptors (dengue); Th2-skewed responses with immune-complex deposition and complement activation and poorly neutralizing antibody (formalin-inactivated vaccines). Grade: E.

G29. Non-specific (heterologous) effects of vaccines.

-Diseases: live vaccines (BCG, measles, OPV) were associated with lower non-targeted infectious mortality in some trials, while observational data suggested higher female mortality after DTP in Guinea-Bissau; a WHO advisory review judged the evidence to be of low quality and made no policy change.

-Mechanism: "trained immunity" through epigenetic and metabolic reprogramming of innate cells is proposed. Grade: H to C.

G30. Emerging, incompletely characterized post-vaccination syndromes (after COVID-19 vaccination).

-Diseases: reports of persistent fatigue, orthostatic intolerance, tinnitus, and small-fiber neuropathy after vaccination; no validated case definition exists, studies are small and uncontrolled, and large cohorts do not show an overall increase in autoimmune disease,

although small signals exist for specific conditions (e.g., immune thrombocytopenia, Guillain-Barre syndrome with Ad26.COV2.S).

-Mechanism: hypotheses include persistent antigen, autoantibody generation, and innate priming; none established. Grade: H.

G-VI. Mechanisms recurrent across vaccine adverse events

The vaccine events above arise through a limited number of mechanism families: (1) immediate hypersensitivity to excipients (IgE and complement-activation pseudoallergy); (2) reactogenicity and fever from innate activation (TLR, inflammasome, interferon, IL-1/IL-6/TNF), which causes febrile seizures and syncope-adjacent events; (3) replication of live-attenuated agents with reversion, neurovirulence, or uncontrolled spread in immunodeficient or very young or old hosts; (4) molecular mimicry and bystander autoimmunity in genetically susceptible hosts (for Guillain-Barre syndrome and narcolepsy; proven for some infections, hypothesized for vaccines); (5) immune-complex and antibody-mediated platelet and endothelial activation (anti-PF4 in VITT; ITP); (6) antibody-dependent enhancement and Th2-skewed immunity; (7) adjuvant-driven innate inflammation; (8) administration-related injury (SIRVA, syncope, nerve injury); and (9) sex- and age-dependent immunoregulation (male adolescents for myocarditis, older adults for viscerotropic yellow fever). These categories overlap with those in Section 3.14, which treats vaccines as one expression of general immunologic mechanisms.

3.10 Category H: Hospitalization-related and critical-care harm

The hospital environment and its protocols generate distinct, largely preventable pathologies through immobility, sleep and sensory disruption, fluid and nutrition management, life-support technology, and cascading interventions.

H1. Prolonged immobilization: pressure injury (PSI 03).

-Diseases: pressure ulcers.

-Mechanism: sustained compression and shear exceeding capillary closing pressure (about 32 mmHg) cause ischemia, hypoxia, and reperfusion injury with irreversible necrosis, especially over bony prominences. Grade: E.

H2. Hospital-associated deconditioning and disability.

-Diseases: loss of muscle mass and function, functional decline, loss of independence in older adults.

-Mechanism: disuse triggers anabolic resistance and ubiquitin-proteasome-mediated proteolysis with reduced mitochondrial capacity; inflammation and under-nutrition compound it. Grade: E.

H3. ICU-acquired weakness (critical illness polyneuropathy and myopathy).

-Diseases: prolonged ventilator dependence, long-term disability.

-Mechanism: sepsis-related microvascular and bioenergetic failure, sodium-channel inactivation, selective myosin loss, hyperglycemia, and compounding by corticosteroids and neuromuscular blockers. Grade: E.

H4. Delirium in hospitalized older adults.

-Diseases: delirium, falls, prolonged stay, long-term cognitive decline.

-Mechanism: multifactorial: neuroinflammation, cholinergic deficiency, sleep and circadian disruption, hypoxia, and deliriogenic drugs (anticholinergics, benzodiazepines, opioids) in a vulnerable brain. Grade: E.

H5. In-hospital falls and fractures (PSI 08).

-Diseases: hip fracture, head injury.

-Mechanism: orthostatic hypotension and impaired postural control from hypotensive and sedative drugs, delirium, deconditioning, and unfamiliar environments. Grade: E.

H6. Hospital-associated venous thromboembolism.

-Diseases: deep vein thrombosis, pulmonary embolism.

-Mechanism: stasis, inflammation-driven hypercoagulability, and vascular injury from lines (see C3). Grade: E.

H7. Sleep deprivation and circadian disruption.

-Diseases: delirium, impaired glucose regulation, immune dysfunction.

-Mechanism: noise, light, and overnight vital signs and procedures reduce slow-wave and REM sleep and disturb cortisol and melatonin rhythms. Grade: P.

H8. Hospital-acquired anemia from phlebotomy.

-Diseases: anemia, and in some patients transfusion exposure.

-Mechanism: cumulative diagnostic blood loss without proportional marrow compensation in inflamed patients. Grade: P.

H9. Under-nutrition and refeeding syndrome.

-Diseases: malnutrition; with refeeding, hypophosphatemia, hypokalemia, hypomagnesemia, arrhythmia, heart failure, and Wernicke encephalopathy.

-Mechanism: carbohydrate refeeding raises insulin, driving intracellular shift of phosphate, potassium, and magnesium and increasing thiamine demand in depleted patients. Grade: E.

H10. Isotonic saline resuscitation (0.9% NaCl).

-Diseases: hyperchloremic metabolic acidosis and, in large trials of critically ill adults, a modest excess of major adverse kidney events compared with balanced crystalloids.

-Mechanism: supraphysiologic chloride lowers the strong ion difference so the kidney excretes bicarbonate; chloride-induced renal afferent vasoconstriction (tubuloglomerular feedback) may reduce GFR. Grade: E (acidosis); P (kidney outcomes).

H11. Fluid overload and hypotonic maintenance fluids.

-Diseases: pulmonary and tissue edema, abdominal compartment syndrome, AKI; hyponatremic encephalopathy in children given hypotonic fluids.

-Mechanism: excess volume raises venous pressure and capillary hydrostatic pressure; non-osmotic ADH release in ill patients impairs free-water excretion so hypotonic fluids lower serum sodium and cause cerebral edema. Grade: E.

H12. Parenteral nutrition.

-Diseases: hepatic steatosis, cholestasis, biliary sludge and gallstones (intestinal-failure-associated liver disease), catheter infection, metabolic bone disease.

-Mechanism: loss of enteral stimulation reduces cholecystokinin and bile flow; continuous carbohydrate loads and omega-6-rich lipid emulsions drive lipogenesis, phytosterol- and endotoxin-mediated hepatic inflammation; bacterial overgrowth. Grade: E.

H13. Mechanical ventilation.

-Diseases: ventilator-induced lung injury (volutrauma, barotrauma, atelectrauma, biotrauma), ventilator-induced diaphragm dysfunction, pneumothorax.

-Mechanism: overdistension and cyclic opening and closing of alveoli cause mechanotransduction-driven release of cytokines into the circulation and distant organ injury; controlled diaphragm inactivity causes rapid atrophy; low-tidal-volume ventilation reduces mortality in ARDS. Grade: E.

H14. Oxygen toxicity and hyperoxia.

-Diseases: absorption atelectasis, tracheobronchitis, lung injury; retinopathy of prematurity and bronchopulmonary dysplasia in preterm infants; higher mortality with liberal oxygen in meta-analyses of acutely ill adults.

-Mechanism: excess reactive oxygen species overwhelm antioxidant defenses in lung epithelium and the immature retinal vasculature. Grade: E (preterm infants); P (adults).

H15. Stress-ulcer prophylaxis in low-risk patients.

-Diseases: C. difficile infection, hospital-acquired pneumonia.

-Mechanism: gastric acid suppression allows upper-GI colonization and aspiration of altered flora (see A44). Grade: P.

H16. Deep sedation in the ICU (benzodiazepines, propofol).

-Diseases: delirium, prolonged ventilation and ICU stay, post-ICU cognitive impairment.

-Mechanism: GABAergic suppression of arousal and sleep architecture and accumulation of active metabolites. Grade: E to P.

H17. Inpatient dysglycemia.

-Diseases: severe hypoglycemia with insulin; hyperglycemia-associated infection and poor healing; excess mortality with very tight glucose targets (NICE-SUGAR).

-Mechanism: see A39; hyperglycemia impairs neutrophil function. Grade: E.

H18. Physical restraints and tethering devices.

-Diseases: injury, agitation, delirium, pressure injury, strangulation.

-Mechanism: physical stress, immobility, and sensory deprivation. Grade: E to P.

H19. Post-intensive-care and post-hospital syndromes.

-Diseases: cognitive impairment, depression, post-traumatic stress, persistent weakness, and a period of generalized vulnerability to readmission.

-Mechanism: combined effects of critical-illness inflammation, delirium, sedation, deconditioning, sleep loss, and psychological trauma. Grade: P.

3.11 Category I: Diagnostic cascades, overdiagnosis, and psychological iatrogenesis

The draft's initial outline mentioned this category but did not develop it. These CFs act by multiplying exposure to other CFs or through expectation and stress biology.

I1. Overdiagnosis and overtreatment of indolent disease (thyroid cancer, prostate cancer, ductal carcinoma in situ, some screen-detected lung lesions).

-Diseases: harms of treatment (hypoparathyroidism and nerve injury after thyroidectomy; incontinence and erectile dysfunction after prostatectomy; radiation and surgical complications) in patients who would never have developed symptoms.

-Mechanism: sensitive detection finds lesions with low or no progressive potential, converting biological variation into a patient;

downstream harm arises through the procedural and radiation CFs in Categories C and E. Grade: E.

I2. Incidentalomas and diagnostic cascades.

-Diseases: complications of successive tests, biopsies, and procedures prompted by incidental findings.

-Mechanism: each step adds radiation, contrast, procedural, and anxiety exposure with a probability of additional abnormal findings. Grade: E.

I3. False-positive screening results.

-Diseases: anxiety, distress, biopsy complications.

-Mechanism: stress-axis activation and procedural risk. Grade: E.

I4. Invasive diagnostic procedures.

-Diseases: bleeding, pneumothorax (a large fraction of CT-guided lung biopsies), infection, needle-tract tumor seeding (rare), angiography-related stroke, lumbar puncture headache.

-Mechanism: mechanical injury (see C13, C15). Grade: E.

I5. Low-value and inappropriate care (antibiotics for viral infection, opioids for self-limited pain, imaging for uncomplicated low back pain).

-Diseases: downstream harms via the CFs in Categories A, B, and E.

-Mechanism: exposure without offsetting benefit. Grade: E.

I6. Nocebo effects and diagnostic labeling.

-Diseases: symptom amplification (for example, muscle symptoms attributed to statins in blinded and unblinded comparisons), illness

behavior and absenteeism after labeling with hypertension or "pre-disease."

-Mechanism: expectation-driven modulation of pain and symptom perception through cortico-limbic circuits and cholecystokinin-mediated anxiety-hyperalgesia pathways. Grade: E (nocebo); P (labeling).

I7. Medical trauma and ICU-related psychological injury.

-Diseases: post-traumatic stress, depression, anxiety after critical illness, awareness under anesthesia, or traumatic procedures.

-Mechanism: fear conditioning, delirium-related memories, and dysregulation of the hypothalamic-pituitary-adrenal axis. Grade: E to P.

I8. Diagnostic error (missed, wrong, or delayed diagnosis).

-Diseases: progression of untreated disease (for example, delayed sepsis, myocardial infarction, stroke, or cancer), harm from the wrong treatment. About 5% of US outpatient adults experience a diagnostic error annually.

-Mechanism: cognitive bias, system and communication failures; downstream disease follows the natural history of the untreated condition. Grade: E.

I9. Medicalization of normal variation.

-Diseases: adverse effects of unnecessary pharmacotherapy (for example, acid suppression for normal infant regurgitation).

-Mechanism: exposure to drug CFs without a treatable disease. Grade: H to P.

3.12 Categories J and K: Systems and error CFs; product-quality and environmental CFs

Category J: Systems, error, and human-factors CFs

These CFs are upstream: they route patients to the same downstream mechanisms described in Categories A to F. Their mechanism is the toxicology or pathophysiology of the agent or event that the error delivers.

J1. Medication errors (wrong drug, dose, route, patient, or frequency).

-Diseases: overdose toxicity from the specific agent (e.g., ten-fold dosing errors, daily instead of weekly methotrexate, intrathecal vincristine causing fatal ascending myeloencephalopathy, concentrated potassium causing cardiac arrest, insulin and opioid errors).

-Mechanism: see the corresponding A entries; look-alike and sound-alike names, ambiguous abbreviations, and high-alert drugs raise risk. Grade: E.

J2. Wrong-site or wrong-patient procedures and retained surgical items.

-Diseases: unnecessary or missed surgery, infection, adhesions, fistula, foreign-body granuloma (gossypiboma).

-Mechanism: mechanical and foreign-body inflammatory responses (see C and D). Grade: E.

J3. Blood-product and specimen identification errors.

-Diseases: ABO-incompatible transfusion (F3).

-Mechanism: complement-mediated hemolysis. Grade: E.

J4. Health-information-technology and electronic-record failures.

-Diseases: wrong-patient orders, alert fatigue, copy-forward diagnostic errors.

-Mechanism: human-factors failures leading to any downstream CF. Grade: P.

J5. Handoff, communication, test-follow-up, staffing, and fatigue failures.

-Diseases: delayed treatment and missed results.

-Mechanism: untreated disease progression. Grade: E to P.

J6. Failure to rescue (delayed recognition and treatment of deterioration; PSI 04).

-Diseases: death among surgical inpatients with treatable complications (sepsis, hemorrhage, respiratory failure).

-Mechanism: progression of shock and multi-organ failure when rescue is late. Grade: E.

J7. Line and tubing misconnection and device misplacement.

-Diseases: enteral feed or medication given intravenously, misplaced feeding tube with pneumonia or pneumothorax.

-Mechanism: mechanical and embolic/toxic effects of the misdirected substance. Grade: E.

Category K: Product-quality failures, contamination, and healthcare-environment exposures

K1. Contaminated compounded or sterile injectable products.

-Diseases: fungal meningitis, spinal and paraspinal infection after contaminated epidural steroid injections in 2012 (more than 700 cases and about 60 deaths, predominantly Exserohilum rostratum).

-Mechanism: injection of fungus-contaminated steroid into the epidural or paraspinal space seeds the meninges and bone. Grade: E.

K2. Heparin adulteration (2008).

-Diseases: anaphylactoid reactions, hypotension, and deaths.

-Mechanism: oversulfated chondroitin sulfate contaminant activated the contact system (factor XII, kallikrein, bradykinin) and complement anaphylatoxins. Grade: E.

K3. Diethylene- and ethylene-glycol-contaminated medicines.

-Diseases: acute kidney injury, neuropathy, and deaths, including hundreds of deaths in children in several countries (Elixir Sulfanilamide in 1937 and clusters in 2006 and 2022 to 2023).

-Mechanism: metabolism by alcohol and aldehyde dehydrogenases to toxic acids (2-hydroxyethoxyacetic and diglycolic acid) causes proximal tubular necrosis and neurotoxicity. Grade: E.

K4. Nitrosamine impurities (NDMA, NDEA) in drug products.

-Diseases: theoretical increase in cancer risk after chronic exposure (valsartan, ranitidine, metformin recalls).

-Mechanism: CYP-mediated alpha-hydroxylation yields DNA-alkylating diazonium ions forming O6-alkylguanine adducts; epidemiologic studies have not shown clear excess cancer. Grade: H.

K5. Historically contaminated biologic products.

-Diseases: hepatitis C and HIV in recipients of clotting concentrates, CJD from pituitary-derived growth hormone, SV40 contamination of early polio vaccine (no confirmed excess cancer).

-Mechanism: pooled donor material transmitting viruses or prions. Grade: E (HCV, HIV, CJD); C (cancer from SV40).

K6. Vaccine manufacturing and administration incidents.

-Diseases: paralytic poliomyelitis from incompletely inactivated vaccine (Cutter incident, 1955: about 40,000 abortive cases, 164 with severe paralysis, 10 deaths); infant deaths from muscle relaxant mistaken for diluent (Syria 2014, Samoa 2018).

-Mechanism: residual live virus; neuromuscular blockade causing respiratory failure. Grade: E.

K7. Substandard and falsified medicines.

-Diseases: treatment failure, toxicity, resistance selection.

-Mechanism: wrong or no active ingredient, toxic contaminants, sub-therapeutic exposure. Grade: E.

K8. Material hypersensitivity (latex, chlorhexidine, nickel, acrylates, adhesives).

-Diseases: IgE-mediated anaphylaxis (latex proteins, chlorhexidine), allergic contact dermatitis.

-Mechanism: Type I and Type IV hypersensitivity to device and antiseptic components. Grade: E.

K9. Plasticizers and sterilant residues (DEHP, ethylene oxide).

-Diseases: concerns for endocrine and reproductive effects after high exposure in neonates, transfused patients, and dialysis patients.

-Mechanism: leached phthalate metabolites (MEHP) act as anti-androgenic and PPAR-active agents; ethylene oxide is an alkylating carcinogen at high chronic exposure. Grade: H.

3.13 Category L: Developmental and reproductive iatrogenesis

L1. Thalidomide.

-Diseases: limb reduction defects (phocomelia), ear and organ malformations after exposure in the critical window (about weeks 5

to 8 of gestation).

-Mechanism: cereblon-mediated degradation of SALL4 and p63 and antiangiogenic effects disrupt limb-bud development. Grade: E.

L2. Valproate in pregnancy.

-Diseases: neural-tube defects, major congenital malformations (roughly 10%), lower cognitive scores, increased autism and ADHD risk.

-Mechanism: histone-deacetylase inhibition, folate-pathway disruption, and oxidative stress. Grade: E.

L3. Systemic retinoids.

-Diseases: craniofacial, cardiac, and central-nervous-system malformations.

-Mechanism: retinoic-acid-receptor activation dysregulates Hox genes and neural-crest migration. Grade: E.

L4. ACE inhibitors and angiotensin-receptor blockers in the second and third trimester.

-Diseases: oligohydramnios, pulmonary hypoplasia, renal tubular dysgenesis, neonatal AKI.

-Mechanism: fetal glomerular filtration depends on angiotensin II. Grade: E.

L5. Warfarin embryopathy.

-Diseases: nasal hypoplasia and stippled epiphyses (exposure in weeks 6 to 12), CNS abnormalities.

-Mechanism: inhibition of vitamin K-dependent carboxylation of bone matrix proteins (osteocalcin, matrix Gla protein). Grade: E.

L6. Mycophenolate, methotrexate, misoprostol, topiramate, and other teratogens.

-Diseases: congenital malformations and pregnancy loss (mycophenolate: ear, face, and cardiac defects; misoprostol: limb and cranial nerve defects; topiramate: oral clefts).

-Mechanism: IMPDH inhibition depletes guanine nucleotides; folate antagonism; uterine contraction with vascular disruption. Grade: E.

L7. Diethylstilbestrol (in utero exposure).

-Diseases: clear-cell adenocarcinoma of the vagina and cervix, structural genital anomalies, infertility, preterm birth, and possible effects in subsequent generations.

-Mechanism: estrogen-receptor-mediated disruption of Mullerian-duct differentiation, with epigenetic alteration of developmental genes (e.g., HOXA10). Grade: E.

L8. Antenatal corticosteroids.

-Diseases: neonatal hypoglycemia (late-preterm exposure), possible neurodevelopmental effects with repeated courses, despite clear benefit for lung maturation in imminent early preterm birth.

-Mechanism: glucocorticoid-receptor programming of fetal organs and metabolism. Grade: P to H.

L9. Assisted reproductive technology.

-Diseases: ovarian hyperstimulation syndrome, multiple gestation with prematurity, ectopic pregnancy, and an association with rare imprinting disorders (Beckwith-Wiedemann and Angelman syndromes).

-Mechanism: hCG-induced VEGF-mediated vascular permeability; epigenetic vulnerability of embryos during culture. Grade: E (OHSS,

multiples); P (imprinting disorders).

L10. Gonadotoxic therapy (alkylating chemotherapy, pelvic or testicular radiation).

-Diseases: premature ovarian insufficiency, azoospermia, infertility.

-Mechanism: DNA-damage-induced apoptosis and loss of primordial follicles (with follicle over-activation through PI3K-PTEN signaling) and spermatogonial depletion. Grade: E.

L11. Neonatal pharmacologic vulnerability.

-Diseases: gasping syndrome (benzyl alcohol preservative), ceftriaxone-calcium precipitation, kernicterus after sulfonamides, gray baby syndrome (chloramphenicol), opioid toxicity after codeine in CYP2D6 ultra-rapid metabolizers.

-Mechanism: immature hepatic conjugation, low albumin binding, and a permeable blood-brain barrier. Grade: E.

3.14 Biological mechanisms common to categories of CFs

Across the 12 categories, iatrogenic disease arises through sixteen recurring mechanism families. Each is described below with its defining biology, the categories and representative CFs that use it, the diseases it produces, and its shared molecular nodes. A CF commonly engages more than one family (for example, radiation acts through M12, M14, and M10).

M1. Dose-dependent cytotoxicity and transporter-mediated organ accumulation. Drugs concentrate in tissues that express uptake transporters or have high perfusion and metabolic rate, producing organ-selective injury.

-Examples: cisplatin via OCT2 and CTR1 in proximal tubule and cochlea (A59); tenofovir via OAT1 (A14); aminoglycosides via megalin and hair-cell mechanotransduction channels (A4);

methotrexate in rapidly dividing marrow and mucosa (A62); amiodarone and nitrofurantoin in lung (A34, A8).

-Diseases: acute tubular necrosis, ototoxicity, myelosuppression, mucositis, pulmonary toxicity.

-Shared nodes: transporter expression and genetics, intracellular drug accumulation, lysosomal phospholipidosis, mitochondrial permeability, apoptosis.

M2. Reactive metabolites, oxidative and nitrosative stress, and mitochondrial dysfunction. Bioactivation or redox cycling generates electrophiles and free radicals that deplete glutathione and damage mitochondria.

-Examples: acetaminophen-NAPQI (A16), anthracyclines (A57), bleomycin (A61), nitrofurantoin (A8), aminoglycosides (A4), linezolid and chloramphenicol (A9, A10), NRTIs via polymerase gamma (A14), valproate and propofol (A52, C8), local anesthetics (C12), statins (A37), metformin (A40), hyperoxia (H14).

-Diseases: liver failure, cardiomyopathy, pulmonary fibrosis, myopathy, lactic acidosis, neuropathy, ototoxicity.

-Shared nodes: glutathione depletion, JNK activation, mitochondrial permeability transition, impaired oxidative phosphorylation, mtDNA depletion, ferroptosis and necrosis.

M3. Excessive on-target (pharmacologic extension) effects. The intended action is expressed in excess, in the wrong tissue, or at the wrong time.

-Examples: anticoagulants and thrombolytics (A24 to A28), insulin and sulfonylureas (A39), antihypertensives and diuretics (A29 to A31), opioids and benzodiazepines (A22, A50), lithium, neuromuscular blockers, saline and fluids (H10, H11), immunosuppressants (A75 to A77).

-Diseases: hemorrhage, hypoglycemia, hypotension and falls, respiratory depression, electrolyte disorders, infections.

-Shared nodes: narrow therapeutic index; altered clearance; interactions; renal and hepatic function.

M4. Off-target receptor, enzyme, and ion-channel effects. Drugs bind unintended targets.

-Examples: hERG potassium-channel blockade (A6, A35, A36), D2 blockade in the nigrostriatum and pituitary (A46, A56), 5-HT2C and H1 blockade (A47), muscarinic blockade (A51), COX-1 inhibition in gastric mucosa and platelets (A17), kinase off-targets (A67), MRGPRX2 mast-cell activation (A5, E5).

-Diseases: torsades de pointes, extrapyramidal syndromes, metabolic syndrome, delirium, ulcer, atrial fibrillation, pseudo-allergy.

-Shared nodes: receptor affinity profile, tissue distribution, genetic variants in targets and transporters.

M5. Immune hypersensitivity (Gell-Coombs Types I to IV) and pseudo-allergy.

-Examples: Type I: beta-lactams, vaccine excipients, contrast, latex (A1, G2, E5, K8). Type II and autoantibody-mediated: HIT, drug-induced hemolysis and thrombocytopenia, VITT (A25, A96, G4). Type III: serum sickness, Arthus reactions (G25). Type IV: SJS/TEN, DRESS, abacavir hypersensitivity, allopurinol and carbamazepine reactions, contact dermatitis (A2, A13, A53, A93, K8).

-Pseudo-allergy: complement activation (PEGylated nanoparticles, heparin contaminant, ABO transfusion) and MRGPRX2 (vancomycin, some opioids and neuromuscular blockers).

-Shared nodes: hapten and prohapten formation, HLA-restricted presentation (hapten, pharmacological-interaction, and altered-peptide-repertoire models), cytotoxic T cells, granulysin, FasL,

perforin and granzyme B, mast-cell degranulation, complement C3a and C5a, FcgammaRIIa signaling.

M6. Loss of immune tolerance and autoimmunity. Therapy or antigen exposure disrupts peripheral tolerance or triggers cross-reactivity.

-Examples: checkpoint inhibitors (A68), lymphocyte depletion (A82), TNF and other biologics (A76, A81), drug-induced lupus (A81), putative molecular mimicry or bystander activation after some vaccines or infections (G1, G19, G20, G22, G23).

-Diseases: colitis, pneumonitis, myocarditis, endocrinopathies, lupus, vasculitis, Guillain-Barre syndrome, narcolepsy.

-Shared nodes: checkpoint and regulatory-T-cell dysregulation, shared tumor-tissue antigens, HLA risk alleles (e.g., HLA-DQB1*06:02), cytokines, autoantibody generation.

M7. Immunosuppression and barrier breach. Host defenses are suppressed or bypassed so that infection or malignancy follows.

-Examples: corticosteroids (A21), cytotoxic chemotherapy (A57 to A65), calcineurin, TNF, JAK, anti-CD20, and CAR-T therapies (A69, A74 to A77), transplant conditioning (F12 to F14); breach by catheters, tubes, incisions, and implants (B1 to B4, D3).

-Diseases: opportunistic and device-related infections, viral reactivation (hepatitis B, JC virus, EBV, zoster), post-transplant lymphoproliferative disease, skin cancer, lymphoma.

-Shared nodes: loss of T-cell and B-cell surveillance, neutropenia, loss of mucocutaneous barrier, biofilm.

M8. Microbiome disruption and loss of colonization resistance. Broad antimicrobial exposure removes protective commensals, enabling pathogen overgrowth, toxin production, and resistance selection.

-Examples: clindamycin, fluoroquinolones, cephalosporins (A7), PPIs (A44), early-life antibiotics (A15), NICU antibiotics (B15), prophylaxis and empiric overuse (I5).

-Diseases: C. difficile infection, candidiasis, MDR colonization and infection, and associated chronic diseases (atopy, obesity, IBD) in observational studies.

-Shared nodes: secondary bile-acid depletion, short-chain-fatty-acid loss, reduced regulatory-T-cell induction, horizontal gene transfer.

M9. Biofilm and foreign-body response. Abiotic surfaces acquire a host-protein conditioning film that supports biofilm and chronic macrophage-mediated reaction.

-Examples: catheters, tubes, shunts, mesh, implants, breast implants, prosthetic valves, pacemaker leads (B1 to B3, D1 to D10).

-Diseases: device-associated infection, fibrosis and capsular contracture, osteolysis and loosening, device-associated lymphoma (rare), thrombosis.

-Shared nodes: extracellular polymeric matrix, quorum sensing, tolerance to antibiotics and phagocytes, macrophage and giant-cell activation, TGF-beta.

M10. Mechanical, thermal, ischemic, pressure, and barotrauma injury.

-Examples: operative trauma (C1), needle and catheter injury (C15), pressure injury (H1), ventilator injury (H13), nerve compression (C14), thermal and electrosurgical burns (C30), tourniquet and cuff ischemia (C29), fluoroscopic deterministic injury (E3).

-Diseases: hemorrhage, pneumothorax, peritonitis, necrosis, stricture, neuropraxia, acute lung injury.

-Shared nodes: ischemia-reperfusion injury, DAMP release, sterile inflammation, mechanotransduction (YAP/TAZ, integrin signaling), fibrosis.

M11. Hemostatic and thrombotic dysregulation.

-Bleeding: anticoagulants, antiplatelets, thrombolytics, NSAIDs, SSRIs, VEGF inhibitors (A17, A24 to A28, A49, A66). Thrombosis: heparin (HIT), VITT, estrogens, tamoxifen, IMiDs, JAK inhibitors, IVIG, procoagulant concentrates, catheters and filters, surgical inflammation, immobility (A25, A71, A72, A77, A83, A84, F10, C3, D9, H6).

-Diseases: hemorrhage, stroke, myocardial infarction, venous thromboembolism, microangiopathy.

-Shared nodes: platelet FcgammaRIIa activation, tissue-factor and contact activation, endothelial NO and prostacyclin balance, Virchow's triad, hepatic procoagulant synthesis.

M12. DNA damage, genomic instability, and mutagenesis.

-Examples: ionizing radiation (E1, E2), alkylating agents (A63), topoisomerase-II inhibitors (A64), thiopurines (A79), nitrosamines (K4), DES (L7), immunosuppression that removes viral and tumor surveillance (A75, F13), possible insertional mechanisms of cell therapies (A69).

-Diseases: therapy-related leukemia, solid tumors, bladder cancer, skin cancer, lymphoma, infertility, teratogenesis.

-Shared nodes: double-strand breaks, mismatch-repair failure, KMT2A and chromosome 5 or 7 lesions, p53-mediated apoptosis, latency of years to decades.

M13. Endocrine and metabolic axis disruption.

-Examples: glucocorticoid HPA suppression (A21, A89), insulin and secretagogues (A39), antipsychotic metabolic effects (A47), androgen deprivation and aromatase inhibition (A70, A71), hormone therapy (A83, A84), thyroid disruption by iodine, amiodarone, and lithium (A34, A48, E5), opioid-induced hypogonadism (A23), SGLT2 and GLP-1 effects (A42, A43).

-Diseases: Cushing syndrome, adrenal crisis, diabetes, metabolic syndrome, osteoporosis, thyroid dysfunction, hypogonadism.

-Shared nodes: nuclear-receptor signaling, negative-feedback suppression, insulin resistance, RANKL-driven bone resorption.

M14. Fibrosis and chronic tissue remodeling.

-Examples: bleomycin, amiodarone, nitrofurantoin, methotrexate lung injury (A61, A34, A8, A62), calcineurin inhibitor nephropathy (A75), radiation fibrosis (E1), gadolinium-related nephrogenic systemic fibrosis (E6), long-term methotrexate hepatic fibrosis, adhesions (C17), capsular contracture (D5).

-Diseases: pulmonary fibrosis, renal interstitial fibrosis, skin and soft-tissue fibrosis, cirrhosis, adhesions.

-Shared nodes: TGF-beta/SMAD and CTGF signaling, myofibroblast activation, Hippo/YAP mechanotransduction, impaired fibrinolysis (PAI-1), epithelial-mesenchymal transition, failed repair after repeated injury.

M15. Neuroadaptation, neurotransmitter dysregulation, and neuroinflammation.

-Examples: chronic dopamine blockade and tardive dyskinesia (A46, A56), opioid and benzodiazepine tolerance, dependence, and withdrawal (A22, A50, A88), serotonin toxicity (A49), anticholinergic delirium (A51), postoperative and ICU delirium (C6,

H4, H16), chemotherapy-induced neuropathy (A60), CAR-T neurotoxicity (A69).

-Diseases: dyskinesia, dependence, withdrawal seizures, delirium, neuropathy, encephalopathy.

-Shared nodes: receptor up- and down-regulation, desensitization and beta-arrestin signaling, glutamatergic excitation unmasked by withdrawal, microglial priming, blood-brain-barrier disruption, axonal transport failure.

M16. Developmental programming and teratogenesis.

-Examples: thalidomide and IMiDs (L1, A72), valproate (L2), retinoids (L3), RAAS inhibitors (L4), warfarin (L5), DES (L7), antenatal steroids (L8), ART (L9), neonatal pharmacologic vulnerability (L11).

-Diseases: malformations, neurodevelopmental impairment, genital tract cancer, imprinting disorders, neonatal organ injury.

-Shared nodes: critical windows, protein degradation (cereblon), epigenetic regulators (HDAC, DNA methylation), retinoic-acid and Hox signaling, immature drug clearance and BBB.

Cross-cutting amplifiers. Three factors interact with all sixteen families: host genetic susceptibility (Section 3.16); pharmacokinetic vulnerability (age, renal and hepatic function, interactions, A90 to A92); and system and error failures (Category J), which determine whether an exposure occurs at all. A fourth, host immune state and comorbidity, determines the severity of the final disease.

3.15 Biological mechanisms common to the diseases induced

Viewed from the disease end, many unrelated CFs converge on the same clinical conditions through a few pathways. Understanding these convergences explains why the same disease can be caused by

drugs, procedures, and devices alike, and why one preventive or protective strategy can address several CFs.

Acute kidney injury.

-Routes: hemodynamic (NSAIDs, ACE inhibitors and ARBs, diuretics, calcineurin inhibitors, contrast, hypovolemia, intraoperative hypotension: A18, A29, A30, A75, E5, C4); tubular toxic (aminoglycosides, vancomycin, cisplatin, amphotericin, tenofovir, ifosfamide, contrast: A4, A5, A12, A14, A59, A63); immune interstitial nephritis (beta-lactams, PPIs, NSAIDs, checkpoint inhibitors: A1, A18, A44, A68); obstructive casts or crystals (vancomycin-uromodulin, methotrexate, tumor lysis); thrombotic microangiopathy (VEGF inhibitors, calcineurin inhibitors: A66, A75); pigment nephropathy (statin rhabdomyolysis, propofol infusion syndrome: A37, C8); glycol toxicity (K3).

-Common pathway: renal tubular ischemia and oxidative mitochondrial injury, tubular cell necrosis and apoptosis, inflammatory infiltration, and maladaptive repair with progression to fibrosis and CKD.

Drug-induced liver injury and hepatic steatosis.

-Routes: reactive metabolites (acetaminophen, isoniazid: A16, A11), mitochondrial beta-oxidation inhibition (valproate, NRTIs, aspirin in Reye syndrome: A52, A14, A20), immune-mediated idiosyncratic injury with HLA associations (amoxicillin-clavulanate, halothane: A1, C10), cholestasis from bile-salt-export inhibition, parenteral-nutrition-associated disease (H12), viral reactivation (A74, A76), and fibrosis (methotrexate).

-Common pathway: hepatocyte mitochondrial permeability transition and necrosis or apoptosis, adaptive immune amplification, and stellate-cell-driven fibrosis.

Pulmonary fibrosis, pneumonitis, and acute lung injury.

-Routes: lysosomal phospholipidosis and ROS (amiodarone), redox cycling (nitrofurantoin), iron-dependent DNA breaks in a lung lacking inactivating enzyme (bleomycin), immune pneumonitis (checkpoint inhibitors, mTOR inhibitors, methotrexate), radiation-induced TGF-beta signaling (E1), mechanical and cytokine injury (ventilation, TRALI: H13, F1), and oxygen toxicity (H14).

-Common pathway: alveolar epithelial injury, innate inflammation, TGF-beta- and Hippo/YAP-driven fibroblast activation, and collagen deposition.

Heart failure, cardiomyopathy, arrhythmia, and myocardial infarction.

-Routes: cardiomyocyte topoisomerase-II-beta and mitochondrial injury (anthracyclines), loss of HER2-mediated survival signaling (trastuzumab), immune myocarditis (checkpoint inhibitors, some vaccines, clozapine, smallpox vaccine), channel blockade (hERG, sodium channel), ion-pump poisoning (digoxin), prostacyclin-thromboxane imbalance (NSAIDs and coxibs), fluid and sodium retention (TZDs, NSAIDs), radiation-induced vasculopathy and fibrosis, iron and cobalt toxicity (F6, D1), and surgical supply-demand mismatch (C5).

-Common pathway: mitochondrial energetic failure and oxidative stress, innate or adaptive myocardial inflammation, and altered repolarization or calcium handling.

Thrombosis and bleeding. Routes are summarized in M11: platelet-activating antibodies (HIT, VITT), estrogenic and prothrombotic drugs, inflammatory and surgical hypercoagulability, device surfaces, and on the bleeding side direct factor inhibition, platelet inhibition, and impaired platelet function.

-Common pathway: disturbance of the balance among endothelial NO and prostacyclin, platelet activation, tissue-factor and contact-pathway coagulation, and fibrinolysis.

Infection (opportunistic, device-related, and healthcare-transmitted).

-Routes: barrier breach, immunosuppression, microbiome disruption, contaminated products or environments (M7 to M9, Categories B and K).

-Common pathway: failed host clearance at an interface where organisms form protected communities or exploit suppressed defenses.

Secondary malignancy (iatrogenic cancer).

-Routes: radiation (E1, E2, E4), alkylators and topoisomerase-II inhibitors (A63, A64), thiopurines and calcineurin inhibitors with viral co-factors (A79, A75, F13), hormones (menopausal therapy, tamoxifen, testosterone; A83, A71, A85), cell therapies (A69), in utero DES (L7), device-related lymphoma (D5), possible nitrosamine and photosensitizer effects (K4, A31).

-Common pathway: unrepaired or misrepaired DNA damage, loss of immune surveillance, or chronic proliferative or inflammatory stimulation, with latency from about one year (topoisomerase-II-related leukemia) to decades (radiation solid tumors).

Autoimmune and immune-mediated disease. Routes in M5 and M6.

-Common pathway: HLA-restricted antigen presentation of drug-modified or cross-reactive peptides, loss of regulatory control, cytotoxic T-cell or autoantibody effector responses.

Bone disease (osteoporosis, osteonecrosis, atypical fractures).

-Routes: glucocorticoids, androgen deprivation, aromatase inhibitors, PPIs, anticonvulsant enzyme induction, heparin, thyroid-hormone excess, bariatric malabsorption, bisphosphonates and denosumab (A21, A70, A71, A44, A53, A25, A45, C20, A86, A87).

-Common pathway: imbalance of osteoblast and osteoclast activity (RANKL-OPG axis), micro-damage accumulation, microvascular compromise, and calcium and vitamin D deficit.

Neurologic and psychiatric disease.

-Routes: dopamine-receptor blockade, serotonergic excess, GABAergic and opioid receptor adaptation, anticholinergic burden, axonal-transport and mitochondrial toxicity (neuropathy), neuroinflammation (delirium), and CNS immune-effector toxicity (A46, A49, A50, A22, A51, A60, C6, A69).

-Common pathway: disrupted neurotransmission and receptor adaptation, microglial priming with blood-brain-barrier dysfunction, and axonal energy failure.

Metabolic disease and dysglycemia.

-Routes: antipsychotics, corticosteroids, statins, TZDs, androgen deprivation, calcineurin and mTOR inhibitors, parenteral nutrition, insulin and secretagogues (A47, A21, A37, A41, A70, A75, A80, H12, A39).

-Common pathway: insulin resistance, impaired beta-cell function, and hypothalamic appetite dysregulation.

Cutaneous severe adverse reactions.

-Routes: HLA-restricted T-cell responses to sulfonamides, allopurinol, anticonvulsants, abacavir (the last causing a multi-organ syndrome, not SJS/TEN), nevirapine, and others (A2, A13, A53, A93).

-Common pathway: CD8-positive T-cell and NK-cell activation with granulysin-driven keratinocyte death, FasL and perforin-granzyme effects, and annexin A1-FPR1-mediated necroptosis.

Hematologic disease (cytopenias, hemolysis, aplasia).

-Routes: marrow suppression (chemotherapy, linezolid, chloramphenicol, methotrexate), immune cytopenias (heparin, MMR-associated ITP, drug-induced hemolysis), oxidant hemolysis (G6PD deficiency, A96), iron overload, alloimmunization.

-Common pathway: progenitor DNA-synthesis failure, antibody- or complement-mediated clearance, or oxidant injury to red cells.

Gastrointestinal disease.

-Routes: COX-1 inhibition, mucosal chemotherapy injury, microbiome disruption and C. difficile, opioid dysmotility, anticholinergic ileus, checkpoint colitis, ischemic and surgical injury.

-Common pathway: loss of mucosal protective and barrier functions with immune activation.

Musculoskeletal disease.

-Routes: statin, corticosteroid, and critical-illness myopathy; fluoroquinolone tendinopathy; disuse atrophy (A37, A21, H3, A3, H2).

-Common pathway: mitochondrial dysfunction, proteolysis, and matrix degradation.

Dependence, withdrawal, and psychiatric sequelae.

-Routes: A88 and A89 and Categories H and I.

-Common pathway: allostatic neuroadaptation of reward and stress circuits and receptor-level homeostatic adaptation unmasked by drug removal.

Final common pathways (synthesis). Across all diseases, eight cellular and molecular programs recur: ***(1) regulated cell death (apoptosis, necroptosis, ferroptosis, pyroptosis); (2) mitochondrial permeability transition and ROS; (3) innate inflammatory signaling (TLRs, NF-***

kappaB, NLRP3, IL-1-beta, IL-6, TNF); (4) TGF-beta/SMAD- and YAP-driven fibrosis; (5) endothelial activation and coagulation; (6) HLA-restricted T-cell activation or checkpoint release; (7) DNA-damage-response signaling (p53, mismatch repair); and (8) receptor adaptation and homeostatic rebound. Interventions that interrupt these shared nodes (for example, N-acetylcysteine for glutathione depletion, dexrazoxane for anthracycline cardiotoxicity, leucovorin for folate antagonism, mesna for acrolein, amifostine, balanced fluids, and pharmacogenomic avoidance) illustrate the preventive value of the mechanistic perspective.

3.16 Host and contextual susceptibility (cross-cutting dimension)

Pharmacogenomic and physiologic factors frequently determine whether an exposure causes disease. Established gene-drug pairs with clinical guidance include:

HLA-B*57:01 and abacavir (hypersensitivity); HLA-B*15:02 and carbamazepine or phenytoin (SJS/TEN in many Asian populations); HLA-A*31:01 and carbamazepine (DRESS and other reactions in Europeans and Japanese); HLA-B*58:01 and allopurinol (severe cutaneous reactions); HLA-B*13:01 and dapsone; HLA-B*57:01 and flucloxacillin (liver injury); HLA-DRB1*15:01 and amoxicillin-clavulanate (liver injury); HLA-DQB1*06:02 and Pandemrix-associated narcolepsy.

CYP2C9 and VKORC1 (warfarin dose and bleeding); SLCO1B1*5 (simvastatin myopathy); CYP2D6 ultrarapid metabolism (codeine and tramadol toxicity in children and nursing infants); CYP2C19 (clopidogrel failure; PPI and voriconazole exposure).

TPMT and NUDT15 (thiopurine myelosuppression); DPYD (fluoropyrimidine toxicity); UGT1A1*28 (irinotecan neutropenia and diarrhea); G6PD deficiency (hemolysis with primaquine, dapsone, rasburicase, nitrofurantoin).

RYR1 and CACNA1S (malignant hyperthermia); BCHE variants (prolonged succinylcholine block); POLG variants (valproate hepatotoxicity); mitochondrial m.1555A>G (aminoglycoside deafness); NAT2 slow acetylation (isoniazid and hydralazine toxicity); factor V Leiden and prothrombin variants (thrombosis with estrogens and tamoxifen); inborn errors of immunity (disseminated BCG, live-vaccine strain disease, rotavirus persistence in SCID).

Non-genetic modifiers include age (neonates: immature clearance; older adults: reduced renal and hepatic function, polypharmacy, frailty), sex (women experience more ADRs overall; males are overrepresented in mRNA-vaccine myocarditis), renal and hepatic function, comorbidity (cirrhosis, heart failure, diabetes, immunodeficiency), pregnancy, concomitant drugs, nutritional state, alcohol use, and ancestry-linked allele frequencies. These modifiers explain why population-level incidence is a poor guide to individual risk and why stratified prevention (genotyping, dose adjustment, avoidance in high-risk groups) is effective.

3.17 Temporal patterns and latency

Iatrogenic diseases appear over characteristic timescales, which assists causal inference and surveillance design. Immediate (minutes to hours): anaphylaxis, infusion reactions, local anesthetic toxicity, transfusion reactions, malignant hyperthermia, TRALI. Early (days to weeks): HIT (5 to 10 days), SJS/TEN and DRESS (generally 1 to 8 weeks), serum sickness, VITT (4 to 42 days), vaccine febrile seizures (5 to 12 days), myocarditis after mRNA vaccination (typically within a week), antibiotic-associated C. difficile (during or within weeks after exposure), acute kidney injury. Subacute to chronic (weeks to years): corticosteroid effects, drug-induced lupus, hepatic and pulmonary fibrosis, tardive dyskinesia, metabolic syndrome, osteonecrosis, CKD, device failure and wear, radiation fibrosis. Latent (years to decades): therapy-related leukemia (1 to 10 years), radiation-induced solid tumors (5 to more than 30 years),

prion disease (5 to 40 years), DES-related cancer (decades), and developmental effects. After cessation: withdrawal and rebound syndromes, adrenal crisis, rebound fractures after denosumab discontinuation.

3.18 Evidence quality, causal inference, and benefit-risk context

Distribution of evidence grades. Of the CFs catalogued, the great majority in Categories A through F, H, J, and L are graded E on both causation and mechanism. The lower grades (P, H, C) cluster in four areas: (1) long-latency or population-level associations that are confounded (early-life antibiotics, PPIs and CKD or fractures, anticholinergics and dementia, cesarean delivery and offspring disease); (2) rare events detected only by pharmacovigilance where the mechanism is unknown (several vaccine and GLP-1 signals); (3) physical or chemical exposures with weak human evidence (plasticizers, nitrosamines, gadolinium retention); and (4) claims examined and not supported (MMR and autism, thimerosal, HPV vaccine and POTS, aluminum adjuvants and chronic disease).

Common interpretive errors addressed in this report. (a) Treating a plausible mechanism as evidence of causation (e.g., spike-protein TLR4 signaling in myocarditis; influenza vaccine ganglioside mimicry). (b) Reading spontaneous-report counts as incidence. (c) Quoting extrapolated mortality estimates as measured counts. (d) Ignoring the base rate of the disease in the exposed population. (e) Ignoring confounding by indication. (f) Presenting relative risk without absolute risk.

Benefit-risk. For nearly every CF, the intervention's benefit exceeds its expected harm in properly selected patients. Examples include anticoagulation for atrial fibrillation (bleeding risk is far lower than stroke risk prevented in high-risk patients), anthracyclines in curable cancers (cardiotoxicity risk accepted for survival gains and mitigated with dexrazoxane and monitoring), central lines in critical illness, and vaccination (serious vaccine events are orders of

magnitude rarer than the diseases prevented). The appropriate response to a CF is therefore selection, monitoring, dose and duration optimization, and prevention, not avoidance of effective care. Conversely, CFs arising from low-value care (Category I), errors (Category J), and quality failures (Category K) have little or no offsetting benefit and are the most clearly preventable.

3.19 Prevention and mitigation framework

Mechanistic understanding translates directly into prevention strategies, organized here by the level at which they act.

Eliminate the exposure. Avoid low-value care (Category I); de-prescribe and reduce polypharmacy and anticholinergic and sedative burden (A50, A51, A90); remove unnecessary catheters and lines daily (B1, B2); use non-ionizing alternatives and justification and optimization for imaging (E2); avoid unnecessary opioid prescribing and limit duration (A88).

Screen the host. Pharmacogenomic testing before abacavir (HLA-B57:01), carbamazepine in at-risk ancestries (HLA-B15:02), allopurinol in high-risk ancestries (HLA-B*58:01), thiopurines (TPMT, NUDT15), fluoropyrimidines (DPYD), and rasburicase or dapsone (G6PD); screening for latent tuberculosis and hepatitis B before TNF inhibitors, JAK inhibitors, and anti-CD20 therapy; immunodeficiency screening before live vaccines where indicated; renal and hepatic dose adjustment (A92).

Interrupt the mechanism. N-acetylcysteine for acetaminophen (A16); dexrazoxane with anthracyclines (A57); leucovorin and hydration with methotrexate (A62); mesna with oxazaphosphorines (A63); uridine triacetate for fluoropyrimidine toxicity (A65); balanced crystalloids (H10); lung-protective ventilation (H13); mechanical and pharmacologic thromboprophylaxis (C3, H6); stress-ulcer prophylaxis only in high-risk patients (H15); pre-treatment and protective monitoring for ototoxins (A4, A59).

Prevent infection. Insertion and maintenance bundles for central lines, urinary catheters, and ventilators; surgical-site bundles (appropriate prophylaxis timing, normothermia, glycemic control); antimicrobial stewardship; environmental cleaning with sporicidal agents; water-system management; rigorous endoscope reprocessing; safe-injection practices (Category B).

Design safer products and procedures. Safer device materials and designs (D1 to D12); compounding quality oversight (K1); adjuvant and vector design informed by signals such as VITT and myocarditis (G1, G4); alternative dosing intervals for mRNA vaccines in young males (G1); restriction of products to appropriate populations (e.g., Dengvaxia to seropositive persons; G28).

Strengthen systems. Medication-safety technology and independent double checks for high-alert drugs; wrong-site and retained-item protocols; handoff standards; rapid-response and early-warning systems (J1 to J7); early mobility, sleep protection, and delirium prevention bundles (H2, H4, H7); transparent surveillance and active pharmacovigilance with rapid signal evaluation.

Communicate absolute risk. Shared decision-making that presents absolute risks and benefits for each CF reduces nocebo effects and supports informed choice (I6).

3.20 Integrative CF–disease interaction analysis

Risk frequently depends on combinations rather than isolated exposures. The examples below represent clinically relevant interaction archetypes; their magnitude is context-specific and must not be inferred from mechanistic plausibility alone.

Combination	Convergent mechanism	Possible outcome

NSAID + ACE inhibitor/ARB + diuretic	Afferent vasoconstriction + efferent vasodilation + volume depletion	Acute kidney injury
Opioid + benzodiazepine/gabapentinoid	Combined depression of arousal and ventilatory drive	Respiratory failure, hypoxic injury
Anticoagulant + antiplatelet/NSAID	Hemostasis impairment plus mucosal injury	Major bleeding
QT-prolonging drugs + hypokalemia	Repolarization reserve depletion	Torsades de pointes
Immunosuppression + invasive device	Barrier breach, immune impairment, biofilm	Serious infection
Anthracycline + HER2-directed therapy	Direct myocardial injury plus loss of survival signaling	Cardiomyopathy

Radiation + DNA-damaging chemotherapy	Cumulative genomic and tissue injury	Fibrosis and delayed malignancy

3.21 Expanded mechanistic architecture

The established mechanism families should be interrogated for nested processes including mitochondrial quality control and mitophagy; unfolded-protein response and proteostasis; inflammasome activation and complement; endothelial glycocalyx disruption; immunothrombosis and neutrophil extracellular traps; ferroptosis and other regulated cell-death programs; epigenetic and stem-cell niche disruption; and chronic senescence-associated inflammation. These are candidate explanatory submechanisms, not universal validated pathways for all CFs. Their value lies in producing testable, exposure-specific predictions.

3.22 Biomarkers, early detection, and falsifiable predictions

Exposure–outcome	Candidate measures	Interpretive limitation
Acetaminophen–hepatic injury	ALT, AST, INR; acetaminophen-protein adducts	Biomarkers vary by timing and availability
Anthracycline–cardiac dysfunction	Troponin, natriuretic peptides, echocardiographic strain	Not every abnormality implies permanent disease

Cisplatin–renal injury	Creatinine, cystatin C; investigational urinary KIM-1/NGAL	Emerging biomarkers require context-specific validation
Heparin–HIT	Platelets, PF4 immunoassay, functional platelet activation	Antibody positivity alone is not diagnostic
Statin–muscle injury	Creatine kinase; anti-HMGCR when clinically indicated	Differentiate common symptoms from immune myopathy
Drug–pulmonary toxicity	DLCO, spirometry, high-resolution imaging	Findings are not necessarily exposure-specific

Mechanistic hypotheses should specify predicted time order, exposure gradient, susceptible subgroup, tissue specificity, measurable intermediate, and perturbation capable of preventing or reversing the outcome. Null findings and contradictory studies should be retained.

3.23 Prevention and research priorities

Priorities include high-risk prescribing safeguards; pharmacogenetic screening when clinically validated; renal and hepatic dose adjustment; device and infection-control bundles; drug–drug interaction alerts; monitoring of cumulative radiation and drug

exposures; and avoidance of low-value diagnostic or therapeutic cascades. Research priorities include longitudinal cohorts for delayed outcomes, mechanistic studies that bridge experimental and human data, and interaction analyses that quantify absolute excess risk.

Mechanism of rare vaccine-associated events (myocarditis, narcolepsy, Guillain-Barre syndrome after specific vaccines, persistent post-vaccination symptoms) using prospective biobanked cohorts, immune profiling, and HLA typing.

Pharmacogenomic expansion: population-specific allele frequencies, polygenic risk, and implementation research for HLA and metabolic variants beyond those already guideline-supported.

Reconciling mortality and harm estimates with standardized definitions of preventability and attributable fraction.

Long-latency and confounded associations (early-life antibiotics, PPIs, anticholinergics, cesarean delivery) using sibling, negative-control, and Mendelian-randomization designs.

Low-dose radiation risk and cumulative imaging exposure registries.

Device surveillance with unique device identification and longitudinal registries for implants and mesh.

Synergistic exposures (drug-drug-gene interactions, polypharmacy cascades) using large linked electronic health data.

Evaluation of mitigations (dosing intervals, adjuvant modification, cardioprotection, microbiome restoration) in randomized and pragmatic trials.

Diagnostic error and system-level CFs, which have large burden but limited mechanistic and interventional research.

PART IV. SUMMARY AND CONCLUSIONS

Iatrogenic disease is a heterogeneous set of exposure-specific causal processes, not a single clinical entity. The inventory demonstrates that medical care can affect disease through pharmacological, immune, metabolic, infectious, mechanical, genomic, vascular, endocrine, and neurobiological routes. Disease-centered analysis shows convergence of distinct exposures on common pathological endpoints, while exposure-centered analysis shows that one intervention may produce several mechanistically distinct outcomes.

The highest-value next step for the field is relationship-level evidence verification: link each distinct exposure, disease and mechanism to study-specific data, susceptibility, timing, absolute risk and intervention options. Such mapping would support both safer clinical practice and the discovery of under-investigated biological mechanisms. No numerical inventory can establish literal exhaustiveness in an evolving literature.

Final Thoughts

The American healthcare system is centered on high-tech "treatments". For the most part, the focus is on symptom amelioration or elimination using combinations of high-tech pharmaceuticals, radiation, and surgery, depending on the disease and diagnosis. Little emphasis is placed on eliminating the factors that contribute to the onset and exacerbation of these diseases.

As this Op-ed has demonstrated, many of these treatments are accompanied by side-effects even when administered in isolation. In the real-world, many drugs and other types of treatments are given in parallel, and, in turn, these potential iatrogenic factors are administered in the context of myriad Lifestyle CFs, Biotoxin CFs, Occupational CFs, environmental CFs, etc. The effects of all these combinations with potential synergies and antagonisms are completely unknown, since the number of experiments required to validate them would be astronomical.

For example, in 2006, I published an article on the unknown impacts of combinations of large numbers of drugs. Given the thousands of drugs on the market at that time, assessing the safety profile of all potential combinations of just ten concurrent medications would require ***many trillions of independent clinical trials***. There is no lack of people who take ten or more drugs per day. The point is, even restricting the focus to the effect of pharmaceuticals, the experimental effort needed to understand potential synergies and antagonisms of these combinations is astronomical. Adding in non-pharmaceutical CFs to the mix exacerbates the problem even further.

The healthcare providers are also dependent on the biomedical literature, and its interpretation by the FDA, for taking appropriate actions in addressing these diseases/symptoms. As I have shown in recent Op-eds, the gatekeepers of the biomedical literature have strong pro-healthcare industry biases. This results in a literature that is extremely flawed, and tends to under-report the harms associated with the products of the healthcare industry. Given the complex exposure and genetic histories of medical patients, and the availability of complex treatments whose adverse health impacts in isolation tend to be under-reported, and whose adverse health effects in combination are very uncertain because of synergistic effects from other CFs to which they are exposed, medical decision-makers are in a very precarious position.

For those who may have overlooked it, there is a separate sub-section at the end of section G-1 on vaccines that provides a different perspective on the relation between healthcare providers and vaccines from the perspective provided by the AI software packages.

APPENDIX A. MASTER CF–DISEASE–MECHANISM INDEX

Each row corresponds to one catalogue entry and preserves the disease and mechanism narrative in compact form. Entries with

multiple outcomes should be split into separately evidenced relationship records before use as a formal causal database. The table is embedded entirely within this Word document.

Appendix A.A — Category A (96 entries)

CF ID	Exposure / contributing factor	Diseases / outcomes	Biological mechanism summary
A1	Beta-lactams (penicillins, cephalosporins)	anaphylaxis, urticaria, drug-induced hemolytic anemia, serum-sickness-like reaction, acute interstitial nephritis, cholestatic hepatitis (amoxicillin-clavulanate), rare DRESS and SJS/TEN, seizures at high dose in renal failure	the opened beta-lactam ring covalently haptenates lysine residues on carrier proteins; IgE directed at these haptens cross-links on mast cells and basophils (Type I), antibody-coated red cells are cleared (Type II), and drug-specific T cells drive delayed reactions (Type IV, with HLA-DRB1*15:01 linked to amoxicillin-clavulanate liver injury); at high concentrations beta-lactams antagonize GABA-A receptors.
A2	Sulfonamide antibiotics	SJS/TEN, DRESS, hyperkalemia, cytopenias,	sulfamethoxazole hydroxylamine and

	(trimethoprim-sulfamethoxazole)	hemolysis in G6PD deficiency, crystalluria, interstitial nephritis	nitroso metabolites haptenate proteins and activate T cells; trimethoprim blocks the epithelial sodium channel (ENaC) in the distal nephron, reducing potassium secretion (amiloride-like) and tubular creatinine secretion; folate-pathway antagonism suppresses marrow.
A3	Fluoroquinolones	tendinopathy and Achilles rupture (higher risk with age over 60, corticosteroids, renal transplant), aortic aneurysm and dissection, peripheral neuropathy, CNS toxicity, dysglycemia, QT prolongation, C. difficile infection	induction of matrix metalloproteinases and impaired collagen synthesis in tenocytes and aortic fibroblasts, chelation of divalent cations (Mg, Mn) required for collagen cross-linking enzymes, oxidative stress; GABA-A antagonism in the CNS; hERG potassium-channel block; pancreatic beta-cell K-ATP effects for dysglycemia.

			megalin-mediated uptake into proximal tubular cells and lysosomal accumulation (phospholipidosis), reactive oxygen species and mitochondrial injury; uptake into cochlear hair cells through mechanotransduction channels, with ROS-driven apoptosis; the mitochondrial 12S rRNA m.1555A>G variant confers hypersusceptibility by promoting aminoglycoside binding to the mitoribosome.
A4	Aminoglycosides (gentamicin, tobramycin, amikacin)	acute tubular necrosis, irreversible cochlear and vestibular ototoxicity, neuromuscular blockade	

			vancomycin-uromodulin cast formation obstructs distal tubules; intracellular accumulation in proximal tubule cells drives oxidative stress and autophagic disruption (as in the draft); the infusion reaction is non-IgE mast-cell degranulation through MRGPRX2; the piperacillin-tazobactam interaction may reflect true tubular injury or inhibited creatinine secretion (debated).
A5	Vancomycin	acute kidney injury (ATN and interstitial nephritis; risk rises with high troughs or AUC, duration, critical illness, and combination with piperacillin-tazobactam), infusion reaction ("red man" syndrome), neutropenia	
A6	Macrolides (erythromycin, clarithromycin, azithromycin)	QT prolongation, torsades de pointes and sudden cardiac death (modest absolute risk), drug-interaction toxicity (statin rhabdomyolysis, colchicine toxicity, hypotension with calcium-channel blockers, DOAC accumulation), infantile	block of the hERG (IKr) potassium channel; mechanism-based inhibition of CYP3A4 by erythromycin and clarithromycin; motilin-receptor agonism proposed for pyloric stenosis.

		hypertrophic pyloric stenosis after early-infancy exposure (association)	
A7	Clindamycin and other broad-spectrum antibiotics (fluoroquinolones, third-generation cephalosporins, carbapenems)	antibiotic-associated diarrhea, C. difficile colitis, pseudomembranous colitis, toxic megacolon, recurrent disease, vulvovaginal candidiasis, selection of resistant organisms (see B6)	loss of colonization resistance (depletion of anaerobes such as Bacteroides and Clostridia that convert primary to secondary bile acids and compete for nutrients) allows C. difficile germination and overgrowth; toxins TcdA and TcdB glucosylate Rho GTPases, collapsing the actin cytoskeleton, disrupting tight junctions, and triggering inflammation.
A8	Nitrofurantoin	acute hypersensitivity pneumonitis, chronic interstitial pulmonary fibrosis with long-term use, autoimmune-like hepatitis, peripheral neuropathy (especially with renal impairment),	nitroreductase-mediated redox cycling generates superoxide and hydrogen peroxide in lung and nerve; immune-mediated

		hemolysis in G6PD deficiency	pneumonitis and hepatitis.
A9	Linezolid	thrombocytopenia and anemia (generally beyond two weeks), lactic acidosis, optic and peripheral neuropathy, serotonin syndrome with serotonergic drugs	inhibition of mitochondrial ribosomes (structurally similar to bacterial ribosomes) impairs oxidative phosphorylation; reversible, nonselective monoamine oxidase inhibition.
A10	Chloramphenicol	dose-related marrow suppression, idiosyncratic aplastic anemia (about 1 per 20,000 to 40,000 courses), gray baby syndrome in neonates	inhibition of mitochondrial protein synthesis; reduced glucuronidation (immature UGT enzymes) in neonates leads to accumulation, mitochondrial electron-transport inhibition, and cardiovascular collapse; aplastic anemia is idiosyncratic and may involve nitroso metabolites.

A11	Antituberculous agents (isoniazid, rifampin, pyrazinamide)	drug-induced liver injury (DILI) up to hepatic failure, isoniazid peripheral neuropathy	isoniazid is metabolized by NAT2 and CYP2E1 to hydrazine and acetylhydrazine reactive intermediates (slow acetylators have higher hydrazine exposure); rifampin induces CYP enzymes and inhibits bile-salt export; isoniazid depletes pyridoxine.
A12	Amphotericin B (conventional) and polymyxins (colistin)	nephrotoxicity (distal tubular injury, hypokalemia, hypomagnesemia, renal tubular acidosis), colistin neurotoxicity	amphotericin forms pores in cholesterol-containing host membranes and causes afferent-arteriolar vasoconstriction through tubuloglomerular feedback; polycationic colistin disrupts tubular-cell membranes and induces mitochondrial oxidative stress.
A13	Abacavir	abacavir hypersensitivity syndrome (fever, rash,	abacavir binds non-covalently in the

		gastrointestinal and respiratory symptoms; multi-organ), confined almost entirely to carriers of HLA-B57:01. This is distinct from SJS/TEN and should not be classified under it (correction to draft CF 1)	HLA-B57:01 peptide-binding groove, changing the repertoire of self-peptides presented and activating CD8-positive T cells against the host (altered-peptide-repertoire model). Prospective HLA screening nearly eliminated immunologically confirmed hypersensitivity in screened populations.
A14	Nucleoside reverse-transcriptase inhibitors and tenofovir disoproxil	lactic acidosis, hepatic steatosis, lipoatrophy, neuropathy, myopathy (older NRTIs: stavudine, didanosine, zidovudine); proximal tubulopathy (Fanconi syndrome), chronic kidney disease, and bone loss (tenofovir disoproxil; lower with tenofovir alafenamide)	inhibition of mitochondrial DNA polymerase gamma depletes mtDNA and impairs oxidative phosphorylation; OAT1-mediated uptake concentrates tenofovir in proximal tubule mitochondria.
A15	Early-life and repeated antibiotic exposure	associations with childhood asthma, atopy, obesity, inflammatory	dysbiosis during immune and metabolic programming

		bowel disease, and recurrent C. difficile	windows, loss of short-chain-fatty-acid-producing taxa, and altered regulatory T-cell induction; strongly confounded by indication and family factors.
A16	Acetaminophen (paracetamol)	acute liver failure from overdose or repeated supratherapeutic dosing (a leading cause of acute liver failure in the US and UK), with greater susceptibility in fasting, malnutrition, and chronic alcohol use	CYP2E1 (with CYP1A2 and 3A4) generates N-acetyl-p-benzoquinone imine (NAPQI); once glutathione is depleted, NAPQI covalently binds mitochondrial proteins, causing oxidative stress, JNK activation, mitochondrial permeability transition, and centrilobular necrosis; N-acetylcysteine replenishes glutathione.

A17	NSAIDs: gastrointestinal effects (ibuprofen, naproxen, diclofenac, aspirin)	peptic ulcer, upper gastrointestinal bleeding and perforation, small-bowel enteropathy	COX-1 inhibition reduces gastroprotective prostaglandins (mucus, bicarbonate, mucosal blood flow); direct topical acid-trapping injury; impaired platelet function worsens bleeding; synergy with H. pylori, corticosteroids, and anticoagulants.
A18	NSAIDs: renal and fluid-balance effects	hemodynamic acute kidney injury (especially in volume depletion, heart failure, cirrhosis, CKD, and in the "triple whammy" with ACE inhibitors/ARBs and diuretics), acute interstitial nephritis, minimal-change nephrotic syndrome, hyperkalemia, sodium retention, hypertension, heart-failure exacerbation	loss of prostaglandin-mediated afferent arteriolar vasodilation lowers glomerular pressure; hyporeninemic hypoaldosteronism; immune-mediated interstitial nephritis.

A19	NSAIDs and selective COX-2 inhibitors: cardiovascular events	myocardial infarction, stroke, heart failure, hypertension (rofecoxib was withdrawn in 2004 after the APPROVe trial; diclofenac carries high risk, naproxen relatively lower)	suppression of endothelial COX-2-derived prostacyclin (vasodilator, antiplatelet) without equal suppression of platelet COX-1-derived thromboxane tips the thrombotic balance; renal sodium retention and blood-pressure elevation.
A20	Aspirin and other salicylates	Reye syndrome in children with influenza or varicella, GI bleeding, salicylism (tinnitus, anion-gap metabolic acidosis), aspirin-exacerbated respiratory disease	Reye syndrome involves mitochondrial dysfunction (impaired beta-oxidation and uncoupling) causing microvesicular steatosis, hyperammonemia, and encephalopathy; COX-1 inhibition shunts arachidonate toward leukotrienes in aspirin-exacerbated respiratory disease.
A21	Systemic corticosteroids (prolonged or high-	iatrogenic Cushing syndrome, HPA-axis suppression with adrenal	glucocorticoid-receptor signaling suppresses ACTH and

	dose; also excessive inhaled, topical, or intra-articular use)	crisis on withdrawal, osteoporosis and fractures, avascular necrosis, hyperglycemia and diabetes, opportunistic infections including Pneumocystis, myopathy, psychosis and mood disorders, posterior subcapsular cataract, glaucoma, hypertension, skin atrophy, growth suppression in children	causes adrenal atrophy; increases hepatic gluconeogenesis and insulin resistance; reduces osteoblast differentiation and promotes osteoblast and osteocyte apoptosis while increasing RANKL and prolonging osteoclast survival; reduces intestinal calcium absorption and raises renal excretion; upregulates muscle atrogenes (atrogin-1, MuRF1) and reduces mTOR signaling; induces lymphocyte apoptosis and represses NF-kappaB-driven immunity; femoral-head necrosis involves osteocyte apoptosis and microvascular compromise.
A22	Opioid analgesics: respiratory depression	respiratory depression, hypoxic brain injury, death, particularly with benzodiazepines,	mu-opioid receptor activation opens GIRK potassium channels and reduces

		gabapentinoids, renal failure (morphine-6-glucuronide accumulation), obstructive sleep apnea, or rapid dose escalation	cAMP in brainstem respiratory-rhythm generators (pre-Botzinger complex, Kolliker-Fuse), reducing respiratory drive and chemoreflex sensitivity to hypercapnia.
A23	Opioid analgesics: gastrointestinal and endocrine effects	opioid-induced constipation, ileus, nausea, sphincter of Oddi spasm, opioid-induced androgen deficiency (hypogonadotropic hypogonadism), opioid-induced hyperalgesia	mu receptors on enteric neurons inhibit acetylcholine and VIP release, reducing propulsion and increasing sphincter tone and fluid absorption; hypothalamic suppression of GnRH; central sensitization (NMDA and glial mechanisms) in hyperalgesia.
A24	Warfarin	major hemorrhage (GI, intracranial), hematoma, warfarin-induced skin necrosis, purple-toe syndrome, calciphylaxis association; teratogenic embryopathy (L5)	inhibition of vitamin K epoxide reductase (VKORC1) reduces gamma-carboxylation of factors II, VII, IX, X and proteins C and S; early protein C depletion (short half-

			life) explains transient hypercoagulability and skin necrosis; risk is amplified by CYP2C9*2/*3 and VKORC1 promoter variants and by interactions (e.g., trimethoprim-sulfamethoxazole, azoles, amiodarone).
A25	Heparins (unfractionated and low-molecular-weight)	heparin-induced thrombocytopenia (HIT) with arterial and venous thrombosis, bleeding, hyperkalemia, osteoporosis with prolonged use	heparin binds platelet factor 4 (PF4), exposing neoepitopes; IgG anti-PF4/heparin antibodies form immune complexes that activate platelets and monocytes via Fc-gamma-RIIa, generating thrombin and consuming platelets; thrombocytopenia typically appears 5 to 10 days after first exposure (earlier with prior exposure); hyperkalemia results from aldosterone suppression.

A26	Direct oral anticoagulants (apixaban, rivaroxaban, edoxaban, dabigatran)	major bleeding (particularly gastrointestinal), accumulation and bleeding in acute kidney injury, interaction-related bleeding	direct, reversible inhibition of factor Xa or thrombin impairs fibrin generation; P-glycoprotein and CYP3A4 interactions and renal clearance determine exposure.
A27	Antiplatelet agents (aspirin, P2Y12 inhibitors)	bleeding, thrombotic thrombocytopenic purpura (rare, ticlopidine and clopidogrel), bleeding risk amplification in dual therapy	irreversible inhibition of platelet COX-1 or P2Y12 receptors; rare ADAMTS13-inhibitory autoantibodies cause TTP.

A28	Thrombolytics (alteplase, tenecteplase)	symptomatic intracranial hemorrhage (about 2% to 7% in stroke trials), systemic bleeding, orolingual angioedema	plasminogen activation causes fibrinolysis and systemic fibrinogenolysis; blood-brain-barrier disruption (matrix metalloproteinase-9) and reperfusion injury in infarcted tissue; bradykinin-mediated angioedema, more frequent with concurrent ACE inhibitors.
A29	ACE inhibitors and angiotensin-receptor blockers	hyperkalemia, acute kidney injury (volume depletion, bilateral renal-artery stenosis), cough, angioedema (ACE inhibitors; higher in Black patients), fetopathy (L4)	reduced angiotensin II lowers efferent arteriolar tone and aldosterone; ACE (kininase II) inhibition permits accumulation of bradykinin and substance P, increasing vascular permeability and cough-reflex sensitivity.

A30	Loop diuretics (furosemide, bumetanide)	hypokalemia, hypomagnesemia, volume depletion and AKI, metabolic alkalosis, hyperuricemia, falls, dose-related ototoxicity	inhibition of the Na-K-2Cl cotransporter in the thick ascending limb raises distal sodium delivery, driving potassium and hydrogen secretion; NKCC1 inhibition in the stria vascularis alters endolymph.
A31	Thiazide and thiazide-like diuretics	hyponatremia (often in elderly women), hypokalemia, hypercalcemia, hyperuricemia and gout, glucose intolerance; association of hydrochlorothiazide with non-melanoma skin cancer	inhibition of the sodium-chloride cotransporter impairs urinary dilution and increases distal potassium loss; hydrochlorothiazide is a UV-absorbing photosensitizer.
A32	Mineralocorticoid-receptor antagonists and other hyperkalemia-promoting drugs (spironolactone, eplerenone, amiloride, trimethoprim,	hyperkalemia with arrhythmia, gynecomastia (spironolactone)	reduced aldosterone signaling or ENaC blockade reduces potassium secretion; spironolactone antagonizes androgen receptors.

	heparin, calcineurin inhibitors)		
A33	Digoxin	life-threatening arrhythmias (bidirectional ventricular tachycardia, atrioventricular block), anorexia and nausea, visual disturbances	Na+/K+-ATPase inhibition raises intracellular sodium and, via the Na+/Ca2+ exchanger, intracellular calcium, causing delayed afterdepolarizations; hypokalemia increases drug binding to the pump; accumulation in renal impairment and with interacting drugs.
A34	Amiodarone	pulmonary toxicity (interstitial pneumonitis, organizing pneumonia, fibrosis), hypothyroidism and thyrotoxicosis, hepatotoxicity, corneal microdeposits and optic neuropathy, photosensitivity and blue-gray skin, bradycardia, peripheral neuropathy	lipophilic cationic drug accumulates in lysosomes, inhibiting phospholipases and causing phospholipidosis (foamy macrophages), with mitochondrial dysfunction, ROS, and fibroblast activation (the Hippo/YAP link in the draft is a proposed mechanism); thyroid effects reflect iodine load (about

			37% iodine by weight: Wolff-Chaikoff failure to escape, iodine-induced thyrotoxicosis, and destructive thyroiditis).
A35	Class I antiarrhythmics (flecainide, encainide) and class III agents (sotalol, dofetilide)	proarrhythmia and increased mortality after myocardial infarction (CAST trial); torsades de pointes	use-dependent sodium-channel block slows conduction and promotes re-entry in scarred myocardium; potassium-channel (hERG) block prolongs repolarization.
A36	QT-prolonging drugs across classes (antipsychotics, citalopram, methadone, ondansetron, macrolides, fluoroquinolones, azoles, hydroxychloroquine, arsenic trioxide, some kinase inhibitors)	torsades de pointes, sudden cardiac death	block of IKr (hERG) prolongs repolarization and permits early afterdepolarizations; risk is multiplied by hypokalemia, hypomagnesemia, bradycardia, female sex, structural heart disease, congenital long-QT variants, and stacking of several QT-active drugs.

A37	Statins	myopathy (about 1 per 10,000 patient-years), rhabdomyolysis (about 1 to 3 per 100,000 patient-years), immune-mediated necrotizing myopathy (anti-HMGCR antibodies), small increase in new-onset diabetes, enzyme elevations. Muscle pain in randomized blinded trials is largely not attributable to the drug (nocebo effect), which should temper the draft's description of severe toxicity as typical	HMG-CoA reductase inhibition reduces isoprenoids and coenzyme Q10, impairing mitochondrial function and promoting myocyte apoptosis; SLCO1B1*5 raises systemic exposure; CYP3A4 inhibitors raise levels; statin-exposed autoantigen upregulation in necrotizing myopathy; reduced beta-cell and insulin-signaling function proposed for diabetes.
A38	Beta-blockers	bradycardia, atrioventricular block, bronchospasm (non-selective agents), masking of hypoglycemia, fatigue, rebound angina and arrhythmia on abrupt withdrawal (see A89)	beta-1 and beta-2 blockade; receptor up-regulation during chronic blockade causes rebound hypersensitivity.
A39	Insulin and insulin secretagogues	severe hypoglycemia (seizures, coma,	excess insulin suppresses hepatic

	(sulfonylureas, meglitinides)	arrhythmia, falls, injury; repeated episodes associated with dementia), weight gain	glucose output and increases peripheral glucose uptake, depriving the brain of its obligate substrate; sulfonylureas close pancreatic beta-cell K-ATP channels independent of glucose; long-acting agents (glyburide) accumulate in CKD; recurrent hypoglycemia blunts counter-regulatory responses (hypoglycemia-associated autonomic failure). Insulin ranks among the most frequent causes of emergency visits for ADEs.
A40	Metformin	lactic acidosis (rare, in renal or hepatic failure and hypoperfusion), vitamin B12 deficiency, gastrointestinal intolerance	mitochondrial complex I inhibition increases lactate production; calcium-dependent ileal B12-intrinsic-factor absorption is impaired.

A41	Thiazolidinediones (pioglitazone, rosiglitazone)	fluid retention and heart failure, fractures (particularly in women), weight gain; a myocardial-infarction signal with rosiglitazone (contested); small bladder-cancer association with pioglitazone	PPAR-gamma activation increases distal-nephron sodium reabsorption (ENaC); shifts marrow mesenchymal differentiation toward adipocytes and away from osteoblasts.
A42	SGLT2 inhibitors	euglycemic diabetic ketoacidosis, genital mycotic infections, urinary tract infection, rare Fournier gangrene, volume depletion and AKI, amputation signal with canagliflozin	glycosuria supports yeast growth and osmotic diuresis; lower insulin with higher glucagon promotes ketogenesis during illness, fasting, or surgery.
A43	GLP-1 receptor agonists and dual agonists	gastrointestinal intolerance, cholelithiasis and cholecystitis, delayed gastric emptying with retained gastric contents at anesthesia, pancreatitis (association), non-arteritic anterior ischemic optic neuropathy (recognized by regulators in 2025 as a very rare effect of	slowed gastric transit and reduced gallbladder emptying (accentuated by rapid weight loss); the pathway for optic neuropathy is unknown.

		semaglutide; verify current labeling)	
A44	Proton-pump inhibitors	C. difficile and other enteric infections, pneumonia (association), hypomagnesemia, vitamin B12 and iron deficiency, fractures (association), acute interstitial nephritis and CKD (association), rebound acid hypersecretion on withdrawal	loss of the gastric acid barrier shifts upper-GI microbiota; reduced intestinal TRPM6/7-mediated magnesium absorption; impaired acid-dependent B12 and iron liberation; hypergastrinemia with enterochromaffin-like cell hyperplasia causes rebound; immune-mediated interstitial nephritis.
A45	Thyroid-hormone over-replacement (levothyroxine, liothyronine, including misuse for weight loss)	iatrogenic thyrotoxicosis, atrial fibrillation, accelerated bone loss, anxiety	excess thyroid hormone increases beta-adrenergic sensitivity, metabolic rate, and osteoclast activity.
A46	Typical (first-generation) antipsychotics (haloperidol, chlorpromazine)	acute dystonia, parkinsonism, akathisia, tardive dyskinesia, neuroleptic malignant syndrome, hyperprolactinemia with	striatal D2 blockade (extrapyramidal effects emerge at high occupancy); chronic blockade induces D2 receptor up-regulation

		hypogonadism and bone loss, QT prolongation	and supersensitivity, with oxidative stress and GABAergic dysfunction proposed for tardive dyskinesia; hypothalamic and striatal D2 blockade with muscle rigidity in neuroleptic malignant syndrome; tuberoinfundibular D2 blockade removes tonic inhibition of prolactin.
A47	Atypical (second-generation) antipsychotics (olanzapine, clozapine, quetiapine, risperidone)	weight gain, metabolic syndrome, type 2 diabetes, dyslipidemia; clozapine-specific agranulocytosis, early myocarditis, seizures, severe constipation and ileus, sialorrhea	antagonism of 5-HT2C and histamine H1 (and M3) receptors drives hyperphagia and adiposity, with direct impairment of insulin secretion and sensitivity; clozapine metabolites (nitrenium ion) are cytotoxic to neutrophils and immune hypersensitivity underlies myocarditis; muscarinic blockade reduces gut motility.

A48 Lithium	nephrogenic diabetes insipidus, chronic tubulointerstitial nephropathy and CKD, hypothyroidism, hyperparathyroidism with hypercalcemia, tremor, acute neurotoxicity	lithium enters collecting-duct principal cells via ENaC and inhibits glycogen synthase kinase-3, reducing aquaporin-2 expression and apical insertion; chronic tubular injury and fibrosis; inhibition of thyroid-hormone release; altered parathyroid calcium set-point.

		serotonin syndrome (usually with combinations such as linezolid or MAO inhibitors, tramadol, triptans, or other serotonergic agents), hyponatremia (SIADH), bleeding (especially with NSAIDs or anticoagulants), dose-dependent QT prolongation (citalopram), discontinuation syndrome, sexual dysfunction (a persistent post-treatment form is reported and incompletely characterized), falls and fractures in older adults, treatment-emergent suicidality in young people	SERT inhibition increases synaptic serotonin; excess 5-HT2A (and 5-HT1A) stimulation produces neuromuscular hyperactivity, hyperthermia, and autonomic instability; serotonin promotes ADH release; platelets rely on SERT to take up serotonin, so inhibition impairs aggregation; abrupt cessation unmasks receptor adaptation.
A49	SSRIs and SNRIs		
A50	Benzodiazepines and Z-drugs (zolpidem)	sedation, falls and hip fracture, motor-vehicle crashes, cognitive impairment, delirium in hospitalized older adults, respiratory depression (especially with opioids),	positive allosteric modulation of GABA-A receptors (alpha-1 sedation, alpha-2/3 anxiolysis); chronic exposure alters receptor subunit

		paradoxical disinhibition, physical dependence with withdrawal seizures; observational association with dementia (H)	composition and reduces receptor density, so abrupt withdrawal leaves unopposed glutamatergic excitation.
A51	Anticholinergic burden (diphenhydramine and other first-generation antihistamines, oxybutynin, tricyclic antidepressants, paroxetine, antispasmodics)	delirium, cognitive impairment, urinary retention, constipation and ileus, tachycardia, acute angle-closure glaucoma, heat stroke; observational association between cumulative exposure and dementia; tricyclic overdose causes QRS widening, arrhythmia, and seizures	central M1 blockade impairs cholinergic arousal and attention networks; peripheral antimuscarinic effects; tricyclics block cardiac sodium channels.
A52	Valproate	hepatotoxicity (including fatal microvesicular steatosis, especially in young children and POLG-variant patients), hyperammonemic encephalopathy, pancreatitis, thrombocytopenia, tremor, weight gain, polycystic-ovary-like	valproyl-CoA and 4-ene-valproate metabolites inhibit fatty-acid beta-oxidation and sequester CoA and carnitine; inhibition of carbamoyl-phosphate synthetase impairs ureagenesis; mitochondrial DNA polymerase gamma

		syndrome; teratogenicity (L2)	variants (Alpers-Huttenlocher syndrome) are a contraindication.
A53	Enzyme-inducing and sodium-channel anticonvulsants (carbamazepine, phenytoin, phenobarbital, lamotrigine)	SJS/TEN and DRESS (carbamazepine with HLA-B15:02 in Southeast and South Asian populations and HLA-A31:01 in Europeans and Japanese; phenytoin with CYP2C93 and HLA-B15:02; lamotrigine with rapid titration or valproate co-therapy), osteomalacia and bone loss, hyponatremia (carbamazepine), gingival hyperplasia (phenytoin), cerebellar toxicity, teratogenicity	carbamazepine binds directly and non-covalently to HLA-B*15:02 and the T-cell receptor (pharmacological-interaction concept), activating cytotoxic CD8-positive T cells and releasing granulysin, FasL, perforin and granzyme B; enzyme induction accelerates vitamin D catabolism.
A54	CNS stimulants and sympathomimetics (amphetamines, methylphenidate, pseudoephedrine)	tachycardia, hypertension, arrhythmia, myocardial infarction, psychosis and mania, growth suppression in children, dependence, reversible cerebral vasoconstriction syndrome	increased synaptic dopamine and norepinephrine and direct adrenergic agonism.

		(pseudoephedrine, reported)	
A55	Gabapentinoids and proconvulsant or serotonergic analgesics (gabapentin, pregabalin, tramadol, bupropion)	sedation, falls, respiratory depression when combined with opioids, peripheral edema, misuse (gabapentinoids); seizures, serotonin syndrome, hypoglycemia, and hyponatremia (tramadol); dose-dependent seizures (bupropion)	binding to the alpha-2-delta subunit of voltage-gated calcium channels reduces excitatory neurotransmission; tramadol combines mu-opioid, serotonin and norepinephrine reuptake effects and depends on CYP2D6 for its active metabolite.
A56	Metoclopramide and other dopamine-blocking antiemetics (prochlorperazine, promethazine, droperidol)	acute dystonia, akathisia, tardive dyskinesia (boxed warning for use beyond 12 weeks), QT prolongation (droperidol)	striatal D2 receptor blockade with chronic receptor supersensitivity; hERG block.
A57	Anthracyclines (doxorubicin, daunorubicin, epirubicin)	dose-dependent cardiomyopathy and heart failure (risk rises with cumulative dose, young or old age, prior chest radiation, hypertension, and	poisoning of topoisomerase II-beta in cardiomyocytes causes DNA double-strand breaks and mitochondrial dysfunction;

		trastuzumab), arrhythmia, therapy-related myeloid neoplasms	anthracycline-iron complexes generate free radicals that overwhelm limited cardiac antioxidant defenses; dexrazoxane (iron chelation and Top2B depletion) is protective.
A58	Trastuzumab and other HER2-directed therapy	cardiomyopathy with reduced ejection fraction (often reversible)	HER2/ErbB2 signaling (neuregulin-ErbB4/ErbB2) supports cardiomyocyte survival and stress adaptation; blockade removes this protective pathway, with synergy after anthracycline injury.
A59	Platinum agents (cisplatin, carboplatin, oxaliplatin)	acute tubular necrosis and magnesium wasting, permanent ototoxicity (especially in children), peripheral neuropathy, severe emesis, myelosuppression (carboplatin)	uptake through OCT2 and copper transporter CTR1 concentrates cisplatin in proximal tubular and cochlear cells; DNA cross-linking, reactive oxygen species, and TNF-alpha-driven inflammation cause

			apoptosis; accumulation in dorsal root ganglia (no blood-nerve barrier) causes neuropathy.
A60	Neurotoxic cytostatics (taxanes, vinca alkaloids, oxaliplatin, bortezomib)	chemotherapy-induced peripheral neuropathy (sensory, painful, sometimes permanent), autonomic neuropathy (vincristine)	disruption of microtubule dynamics (taxanes stabilize; vincas depolymerize) impairs axonal transport; axonal mitochondrial damage and oxidative stress; dorsal-root-ganglion accumulation; oxaliplatin's acute cold-induced neuropathy reflects altered voltage-gated sodium-channel kinetics.
A61	Bleomycin	pneumonitis and pulmonary fibrosis (risk rises with cumulative dose, age, renal impairment, prior radiation, and supplemental oxygen), Raynaud phenomenon, skin hyperpigmentation	iron-bleomycin complexes generate reactive oxygen species that cause DNA strand breaks; lung and skin express little bleomycin hydrolase; alveolar epithelial injury and TGF-beta-driven

			fibroblast activation lead to fibrosis.
A62	Methotrexate	myelosuppression, mucositis, hepatic fibrosis with long-term low-dose use, hypersensitivity pneumonitis, high-dose renal injury, leukoencephalopathy (intrathecal or high-dose), fatal toxicity from daily instead of weekly dosing errors; teratogenicity (L6)	tight-binding inhibition of dihydrofolate reductase depletes tetrahydrofolate and thus purine and thymidylate synthesis in rapidly dividing cells; methotrexate and 7-hydroxymethotrexate precipitate in acidic urine; interacting drugs (NSAIDs, PPIs, trimethoprim-sulfamethoxazole) reduce clearance; leucovorin rescue bypasses the block.
A63	Alkylating agents (cyclophosphamide, ifosfamide, melphalan, busulfan, chlorambucil, temozolomide)	myelosuppression, hemorrhagic cystitis and later bladder cancer (cyclophosphamide, ifosfamide), ifosfamide Fanconi syndrome and encephalopathy, therapy-related myelodysplastic syndrome and acute myeloid leukemia	DNA alkylation and cross-linking trigger DNA-damage response, apoptosis, and mutagenesis; the metabolite acrolein injures urothelium (mesna binds it); chloroacetaldehyde

		(latency about 5 to 7 years, often with chromosome 5 or 7 loss), gonadotoxicity (L10), veno-occlusive disease (busulfan), pulmonary fibrosis (busulfan, carmustine)	injures proximal tubule and brain.
A64	Topoisomerase-II inhibitors (etoposide, mitoxantrone, anthracyclines)	therapy-related acute myeloid leukemia with 11q23/KMT2A rearrangements (short latency, 1 to 3 years); mitoxantrone cardiotoxicity	stabilized topoisomerase-II-DNA cleavage complexes yield double-strand breaks that are misrepaired at the KMT2A breakpoint region, generating oncogenic fusion genes.
A65	Fluoropyrimidines (5-fluorouracil, capecitabine)	severe or fatal mucositis, diarrhea, neutropenia and neurotoxicity in DPD deficiency; coronary vasospasm; hand-foot syndrome; hyperammonemic encephalopathy	dihydropyrimidine dehydrogenase (DPYD) normally catabolizes most of a dose; variants (e.g., c.1905+1G>A, c.1679T>G, c.2846A>T, HapB3) prolong exposure to thymidylate-synthase inhibition and RNA misincorporation; vasospasm likely

			reflects endothelial dysfunction; uridine triacetate is an antidote.
A66	VEGF-pathway inhibitors (bevacizumab, ramucirumab, sunitinib, sorafenib, axitinib)	hypertension, proteinuria and thrombotic microangiopathy, arterial thromboembolism, hemorrhage, gastrointestinal perforation, impaired wound healing, posterior reversible encephalopathy syndrome	loss of VEGF-driven nitric-oxide and prostacyclin production causes vasoconstriction and microvascular rarefaction; loss of podocyte-derived VEGF produces glomerular endotheliosis; impaired endothelial and epithelial repair.
A67	Kinase inhibitors (ponatinib, nilotinib, ibrutinib, dasatinib, EGFR inhibitors)	arterial occlusive events (ponatinib, nilotinib), QT prolongation and hyperglycemia (nilotinib), atrial fibrillation and bleeding (ibrutinib), pleural effusion and pulmonary hypertension (dasatinib), rash and interstitial lung disease (EGFR inhibitors)	off-target inhibition of vascular, cardiac, and platelet kinases (e.g., BTK/TEC and CSK/PI3K-Akt pathways in atrial myocytes and platelets); hERG block; EGFR inhibition in skin and lung epithelium.

			blockade of inhibitory checkpoints removes peripheral tolerance, allowing autoreactive T cells, cytokines, and autoantibodies to attack normal tissue, in part through shared antigens between tumor and healthy muscle, heart, or gut; pre-existing autoimmunity and gut microbiome influence risk; CTLA-4 blockade favors colitis and hypophysitis, PD-1 blockade favors pneumonitis and thyroid disease.
A68	Immune checkpoint inhibitors (anti-PD-1, anti-PD-L1, anti-CTLA-4, anti-LAG-3)	immune-related colitis, hepatitis, pneumonitis, thyroiditis, hypophysitis, adrenalitis, fulminant type 1 diabetes, myocarditis (often fatal), myositis and myasthenia overlap, nephritis, dermatitis, neurologic events	
A69	CAR-T cells and T-cell-engaging bispecific antibodies	cytokine release syndrome, immune-effector-cell-associated neurotoxicity (ICANS), hemophagocytic-like syndromes, prolonged cytopenias, B-cell aplasia with hypogammaglobulinemia and infections, secondary T-cell malignancies	massive T-cell activation induces macrophage release of IL-6, IL-1, and IFN-gamma, causing endothelial activation and capillary leak; endothelial activation and blood-brain-barrier disruption underlie ICANS; on-target B-cell depletion;

		(boxed warning added by the FDA in 2024)	insertional or clonal mechanisms are hypothesized for T-cell malignancy.
A70	Androgen-deprivation therapy (GnRH analogs, abiraterone, enzalutamide)	bone loss and fractures, metabolic syndrome and diabetes, cardiovascular events, sarcopenia, cognitive effects; abiraterone-related hypertension and hypokalemia; enzalutamide-related seizures and falls	hypogonadism with loss of aromatized estradiol increases osteoclast activity and fat mass while lowering muscle mass and insulin sensitivity; CYP17 inhibition causes mineralocorticoid excess.
A71	Tamoxifen and aromatase inhibitors	tamoxifen: endometrial hyperplasia and cancer, uterine sarcoma, venous thromboembolism, stroke, cataract; aromatase inhibitors: bone loss and fractures, arthralgia, hypercholesterolemia	tamoxifen is a partial estrogen-receptor agonist in endometrium and liver (increasing procoagulant factors and lowering antithrombin); aromatase inhibitors produce profound estrogen deprivation with RANKL-driven bone resorption.

A72	Immunomodulatory imide drugs (thalidomide, lenalidomide, pomalidomide)	teratogenicity (L1), venous thromboembolism, peripheral neuropathy, second primary malignancies (lenalidomide), cytopenias	cereblon (CRBN) E3-ligase modulation degrades IKZF1/3 (anti-myeloma effect) and SALL4 and p63 (limb and organ malformation); mechanisms for thrombosis and neuropathy are incompletely defined.
A73	Proteasome inhibitors (bortezomib, carfilzomib)	peripheral neuropathy (bortezomib); heart failure, hypertension, thrombotic microangiopathy (carfilzomib)	proteasome inhibition triggers the unfolded-protein response and NF-kappaB dysregulation in neurons, cardiomyocytes, and endothelium.
A74	Anti-CD20 antibodies (rituximab, obinutuzumab, ocrelizumab)	hepatitis B reactivation (including fulminant), progressive multifocal leukoencephalopathy, hypogammaglobulinemia, late-onset neutropenia, infusion reactions	B-cell depletion impairs humoral immunity and B-cell-dependent control of viral latency; infusion reactions reflect complement and Fc-receptor-mediated cytokine release.

A75	Calcineurin inhibitors (tacrolimus, cyclosporine)	acute and chronic nephrotoxicity, hypertension, hyperkalemia, hypomagnesemia, neurotoxicity (tremor, PRES), post-transplant diabetes, skin cancer, lymphoproliferative disease	inhibition of calcineurin-NFAT signaling reduces IL-2 and T-cell activation; off-target increases in endothelin-1 and thromboxane with reduced nitric oxide cause afferent vasoconstriction and ischemia; TGF-beta-mediated arteriolar hyalinosis and striped interstitial fibrosis; NFAT inhibition in beta cells reduces insulin gene expression.

A76	TNF inhibitors (infliximab, adalimumab, etanercept, certolizumab, golimumab)	serious bacterial and opportunistic infections, reactivation of tuberculosis and hepatitis B, demyelinating disease, drug-induced lupus, paradoxical psoriasis, hepatosplenic T-cell lymphoma (with thiopurines), worsening heart failure, infusion reactions with anti-drug antibodies	TNF is required for granuloma maintenance, so blockade permits latent mycobacterial reactivation; blockade increases plasmacytoid-dendritic-cell interferon-alpha, driving paradoxical psoriasis; immunogenicity of antibody biologics.
A77	Janus-kinase inhibitors (tofacitinib, baricitinib, upadacitinib)	major adverse cardiovascular events, venous thromboembolism, serious infection including herpes zoster, malignancy (boxed warnings after the ORAL Surveillance trial), cytopenias, lipid elevation, gastrointestinal perforation	broad blockade of cytokine signaling (type I interferon, IL-6, common-gamma-chain cytokines) impairs antiviral defense; mechanisms of thrombosis and cardiovascular risk are not fully defined.
A78	Natalizumab and other targeted immune-trafficking drugs (sphingosine-	progressive multifocal leukoencephalopathy (JC virus), cryptococcal	alpha-4-integrin blockade reduces CNS immune surveillance (risk rises with anti-

	1-phosphate modulators)	infection, macular edema, bradycardia	JCV antibody index, duration beyond two years, and prior immunosuppression); S1P-receptor modulation sequesters lymphocytes and affects cardiac conduction.
A79	Thiopurines (azathioprine, 6-mercaptopurine)	myelosuppression (TPMT or NUDT15 deficiency), pancreatitis, hepatotoxicity, lymphoma (including hepatosplenic T-cell lymphoma in young men with IBD), non-melanoma skin cancer	incorporation of 6-thioguanine nucleotides into DNA causes mismatch-repair-dependent cytotoxicity, with excessive accumulation in TPMT or NUDT15 variants; 6-methylmercaptopurine causes hepatotoxicity; 6-thioguanine sensitizes skin to UVA.
A80	mTOR inhibitors (sirolimus, everolimus)	impaired wound healing and lymphocele, hyperlipidemia, proteinuria, non-infectious pneumonitis, oral ulceration, new-	mTORC1 inhibition reduces cell proliferation, angiogenesis, and epithelial repair; reduced lipoprotein lipase activity;

		onset diabetes, cytopenias	podocyte mTOR disruption.
A81	Drug-induced autoimmune syndromes (hydralazine, procainamide, minocycline, propylthiouracil, DPP-4 inhibitors, TNF inhibitors)	drug-induced lupus, ANCA-associated vasculitis, autoimmune hepatitis, bullous pemphigoid	DNA hypomethylation in CD4-positive T cells increases autoreactivity (procainamide, hydralazine); drug-altered myeloperoxidase and neutrophil extracellular trap formation (propylthiouracil); reactive metabolites forming neo-antigens; mechanism for DPP-4 inhibitor-associated pemphigoid is unknown.
A82	Lymphocyte-depleting therapies and secondary autoimmunity (alemtuzumab, anti-thymocyte globulin, cladribine)	autoimmune thyroid disease, immune thrombocytopenia, anti-GBM disease	lymphopenia drives homeostatic proliferation of autoreactive clones, reduced regulatory T-cell function, and BAFF-driven B-cell hyperactivity during reconstitution.

A83	Menopausal hormone therapy	breast cancer (combined estrogen-progestin, modest absolute excess in the Women's Health Initiative), venous thromboembolism, stroke, gallbladder disease, endometrial cancer (unopposed estrogen), coronary events in older or late-initiating users	oral estrogens increase hepatic synthesis of procoagulant factors and reduce antithrombin and protein S (transdermal estradiol has lower thrombotic risk); estrogen and progestin stimulate mammary epithelial proliferation through ER-alpha and progesterone receptor signaling; unopposed estrogen drives endometrial proliferation.

A84	Combined hormonal contraceptives	venous thromboembolism (higher with desogestrel, drospirenone, or cyproterone than with levonorgestrel, and with factor V Leiden), arterial thrombosis and stroke (particularly with smoking and migraine with aura), hypertension, hepatic adenoma, small increases in breast and cervical cancer risk	ethinylestradiol increases coagulation factors and angiotensinogen and induces acquired activated-protein-C resistance; progestin type modifies the effect.
A85	Testosterone and anabolic-androgenic steroids	erythrocytosis and thrombosis, suppression of the hypothalamic-pituitary-gonadal axis (azoospermia, infertility), hepatotoxicity (cholestasis, peliosis, adenoma with 17-alpha-alkylated agents), cardiomyopathy and dyslipidemia, gynecomastia; in a large trial of therapeutic testosterone, no excess of major cardiovascular events but more atrial fibrillation, acute kidney	suppression of hepcidin and stimulation of erythropoiesis; negative feedback on LH and FSH; aromatization to estrogen; direct hepatocellular and myocardial effects.

		injury, and pulmonary embolism	
A86	Bisphosphonates (alendronate, zoledronate)	osteonecrosis of the jaw (about 1 per 10,000 to 100,000 patient-years at osteoporosis doses; far higher at oncology doses), atypical femoral fractures, esophagitis and ulceration (oral), acute-phase reaction (IV), hypocalcemia, renal toxicity (IV), uveitis	nitrogen-containing bisphosphonates inhibit farnesyl pyrophosphate synthase, reducing protein prenylation and inducing osteoclast apoptosis; profound remodeling suppression allows microdamage accumulation, with anti-angiogenic and infection-promoting effects after dental trauma; topical mucosal injury; gamma-delta T-cell cytokine release.
A87	Denosumab	osteonecrosis of the jaw, atypical femoral fractures, severe hypocalcemia (especially in CKD), multiple vertebral fractures after discontinuation, skin infections	RANKL neutralization profoundly but reversibly inhibits osteoclasts; on cessation, rebound osteoclastogenesis causes rapid bone loss.

			chronic mu-opioid receptor activation causes mesolimbic dopamine reward sensitization (disinhibition of ventral tegmental dopamine neurons) and neuroadaptation (cAMP superactivation, receptor desensitization, NMDA-dependent plasticity) with recruitment of stress systems (CRF, dynorphin), producing the allostatic state of dependence; risk rises with dose, duration, co-prescribed sedatives, and psychiatric comorbidity.
A88	Prescription opioids: opioid use disorder, persistent use, and overdose	opioid use disorder, persistent long-term use after short prescriptions (the probability of continued use at one year rises with each additional day supplied, most steeply in the first week), overdose, tolerance and hyperalgesia, neonatal opioid withdrawal syndrome	
A89	Abrupt-cessation (Type E) syndromes: corticosteroids, beta-blockers, clonidine, intrathecal baclofen, antiepileptics, PPIs,	adrenal crisis; rebound angina, myocardial infarction, and tachyarrhythmia; hypertensive crisis; baclofen withdrawal with hyperthermia and	homeostatic adaptation to chronic drug effect (adrenal atrophy; beta-receptor up-regulation; alpha-2 receptor down-regulation with

	and the benzodiazepine and antidepressant syndromes in A49 and A50	rhabdomyolysis; status epilepticus; rebound acid hypersecretion	catecholamine surge; GABA-B down-regulation; enterochromaffin-like cell hyperplasia) is unmasked when the drug is stopped.
A90	Polypharmacy and prescribing cascades	falls and fractures, delirium, ADE-related hospitalization, and cascade-driven disease (e.g., calcium-channel-blocker edema treated with a loop diuretic; metoclopramide parkinsonism treated with levodopa; NSAID-induced hypertension treated with an antihypertensive; cholinesterase-inhibitor incontinence treated with an anticholinergic)	cumulative pharmacodynamic burdens (anticholinergic, sedative, hypotensive, QT-prolonging), age-related reductions in renal clearance and hepatic metabolism, increased receptor sensitivity, and misattribution of an adverse effect to a new disease; risk rises steeply beyond about five concurrent drugs. This entry generalizes the draft's CF 50.
A91	Pharmacokinetic and transporter interactions	toxicity from inhibition (clarithromycin with simvastatin causing rhabdomyolysis; clarithromycin with calcium-channel blockers	inhibition or induction of CYP3A4, 2C9, 2D6, 2C19, P-glycoprotein, OATP, and UGT enzymes alters drug exposure;

		causing hypotension and AKI; warfarin with trimethoprim-sulfamethoxazole, azoles, or amiodarone causing bleeding; azoles with vincristine causing neuropathy; ritonavir or cobicistat with inhaled or injected corticosteroids causing Cushing syndrome and adrenal suppression) and loss of efficacy from induction (St John's wort, rifampin lowering DOAC or transplant-drug levels causing thrombosis or rejection)	prodrug activation (clopidogrel, tamoxifen, codeine) can fail or intensify.
A92	Renal and hepatic dosing failure with narrow-therapeutic-index drugs (aminoglycosides, vancomycin, digoxin, lithium, methotrexate, enoxaparin, DOACs, gabapentinoids, morphine, metformin)	drug-specific accumulation toxicity	reduced clearance in CKD, AKI, hepatic impairment, and hypoalbuminemia, with omission of dose adjustment or creatinine-based misestimation of GFR in sarcopenia and critical illness.

A93	Allopurinol and other urate-lowering agents	severe cutaneous adverse reactions and DRESS (HLA-B58:01 in Han Chinese, Thai, Korean, and African-American patients; risk amplified by renal impairment and high starting doses); febuxostat cardiovascular-death signal in one large trial; rasburicase hemolysis and methemoglobinemia in G6PD deficiency	oxypurinol interacts with HLA-B58:01 and T-cell receptors (pharmacological-interaction concept) to activate cytotoxic T cells with granulysin release; oxypurinol accumulates in renal impairment.
A94	Hydroxychloroquine and chloroquine	retinopathy (cumulative dose and duration dependent), cardiomyopathy, QT prolongation, hypoglycemia	lysosomotropic accumulation and melanin binding in retinal pigment epithelium; phospholipidosis-like cardiac and muscle injury.
A95	Systemic retinoids (isotretinoin, acitretin) and tetracycline co-exposure	teratogenicity (L3), hypertriglyceridemia, hepatotoxicity, pseudotumor cerebri (greater with tetracyclines), mucocutaneous dryness;	retinoic-acid-receptor activation alters lipid metabolism and cerebrospinal-fluid dynamics.

		reported mood effects remain contested	
A96	Oxidant drugs and methemoglobinemia (dapsone, benzocaine, nitrates, primaquine, rasburicase)	methemoglobinemia, hemolytic anemia (especially in G6PD deficiency)	oxidation of hemoglobin iron (Fe2+ to Fe3+) overwhelms NADH-cytochrome b5 reductase, and in G6PD deficiency the lack of NADPH-dependent glutathione regeneration permits oxidative red-cell destruction.

Appendix A.B — Category B (16 entries)

CF ID	Exposure / contributing factor	Diseases / outcomes	Biological mechanism summary

			the catheter bypasses the urethral sphincter; organisms ascend along intraluminal or extraluminal biofilm; mucosal abrasion facilitates invasion; urease-producing organisms alkalinize urine and precipitate crystalline biofilm.
B1	Indwelling urinary catheters	catheter-associated urinary tract infection (CAUTI), pyelonephritis, urosepsis, catheter encrustation and struvite stones (urease-producing Proteus), urethral injury	
B2	Central venous catheters and other intravascular devices	central line-associated bloodstream infection (CLABSI), septic thrombophlebitis, endocarditis, metastatic infection, peripheral-line S. aureus bacteremia	extraluminal migration of skin flora along the insertion tract (short-term lines) or intraluminal contamination of hubs (long-term lines), followed by biofilm and fibrin-sheath colonization that seeds the

			bloodstream episodically.
B3	Endotracheal intubation and hospital-acquired pneumonia	ventilator-associated pneumonia, non-ventilator hospital-acquired pneumonia, respiratory failure	the tube bypasses the glottis and impairs mucociliary clearance; subglottic secretions pool above the cuff and are micro-aspirated; biofilm forms on the tube; sedation, supine positioning, dysphagia, and acid suppression increase aspiration and colonization.
B4	Surgical incision and operation	superficial, deep, and organ-space surgical site infection, sepsis, implant infection	barrier transection allows inoculation of skin flora or environmental organisms; hypothermia, hypoxia, hyperglycemia,

			and hypoperfusion impair neutrophil oxidative killing; foreign material (sutures, implants) lowers the inoculum required for infection by orders of magnitude.
B5	Healthcare-environment Clostridioides difficile transmission	C. difficile infection, toxic megacolon, recurrent disease, sepsis	alcohol-resistant spores persist on surfaces and hands and are transmitted between patients; in an antibiotic-disrupted gut, primary bile acids trigger spore germination; toxins A and B glucosylate Rho GTPases; hypervirulent ribotypes (e.g., 027) add binary toxin and toxin hyperproduction.

			antibiotic selective pressure enriches resistant clones and drives horizontal transfer of resistance plasmids and transposons (mecA, vanA, carbapenemases); gut domination after antibiotics increases translocation; colonization pressure on wards and biofilm tolerance perpetuate transmission.
B6	Multidrug-resistant organisms (MRSA, VRE, ESBL-producing and carbapenem-resistant Enterobacterales, carbapenem-resistant Acinetobacter)	bloodstream, pulmonary, urinary, and wound infections with higher mortality and treatment failure	
B7	Candida and invasive fungal infection (including Candida auris)	candidemia, intra-abdominal candidiasis, endophthalmitis, fungal endocarditis, device-related infection	loss of competing bacterial flora removes colonization resistance; mucosal injury, central lines, parenteral nutrition, and abdominal surgery permit

			translocation; C. auris colonizes skin, persists on surfaces, and is frequently multidrug-resistant.
B8	Hospital construction and air-handling failures (invasive mold infection)	invasive aspergillosis and mucormycosis in hematologic malignancy, stem-cell and organ transplant recipients	inhalation of aerosolized conidia during construction or with inadequate filtration; neutropenia and corticosteroids impair macrophage and NADPH-oxidase-dependent neutrophil killing.
B9	Building water systems (Legionella and other waterborne organisms)	Legionnaires disease, Pseudomonas, Serratia, and non-tuberculous mycobacterial infection	amoeba-hosted and biofilm-protected organisms in warm stagnant water are aerosolized; Legionella replicates within alveolar macrophages

			using the Dot/Icm type IV secretion system.
B10	Cardiac heater-cooler devices (Mycobacterium chimaera)	prosthetic-valve endocarditis, vascular-graft infection, and disseminated non-tuberculous mycobacterial disease, often 1 to 5 years after surgery	contaminated water tanks aerosolize organisms into the operating field during cardiopulmonary bypass; slow-growing biofilm-forming mycobacteria seed implanted prosthetic material.
B11	Contaminated reprocessed endoscopes (especially duodenoscopes)	carbapenem-resistant Enterobacterales bloodstream infection and cholangitis, other cross-infection	complex distal-tip design and biofilm with residual bioburden defeat high-level disinfection.
B12	Unsafe injection and infusion practices	hepatitis B, hepatitis C, and HIV outbreaks (syringe reuse, multi-dose-vial contamination, shared	direct parenteral inoculation of bloodborne virus.

		insulin pens, endoscopy and pain-management clinics)	
B13	Dialysis-related infection	catheter-related bacteremia, access-site infection, peritoneal-dialysis peritonitis, hepatitis B transmission	biofilm on dialysis catheters, repeated access, and uremia-related immune dysfunction; peritoneal contamination at connection.
B14	Hospital-acquired viral infection (norovirus, influenza, RSV, SARS-CoV-2)	nosocomial outbreaks with severe disease in elderly, immunocompromised, and neonatal patients	person-to-person, fomite, and aerosol transmission in congregate care among vulnerable hosts.
B15	Neonatal intensive-care infection and necrotizing enterocolitis	late-onset neonatal sepsis (coagulase-negative staphylococci, S. aureus, Candida), necrotizing enterocolitis	immature innate immunity and barrier function, central lines, parenteral nutrition, and prolonged empiric antibiotics (which reduce protective

			Bifidobacterium and promote TLR4-driven intestinal inflammation).
B16	Post-procedural endophthalmitis (cataract surgery, intravitreal injection)	endophthalmitis with vision loss	inoculation of conjunctival flora into the immune-privileged vitreous; bacterial toxins and uncontrolled inflammation destroy the retina.

Appendix A.C — Category C (31 entries)

CF ID	Exposure / contributing factor	Diseases / outcomes	Biological mechanism summary
C1	Operative organ, vascular, and nerve injury (including accidental puncture or laceration, PSI 15)	bile-duct injury and stricture, ureteral injury, bowel perforation with peritonitis, hemorrhage, sepsis	mechanical transection or thermal injury of tissue; spillage of enteric contents activates a macrophage and neutrophil response, third-

			spacing, and septic shock; electrosurgical thermal spread causes delayed ischemic necrosis; anatomic misidentification.
C2	Postoperative hemorrhage and hematoma (PSI 09)	hemorrhagic shock, reoperation, wound complications	surgical bleeding amplified by anticoagulants, dilutional and consumptive coagulopathy, hypothermia, and acidosis.
C3	Perioperative venous thromboembolism (PSI 12)	deep vein thrombosis and pulmonary embolism	Virchow's triad is completed by endothelial injury and tissue-factor release, an acute-phase hypercoagulable state (elevated fibrinogen and PAI-1 with fibrinolysis shutdown, driven by IL-6 and TNF-alpha), and venous stasis from

			immobilization; risk is highest after orthopedic and cancer surgery.
C4	Postoperative acute kidney injury (PSI 10)	acute kidney injury, dialysis dependence, progression to CKD	intraoperative hypotension and hypoperfusion, ischemia-reperfusion injury, inflammation, nephrotoxin co-exposure, bypass-related hemolysis with free hemoglobin and iron, and venous congestion.
C5	Perioperative myocardial injury, infarction, and stroke	myocardial injury after noncardiac surgery, myocardial infarction, atrial fibrillation, perioperative stroke	supply-demand mismatch (hypotension, tachycardia, anemia), catecholamine surge, and a prothrombotic, inflammatory milieu that destabilizes plaque; cardioembolism

			from new atrial fibrillation; embolization or hypoperfusion in cardiac and carotid surgery.
C6	Postoperative delirium and cognitive dysfunction	delirium, persistent cognitive decline in vulnerable patients	surgical trauma releases cytokines (IL-1-beta, IL-6) and DAMPs (HMGB1) that increase blood-brain-barrier permeability and prime microglia; cholinergic deficiency, sleep and circadian disruption, anticholinergic, benzodiazepine, and opioid exposure, and hypoperfusion add to this; underlying neurodegeneration increases vulnerability.
C7	Malignant hyperthermia (volatile	hypermetabolic crisis, hyperthermia,	pathogenic RYR1 (or CACNA1S) variants cause

	anesthetics, succinylcholine)	rhabdomyolysis, hyperkalemia, death	uncontrolled sarcoplasmic-reticulum calcium release when triggered; dantrolene blocks the ryanodine receptor.
C8	Propofol infusion syndrome	lactic acidosis, rhabdomyolysis, cardiac failure, hyperkalemia, renal failure (high-dose, prolonged infusion, especially in children and critical illness)	impaired mitochondrial fatty-acid oxidation and respiratory-chain function.
C9	Succinylcholine	hyperkalemic cardiac arrest in denervation injury, burns, prolonged immobilization, or muscular dystrophy; prolonged paralysis in butyrylcholinesterase (BCHE) variants	depolarization of up-regulated extrajunctional acetylcholine receptors releases potassium; impaired plasma hydrolysis prolongs block.
C10	Halogenated anesthetics	immune-mediated fulminant hepatitis	oxidative metabolism generates

	(halothane, rarely newer agents)		trifluoroacetyl-protein adducts that act as neoantigens.
C11	Anesthetic exposure in the developing brain	possible neurodevelopmental effects after early repeated or prolonged exposure	preclinical studies show NMDA and GABA-mediated neuroapoptosis in immature brain; a large randomized trial of a single brief exposure in infancy found no effect on IQ at age 5, and evidence for prolonged or repeated exposure remains uncertain.

C12	Local-anesthetic systemic toxicity	seizures, cardiovascular collapse	sodium-channel block in CNS then myocardium; bupivacaine also inhibits mitochondrial carnitine-acylcarnitine translocase, reducing ATP; intravenous lipid emulsion is a rescue therapy.
C13	Neuraxial anesthesia and analgesia	post-dural-puncture headache, epidural hematoma (especially with anticoagulants), epidural abscess, nerve injury, high spinal block	CSF leak causes intracranial hypotension and traction on pain-sensitive structures; bleeding or infection in a closed space compresses the cord; direct needle or toxic injury.

C14	Perioperative peripheral nerve injury (positioning, tourniquet, retractors, regional blocks)	neuropraxia and axonal injury, brachial plexopathy, ulnar and peroneal neuropathy	compression or stretch produces ischemia, demyelination, and axonal degeneration.
C15	Needle and catheter injury (thoracentesis, central-line placement; PSI 06)	iatrogenic pneumothorax, hemothorax, arterial puncture, cardiac tamponade, air embolism	pleural or vascular puncture introduces air or blood into the negative-pressure pleural space or compartments; loss of lung-chest-wall cohesion causes atelectasis; positive-pressure ventilation converts a small pneumothorax to tension.
C16	Persistent postsurgical pain	chronic neuropathic and mixed pain after hernia repair, thoracotomy, mastectomy, amputation, and other operations	surgical nerve injury induces peripheral and central sensitization (glial activation, NMDA-

			dependent plasticity).
C17	Peritoneal adhesions	adhesive small-bowel obstruction, chronic pelvic pain, secondary infertility	peritoneal trauma causes fibrin deposition and suppressed fibrinolysis (reduced tissue plasminogen activator, increased PAI-1), allowing fibroblast and capillary ingrowth into fibrous bands.
C18	Splenectomy	overwhelming post-splenectomy infection (encapsulated organisms, Capnocytophaga), thrombosis, pulmonary hypertension	loss of marginal-zone B cells and IgM-memory, blood filtration, and opsonization.

C19	Thyroid, parathyroid, and neck surgery	hypoparathyroidism with hypocalcemia, recurrent laryngeal nerve injury, airway-compromising hematoma	parathyroid devascularization or removal; nerve stretch or transection.
C20	Bariatric surgery	iron, B12, folate, thiamine (Wernicke encephalopathy), and copper (myeloneuropathy) deficiency; calcium and vitamin D deficiency with osteoporosis; dumping syndrome; marginal ulcer; internal hernia; gallstones; post-bypass hyperinsulinemic hypoglycemia; alcohol use disorder	reduced acid and intrinsic factor, duodenal bypass (iron, calcium), rapid transit, altered alcohol first-pass metabolism, and incretin hypersecretion.

C21	Surgical menopause (bilateral oophorectomy before natural menopause) and hysterectomy	bone loss, cardiovascular disease, cognitive decline (association), sexual dysfunction	abrupt loss of ovarian estrogen and androgen; hysterectomy with ovarian conservation may lead to earlier ovarian failure.
C22	Endoscopic procedures (colonoscopy, ERCP, endoscopic resection)	perforation, delayed post-polypectomy bleeding, post-polypectomy coagulation syndrome, post-ERCP pancreatitis (about 2% to 10%), sedation-related cardiopulmonary events	mechanical, barotraumatic, and thermal injury; in ERCP, papillary edema, pancreatic-duct hydrostatic or contrast injury, and premature trypsinogen activation.
C23	Cardiac surgery and cardiopulmonary bypass	systemic inflammatory response and vasoplegia, acute kidney injury, stroke and cognitive decline, atrial fibrillation, bleeding	contact activation of complement, kallikrein, and cytokines at the blood-circuit interface, ischemia-reperfusion injury, hemolysis, and microemboli from

			aortic manipulation.
C24	Cardiac catheterization and percutaneous coronary intervention	access-site hematoma, pseudoaneurysm, retroperitoneal bleeding, stroke, coronary dissection or perforation, contrast nephropathy (E5), radiation skin injury (E3)	arterial puncture combined with anticoagulation; mechanical plaque and vessel injury.
C25	Transcatheter aortic-valve implantation	conduction block requiring pacemaker, stroke, leaflet thrombosis, paravalvular leak	compression of the conduction system adjacent to the membranous septum; embolization of calcific debris; thrombus formation on the prosthesis.
C26	Cesarean and instrumental delivery	maternal hemorrhage, infection, thromboembolism, placenta accreta spectrum in later	uterine scar defects permit abnormally deep trophoblast invasion; mechanical

		pregnancies, pelvic-floor disorders and obstetric anal sphincter injury after instrumental delivery or episiotomy; offspring associations with asthma, allergy, and obesity after cesarean delivery	sphincter disruption; the offspring associations are attributed to altered microbial seeding and absent labor-related hormone and stress signals but are confounded by indication.
C27	Induction and augmentation of labor with oxytocin	uterine tachysystole with fetal hypoxia, uterine rupture (prior scar), postpartum hemorrhage from atony, water intoxication	excessive contractions reduce uteroplacental perfusion; oxytocin-receptor desensitization contributes to atony; oxytocin has antidiuretic activity.

C28	Spinal surgery	adjacent-segment degeneration, failed-back-surgery syndrome, epidural fibrosis, dural tear, post-operative infection and epidural hematoma	altered biomechanics transfers load to neighboring levels; scar and fibrosis around nerve roots.
C29	Prolonged intubation and tracheostomy	subglottic and tracheal stenosis, tracheo-innominate fistula, vocal-cord injury	cuff pressure above mucosal capillary perfusion pressure (about 25 to 30 mmHg) causes mucosal ischemia, ulceration, granulation, and scar contracture.
C30	Thermal injury in the operating and imaging environment	burns (electrosurgical alternate-site and MRI-related), airway and surgical fires	high current density through small contact areas or capacitive coupling; ignition in oxygen-enriched atmospheres.

C31	Epidural steroid injection	spinal-cord and brainstem infarction (rare), epidural abscess, adrenal suppression, bone loss, fungal meningitis from contaminated product (K1)	inadvertent intra-arterial injection of particulate steroid into radicular or vertebral arteries causes embolic infarction; systemic absorption causes HPA-axis suppression.

Appendix A.D — Category D (12 entries)

CF ID	Exposure / contributing factor	Diseases / outcomes	Biological mechanism summary

D1	Metal-on-metal hip bearings and corroding modular tapers	adverse local tissue reactions (pseudotumor, soft-tissue necrosis), osteolysis, and systemic cobalt toxicity (cardiomyopathy, neuropathy, hypothyroidism, visual and hearing changes)	metal particles and ions activate macrophages (including the NLRP3 inflammasome) and drive a lymphocyte-dominated Type IV hypersensitivity; cobalt ions impair mitochondrial function and activate hypoxia-inducible-factor signaling.
D2	Polyethylene and other wear debris in joint arthroplasty	periprosthetic osteolysis and aseptic loosening	macrophage phagocytosis of submicron particles releases TNF-alpha, IL-1, and RANKL, activating osteoclasts ("particle disease").
D3	Periprosthetic joint and orthopedic-	acute and chronic implant infection requiring revision	"race for the surface" between bacteria and host tissue integration;

	hardware infection		biofilm on implant surfaces and compromised local immunity in the peri-implant tissue.
D4	Surgical mesh (hernia repair, pelvic-organ-prolapse repair, stress-incontinence slings)	chronic pain, mesh exposure or erosion, infection, dyspareunia, organ injury, recurrence; the FDA ordered transvaginal mesh for prolapse off the US market in 2019	chronic foreign-body reaction, mesh contraction and stiffness mismatch with surrounding tissue, nerve entrapment, and biofilm.

D5	Breast implants	capsular contracture, breast-implant-associated anaplastic large-cell lymphoma (BIA-ALCL, mostly with textured implants), rupture; "breast implant illness" (systemic symptoms, causation unproven)	subclinical biofilm infection drives myofibroblast-mediated fibrotic capsule formation (TGF-beta); textured surfaces with chronic bacterial and inflammatory stimulation promote clonal T-cell expansion, with JAK/STAT3 pathway mutations in lymphoma.
D6	Cardiac implantable electronic devices (pacemakers, ICDs)	pocket and lead infection with endocarditis, venous lead thrombosis and occlusion, tricuspid regurgitation, inappropriate shocks, pacing-induced cardiomyopathy	biofilm on generator and leads; lead-endothelium interaction; dyssynchronous right-ventricular pacing causes maladaptive remodeling.

D7	Prosthetic heart valves	thromboembolism, prosthetic-valve endocarditis, hemolysis, structural valve degeneration, bleeding from required anticoagulation	blood-surface interaction and shear stress activate platelets and coagulation (mechanical valves) and damage red cells; progressive calcification of bioprosthetic tissue.
D8	Coronary and peripheral stents	stent thrombosis, in-stent restenosis, neoatherosclerosis	delayed endothelialization and hypersensitivity to polymer or drug (late thrombosis); vascular injury triggers smooth-muscle proliferation and neointimal hyperplasia.

D9	Inferior vena cava filters	filter fracture, migration, caval perforation, caval thrombosis, recurrent deep vein thrombosis	foreign-body thrombogenicity and mechanical fatigue.
D10	CSF shunts and external ventricular drains	shunt obstruction, ventriculitis and meningitis, over-drainage with subdural hematoma	biofilm; choroid-plexus and protein occlusion; siphon effect.
D11	Intrauterine devices and hysteroscopic sterilization implants	uterine perforation, early pelvic inflammatory disease, expulsion, pain; nickel hypersensitivity and device fragmentation with the hysteroscopic implant, which left the US market in 2018	mechanical injury; introduction of vaginal flora at insertion; nickel-driven hypersensitivity and chronic inflammation.
D12	Hemodialysis access (grafts	stenosis, thrombosis, steal	turbulent shear stress at

	and arteriovenous fistulas)	syndrome, infection, central venous stenosis	anastomoses drives smooth-muscle migration and neointimal hyperplasia.

Appendix A.E — Category E (7 entries)

CF ID	Exposure / contributing factor	Diseases / outcomes	Biological mechanism summary
E1	Therapeutic ionizing radiation	acute dermatitis, mucositis, esophagitis, and pneumonitis; late fibrosis (lung, skin, soft tissue), radiation heart disease (coronary disease, valvular disease, pericarditis, cardiomyopathy; risk of major coronary events rose by about 7% per gray of mean heart dose in a large breast-cancer cohort), xerostomia, osteoradionecrosis,	radiation causes direct and ROS-mediated DNA double-strand breaks, with apoptosis and mitotic catastrophe of dividing cells and endothelium; chronic inflammation, microvascular injury and ischemia, stem-cell depletion, and sustained TGF-beta/CTGF signaling activate fibroblasts and deposit collagen;

		myelopathy and brain necrosis, cognitive decline, hypothyroidism, lymphedema, bowel stricture and proctitis, carotid vasculopathy, infertility, and second cancers (sarcoma, leukemia, breast, lung; latency 5 to more than 30 years)	surviving cells with misrepaired DNA initiate carcinogenesis.
E2	Diagnostic CT and other ionizing imaging	small increases in lifetime cancer risk, particularly after childhood exposure (a large UK cohort estimated that cumulative head doses of roughly 50 to 60 mGy in children were associated with about threefold higher relative risks of leukemia and brain tumors, corresponding to	low-dose DNA damage with stochastic mutagenesis; population risk estimates rely on linear no-threshold extrapolation from higher-dose data.

		about one excess case of each per 10,000 head scans in the following decade; reverse causation and confounding by indication remain debated)	
E3	Fluoroscopically guided interventions	radiation skin injury (erythema through necrosis at peak skin doses beyond a few gray), cataract, epilation	deterministic cell killing with microvascular injury when threshold doses are exceeded.
E4	Radiopharmaceuticals and radioiodine therapy	salivary-gland dysfunction and sialadenitis, xerostomia, myelosuppression, gonadal effects, small increases in second-cancer risk	local beta or alpha energy deposition; sodium-iodide-symporter uptake in salivary tissue. Historical agents (Thorotrast, radium) caused liver angiosarcoma, leukemia, and osteosarcoma.

E5	Iodinated contrast media	contrast-associated acute kidney injury (risk concentrated in patients with eGFR below about 30 mL/min/1.73 m2 and in intra-arterial first-pass exposure; the risk with modern low- and iso-osmolar agents given intravenously is lower than historically believed, and the draft's emphasis on highly osmolar agents is outdated), immediate hypersensitivity, delayed rash, thyroid dysfunction, extravasation injury	medullary vasoconstriction and hypoxia (adenosine, endothelin), direct tubular toxicity with ROS and increased viscosity; IgE-dependent and non-IgE (MRGPRX2) mast-cell activation; T-cell-mediated delayed reactions; iodine load causes Wolff-Chaikoff failure or iodine-induced thyrotoxicosis.
E6	Gadolinium-based contrast agents	nephrogenic systemic fibrosis (severe CKD or AKI exposed to	dissociation (transmetallation) releases free Gd3+ that

		older linear agents), tissue retention in brain and bone (clinical significance unclear; "gadolinium deposition disease" is unproven)	deposits in tissue; circulating fibrocytes and macrophages activate and drive TGF-beta-mediated fibrosis of skin and organs.
E7	Magnetic-resonance hazards	projectile injury, thermal burns, device and lead heating or malfunction, acoustic injury	static-field forces, radiofrequency heating, and gradient-induced currents.

Appendix A.F — Category F (15 entries)

CF ID	Exposure / contributing factor	Diseases / outcomes	Biological mechanism summary
F1	Allogeneic transfusion: transfusion-related acute lung injury (TRALI)	non-cardiogenic pulmonary edema within six hours of transfusion	a "two-hit" process: recipient inflammation primes pulmonary neutrophils, and donor anti-HLA or anti-neutrophil antibodies or bioactive lipids then activate them,

			releasing proteases and neutrophil extracellular traps that damage the alveolar capillary barrier; plasma from male donors reduces risk.
F2	Allogeneic transfusion: transfusion-associated circulatory overload (TACO)	hydrostatic pulmonary edema	rapid volume expansion exceeds cardiovascular reserve (older age, heart failure, renal failure), elevating pulmonary capillary hydrostatic pressure.
F3	Acute hemolytic transfusion reaction (ABO incompatibility)	intravascular hemolysis, DIC, acute kidney injury, shock, death	preformed IgM anti-A or anti-B activates complement (C3a, C5a), triggers cytokine release and tissue-factor-driven coagulation, and free hemoglobin scavenges nitric oxide and injures renal tubules.
F4	Allergic, febrile, and anaphylactic	urticaria, fever, anaphylaxis	recipient IgE against donor plasma

	transfusion reactions	(including in IgA-deficient recipients with anti-IgA antibodies)	proteins; cytokines accumulating in stored cellular products.
F5	Transfusion-associated graft-versus-host disease	fatal marrow aplasia, rash, hepatitis, and diarrhea	viable donor T cells (especially when donor and recipient share HLA haplotypes) engraft in an immunocompromised or HLA-haplotype-sharing recipient and attack host tissue; irradiation of cellular products prevents it.
F6	Chronic transfusion: iron overload and alloimmunization	hemosiderosis with cardiomyopathy, cirrhosis, endocrinopathy; red-cell alloimmunization with delayed hemolytic reactions and hemolytic disease of the fetus	the body lacks a regulated iron-excretion pathway, so labile plasma iron generates radicals through Fenton chemistry; minor-antigen mismatches (Kell, Rh, Duffy) elicit anamnestic antibody responses.
F7	Transfusion-transmitted	hepatitis B, hepatitis C, HIV (now	direct inoculation during donor

	infection	exceedingly rare with nucleic-acid testing), bacterial sepsis from contaminated platelets, babesiosis, West Nile virus, Chagas disease, malaria; variant CJD (a small number of probable transfusion transmissions in the UK)	window periods or contamination.
F8	Massive transfusion	citrate toxicity (hypocalcemia, hypomagnesemia), hyperkalemia, hypothermia, dilutional coagulopathy, acidosis	citrate chelation of divalent cations; potassium leak from stored red cells; cold, citrated, factor-poor products.

F9	Transfusion-related immunomodulation	postoperative infection and cancer-recurrence associations	donor leukocytes and soluble mediators (sCD40L, sFasL), regulatory-T-cell induction, and microchimerism are proposed; confounded by the indication for transfusion.
F10	Plasma-derived and recombinant protein products (IVIG, anti-D, clotting concentrates)	thrombosis, hemolysis, aseptic meningitis, acute kidney injury (sucrose-stabilized products), anaphylaxis; historical hepatitis C and HIV transmission through contaminated concentrates	increased viscosity and procoagulant contaminants (e.g., activated factor XI), passive isohemagglutinins, osmotic nephrosis, IgA-directed antibodies, viral contamination.
F11	Hemostatic agents (tranexamic acid, recombinant factor VIIa, prothrombin complex concentrate)	seizures (high-dose tranexamic acid in cardiac surgery), arterial and venous thrombosis	tranexamic acid antagonizes glycine and GABA-A receptors; systemic procoagulant effects.

F12	Donor-derived disease transmission in solid-organ transplantation	donor-derived infection (viral, bacterial, fungal, parasitic) and donor-derived malignancy	transplanted tissue transmits latent or occult pathogens and cells into a recipient on immunosuppression.
F13	Post-transplant lymphoproliferative disorder and opportunistic disease	EBV-driven B-cell lymphoproliferation, cytomegalovirus disease, other opportunistic infections	suppression of T-cell surveillance permits EBV-transformed B-cell proliferation (see A75).
F14	Hematopoietic cell transplantation	mucositis, sinusoidal obstruction syndrome (veno-occlusive disease), acute and chronic graft-versus-host disease, infection, graft failure, late cataract, endocrinopathy, and secondary malignancy	conditioning regimens injure endothelium and epithelium; alloreactive donor T cells attack host tissue amplified by tissue-damage-driven cytokines; prolonged immune deficiency.
F15	Iatrogenic prion transmission	Creutzfeldt-Jakob disease after cadaveric human growth hormone	misfolded PrPSc seeds templated conversion of host PrPC and propagates

		and human dura mater grafts (each with more than 200 recognized cases worldwide), neurosurgical instruments, corneal transplants, and variant CJD via transfusion	along neural pathways over incubation periods of years to decades; prions resist standard sterilization.

Appendix A.G — Category G (30 entries)

CF ID	Exposure / contributing factor	Diseases / outcomes	Biological mechanism summary
G1	mRNA COVID-19 vaccines (BNT162b2, mRNA-1273): myocarditis and pericarditis	myocarditis and pericarditis, concentrated in adolescent and young adult males within about a week of the second dose. Early CDC estimates were about 12.6 cases per million second doses across ages 12 to 39 and roughly 50 to 70 per million second doses in males aged 12 to 24, with higher rates in some Nordic	unresolved. Proposed contributors are (a) innate immune activation by the lipid nanoparticle and mRNA with elevated cytokines (IL-1-beta, IL-1 receptor antagonist, IL-15, interferon-gamma) and activated CD8-positive T and NK cells; (b) detection of free circulating

		and Asian datasets (particularly for mRNA-1273) and lower rates with longer dosing intervals and lower doses; most cases were mild with rapid recovery, although cardiac MRI abnormalities persisted in a proportion and long-term significance is still being studied. SARS-CoV-2 infection itself causes myocarditis at higher rates than vaccination in several large cohorts	spike antigen in affected adolescents; (c) molecular mimicry between spike epitopes and cardiac alpha-myosin heavy chain or troponin (hypothesized; autoantibodies were not consistently found); (d) spike-protein signaling through TLR4 on cardiomyocytes (supported mainly by in vitro work); and (e) sex-hormone modulation of Th1 inflammatory responses (testosterone) to explain male predominance. The draft presented (c) and (d) as established; they are not.
G2	Anaphylaxis to vaccines (mRNA	immediate hypersensitivity and	IgE to excipients (gelatin, yeast

vaccines and others)	anaphylaxis; about 5 per million doses with mRNA COVID-19 vaccines in US surveillance, compared with about 1 per million for other vaccines	proteins, trace egg protein, latex stoppers) or complement-activation-related pseudoallergy to PEGylated lipid nanoparticles (PEG-2000 and polysorbate cross-reactivity), possibly involving anti-PEG antibodies and MRGPRX2-mediated mast-cell activation.

G3	mRNA COVID-19 vaccines: other recognized or signal events	vasovagal syncope (especially in adolescents), axillary lymphadenopathy, shoulder injury related to vaccine administration (G26), transient menstrual-cycle changes (small, short-lived), Bell's palsy (inconsistent signal), immune thrombocytopenia (not consistently supported), herpes zoster reactivation (weak signal)	vasovagal reflex to injection; innate-immune-driven germinal-center activation in draining nodes; other mechanisms undefined.
G4	Adenoviral-vector COVID-19 vaccines (ChAdOx1-S, Ad26.COV2.S): vaccine-induced immune thrombotic thrombocytopenia (VITT, also called thrombosis with thrombocytopenia syndrome)	cerebral venous sinus thrombosis, splanchnic and other thromboses with thrombocytopenia and DIC, typically 4 to 42 days after vaccination; about 4 per million doses overall in the US with Ad26.COV2.S and higher in women aged 30 to 49; European and UK estimates for	high-titer IgG against platelet factor 4 develops without prior heparin exposure; these antibodies bind PF4 and activate platelets, neutrophils, and monocytes through Fc-gamma-RIIa, producing thrombosis, consumptive thrombocytopenia,

		ChAdOx1-S were on the order of 1 per 50,000 to 1 per 100,000 in younger adults; early mortality was high	and NETosis, as in autoimmune HIT. The trigger for anti-PF4 formation is incompletely defined (proposed: electrostatic binding of PF4 to the adenoviral capsid or free DNA with an inflammatory co-signal; clonally restricted antibodies using IGLV3-21*02 light chains have been described). Treatment uses IVIG and non-heparin anticoagulants.
G5	Adenoviral-vector COVID-19 vaccines: Guillain-Barre syndrome	Guillain-Barre syndrome with Ad26.COV2.S (a few to about ten excess cases per million doses in US surveillance; a label warning was added)	not established; post-vaccination autoimmunity against peripheral nerve gangliosides or myelin is hypothesized.

G6	MMR and MMRV: febrile seizures	febrile seizures about 5 to 12 days after the first dose at 12 to 23 months (roughly 1 per 3,000 to 4,000 MMR doses; about 1 additional seizure per 2,300 to 2,600 doses when MMRV is used instead of MMR plus separate varicella vaccine). Febrile seizures after vaccination have not been associated with an increased risk of later epilepsy or neurodevelopmental sequelae	replication of live-attenuated virus stimulates innate sensors (TLRs) and release of IL-1-beta, IL-6, and TNF-alpha, which act on the hypothalamus to induce fever; fever lowers the seizure threshold in susceptible toddlers.
G7	MMR: immune thrombocytopenia (ITP)	transient ITP, about 1 per 30,000 to 40,000 doses, usually self-limited; the risk after natural measles or rubella infection is higher	immune-mediated platelet destruction (antiplatelet antibodies or immune complexes triggered by viral antigen exposure).
G8	MMR: anaphylaxis and other hypersensitivity	anaphylaxis (about 1 per million doses), urticaria	IgE to gelatin or neomycin excipients; egg

			allergy is not a contraindication.
G9	Rubella-containing vaccines: joint symptoms	transient arthralgia and arthritis, most often in post-pubertal women	replication of attenuated rubella virus in synovial tissue with immune-complex formation; persistent chronic arthritis has not been established.
G10	Measles-containing vaccine in severe immunodeficiency	measles inclusion-body encephalitis, giant-cell pneumonitis, disseminated vaccine-strain infection	absent T-cell control of the attenuated virus (contraindicated in severe cellular immunodeficiency; screening prevents it).
G11	Mumps component: strain-specific aseptic meningitis, parotitis, orchitis	aseptic meningitis with Urabe and Leningrad-Zagreb strains (not with the Jeryl Lynn strain used in the US); rare parotitis	strain-dependent neurovirulence of live mumps virus.

G12	MMR and autism or inflammatory bowel disease (claimed association). The hypothesis arose from a 1998 case series that wa	See catalogue narrative	no supported mechanism.
G13	Thimerosal (ethylmercury) in vaccines and neurodevelopmental disorders (claimed association)	See catalogue narrative	
G14	Rotavirus vaccines: intussusception	intussusception, about 1 per 10,000 infants with the first rotavirus vaccine (RotaShield, withdrawn in 1999) and about 1 to 6 excess cases per 100,000 infants with current vaccines (clustered 3 to 7 days after the first dose); vaccine-strain persistent diarrhea in severe combined	replication of attenuated rotavirus in the gut with lymphoid (Peyer's patch) hyperplasia that acts as a lead point for intussusception; absent T-cell clearance in SCID.

		immunodeficiency (contraindicated)	
G15	Oral poliovirus vaccine: vaccine-associated paralytic poliomyelitis and circulating vaccine-derived poliovirus	paralytic poliomyelitis (about 1 case per 2.4 million doses distributed; much higher in immunodeficiency) and outbreaks of circulating vaccine-derived poliovirus in under-immunized populations	reversion of Sabin strains through mutations in the 5' untranslated region and capsid, and recombination with other enteroviruses, restores neurovirulence and transmissibility; the US moved to inactivated polio vaccine only in 2000.

		injection-site abscess, regional lymphadenitis, osteitis, and disseminated BCG disease in primary immunodeficiency (severe combined immunodeficiency, chronic granulomatous disease, defects of the IL-12/interferon-gamma axis)	
G16	BCG vaccine		failure of macrophage-IFN-gamma-dependent control of live Mycobacterium bovis BCG.
G17	Yellow fever vaccine (17D strain)	yellow-fever-vaccine-associated viscerotropic disease (on the order of 0.3 to 0.4 per 100,000 doses overall and several-fold higher at age 60 and older), neurotropic disease, anaphylaxis	uncontrolled vaccine-virus replication associated with impaired innate (type I interferon) responses, immunosenescence, and thymic disease; rare host genetic variants have been described.
G18	Smallpox (vaccinia) vaccines	myopericarditis, eczema vaccinatum, progressive and generalized vaccinia,	replication of live vaccinia with immune-mediated cardiac

		postvaccinal encephalitis, accidental inoculation	inflammation; uncontrolled spread in immunodeficiency or compromised skin barrier (atopic dermatitis).
G19	Inactivated and adjuvanted influenza vaccines: Guillain-Barre syndrome	Guillain-Barre syndrome, about 1 to 2 excess cases per million doses in some seasons (none in others; about 10 per million with the 1976 swine-flu vaccine); natural influenza infection raises Guillain-Barre risk more than vaccination does	not established. Molecular mimicry between microbial and nerve-ganglioside epitopes is proven for Campylobacter jejuni lipo-oligosaccharide (anti-GM1 antibodies) but is only hypothesized for influenza vaccine antigens (the draft stated it as fact).
G20	Pandemrix (AS03-adjuvanted H1N1pdm09 vaccine): narcolepsy type 1	narcolepsy with cataplexy, on the order of 1 in 20,000 vaccinated children and adolescents in the most affected countries (Finland, Sweden), strongly	hypothesized autoimmune loss of hypocretin (orexin) neurons through cross-reactive T- and B-cell responses (proposed mimicry

		dependent on HLA-DQB1*06:02	between influenza nucleoprotein and hypocretin receptor 2), amplified by the AS03 adjuvant and by wild H1N1 infection (also linked to narcolepsy in China).
G21	Influenza vaccine: other reactions	anaphylaxis (rare; trace ovalbumin; egg allergy is not a contraindication), oculorespiratory syndrome, febrile seizures in young children (increased with co-administration of certain vaccines)	IgE to excipients; innate-driven fever.
G22	Zoster vaccines	recombinant adjuvanted zoster vaccine (AS01B): marked reactogenicity (grade 3 systemic events in roughly 10% of recipients) and a small excess of	AS01B (MPL plus QS-21) produces strong innate activation and cytokine release; the Guillain-Barre mechanism is unknown; live vaccine strain

		Guillain-Barre syndrome (about 3 per million doses in Medicare analyses of adults aged 65 and older); live zoster vaccine (discontinued in the US in 2020): vaccine-strain VZV rash, meningitis, and pneumonitis in immunocompromised recipients	replicates in impaired hosts.
G23	RSV vaccines (older adults and pregnancy)	Guillain-Barre syndrome after Arexvy and Abrysvo (about 7 and 9 excess cases per million doses, respectively, in a Medicare analysis of adults aged 65 and older, leading to a label warning in January 2025; the FDA concluded that evidence was insufficient to establish causation and that benefits continue to outweigh risks); numerically more preterm births with maternal	unknown for both.

		Abrysvo in trials, leading to restriction of use to 32 to 36 weeks of gestation	
G24	HPV vaccines	syncope (post-injection), rare anaphylaxis (about 1 to 2 per million doses). Large cohort studies and WHO, EMA, and CDC reviews found no causal association with POTS, complex regional pain syndrome, Guillain-Barre syndrome, multiple sclerosis, other autoimmune disease, or premature ovarian insufficiency	vasovagal reflex; IgE to excipients.
G25	Tetanus-, diphtheria-, and pertussis-containing vaccines	Arthus-type local reactions with frequent boosters, brachial neuritis (rare, about 1 per 100,000 doses or fewer; favored as causal by the Institute of Medicine), febrile seizures, hypotonic-	Type III immune-complex reactions in the presence of high pre-existing antitoxin; fever and innate-immune activation.

		hyporesponsive episodes and persistent crying (whole-cell pertussis). The claim that whole-cell pertussis causes permanent encephalopathy was not supported by case-control and cohort studies	
G26	Shoulder injury related to vaccine administration (SIRVA; any intramuscular vaccine)	bursitis, tendinopathy, adhesive capsulitis with persistent shoulder pain and reduced motion	injection into the subacromial or subdeltoid bursa (too high or too deep) causes needle trauma and bursal deposition of antigen and adjuvant with local inflammation.
G27	Aluminum adjuvants and other inactivated or conjugate vaccines (hepatitis A and B, pneumococcal, meningococcal, Hib, typhoid, rabies, others)	injection-site nodules and granulomas (persistent itching nodules in a few recipients), contact aluminum allergy, macrophagic myofasciitis (a histologic finding without an	aluminum salts form an antigen depot and activate innate pathways (NLRP3 inflammasome and DAMP release) that enhance immunogenicity

		established clinical syndrome), fever (especially meningococcal B vaccines), rare anaphylaxis (hepatitis B about 1 per million doses). Large registry studies have not found associations between aluminum in childhood vaccines and autoimmune, allergic, or neurodevelopmental disorders; hepatitis B vaccine and multiple sclerosis have been repeatedly evaluated without support; "ASIA syndrome" remains a hypothesis	and cause local inflammation.
G28	Vaccine-associated enhanced disease (Dengvaxia, formalin-inactivated RSV and measles vaccines)	severe dengue in dengue-seronegative recipients of CYD-TDV (use restricted to seropositive persons); fatal enhanced RSV disease in infants after the 1960s formalin-inactivated vaccine; atypical measles after	sub-neutralizing antibodies promote antibody-dependent enhancement of infection through Fc-gamma receptors (dengue); Th2-skewed responses with immune-complex

		formalin-inactivated measles vaccine	deposition and complement activation and poorly neutralizing antibody (formalin-inactivated vaccines).
G29	Non-specific (heterologous) effects of vaccines	live vaccines (BCG, measles, OPV) were associated with lower non-targeted infectious mortality in some trials, while observational data suggested higher female mortality after DTP in Guinea-Bissau; a WHO advisory review judged the evidence to be of low quality and made no policy change	"trained immunity" through epigenetic and metabolic reprogramming of innate cells is proposed.
G30	Emerging, incompletely characterized post-vaccination syndromes (after COVID-19 vaccination)	reports of persistent fatigue, orthostatic intolerance, tinnitus, and small-fiber neuropathy after vaccination; no validated case definition exists,	hypotheses include persistent antigen, autoantibody generation, and innate priming; none established.

			studies are small and uncontrolled, and large cohorts do not show an overall increase in autoimmune disease, although small signals exist for specific conditions (e.g., immune thrombocytopenia, Guillain-Barre syndrome with Ad26.COV2.S)

Appendix A.H — Category H (19 entries)

CF ID	Exposure / contributing factor	Diseases / outcomes	Biological mechanism summary
H1	Prolonged immobilization: pressure injury (PSI 03)	pressure ulcers	sustained compression and shear exceeding capillary closing pressure (about 32 mmHg) cause ischemia, hypoxia, and reperfusion injury with irreversible necrosis, especially over bony prominences.

H2	Hospital-associated deconditioning and disability	loss of muscle mass and function, functional decline, loss of independence in older adults	disuse triggers anabolic resistance and ubiquitin-proteasome-mediated proteolysis with reduced mitochondrial capacity; inflammation and under-nutrition compound it.
H3	ICU-acquired weakness (critical illness polyneuropathy and myopathy)	prolonged ventilator dependence, long-term disability	sepsis-related microvascular and bioenergetic failure, sodium-channel inactivation, selective myosin loss, hyperglycemia, and compounding by corticosteroids and neuromuscular blockers.
H4	Delirium in hospitalized older adults	delirium, falls, prolonged stay, long-term cognitive decline	multifactorial: neuroinflammation, cholinergic deficiency, sleep and circadian disruption, hypoxia, and deliriogenic drugs (anticholinergics, benzodiazepines,

			opioids) in a vulnerable brain.
H5	In-hospital falls and fractures (PSI 08)	hip fracture, head injury	orthostatic hypotension and impaired postural control from hypotensive and sedative drugs, delirium, deconditioning, and unfamiliar environments.
H6	Hospital-associated venous thromboembolism	deep vein thrombosis, pulmonary embolism	stasis, inflammation-driven hypercoagulability, and vascular injury from lines (see C3).
H7	Sleep deprivation and circadian disruption	delirium, impaired glucose regulation, immune dysfunction	noise, light, and overnight vital signs and procedures reduce slow-wave and REM sleep and disturb cortisol and melatonin rhythms.

H8	Hospital-acquired anemia from phlebotomy	anemia, and in some patients transfusion exposure	cumulative diagnostic blood loss without proportional marrow compensation in inflamed patients.
H9	Under-nutrition and refeeding syndrome	malnutrition; with refeeding, hypophosphatemia, hypokalemia, hypomagnesemia, arrhythmia, heart failure, and Wernicke encephalopathy	carbohydrate refeeding raises insulin, driving intracellular shift of phosphate, potassium, and magnesium and increasing thiamine demand in depleted patients.
H10	Isotonic saline resuscitation (0.9% NaCl)	hyperchloremic metabolic acidosis and, in large trials of critically ill adults, a modest excess of major adverse kidney events compared with balanced crystalloids	supraphysiologic chloride lowers the strong ion difference so the kidney excretes bicarbonate; chloride-induced renal afferent vasoconstriction (tubuloglomerular feedback) may reduce GFR.

H11	Fluid overload and hypotonic maintenance fluids	pulmonary and tissue edema, abdominal compartment syndrome, AKI; hyponatremic encephalopathy in children given hypotonic fluids	excess volume raises venous pressure and capillary hydrostatic pressure; non-osmotic ADH release in ill patients impairs free-water excretion so hypotonic fluids lower serum sodium and cause cerebral edema.
H12	Parenteral nutrition	hepatic steatosis, cholestasis, biliary sludge and gallstones (intestinal-failure-associated liver disease), catheter infection, metabolic bone disease	loss of enteral stimulation reduces cholecystokinin and bile flow; continuous carbohydrate loads and omega-6-rich lipid emulsions drive lipogenesis, phytosterol- and endotoxin-mediated hepatic inflammation; bacterial overgrowth.
H13	Mechanical ventilation	ventilator-induced lung injury (volutrauma, barotrauma, atelectrauma, biotrauma), ventilator-induced	overdistension and cyclic opening and closing of alveoli cause mechanotransduction-driven release of cytokines into the

		diaphragm dysfunction, pneumothorax	circulation and distant organ injury; controlled diaphragm inactivity causes rapid atrophy; low-tidal-volume ventilation reduces mortality in ARDS.
H14	Oxygen toxicity and hyperoxia	absorption atelectasis, tracheobronchitis, lung injury; retinopathy of prematurity and bronchopulmonary dysplasia in preterm infants; higher mortality with liberal oxygen in meta-analyses of acutely ill adults	excess reactive oxygen species overwhelm antioxidant defenses in lung epithelium and the immature retinal vasculature.
H15	Stress-ulcer prophylaxis in low-risk patients	C. difficile infection, hospital-acquired pneumonia	gastric acid suppression allows upper-GI colonization and aspiration of altered flora (see A44).
H16	Deep sedation in the ICU	delirium, prolonged	GABAergic suppression of arousal

	(benzodiazepines, propofol)	ventilation and ICU stay, post-ICU cognitive impairment	and sleep architecture and accumulation of active metabolites.
H17	Inpatient dysglycemia	severe hypoglycemia with insulin; hyperglycemia-associated infection and poor healing; excess mortality with very tight glucose targets (NICE-SUGAR)	see A39; hyperglycemia impairs neutrophil function.
H18	Physical restraints and tethering devices	injury, agitation, delirium, pressure injury, strangulation	physical stress, immobility, and sensory deprivation.

H19	Post-intensive-care and post-hospital syndromes	cognitive impairment, depression, post-traumatic stress, persistent weakness, and a period of generalized vulnerability to readmission	combined effects of critical-illness inflammation, delirium, sedation, deconditioning, sleep loss, and psychological trauma.

Appendix A.I — Category I (9 entries)

CF ID	Exposure / contributing factor	Diseases / outcomes	Biological mechanism summary
I1	Overdiagnosis and overtreatment of indolent disease (thyroid cancer, prostate cancer, ductal carcinoma in situ, some screen-detected lung lesions)	harms of treatment (hypoparathyroidism and nerve injury after thyroidectomy; incontinence and erectile dysfunction after prostatectomy; radiation and surgical complications) in patients who would never have developed symptoms	sensitive detection finds lesions with low or no progressive potential, converting biological variation into a patient; downstream harm arises through the procedural and radiation CFs in

			Categories C and E.
I2	Incidentalomas and diagnostic cascades	complications of successive tests, biopsies, and procedures prompted by incidental findings	each step adds radiation, contrast, procedural, and anxiety exposure with a probability of additional abnormal findings.
I3	False-positive screening results	anxiety, distress, biopsy complications	stress-axis activation and procedural risk.
I4	Invasive diagnostic procedures	bleeding, pneumothorax (a large fraction of CT-guided lung biopsies), infection, needle-tract tumor seeding (rare), angiography-related stroke, lumbar puncture headache	mechanical injury (see C13, C15).
I5	Low-value and inappropriate care (antibiotics	downstream harms via the CFs in	exposure without offsetting benefit.

	for viral infection, opioids for self-limited pain, imaging for uncomplicated low back pain)	Categories A, B, and E	
I6	Nocebo effects and diagnostic labeling	symptom amplification (for example, muscle symptoms attributed to statins in blinded and unblinded comparisons), illness behavior and absenteeism after labeling with hypertension or "pre-disease."	expectation-driven modulation of pain and symptom perception through cortico-limbic circuits and cholecystokinin-mediated anxiety-hyperalgesia pathways.
I7	Medical trauma and ICU-related psychological injury	post-traumatic stress, depression, anxiety after critical illness, awareness under anesthesia, or traumatic procedures	fear conditioning, delirium-related memories, and dysregulation of the hypothalamic-pituitary-adrenal axis.

		progression of untreated disease (for example, delayed sepsis, myocardial infarction, stroke, or cancer), harm from the wrong treatment. About 5% of US outpatient adults experience a diagnostic error annually	cognitive bias, system and communication failures; downstream disease follows the natural history of the untreated condition.
I8	Diagnostic error (missed, wrong, or delayed diagnosis)		
I9	Medicalization of normal variation	adverse effects of unnecessary pharmacotherapy (for example, acid suppression for normal infant regurgitation)	exposure to drug CFs without a treatable disease.

Appendix A.J — Category J (7 entries)

CF ID	Exposure / contributing factor	Diseases / outcomes	Biological mechanism summary
J1	Medication errors (wrong drug, dose, route,	overdose toxicity from the specific agent (e.g., ten-fold	see the corresponding A entries; look-

	patient, or frequency)	dosing errors, daily instead of weekly methotrexate, intrathecal vincristine causing fatal ascending myeloencephalopathy, concentrated potassium causing cardiac arrest, insulin and opioid errors)	alike and sound-alike names, ambiguous abbreviations, and high-alert drugs raise risk.
J2	Wrong-site or wrong-patient procedures and retained surgical items	unnecessary or missed surgery, infection, adhesions, fistula, foreign-body granuloma (gossypiboma)	mechanical and foreign-body inflammatory responses (see C and D).
J3	Blood-product and specimen identification errors	ABO-incompatible transfusion (F3)	complement-mediated hemolysis.
J4	Health-information-technology and electronic-record failures	wrong-patient orders, alert fatigue, copy-forward diagnostic errors	human-factors failures leading to any downstream CF.

J5	Handoff, communication, test-follow-up, staffing, and fatigue failures	delayed treatment and missed results	untreated disease progression.
J6	Failure to rescue (delayed recognition and treatment of deterioration; PSI 04)	death among surgical inpatients with treatable complications (sepsis, hemorrhage, respiratory failure)	progression of shock and multi-organ failure when rescue is late.
J7	Line and tubing misconnection and device misplacement	enteral feed or medication given intravenously, misplaced feeding tube with pneumonia or pneumothorax	mechanical and embolic/toxic effects of the misdirected substance.

Appendix A.K — Category K (9 entries)

CF ID	Exposure / contributing factor	Diseases / outcomes	Biological mechanism summary

		fungal meningitis, spinal and paraspinal infection after contaminated epidural steroid injections in 2012 (more than 700 cases and about 60 deaths, predominantly Exserohilum rostratum)	
K1	Contaminated compounded or sterile injectable products		injection of fungus-contaminated steroid into the epidural or paraspinal space seeds the meninges and bone.
K2	Heparin adulteration (2008)	anaphylactoid reactions, hypotension, and deaths	oversulfated chondroitin sulfate contaminant activated the contact system (factor XII, kallikrein, bradykinin) and complement anaphylatoxins.
K3	Diethylene- and ethylene-glycol-contaminated medicines	acute kidney injury, neuropathy, and deaths, including hundreds of deaths in children in	metabolism by alcohol and aldehyde dehydrogenases to toxic acids (2-hydroxyethoxyacetic and diglycolic acid)

	several countries (Elixir Sulfanilamide in 1937 and clusters in 2006 and 2022 to 2023)	causes proximal tubular necrosis and neurotoxicity.
		CYP-mediated alpha-hydroxylation

Comments (1)

What do you think?

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Oct. 26, 2026, 2:37 p.m.

And we wonder why Conventional Medicine is one of, if not THE leading cause of death in the USA?

The failure of Con-med is deeper than some side effects of a few therapies. It is baked into its very core principles. The body is seen as a machine and diseases are seen as failure of part(s) of a machine that can be repaired/replaced to repair the machine. Diseases are improperly Defined as a few common symptoms that a group of patients have. Palliation/suppression of those few symptoms is deemed success almost regardless of consequences, which may be other symptoms or side effects or "diseases" that also have to be palliated/suppressed. I call it biochemical whack-a-mole medicine.

But diseases are NOT localized to a particular organ system as con-med supposes. Every disease symptom is a manifestation of the disease of the entire body. The whole body - all aspects of the mind, emotions and physical body - must be cured in order for any local symptom to be cured, rather than suppressed. Almost every other medical system (homeopathy, Chinese medicine, Ayurveda, etc.) defines disease as All the symptoms - mental, emotional and physical - that the patient experiences at any one time. And any proper treatment must remove or relieve All those symptoms to be considered a success.

True healing follows the law of natural healing, Hering's Law (rule of thumb based on Dr Hahnemann's writings) which states that healing progresses from the inside (more critical systems) to the outside and in reverse order of the onset of symptoms. Con-med ROUTINELY violates the tenants of natural healing. Consider Dermatology. Suppressing localized symptoms as con-med does so often just leads to deeper manifestations of disease. Which is why Con-med has such a poor record of treating chronic disease, few cures, but lots of long term treatment.

We should adopt India's approach to medicine. Eliminate the undeserved monopoly that conventional medicine has. India has three different medical systems that compete - Homeopathic, Ayurvedic and Conventional. All three have a regulator, medical schools, hospitals, pharmacies, doctors, etc.. Doctors of all three can see patients in any hospital. As a result India gives their patients choice. They can choose if they want medical chemical drugging or not. For ayurvedic we would substitute Functional Medicine/Herbal/Chiropractic/Chinese Med/etc. Competition in medical care like anywhere else makes it more affordable with better accountability.

Time to bring the other medical approaches that were exiled to the desert 100 years ago, back into the tent. But with an independent regulatory regime answerable to themselves and the American people. Not to con-med.

Reply

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K9	Plasticizers and sterilant residues (DEHP, ethylene oxide)	concerns for endocrine and reproductive effects after high exposure in neonates, transfused patients, and dialysis patients	leached phthalate metabolites (MEHP) act as anti-androgenic and PPAR-active agents; ethylene oxide is an alkylating carcinogen at high chronic exposure.

Appendix A.L — Category L (11 entries)

CF ID	Exposure / contributing factor	Diseases / outcomes	Biological mechanism summary
L1	Thalidomide	limb reduction defects (phocomelia), ear and organ malformations after exposure in the critical window (about weeks 5 to 8 of gestation)	cereblon-mediated degradation of SALL4 and p63 and antiangiogenic effects disrupt limb-bud development.

L2	Valproate in pregnancy	neural-tube defects, major congenital malformations (roughly 10%), lower cognitive scores, increased autism and ADHD risk	histone-deacetylase inhibition, folate-pathway disruption, and oxidative stress.
L3	Systemic retinoids	craniofacial, cardiac, and central-nervous-system malformations	retinoic-acid-receptor activation dysregulates Hox genes and neural-crest migration.
L4	ACE inhibitors and angiotensin-receptor blockers in the second and third trimester	oligohydramnios, pulmonary hypoplasia, renal tubular dysgenesis, neonatal AKI	fetal glomerular filtration depends on angiotensin II.
L5	Warfarin embryopathy	nasal hypoplasia and stippled epiphyses (exposure in weeks 6 to 12), CNS abnormalities	inhibition of vitamin K-dependent carboxylation of bone matrix proteins (osteocalcin,

			matrix Gla protein).
L6	Mycophenolate, methotrexate, misoprostol, topiramate, and other teratogens	congenital malformations and pregnancy loss (mycophenolate: ear, face, and cardiac defects; misoprostol: limb and cranial nerve defects; topiramate: oral clefts)	IMPDH inhibition depletes guanine nucleotides; folate antagonism; uterine contraction with vascular disruption.
L7	Diethylstilbestrol (in utero exposure)	clear-cell adenocarcinoma of the vagina and cervix, structural genital anomalies, infertility, preterm birth, and possible effects in subsequent generations	estrogen-receptor-mediated disruption of Mullerian-duct differentiation, with epigenetic alteration of developmental genes (e.g., HOXA10).
L8	Antenatal corticosteroids	neonatal hypoglycemia (late-preterm exposure), possible neurodevelopmental effects with	glucocorticoid-receptor programming of fetal organs and metabolism.

		repeated courses, despite clear benefit for lung maturation in imminent early preterm birth	
L9	Assisted reproductive technology	ovarian hyperstimulation syndrome, multiple gestation with prematurity, ectopic pregnancy, and an association with rare imprinting disorders (Beckwith-Wiedemann and Angelman syndromes)	hCG-induced VEGF-mediated vascular permeability; epigenetic vulnerability of embryos during culture.

L10	Gonadotoxic therapy (alkylating chemotherapy, pelvic or testicular radiation)	premature ovarian insufficiency, azoospermia, infertility	DNA-damage-induced apoptosis and loss of primordial follicles (with follicle over-activation through PI3K-PTEN signaling) and spermatogonial depletion.
L11	Neonatal pharmacologic vulnerability	gasping syndrome (benzyl alcohol preservative), ceftriaxone-calcium precipitation, kernicterus after sulfonamides, gray baby syndrome (chloramphenicol), opioid toxicity after codeine in CYP2D6 ultra-rapid metabolizers	immature hepatic conjugation, low albumin binding, and a permeable blood-brain barrier.

APPENDIX B. DISEASE-CENTERED REVERSE MAPPING

This table is an interpretive crosswalk rather than an independently validated epidemiological count. It highlights multiple routes to the same clinical endpoint.

Resulting disease	Illustrative CFs	Mechanistic convergence
Acute kidney injury	NSAIDs, aminoglycosides, vancomycin, cisplatin, contrast-related exposures, surgical hypoperfusion	Hemodynamic, tubular-toxic, immune and ischemic pathways
Cardiomyopathy	Anthracyclines, trastuzumab, selected targeted therapies, radiotherapy	DNA damage, mitochondrial dysfunction, loss of cardioprotective signaling
Peripheral neuropathy	Platinum agents, taxanes, linezolid, nitrofurantoin, older antiretrovirals	Axonal transport, mitochondrial injury, direct neurotoxicity
Major hemorrhage	Anticoagulants, antiplatelets, thrombolytics, procedures	Coagulation suppression, platelet dysfunction, tissue injury

Serious infection	Immunosuppressants, indwelling devices, surgery, broad-spectrum antibiotics	Impaired host defense, barrier breach, biofilm, dysbiosis
Osteoporosis and fracture	Corticosteroids, excess thyroid hormone, selected endocrine therapies, falls-inducing sedatives	Altered bone turnover and fall-related injury
Delirium	Anticholinergics, sedatives, surgery, ICU exposures	Neurotransmitter imbalance, neuroinflammation, circadian disruption
Secondary malignancy	Alkylating agents, radiation, selected immune therapies	Genotoxicity, impaired immune surveillance, chronic tissue injury

APPENDIX C. RELATIONSHIP-LEVEL EVIDENCE AND RESEARCH TEMPLATE

Required field	Definition / recording rule
Exposure identifier	Exact drug/device/procedure, formulation, route, dose, duration

Outcome identifier	Specific diagnosis; distinguish symptoms and laboratory abnormalities
Causal evidence	Study design, population, comparator, effect size, uncertainty, confounding
Mechanism evidence	Human direct, human indirect, animal, in vitro, theoretical
Temporal window	Exposure onset, latency, persistence, dechallenge
Susceptibility	Genetic, physiologic, comorbid and interaction modifiers
Biomarkers	Exposure, mechanism, injury, diagnostic and prognostic markers
Reference	PMID/DOI, study year, verified quotation-free finding
Prevention	Supported monitoring, screening, avoidance or mitigation

APPENDIX D. ABBREVIATIONS AND SELECTED SOURCES

ABBREVIATIONS AND KEY SOURCES

Abbreviations. ADE, adverse drug event; ADR, adverse drug reaction; AHRQ, Agency for Healthcare Research and Quality; AKI, acute kidney injury; CF, contributing factor; CLABSI, central-line-associated bloodstream infection; CAUTI, catheter-associated urinary tract infection; DRESS, drug reaction with eosinophilia and systemic symptoms; HAI, healthcare-associated infection; HIT, heparin-induced thrombocytopenia; ICANS, immune effector cell-associated neurotoxicity syndrome; ITP, immune thrombocytopenia; PSI, Patient Safety Indicator; SJS/TEN, Stevens-Johnson syndrome/toxic epidermal necrolysis; SSI, surgical site infection; VITT, vaccine-induced immune thrombotic thrombocytopenia.

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